



# **Disability Rights Initiative Cambodia**

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## **Joint Programme Document**

## Disability Rights Initiative Cambodia

**Country:** Kingdom of Cambodia

**Programme Objective:** Improved quality of life for people with disability in Cambodia

### Expected Outcomes:

**Joint programme outcome:** People with disability have increased opportunities for participation in social, economic, cultural and political life through effective implementation of the National Disability Strategic Plan (NDSP)

**Outcome 1:** MoSVY/DAC effectively coordinates implementation of the National Disability Strategic Plan, aligned to the CRPD.

**Outcome 2:** Disabled People's Organisations effectively represent the needs and priorities and advocate for the rights of people with disability.

**Outcome 3:** Improved rehabilitation services for people with disability.

**Outcome 4:** Increased capacity of and collaboration between subnational decision makers, civil society and communities to achieve the rights of people with disability.

**Participating UN organizations:** UNDP, UNICEF and WHO

<p>Programme Duration: 5 years</p> <p>Anticipated start/end dates: December 2013</p> <p>Fund Management Option(s): pass-through funding</p> <p>Administrative Agent: UNDP Multi-Partner Trust Fund Office in New York</p>	<p>Total estimated budget*: US\$12,727,869</p> <p>Out of which:</p> <p>1. Funded Budget: US\$7,538,461</p> <p>2. Unfunded budget: US\$5,189,408</p> <p>* The amounts are indicative only. The actual UN rate of operational exchange on the date of receipt of contributions will be applied.</p>
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## Acknowledgements

### **Design Team**

This Investment Design Document was developed by a Design Team with the following members:

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## Acronyms

ABC	Association of the Blind in Cambodia
APR	Annual Progress Report
AusAID	Australian Agency for International Development
CBR	Community Based Rehabilitation
CCWC	Commune Committee for Women and Children
CDB	Commune Database
CDHS	Cambodia Demographic and Health Survey
CDP	Commune Development Plans
CDPO	Cambodian Disabled People’s Organisation
CEDAW	Convention on the Elimination of All Forms of Violence Against Women
CIDI	Cambodia Initiative for Disability Inclusion
CIP	Commune Investment Program
CMAA	Cambodian Mine Action and Victim Assistance Authority
CPAP	Country Program Action Plan
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CSES	Cambodia Socio-Economic Survey
CSO	Civil Society Organisation
DAC	Disability Action Council
DPAF	Disability Performance Assessment Framework (AusAID)
DPO	Disabled People’s Organisation
DRIC	Disability Rights Initiative Cambodia
DSA	Daily Subsistence Allowance
DWPWD	Department of Welfare for People with Disability (MoSVY)
ECCD	Early Childhood Care and Development
ERW	Explosive Remnants of War
HACT	Harmonised Approach to Cash Transfers
HEF	Health Equity Fund
INGO	International Non-government Organisation
LGCR	Local Governance and Child Rights
M&E	Monitoring and Evaluation
M&EF	Monitoring and Evaluation Framework
MEF	Ministry of Economy and Finance
MoH	Ministry of Health
MoI	Ministry of the Interior
MoSVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation
MoU	Memorandum of Understanding
MPTF Office	Multi-Partner Trust Fund Office
NCDD-S	National Committee for Subnational Democratic Development
NCDP	National Centre for Disabled Persons
NDCC	National Disability Coordination Committee
NDSP	National Disability Strategic Plan
NGO	Non-Government Organisation
NIM	National Implementation Modality

NIS	National Institute of Statistics
NOB	National Officer (B grade)
NPA	National Plan of Action for Persons with Disabilities, including landmine/ERW Survivors 2009-2011
NPO	National Professional Officer
NSDP	National Strategic Development Plan
PCT	Program Coordination Team
POVCTF	Provincial Multi-sectoral Orphans and Vulnerable Children Task Force
PRC	Physical Rehabilitation Centre
PRSS	Priority Rehabilitation Service Scheme
PUNO	Participating United Nations Organisations
PWDF	Persons with Disabilities Foundation
RGC	Royal Government of Cambodia
RMR	Risk Management Register
SGS	Small Grants Scheme
SHG	Self-help Group
SSM	Social Services Mapping
ToC	Theory of Change
TRC	Technical Review Committee
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
VHSG	Village Health Support Group
WCCC	Women and Children Consultative Committee
WHO	World Health Organisation

## Glossary

Term	Definition
<b>Civil Society Organisation</b>	Civil society organisations (CSOs) are independent non-Government organisations serving the interest and welfare of social groups, through activities such as provision of services, community mobilisation, policy research and advocacy, and are often formed and governed by members of those social groups themselves. CSOs have a special ability to undertake activities that are crucial for an effective response to the situation on the ground. CSOs include INGOs, NGOs, DPOs, SHGs and CBOs.
<b>Community based rehabilitation</b>	Community based rehabilitation (CBR) focuses on enhancing the quality of life for people with disability and their families, meeting basic needs and ensuring inclusion and participation. It is a multi-sectoral strategy that empowers people with disability to access and benefit from education, employment, health and social services. CBR is implemented through the combined efforts of people with disability, their families, organisations and communities, relevant government and non-government health, education, vocational, social and other services.
<b>Disability</b>	In the International Classification of Functioning, Disability and Health, disability is an umbrella term for impairments, activity limitations and participation restrictions, denoting the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors). <sup>1</sup>
<b>Disability support services</b>	These support services are distinguished from the informal sector, generally provided by family and friends, and make up formal services (government, non-profit, profit) that mainly support individuals to undertake activities of daily life and participate in the community. These services commonly include community support and independent living services, sign language interpreters, employment and education support services and information and advice services.
<b>Impairment</b>	In the International Classification of Functioning, Disability and Health, an impairment is a loss or abnormality in body structure or physiological function (including mental functions), where abnormality means significant variation from established norms. <sup>2</sup>



Prakas	A Prakas/proclamation is a ministerial or inter-ministerial decision signed by the relevant Minister(s). A proclamation must conform to the Cambodian Constitution and to the law or sub-decree to which it refers.
Quality of life	An individual's perception of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns. It is a broad-ranging concept, incorporating in a complex way the person's physical health, psychosocial state, level of independence, social relationships, personal beliefs, and relationship to the environmental factors around them. <sup>3</sup>
Rehabilitation	A set of measures that assists individuals who experience or are likely to experience disability to achieve and maintain optimal functioning in interaction with their environment. <sup>4</sup> A distinction is sometimes made with habilitation, which aims to help those who acquire disabilities congenitally or early in life to develop maximal functioning and rehabilitation, where those who have experienced a loss in function are assisted to regain maximal functioning.

## Executive summary

### Situational analysis

With the exception of children aged 2-9, there are no reliable estimates of the number of people with disability in Cambodia, nor of their quality of life or access to disability-specific and mainstream services. The World Bank and WHO estimate that 15 per cent of the world's population have a disability of whom 2.2 per cent have very significant difficulties functioning. In Cambodia, this equates to over two million people with disability (difficulties functioning) and over 320,000 people with very significant difficulties.

The lack of access to appropriate, quality and affordable health, rehabilitation and disability services across all age ranges has a significant impact on the well-being and participation of people with disability in Cambodia. Rehabilitation services are primarily focussed on physical disabilities and are insufficient to meet demand. There are even less services for people with other forms or disability, particularly those with vision, hearing, intellectual and psychosocial impairments. People with disability frequently face stigma and discrimination and violations of their human rights.

The Royal Government of Cambodia's (RGC's) commitment to improving the lives of people with disability through recognition of their rights was demonstrated through ratification of the Convention on the Rights of Persons with Disabilities (CRPD) in 2012. There are, however, several key challenges facing the RGC in implementing the CRPD: 1) the lack of clear division of roles and responsibilities for the multiple government units with disability responsibilities; 2) variable levels of knowledge and experience within these Government units; 3) limited commitment to ensure the meaningful participation of disabled people's organisations (DPOs) and civil society organisations (CSOs); 3) challenges facing the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) in facilitating coordination with other Ministries; 4) relatively low levels of RGC funding for disability; and 5) a lack of reliable data on disability.

Cambodia has a relatively large civil society community focused on people with disability. The Cambodian Disabled People's Organisation (CDPO) is the peak body representing people with disability in Cambodia. There are a large number of DPOs, self-help groups (SHGs) and NGOs working in disability. There is, however, an absence of one informed and strategic 'voice' representing people with disability. There is a lack of dialogue between organisations (including INGOs, local NGOs and DPOs) as to who is doing what, where, why and how, and on opportunities to collaborate and reduce duplication. This includes areas such as rehabilitation. The low level of meaningful collaboration results in missed opportunities for civil society to advocate effectively as one voice.

### Program outline

The proposed name of this joint United Nations – AusAID program is the Disability Rights Initiative Cambodia (DRIC). The DRIC will be a 5.5 year program with a projected budget of AUD\$12.792 million. It will commence in the latter half of 2013 with an inception phase through till the end of December 2013. Program implementation will substantively commence in January 2014 and continue over 5 calendar years to December 2018, (Years 1 – 5).

The long term goal of the program is the "improved quality of life for people with disability" in Cambodia. This is an aspirational goal which will not be fully achieved within the life of the program, given the limited resources available in relation to the scale of the problem. Nonetheless, achievement of the end-of-program outcome, (*People with disability have increased opportunities for participation in social, economic, cultural and political life through effective implementation of the National Disability Strategic Plan (NDSP)*), will contribute to improved quality of life for people with disability.

The program has been designed with four components, each of which will contribute to achievement of the end-of-program outcome. The components, their specific end-of-program outcomes and brief component descriptions follow:

**Component 1: Supporting Government implementation of the Convention on the Rights of Persons with Disabilities (UNDP)**

End-of-program outcome: *MoSVY/DAC effectively coordinates implementation of the National Disability Strategic Plan, aligned to the CRPD.* UNDP will support the Disability Action Council (DAC) in the development of a feasible and inclusive whole-of-government NDSP, based on the CRPD. Key to this will be building the capacity of DAC to effectively coordinate implementation of the NDSP in priority areas. Allied to this will be a functional analysis and capacity assessment of DAC and MoSVY as a basis for on-going assistance to address key capacity gaps in priority areas. A legal framework review will be conducted to assess the compatibility of Cambodia's legal framework with the CRPD, and will be used as a platform to support MoSVY and DAC in drawing up an action plan for legislative reform. UNDP will convene an Annual Policy Dialogue on Disability between MoSVY, DAC, key line Ministries, civil society, the UN and AusAID and use this to monitor progress and to leverage action in key areas. UNDP, in close consultation with the National Institute of Statistics (NIS), will also undertake a meta-analysis of available Cambodian disability data to make use of available evidence and to make recommendations for how to improve information relating to disability.

**Component 2: Supporting Disabled People's Organisations to raise the voice and protect the rights of people with disability (UNDP)**

End-of-program outcome: *Disabled People's Organisations effectively represent the needs and priorities and advocate for the rights of people with disability.* A primary focus will be to strengthen the capacity of CDPO to 1) undertake policy research and advocacy; 2) act as a channel for policy dialogue between civil society and the RGC; 3) strengthen the capacity of DPOs and act as an effective coordinator of civil society in the disability sector; and 4) ensure the representation of the full spectrum of people with disability, including women, and those with hearing, sight and intellectual disabilities (who are currently under-represented). CDPO will be supported to engage with other disability civil society organisations in the region to identify and share good practices and common strategic approaches. UNDP will also support the strengthening of existing DPOs and establishment of new DPOs to ensure effective representation of diverse groups of people with disability.

**Component 3: Supporting rehabilitation systems strengthening (WHO)**

End-of-program outcome: *Improved rehabilitation services for people with disability.* Taking a health systems strengthening approach and working with multiple stakeholders, WHO will support development of the Government's capacity to lead, regulate and plan the rehabilitation sector. Key strategies, will be building the capacity of key rehabilitation sector stakeholders, in particular MoSVY and People with Disabilities Foundation; establishment of a rehabilitation sector leadership and coordination mechanism; increasing the involvement of the Ministry of Health in rehabilitation; a provincial rehabilitation demonstration project to trial a coordinated and streamlined approach to rehabilitation service provision; and support for development of a national rehabilitation strategic plan. WHO will also work with the RGC to strengthen their capacity to manage Physical Rehabilitation Centre's (PRCs) efficiently and support the transition of management from INGOs. This will be accompanied by advocacy for increased government financial investment in disability and rehabilitation service delivery. WHO will collaborate with the RGC and INGOs to identify priority areas for increasing access to rehabilitation services. The WHO will administer a grants scheme (\$200,000 annually) to directly support priority rehabilitation services.

#### **Component 4: Inclusive governance and inclusive community development (UNICEF)**

End-of-program outcome: *Increased capacity of and collaboration between subnational decision makers, civil society and communities to achieve the rights of people with disability.* The component package will consist of: a) capacity development activities for local government including Provincial Governors, provincial, district and commune decision-makers; b) the roll out of a commune contract community worker to be a commune level disability focal point and to provide outreach support to people with disability; and c) a small grants scheme (\$500,000 per year) aimed at strengthening the link between non-government service providers (NGOs/CBOs) and local decision-makers and to provide disability support services to people with disability. The development of the capacity of the subnational decision-makers and people with disability is a key component of this work.

#### **Program rationale**

The program is well placed to take advantage of a number of strategic opportunities. The principal opportunity is Cambodia's recent ratification (2012) of the CRPD which reflects an increased political commitment to people with disability. The RGC is conscious of the need to demonstrate real gains against its reporting obligations under the Convention and is actively requesting international assistance. The Government's recent decision to elevate the status of the DAC to a General Secretariat provides the opportunity for the development of a feasible and inclusive whole-of-government NDSP and for DAC to build its capacity to play a leading role in effective coordination of NDSP implementation. While the challenges are considerable, these opportunities are real and unlikely to be repeated in such a conducive manner. Similarly, the relatively recent establishment of the Persons with Disabilities Foundation (PWDF) provides an opportunity for much needed rehabilitation sector systems strengthening, against the backdrop of the on-going withdrawal of the substantial support provided by INGOs.

Internationally, there is good evidence that progress in improving the lives of people with disability is often driven by effective advocacy by strong DPOs. The ratification of the CRPD provides Cambodian DPOs with new advocacy opportunities. The CDPO has been able to increase its capacity with previous AusAID and other donor support and is developing a new strategic plan. This new Joint UN - AusAID program is well placed to assist the CDPO to build on its capacity to take advantage of current and emerging opportunities.

The subnational level of work under Component 4, recognises the importance of working at the local level where a real difference can be made to the lives of people with disability. This component aims to put disability, (i.e., the RGC's commitments under the CRPD), on the agenda of subnational decision makers and leverage opportunities arising from the priority accorded to decentralisation by the Government.

Support for Government will be better resourced to allow a significantly greater level of dialogue on strategic directions and policy and, most importantly, how to make commitments real through effective implementation. The program will also promote greater collaboration between government and civil society at national and subnational levels.

The program contains a deliberate mixture of systems strengthening initiatives in relation to MoSVY/DAC, DPOs, rehabilitation, subnational governance and community development, coupled with direct financial support for service delivery through the rehabilitation grants (focussed on PRCs) and community based rehabilitation (CBR). This dual track approach is central to the program's strategy. It is recognised that systems strengthening is needed for results to be sustainable and that direct support for service delivery is needed in the short term to meet the real and immediate needs of people with disability. Thirty one per cent of available annual funding will be allocated to grants to support rehabilitation services and small grants with a CBR focus.

The challenges of systems strengthening work are considerable and results may at first be modest. As donor funding of service delivery is, however, not sustainable in the longer term, assisting the RGC to develop and strengthen systems for disability policy and services is essential.

As a better understanding of the operating environment is needed to determine the best entry points and optimal interventions for some activities, flexibility has been built into some parts of the design. For example, under Component 1, a functional analysis and capacity assessment of the key disability units in MoSVY/DAC will be undertaken as a foundational piece of work in determining how best to provide support. Similarly, the early analytical pieces of work to be undertaken through the rehabilitation and inclusive governance components will be used to inform the direction of systems strengthening work.

The program represents a synergistic combination of work at national and subnational levels. While Component 1 will primarily have a national focus, this will be complemented by the work with subnational decision makers in Component 4. Lessons learned at the subnational level will be fed back to national decision makers to promote replication of good practice on a wider scale. There will be a substantial engagement with DPOs at both national and subnational levels through individual DPOs and the CDPO, with mutual benefits. Rehabilitation sector system strengthening will address both national and subnational systems, while financial support for rehabilitation services will occur at the subnational level.

The primary focus of the program is on disability specific initiatives such as support for government bodies with responsibility for disability, DPOs and direct support of disability services. The program also provides an opportunity to support and influence the mainstreaming of disability. This will primarily occur in Component 1 through support for the development and coordination of the NDSP which will contain line ministry specific plans on disability and in Component 4 through increasing the capacity of officials at provincial, district and commune levels to implement the NDSP.

The program is designed to make a significant contribution to reducing stigma and discrimination against people with disability by increasing the capacity of key government and civil society disability-specific institutions to implement the NDSP; by addressing physical, institutional, communication and other barriers; and by promoting development processes to be more inclusive of people with disability.

# 1. Analysis and strategic context in Cambodia

## 1.1 National development context

It is important to situate an understanding of the lives of people with disability in Cambodia within the broader political, economic, social and cultural context within which decisions that affect them take place. (Additional detail on the issues covered in this section is contained in Annex 7.)

At a political level, the Royal Government of Cambodia's (RGC) statement of priorities is outlined in the *Rectangular Strategy Phase II* (2008 – 2013), which is centred on good governance. The *National Strategic Development Plan* (NSDP) is the road map for implementation of the *Rectangular Strategy Phase II*. The NSDP is in turn supported by a range of other RGC strategies covering line Ministries and whole-of-government issues. One of the most important strategies is the *National Program for Sub-National Democratic Development* (2010 – 2019), which also highlights the vision of the decentralisation reform. A recent study by the World Bank, found that while significant progress has been made in the policy and legislative framework for decentralisation, there are a number of emerging political economy issues<sup>5</sup>.

There has been a considerable decrease in poverty rates in Cambodia from 34.7 per cent in 2004 to 20 per cent in 2011.<sup>6</sup> Despite these positive achievements, there are a number of significant challenges facing Cambodia's population of 13.4 million people.<sup>7</sup> This includes growing inequality between urban and rural settings, provinces, and social groups.<sup>8</sup>

Although the RGC has ratified several important international treaties, reporting against the treaties is often delayed, as is implementation (as demonstrated through submission of combined progress reports for multiple time periods and the significant lists of issues raised by treaty bodies relating to reports).<sup>9</sup>

## 1.2 Lives of people with disability in Cambodia

The World Health Organisation (WHO) and World Bank's *World Report on Disability* (2011) estimates that 15 per cent of the world's population have a disability of whom 2.2 per cent have very significant difficulties functioning. In Cambodia, this equates to over 2 million people with disability (difficulties functioning) and over 320,000 people with very significant difficulties. Official statistics on people with disability in Cambodia are not considered reliable (see section 1.5).

With a predominantly Buddhist population, it is often thought that disability is seen as a result of a sin in a past life. There are however, other cultural norms that impact on people's perception of disability.<sup>10</sup>

As a post-conflict country, Cambodia plays host to a number of risk factors which can lead to high prevalence of psychosocial impairments. For example, the prevalence of post-traumatic stress disorder is substantially higher than the global average.<sup>11</sup> Little is being done to address this challenge with just 0.2 per cent of the total health budget spent on mental health.<sup>12</sup>

The lack of access to appropriate, quality and affordable health, rehabilitation and disability services has a significant impact on the well-being and participation of people with disability in Cambodia. The lack of early identification, intervention and support for young children with disability can reduce their ability to enter school on time and learn effectively.

Issues preventing children with disability attending school include social discrimination, lack of transport, lack of assistive devices, physical barriers, teachers' lack of skills in appropriate teaching methodologies and the need for children to help with housework.<sup>13</sup> The recent Global Partnership for Education study found that 10.1 per cent of Cambodian children had a disability, with cognitive

and speech impairments the most common.<sup>14</sup> In Cambodia, children with intellectual disability and their families face significant stigma and discrimination, with very few organisations providing services and support.<sup>15</sup>

People who are deaf or have a hearing impairment are particularly marginalised. It is estimated there are over 50,000 people who are deaf in Cambodia and 500,000 with hearing impairment; however just 1,800 people who are deaf have been taught sign language.<sup>16</sup>

A recent Cambodian study examined prevalence of violence against women with disability compared to their peers without disability. It found that when compared to their peers without disability, women with disability:

- Experienced significantly higher rates of emotional, physical and sexual violence by household members (other than partners);
- Were considered less valuable and more burdensome within the household;
- Were 2.5 times more likely to require permission from a partner to seek healthcare; and,
- Experience higher rates of psychological distress (as a result of partner violence) and are less able to disclose family violence or seek appropriate support (often because communities/non-government organisations (NGOs) do not seek to include them in prevention/support programs).<sup>17</sup>

### 1.3 Government and people with disability

The RGC's commitment to improving the lives of people with disability through recognition of their rights was demonstrated through ratification of the Convention on the Rights of Persons with Disabilities (CRPD) in 2012.

Following recommendations from a National Task Force on Disability established in the early/mid 1990's, the Disability Action Committee was established in 1996 and then recognised as a semi-autonomous body by the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY) in 1999<sup>18</sup>. At that time the name was changed to the Disability Action Council (DAC).

Following the adoption of the Law on the Promotion and the Protection of the Rights of Persons with Disabilities in 2009 (herein referred to as the '*Disability Law*'), DAC became an RGC entity. This change emphasised DAC's role as the national coordination and advisory mechanism on disability. At the time of writing, further changes to the DAC Secretariat are in train through a new Sub-Decree, including elevating the status of the Secretariat to a General Secretariat.

The Department of Welfare for Persons with Disabilities (DWPWD), within MoSVY, is the responsible entity for development of national policies and laws relating to disability and rehabilitation (i.e., the DAC Secretariat and other RGC bodies can provide input, but are not authorised to lead on policy and legislative development).

Article 46 of the *Disability Law* established the Persons with Disabilities Fund (a public administration institution). The Fund is now known as the Persons with Disabilities Foundation (PWDF). The PWDF is responsible for:

1. Funding services for people with disability such as health, rehabilitation, and education.
2. Promoting and enhancing the welfare of people with disability, including in particular those who are poor and who do not receive services and support; and
3. Providing loans and credits for reasonable accommodation of disability.

In 2005, the Anti-Personnel Mine Ban Conventions' Standing Committee on Victim Assistance and Socio-Economic Reintegration developed a framework to assist the most-affected countries, including Cambodia, develop victim assistance plans. The DAC started the process of the

development of the National Plan of Action for Persons with Disabilities, including landmine/ERW Survivors (NPA) in 2007 and it was finalised in 2009 covering the period to 2011.

While the NPA included all people with disability, it was still guided by the framework for victim assistance as set out in the five priority areas adopted by the states parties to Anti- Personnel Mine Ban Convention: emergency and continuing medical care; physical rehabilitation; psychological and social support; economic reintegration; and laws, public policies and national planning.<sup>19</sup> A National Disability Coordination Committee (NDCC) which comprised largely the same membership as the DAC was established to support implementation of the NPA. The 2011 review report of the NPA noted that just 12 of 27 objectives had been met.

The *Disability Law* provides that: “*In the case of any provisions that contradict the provisions of this law, the provisions of those international treaties shall be considered as the principle provisions*” (Article 49).

While this positively addresses areas where the Law is not aligned to the CRPD, (for example, several references to primary prevention), or where there are gaps, (such as no mention of access to justice), the Law provides little in the way of practical guidance for how the CRPD might be implemented.

There are several key challenges facing the RGC in implementing the CRPD:

- The lack of clear division of roles and responsibilities for the multiple government units with disability responsibilities;
- Low levels of knowledge and experience within these Government units;
- Limited commitment to ensure the meaningful participation of disabled people’s organisations (DPOs) and civil society organisations (CSOs);
- Challenges facing MoSVY in facilitating coordination with other Ministries (MoSVY has less resources than other Ministries); and,
- Relatively low levels of RGC funding for government units with disability responsibilities.

## 1.4 Civil society and people with disability

Cambodia has a relatively large civil society community focused on people with disability.

Established in 1994, the Cambodian Disabled People’s Organisation (CDPO) is a body made up of and for people with disability. CDPO has 33 staff at their headquarters in Phnom Penh, and subnational DPO members in all 23 provinces. CDPO has over 10,000 individual members within a subnational membership structure. While CDPO is the peak body representing people with disability in Cambodia, it does not yet appear to be considered the ‘umbrella’ DPO – i.e., the only other national DPO is not a member. Despite recent progress in improving the use of research to inform advocacy and utilising more collaborative capacity development approaches for subnational members (e.g. mentoring), there are still areas where CDPO would benefit from sustained support.

The Association of the Blind in Cambodia (ABC), the only other national DPO, was established in 2000. ABC is a member of the World Blind Union and the International Council for Education of Visually Impaired.<sup>20</sup> There is no national or subnational DPO for people who are deaf or hearing impaired. The National Centre for Disabled Persons (NCDP) a semi-autonomous entity under the auspices of the Ministry of Social Affairs, Veteran and Youth Rehabilitation, was established in May 1997 and works to support Cambodian people with disability.

There is no robust information on the total number of self-help groups (SHGs) of people with disability in Cambodia, although one estimate puts it at just over 2,000, supported by 16 disability-focused NGOs. While the NGO partners that supported the establishment of SHGs has moved from supporting micro-finance activities to also focus on advocacy, this is not yet well understood by many SHGs. Many SHGs still represent some of the poorest people in Cambodia, and it is therefore



understandable that their priorities are focused on meeting basic needs, before becoming self-advocates.<sup>21</sup>

Many children, young people and adults with intellectual disability are often reliant on parents and families to advocate on their behalf. There are very few intellectual disability SHGs in Cambodia, although the Parents Association of Children with Intellectual Disability has been established to support this advocacy but requires significant support (both financial and technical).

While there are many women with disabilities working for DPOs and SHGs (at all levels), the consultations for this program design indicated that gender equality within DPOs and SHGs needs to be addressed.

Civil society organisations national and international currently manage the majority of specialised and support services for people with disability (see section 1.6).

## 1.5 Information on people with disability

Information on people with disability in Cambodia is available from general population surveys, sample surveys, administrative data and mine/ERW victim information, including the:

- Census;
- Commune Database;
- UNICEF Social Service Mapping;
- Cambodia Socio-Economic Survey (CSES);
- Cambodia Demographic and Health Survey (CDHS);
- Childhood Disability Survey;
- Education Management Information System;
- Physical Rehabilitation Centres;
- ID Poor; and,
- Cambodia Mine/ERW Victim Information System (CMVIS).

Other than the *Disability Prevalence Study on Children 2 – 9 Years Old*, all data is considered to have limitations in reliability, often due to methodological problems. Key challenges include stigma and discrimination associated with disability, resulting in under-reporting. Other factors in under-reporting are that some people have never had their disability assessed or consider it a normal part of aging. There are also issues with the low levels of disability-related capacity within the National Institute of Statistics (NIS). Within the disability sector, capacity is limited in regards to understanding the full range of current data collection tools and good quality data collection methodologies. Currently, there is no mechanism that brings together the NIS and government units responsible for disability to discuss information needs. As a result of all these factors, there is virtually no reliable national data on the number of people with disability in Cambodia, the types of impairments and quality of life (including barriers and whether needs are being met).

Positively, Cambodia does have a wide range of smaller-scale qualitative and quantitative studies on people with disability – most of which were undertaken by NGOs working with and for people with disability. However, these valuable resources do not appear to be informing policy and programming to the degree to which they should. This may be attributed to the quality of dissemination of research findings and because key decision-makers are often not involved in the research process, nor fully aware of the results.

## 1.6 Rehabilitation, disability support services and community-based rehabilitation

Cambodia's landmine legacy, the RGC's commitment to disability and a relatively strong civil society sector focused on people with disability have significantly contributed to the establishment

of physical rehabilitation services and community-based rehabilitation (CBR) programs in Cambodia.

The backbone of Cambodia's rehabilitation services is the Physical Rehabilitation Centres (PRCs), which were established over two decades ago and remain primarily funded and managed by international non-government organisations (INGO). An evaluation of the PRCs in 2006 recommended that the RGC take greater responsibility in oversight and management of the rehabilitation sector. Although this was agreed to by the RGC, there was a lack of detailed agreement between MoSVY and the INGOs specifying expectations and plans for the handover (e.g. how MoSVY might ensure increased financial support from the Ministry of Economy and Finance (MEF), and how the issue of low civil servant salaries (compared to INGO salaries) would be managed). Subsequently, each INGO developed separate memorandums of understanding (MoUs) with MoSVY specifying differing expectations and plans for a handover of their PRC's. These plans were often informed by the availability (or otherwise) of INGO donor funding rather than need. Without a clear and agreed transition plan (which includes detailed financial information and feasible milestones) the handover will result in the diminishing availability and quality of rehabilitation services to people with disability. These challenges have already been encountered by a few PRCs that were handed over to MoSVY.

Financing mechanisms for rehabilitation services, including funding pathways, are unclear. The absence of a standardised client information system makes it difficult to monitor total client numbers.

While services for people with physical disability offered through the PRCs are inadequate to meet demand, there are even less services for peoples with other forms or disability, particularly those with vision, hearing, intellectual and psychosocial impairments. Currently services for people with these impairments are under-developed and usually only located in large urban areas.

CBR is a flexible, dynamic approach which empowers people with disability and assists to provide or refer to a variety of services needed to participate fully in community life. CBR has a long history in Cambodia, dominated by local NGOs developing a range of programs in a variety of locations. As yet, Cambodia has not implemented a shared national vision of CBR, based on the WHO CBR Guidelines (2010), which conceives CBR programs across a broad framework. The national CBR guidelines are based on the WHO Guidelines and a CBR Committee supported by the DAC Secretariat and Department of Welfare for People with Disability.

People with disability require a range of 'disability support services' that assist their functionality and participation in everyday activities. Examples are sign language interpreters and assistive technologies, such as those that enable people with vision impairments to access print media. Support services that enable individuals to participate in society are under-developed in Cambodia, as is the case in many other low and middle income countries.

There are two professional associations in the rehabilitation sector: the Cambodian Physical Therapy Association, and the Cambodian Association of Prosthetists and Orthotists. Cambodia has a specialised training institute for prosthetic and orthotic technicians, the Cambodian School of Prosthetics and Orthotics.

## **1.7 Evidence base and lessons learned**

This design draws on recommendations from several recently commissioned evaluations of AusAID disability projects. Key recommendations included:

- Increased support for capacity development of key partner organisations, while ensuring this remains focused on key priorities. This includes, for example, developing a long-term capacity

development program to support people with disability working in the disability sector (including by utilising AusAID's volunteer programs) and to provide technical support to RGC institutions responsible for disability.

- Include a focus on the subnational level to ensure decision-makers at provincial, district and commune level are aware of their responsibilities under the CRPD and the Disability Law.
- Review all existing data sources on people with disability and promote the development of standardised tools in the collection of data.
- Promote enhanced cooperation between CDPO and other NGOs working with local DPOs and SHGs.
- Continue and expand opportunities for grant funding to organisations working with people with disability at a local level, including ensuring that children and people with intellectual and severe disability are included.

Recommendations from these evaluations mirrored for the most part, lessons AusAID had been identifying over several years of support for disability programming. AusAID's support has included direct support to the RGC, primarily DAC, and CDPO, as well as a small grants program managed by the Australian Red Cross.

There are several other key issues and lessons learned from AusAID's experience in disability programming in Cambodia:

1. The increase in new RGC units or mechanisms specifically focused on disability, the lack of clarity resulting from overlapping roles and responsibilities, and a significant number of new staff within those units, some with limited disability experience, has been challenging. This has been compounded by low levels of capacity within RGC to produce feasible, coherent and properly costed work plans and budgets. While there has been improvement in recent months, it is expected the new program will need to invest considerable effort up-front to support relevant RGC institutions in developing fundable work plans.
2. While there are many civil society organisations focused on disability, including CDPO with its substantial subnational membership structure, there is an absence of one informed and strategic 'voice' representing people with disability. While there are some positive examples of cooperation and coordination within the civil society disability sector, these tend to be isolated and cannot be considered representative. There is a lack of dialogue between organisations (including INGOs, local NGOs and DPOs) as to who is doing what, where, why and how, and whether there are opportunities to collaborate and reduce duplication. This includes areas such as rehabilitation. The low level of meaningful collaboration results in missed opportunities for civil society to advocate effectively and loudly as one voice. There have also been limited examples of DPOs leading the debate on the needs of people with disability on behalf of civil society. Currently, DPOs do not effectively represent all people with disability, including in particular children and women with disability and people with intellectual, psychosocial and hearing impairments. The lack of a strategic campaign demanding that development be inclusive of people with disability makes it difficult for the RGC and other development partners to be informed and make good quality decisions on priority issues (i.e., the lack of demand reduces opportunities for supply).
3. Finally, unless the challenges faced by both the RGC and civil society are effectively addressed, efforts to ensure development is inclusive of people with disability may have limited results. RGC units and civil society organisations focused on people with disability need to work together, using their respective skills, mandates, influence and leverage to encourage other mainstream stakeholders to be more inclusive. While AusAID has tried to encourage key

partners to work more effectively together, this has not always been acted on. This program will therefore need to find new ways of incentivising cooperation between the RGC and civil society.

## 2. Program description

### 2.1 Long-term goal and end-of-program outcome

Consistent with Pillar 1 in AusAID's Disability Performance Assessment Framework (DPAF), the **program goal** is the *improved quality of life for people with disability*. For evaluation purposes, this is seen as a long-term, aspirational goal. While achievement of program outcomes will contribute to improvements in the quality of life for Cambodians with a disability within the life of the program, given the situational analysis and available resources it is not expected that the program will have sufficient impact for this goal to be adequately achieved within the five year life of the program.

For the program as a whole, the end-of-program outcome is set at an ambitious but realistic level: *People with disability have increased opportunities for participation in social, economic, cultural and political life through effective implementation of the National Disability Strategic Plan, aligned to the Convention on the Rights of Persons with Disabilities.*<sup>22</sup>

The program has been designed with four components, each of which will contribute to achievement of the end-of-program outcome. More specific end-of-program outcomes have been defined for each component. The components, implementing agencies and their end-of-program outcomes are:

#### **Component 1: Supporting Government implementation of the Convention on the Rights of Persons with Disabilities (UNDP)**

*MoSVY/DAC effectively coordinates implementation of the National Disability Strategic Plan, aligned to the CRPD.*

#### **Component 2: Supporting Disabled People's Organisations to raise the voice and protect the rights of people with disability (UNDP)**

*Disabled People's Organisations effectively represent the needs and priorities and advocate for the rights of people with disability.*

#### **Component 3: Supporting rehabilitation systems strengthening (WHO)**

*Improved rehabilitation services for people with disability.*

#### **Component 4: Inclusive governance and inclusive community development (UNICEF)**

*Increased capacity of and collaboration between subnational decision makers, civil society and communities to achieve the rights of people with disability.*

### 2.2 Program overview

The proposed name of this joint UN – AusAID program is the Disability Rights Initiative Cambodia (DRIC). The DRIC will be a 5.5 year program with a projected budget of AUD\$12.792 million. It will commence in the latter half of 2013 with an inception phase through till the end of December 2013. Program implementation will substantively commence in January 2014 and continue over 5 calendar years to December 2018, (Years 1 – 5).

The program is well placed to take advantage of a number of strategic opportunities. The principal opportunity is Cambodia's recent ratification (2012) of the CRPD which reflects an increased political commitment to people with disability. The RGC is conscious of the need to demonstrate real gains against its reporting obligations under the Convention and is actively requesting international assistance. The Government's recent decision to elevate the status of the DAC to a General Secretariat provides the opportunity for the development of a feasible and inclusive whole-

of-government National Disability Strategic Plan (NDSP) and for DAC to build its capacity to play a lead role in effective coordination of NDSP implementation. While the challenges are considerable, these opportunities are real and unlikely to be repeated in such a conducive manner. Similarly, the relatively recent establishment of the Persons with Disabilities Foundation (PWDF) provides an opportunity for much needed rehabilitation sector systems strengthening, against the backdrop of the on-going withdrawal of the substantial support provided by INGOs.

Internationally, there is good evidence that progress in improving the lives of people with disability is often driven by effective advocacy by strong DPOs<sup>23</sup>. The ratification of the CRPD provides Cambodian DPOs with new advocacy opportunities. The CDPO has been able to increase its capacity with previous AusAID and other donor support and is developing a new strategic plan. This new Joint UN - AusAID program is well placed to assist the CDPO to build on its capacity to take advantage of current and emerging opportunities.

The subnational level of work, under Component 4, recognises the importance of working at the local level where a real difference can be made to the lives of people with disability. This component aims to put disability, (i.e., the RGC's commitments under the CPRD), on the agenda of subnational decision makers and leverage opportunities arising from the priority accorded to decentralisation by the Government.

While the program is ambitious, there are considerable challenges, as detailed in the situational analysis, that are well understood. The sections outlining each of the components (2.5 – 2.8, below) detail the strategies that will be adopted in response to the challenges identified and the level of achievement that can be reasonably expected. The level of achievement is further elaborated in the Monitoring and Evaluation Framework (M&EF) (Annex 5). The program will have a strong focus on systematic and structured analysis of what is working well and what is not so that necessary adaptations can be made (see Section 3.3, Monitoring and Evaluation).

Support for Government will be better resourced to allow a significantly greater level of dialogue on strategic directions and policy and, most importantly, how to make commitments real through effective implementation. The program will also promote greater collaboration between government and civil society at national and subnational levels.

The program contains a deliberate mixture of systems strengthening initiatives in relation to MoSVY/DAC, DPOs, rehabilitation, subnational governance and community development, coupled with direct financial support for service delivery through the rehabilitation grants (focussed on PRCs) and community based rehabilitation. This dual track approach is central to the program's strategy. It is recognised that systems strengthening is needed for results to be sustainable and that direct support for service delivery is needed in the short term to meet the real and immediate needs of people with disability. Thirty one per cent of available annual funding will be allocated to grants to support rehabilitation services and small grants with a CBR focus.

The challenges of systems strengthening work are considerable and results may at first be modest. As donor funding of service delivery is, however, not sustainable in the longer term, assisting the RGC to develop and strengthen systems for disability policy and services is essential.

As a better understanding of the operating environment is needed to determine the best entry points and optimal interventions for some activities, flexibility has been built into some parts of the design. For example, under Component 1, a functional analysis and capacity assessment of the key disability units in MoSVY/DAC will be undertaken as a foundational piece of work in determining how best to provide support. Similarly, the early analytical pieces of work to be undertaken through the rehabilitation and inclusive governance components will be used to inform the direction of systems strengthening work.

The program represents a synergistic combination of work at national and subnational levels. While Component 1 will primarily have a national focus, this will be complemented by the work with subnational decision makers in Component 4. Lessons learned at the subnational level will be fed back to national decision makers to promote replication of good practice on a wider scale. There will be a substantial engagement with DPOs at both national and subnational levels through individual DPOs and the CDPO, with mutual benefits. Rehabilitation sector system strengthening will address both national and subnational systems, while financial support for rehabilitation services will occur at the subnational level.

The primary focus of the program is on disability specific initiatives such as support for government bodies with responsibility for disability, DPOs and direct support of disability services. The program also provides an opportunity to support and influence the mainstreaming of disability. This will primarily occur in Component 1 through support for the development and coordination of the NDSP which will contain line ministry specific plans on disability and in Component 4 through increasing the capacity of officials at provincial, district and commune levels to implement the NDSP.

The program is designed to make a significant contribution to reducing stigma and discrimination against people with disability by increasing the capacity of key government and civil society disability-specific institutions to implement the NDSP; by addressing physical, institutional, communication and other barriers; and by promoting development processes to be more inclusive of people with disability.

Other program design options were considered but have not been included. For cost reasons it was decided not to propose financial support for a large scale national data collection exercise, such as a survey for much needed information on disability prevalence and quality of life<sup>24</sup>, although a limited scope of work on disability information has been incorporated in Component 1. Support for disability social protection schemes, a focus on education, direct support to key line Ministries such as education or health, or advocacy and awareness raising are other options considered but not recommended. Given the opportunities that currently exist it was decided that areas where the program could make the greatest impact are support for effective implementation of the NDSP/CRPD and strengthening of DPOs, the rehabilitation sector, subnational governance and community development and direct financial support for disability services. This is also in line with the parameters of AusAID's funding, which is focused primarily on disability-specific initiatives.

Efforts will be made to attract financial support for the program from other donors. Should these efforts be successful, elements of the program are readily scalable. These include the service delivery components (the rehabilitation services grants and the community based rehabilitation grants); support for the establishment of new DPOs and increased support for existing DPOs; support for data collection on disability prevalence and quality of life, and working in a greater number of provinces in Component 4, Inclusive governance and inclusive community development.

In addition to providing direct funding to the program, AusAID has a range of other support mechanisms (research grants, fellowships, scholarships, and volunteer and partnerships schemes) which the program will seek to utilise.

### **2.3 Theory of change**

The program's theory of change (ToC) is summarised in a diagram in Figure 1, below. The program goal, *improved quality of life for people with disability*, has deliberately been pitched at a high level. This is to give clarity on the overall intention. Given the challenges identified in the situational analysis, even a five year program is unlikely to fully achieve the program goal. The program goal should

therefore be seen in context: that this is the first AusAID supported consolidated disability program in Cambodia, and the likely need for a follow-on program to build on what will be achieved. The overall goal of the program is likely to require several decades of effort; in many respects this is not dissimilar to women's empowerment/gender equality programs. Nonetheless, achievement of the end-of-program outcome, (*People with disability have increased opportunities for participation in social, economic, cultural and political life through effective implementation of the NDSP*), will contribute in part to improved quality of life for people with disability. In turn, each of the end-of-program outcomes for the four program components will contribute to the end-of-program outcome for the program as a whole.

The intermediate outcomes for each program component will contribute towards the achievement of the components' end-of-program outcome. However, the achievement of the end-of-program outcome for each component is not simply dependent on achievement of the intermediate outcomes for that component. For one end-of-program outcome, several intermediate outcomes from a number of program components may contribute to its achievement. For example, effective implementation of the NDSP will not just be dependent upon development of a feasible and inclusive NDSP and increasing MoSVY's/DAC's coordination capacity. Effective implementation of the NDSP will be influenced by effective advocacy by CDPO and other DPOs, increased access to rehabilitation services, and increased disability-related capacity of subnational decision makers. Coordinated activities and policy advocacy across the four program components will be necessary to achieve the outcomes for the whole-of-program and each component.

For the purposes of illustration, the ToC diagram has only gone down to the level of intermediate outcomes. For each of the intermediate outcomes to be realised there are a range of lower level outcomes or intended results that also need to be achieved. These intended results and illustrative key indicators are set out in the M&E Framework in Annex 5 and reflect the range of strategies that will be deployed to enable change.

The ToC diagram sets out prerequisites for the end-of-program outcomes to be achieved. The intention is for the program to actively promote achievement of these pre-requisites rather than assuming they will just happen as program spin-offs.

Recognising the dynamic nature of strategy development and policy making and the many influences at play, the program will scan the horizon and take advantage of windows of opportunity as they arise. The principal opportunity is Cambodia's ratification of the CRPD and the demand by the RGC for technical assistance to enable it to effectively meet its international obligations. The program will continuously scan the environment to identify emerging opportunities.

Given the complex setting and problems that need to be addressed, it is recognised that a causal chain model implying a linear relationship between inputs, outputs and outcomes is simplistic and unrealistic. The design has identified key programmatic type risks for the program as a whole and for each component that may limit the extent to which change may be realised. The mitigation strategies for these risks are an essential part of the program's ToC and provide a sense of the complexity of the change process that is not possible to adequately illustrate in one diagram. (See Risk Management Register, Annex 6.) Additional information on how the program intends to promote change is contained in the description for each component, especially under the 'how will we do it?' and 'will it work?' sub-headings (Sections 2.5 to 2.8, below).

The ToC will be reviewed and adjusted annually as part of the program's annual review processes.

**Figure 1: Theory of Change for the Joint UN – AusAID Cambodia Disability Program**

(see next page)

**Program Goal (long term): Improved quality of life for people with disability**

**End-of-program outcome (whole program):** People with disability have increased opportunities for participation in social, economic, cultural and political life through effective implementation of the NDSP/CRPD

Whole program end-of-program outcome

MoSVY/DAC effectively coordinates implementation of the NDSP, aligned to the CRPD

Disabled people's organisations effectively represent the needs and priorities and advocate for the rights of people with disability

Improved rehabilitation services for people with disability

Increased capacity of and collaboration between sub national decision makers, civil society & communities to achieve the rights of people with disability

Component end-of-program outcomes

Feasible & inclusive NDSP developed, aligned to CRPD

Increased capacity of CDPO/DPOs to fulfill their mandates

Increased access to quality rehabilitation services

People with disability have access to community based services & support from local decision makers in reducing barriers to participation

Component intermediate outcomes

Increased capacity of MoSVY/DAC to coordinate development & implementation of NDSP

Effective inclusion and representation of diverse groups of people with disability

Strengthened rehabilitation sector leadership, planning & coordination

Increased capacity of subnational decision makers in select areas to implement the NDSP/CRPD

Enabling program activities in the four components including strategic and policy assistance, advocacy, capacity building, systems strengthening, core funding and service delivery funding through small grants

**Key pre-requisites for end of program outcomes to be achieved (to be addressed in programming)**

1. Government maintains and increases funding for the disability sector.
2. Government and civil society are willing to effectively collaborate.
3. Government acts to effectively address the complex disability governance and coordination mechanisms.
4. Civil society recognises and supports CDPO as a leader for people with disability in Cambodia.

Coordinated activities and policy advocacy across the four program components



## 2.4 Guiding principles

The program will take all opportunities to promote the principles of the CRPD in its interactions with partners and in the way the program is implemented.

The principles of the CRPD are: 1) Respect for inherent dignity, individual autonomy, including the freedom to make one's own choices, and independence of persons; 2) non-discrimination; 3) full and effective participation and inclusion in society; 4) respect for difference and acceptance of persons with disability as part of human diversity and humanity; 5) equality of opportunity; 6) accessibility; 7) equality between men and women; and 8) respect for the evolving capacities of children with disability and respect for the right of children with disability to preserve their identities.

In addition to the rights based principles of the CRPD, the program will be guided by the following operational principles in the way it goes about its work:

1. **Close engagement with the RGC at all levels to promote the effective implementation of the National Disability Strategic Plan, aligned to the CRPD.** The program will support the key leadership role of the RGC at national, provincial, district and commune levels in coordinating and implementing the NDSP and work closely with Government to build their capacity.
2. **People with disability will play an active and central role in the program.** The active participation and contributions of people with disability will be promoted and enabled. This will include membership on the Program Board, supporting disabled people's organisations to raise the voice and protect the rights of people with disability, participatory monitoring and evaluation (M&E), and enabling and ensuring the involvement of people with disability in all program activities.
3. **Fostering of effective partnerships between a broad range of stakeholders.** To maximise the impact of the work of all stakeholders, the program will create and take opportunities to promote partnerships between the RGC (multi-sector and nationally and sub nationally), DPOs, NGOs, INGOs, faith-based organisations and the private sector.
4. **Gender equality will be integrated into all aspects of program implementation.** The program will be mindful that women and girls with disability and female family members and care givers often face multiple forms of discrimination due to their gender, disability and generally lower economic status. The program will proactively identify opportunities to address the impact of gender inequality on women and girls with disability and develop responses.
5. **Diversity among people with disability will be recognised and addressed.** The program will recognise the diverse types of barriers that people with disability encounter, and that the needs and priorities of some groups (e.g., people with intellectual, visual and hearing impairments) are currently poorly served. Within available resources, the program will address the needs of people with a range of different types of disability. More broadly, the program will recognise that the lived experiences and perspectives of people with disability are diverse and effective approaches to meet people's needs may vary.
6. **Children and adolescents with disability.** The program will respond to the challenges faced by children and adolescents with disability by considering their needs and capacities and formulating appropriate responses within each of the program's four components.
7. **Child Protection.** The program will adhere to AusAID's Child Protection policy. Any workers and partners that come into direct contact with children will be rigorously assessed to ensure they meet AusAID and UNICEF Child Protection policies. As part of the Small Grants Scheme capacity building component, child protection will be addressed with all potential civil society partners.

8. **Mainstreaming of disability.** The program will support the DAC to mainstream the RGC’s response to disability through effective engagement with key line Ministries in the development and implementation of the NDSP. The three UN program partners will promote mainstreaming of disability within their agencies and other key UN agencies.
9. **Effective coordination between the four program components will be highly valued and achieved.** Achievement of the program’s outcomes will be maximised through effective coordination among the four components through program governance and management mechanisms and a commitment to day-to-day collaboration.
10. **Using data and evidence for learning and program adaptation.** The program will regularly analyse quantitative and qualitative data on the effectiveness of program components in order to maintain a flexible and responsive strategic approach. Strategies will be modified if data and experience suggests expected outcomes may not be achieved and in response to emerging opportunities.
11. **The dissemination of knowledge will be promoted in a transparent way.** Knowledge generated by the program will be actively disseminated to all stakeholders to promote the development of an understanding of effective ways of conducting disability development work. This will include dissemination of information relating to less than optimal performance for the purpose of promoting dialogue on alternative approaches and strategies.

## 2.5 Component 1: Supporting the RGC’s implementation of the CRPD

**End-of-Program outcome:** MoSVY/DAC effectively coordinates implementation of the National Disability Strategic Plan, aligned to the CRPD

**Intermediate outcomes:**

1. Feasible and inclusive National Disability Strategic Plan developed, aligned to the Convention on the Rights of Persons with Disabilities
2. Increased capacity of MoSVY/DAC to coordinate development and implementation of the National Disability Strategic Plan

**Intended results:**

- 1.1 NDSP complying with the CRPD, Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Violence Against Women (CEDAW) and other international conventions to which Cambodia is a party is adopted following a disability- inclusive process
- 1.2 The Law on the Protection and Promotion of the Rights of Persons with Disabilities and implementing legislation is revised in alignment with CRPD, CRC, CEDAW and other international conventions to which Cambodia is a party
- 2.1 Implementation of NDSP is monitored transparently across the whole-of-government
- 2.2 In-depth analysis of existing disability related data sources performed and recommendations for improvement of comprehensive disability related data collection, analysis and utilisation provided
- 2.3 Reporting under CRPD is completed on time following a disability-inclusive process

**Implementing agency:** UNDP

**Why are we doing this?**

In recent years, the RGC has made a number of important steps towards strengthening the legal and policy framework for disability, notably through adoption in 2009 of the *Law on the Protection and the Promotion of the Rights of Persons with Disabilities (the “Disability Law”)* followed by several Sub-

Decrees and Prakas, whose implementation has been supported through the *National Plan of Action*, which was subsequently extended to cover the period until the end of 2013.

However, neither the *Disability Law* nor the NPA provide an adequate framework for realising the rights of people with disability. Their implementation and monitoring remain weak, with inadequate data collection to support monitoring, and with inadequate opportunities for people with disability to participate in the design, implementation and monitoring of disability policy and budget-setting. Disability issues are not mainstreamed into the national poverty reduction strategy. Disability policy is still largely predicated on a medical rather than a social model, and while efforts have been made to address disability issues in education and employment, they are insufficient to protect the rights and meet the needs of people with disability. In particular, the needs of children and women with disabilities and those with hearing and intellectual impairments have not been adequately addressed.

The ratification by the RGC of the CRPD in December 2012 provides a highly strategic opportunity to strengthen the legal and policy framework for disability and its implementation, and thereby improve the lives of people with disability:

- Ratification is an indication of political commitment to protect the rights of people with disability, and also places legal obligations on the RGC to respect and protect the human rights of people with disability. This provides new leverage opportunities to improve the RGC's response to disability.
- Regular reporting on implementation of the CRPD to the Committee on the Rights of Persons with Disabilities (the "Committee") will provide an opportunity for transparent, evidenced-based and objective review of disability rights in Cambodia. The Committee will provide a framework and recommendations for improvement which enjoy the Committee's normative force.
- The high level of ratification of the CRPD by states in the region and beyond provides new opportunities for exchanges of experience in implementing disability rights under the CRPD.

At the same time, the commitment to prepare a new National Disability Strategic Plan (NDSP) for the period 2014-2018 to replace the NPA provides a strategic opportunity to translate the new legal obligations under the CRPD into concrete implementation to improve the lives of people with disability. This window of opportunity should also address the implementation of other international conventions such as CRC and CEDAW for women and children with disability, as well as linkages between NDSP and other national policies and strategies such as the National Social Protection Strategy).

However, engagement with the international rights-protection machinery of CRPD will not be enough on its own to ensure that these opportunities are successfully exploited. The RGC will require on-going external financial and technical support to fully implement the legislation, the NDSP and other strategies, and to adequately address the rights and needs of people with disability:

- Cambodia's legislative framework needs substantial revision and supplementation in order to meet its obligations under the CRPD (as well as disability-related obligations under other instruments to which Cambodia is a party, including CRC and CEDAW), not only with regard to the Disability Law (which itself has only been partially implemented through Prakas and sub-decrees) but in relation to the whole framework of laws in all fields affecting the lives of people with disability.
- The NDSP will need to be based on a concrete, time-bound series of actions in respect of each of the fields covered by the CRPD, supported by data collection and analysis systems to enable

adequate monitoring of progress. The current NPA meets these requirements only in part, and the RGC, (in particular MoSVY/DAC), will need substantial technical support in drawing up a plan which can meet Cambodia's obligations under the CRPD. In particular, the NDSP will need concrete strategies to achieve measurable progress in each of the following areas, with particular emphasis on non-discrimination and gender equality:

- Integration of people with disability into the labour market, including safeguards against discrimination by employers and for enforcement of the duty to make reasonable accommodation in the workplace;
- Inclusive and accessible education;
- Access to health care services;
- Access to inclusive and comprehensive habilitation and rehabilitation services;
- Equal access to the physical environment, transportation, information and communication and other facilities and services;
- Non-discriminatory access to social protection;
- Inclusion of people with disability in national and local planning processes; and,
- Accountability mechanisms to ensure accessible remedies for violations of the human rights of people with disability.

The NDSP must be adopted through an inclusive process in which a diverse range of people with disability have a genuine opportunity to participate, including traditionally under-represented groups such as women and children with disability, and persons with visual, hearing and intellectual impairments.

Progress on the NDSP must be regularly reported using data related to outcomes consistent with the CRPD, regularly reviewed through inclusive policy dialogues, with refocusing of the NDSP based on the data collected and policy dialogues. Implementation of the CRPD needs to be adequately reported to the CRPD Committee, and the Committee's recommendations need to be integrated in revisions to the NDSP.

### ***How will we do it?***

Consistent with the objective of strengthening RGC's capacity to fulfil its obligations under CRPD, and the corresponding need to hold the RGC accountable for achieving programme outputs, responsibility for implementing programme activities will be given to DAC/MoSVY so far as possible, whether under grant funding or national implementation modality (see further under 2.9.3 below).

In relation to capacity, a number of weaknesses of the RGC (specifically, that of MoSVY/DAC) have been identified:

- While MoSVY/DAC has the mandate to lead on disability policy across the whole of Government, including ensuring mainstreaming and implementation of disability rights by other line Ministries, its capacity to do so is currently very weak, resulting in poor coordination and implementation. While DAC/MoSVY has engaged with some key Ministries such as the Ministry of Education and Ministry of Health, this has not yet been fully successful. Relationships with other Ministries (such as Women's Affairs, and Economy and Finance) need significant strengthening. At the subnational levels, further effort is required to ensure inclusive disability policy is mainstreamed across the whole-of-government.
- The rights-based approach to disability and the related fundamental concepts of the CPRD are still relatively poorly understood by many governments, and it is likely that the capacity assessment of DAC will confirm substantial capacity gaps in this area.
- Since DAC's integration within MoSVY it has yet to engage successfully with people with disability and DPOs, while for their part DPOs and other NGOs have low levels of trust in DAC,

impairing its ability to act as a forum for policy dialogue and coordinated action between state and non-state actors.

- Within the RGC itself, the respective mandates and functions of different bodies including DAC, the DWPWD and PWDF are unclear and overlapping.
- Government capacities for data collection, analysis and evidence-based policy-making are relatively weak, especially in the area of disability.
- The responsibility of reporting to the CRPD Committee is new and MoSVY/DAC will require technical support to strengthen its capacity to perform this function.

To strengthen DAC/MoSVY capacity and address these constraints, UNDP will draw on its extensive global experience of capacity-building of government agencies to engage in participatory processes of policy-making, implementation and development, including the implementation of international commitments under UN human rights instruments. More specifically, UNDP will draw on its long history of capacity development of RGC institutions, such as the Cambodian Mine Action and Victim Assistance Authority (CMAA). Through partnership building and capacity development of CMMA, UNDP was able to gradually transfer responsibilities for project implementation from UNDP to CMAA and increase the capacity of the national counterpart to fulfil its legislative obligations. UNDP will apply lessons learned from this and other institutional building partnerships to strengthen both DAC's and MOSVY's ability to improve the lives of people with disability.

UNDP will also ensure linkages between this component and other relevant UNDP programmes, including support to the National Social Protection Strategy.

The inception of the program will coincide with the on-going process for drafting the NDSP, which is expected to be adopted by end-2014. The NDSP will be the vehicle for implementation and monitoring of disability policy by the RGC throughout this program's lifetime (2014-2018). The first activity under the program will therefore be support to the NDSP drafting process, with a focus on ensuring that people with disability play a central role in the drafting process, and that the NDSP gives them a key role in the processes of policy-making, implementation and monitoring. The program will do this through:

- Supporting DAC to organise consultative workshops involving line Ministries, subnational governments, DPOs and representatives of a diverse group of people with disability (including women, children and parents of children with disability) to provide inputs to the plan.
- Supporting DAC to conduct analysis on the basis of available data to provide the best evidence under current conditions for a prioritised and feasible NDSP addressing the most urgent issues facing people with disability (including providing technical assistance as well as financial support).
- Supporting (through technical assistance to DAC and other stakeholders) a rights-based approach and mainstreaming of the core CRPD philosophy and principles (e.g., anti-discrimination, duty to make reasonable accommodation), throughout the different sections of the NDSP.
- Providing technical advice on all aspects of the planning process, including budgeting, monitoring and evaluation, coordination, and communications.

The main focus of the component, however, will be to support the capacity development of DAC in particular and other relevant units in MoSVY to implement the NDSP after adoption.

At the outset of the program, UNDP will support the RGC to conduct functional and capacity self-assessments in relation to disability policy and program functions within the RGC with the following objectives:

- To map the legal and organisational mandates relevant to people with disability across the whole of Government, focusing on MoSVY, DAC and PWDF but also other line Ministries and subnational government. Provisions for coordination of policy and programs between units within MoSVY and with line Ministries will be identified along with gaps and overlaps in functions.
- To assess the capacity of DAC and relevant units within MoSVY (DWPWD, PWDF) to perform their responsibilities and functions, including:
  - Mainstreaming and coordinating disability policy across whole-of-government at national and subnational levels. In this area UNDP will draw on its experience of supporting the Ministry of Women’s Affairs to ensure that line Ministries and subnational actors address gender equality across the whole-of-government.
  - Coordination between state and non-state actors, including DPOs.
  - Public information, communication, advocacy and consultation.
  - Substantive technical capacities both related to disability (including the normative content, principles and philosophy of the CRPD) and in other areas (budget/finance, gender, strategic planning, monitoring and evaluation, legislative drafting, etc.).

Based on the findings of the functional and capacity assessment, UNDP will provide support for revisions of strategic plans to DAC and possibly other disability-related units and departments (DWPWD, PWDF). The revision of these strategic plans, which have not been sufficiently concrete to provide adequate direction, will have the following aims:

- To clarify the respective roles and functions for disability policy between DAC/DWPWD/PWDF, and where necessary to assist in a process to amend regulations to reflect that clarification.
- To provide a framework for and facilitate the development of concrete work plans for DAC and other stakeholders to deliver coordination of NDSP implementation over the lifetime of the program.
- To address the capacity development needs of DAC (and as necessary other stakeholders) in support of their responsibilities for coordinating implementation of the NDSP.

While DAC will be the focal point for the assessment, it should also address key capacity gaps and needs in other line Ministries (and, subject to further consideration on feasibility, at subnational levels), with an emphasis on DAC’s own responsibility to promote understanding of CRPD and the social model of disability throughout the whole of government, and to develop capacities of focal points in other agencies. It should also address issues of functional overlap, gaps and coordination needs to assist RGC in improving the architecture for the implementation of disability policy.

Recognising that this is a major task, and that even developed countries which have had strong disability frameworks for decades still have a long way to go to achieve adequate implementation of the CRPD, the program will support prioritisation of needs with a focus on feasibility, recognising that the capacity development process for DAC and MoSVY will need to continue beyond the lifetime of this program. While the details will depend on the specific findings of the assessment, it is likely that the specific activities supported by the program will include:

- technical assistance, training and workshops to strengthen understanding of the CRPD, including on the rights-based approach and the social model of disability, discrimination, reasonable accommodation, and inclusiveness.
- regional exchanges with other countries on implementation of and reporting under the CRPD, and supporting engagement with regional inter-governmental bodies (ESCAP, ASEAN) as well as with the Committee on the Rights of Persons with Disabilities.

- training of trainers within DAC/MoSVY to build DAC's/MoSVY's capacity to provide ongoing training on the CRPD and disability issues to relevant officials at both national and subnational levels.
- training/technical assistance on strategic planning, budgeting, communications, monitoring and evaluation.

At the same time, UNDP will support RGC to commission a legal framework review with international expert support to assess the compatibility of Cambodia's legal framework with the CRPD and identify areas in which amendments or clarifications are required. As noted above, this review will go beyond the Disability Law to consider the full body of laws and implementing regulations which affect the lives of people with disability, organised around the different obligations under CRPD. UNDP will draw on similar exercises which have been undertaken in other countries in relation to the CRPD and other human rights treaties such as the CEDAW and the CRC.

Again, recognising that harmonising Cambodia's legal framework with CRPD is a major undertaking which cannot realistically be completed within the lifetime of the program, the review will provide recommendations for prioritisation and sequencing, beginning with necessary reforms to the Disability Law and implementing legislation. This will be used as a platform to support MoSVY/DAC in drawing up an action plan for legislative reform, together with line Ministries and other stakeholders, to address the most urgent needs which can feasibly be accomplished within the program lifetime.

In relation to engagement with the CRPD mechanisms (reporting and engagement with the CRPD Committee), the project will facilitate exchanges with other countries which have successfully completed their first round of reporting under the CRPD to share good practices and lessons learned.

In addition, in order to improve information on baseline prevalence and quality of life of people with disability, (including barriers to social and economic participation, such as the absence of specialised services), UNDP will support NIS to undertake a meta-analysis to identify, describe and analyse the available Cambodian data sources with regards to people with disability and draw critical conclusions. This will require disaggregating databases where possible by type of disability, age, gender, ethnicity, and place of residence and identifying and analysing other factors that may be related to disability outcomes – such as socio-economic status and size of household.

On the basis of these results and bearing in mind other international approaches to data gathering in this area, (e.g. UNICEF's Multi Indicator Cluster Survey), appropriate recommendations will be made for re-enforcing existing data sources or introducing new types of disability-related data collection. Recommendations will also be made on how to improve the analysis and utilisation of data. The outcome of this exercise should serve as a basis for additional programming and fund raising related to data collection.

In addition, UNDP will support MoSVY and DAC to convene an Annual Partnership Dialogue on Disability with key line Ministries, the UN, AusAID (and other relevant development partners) and civil society. This will assist MoSVY and DAC in the monitoring of progress of NDSP implementation and with leveraging of action in key areas.

In its first year the component will focus on support to the NDSP and the functional and capacity assessment. The detail and sequencing of further activities will be determined in agreement between UNDP and DAC/MoSVY, based on the recommendations of the assessment (which should itself provide recommendations in terms of priorities and sequencing) and set out in Annual Work Plans to be agreed between the parties.

### ***Will it work?***

Achievement of results will depend critically upon the capacity and political will of DAC/MoSVY since, under the component's modality, they will be given responsibility, so far as possible for implementing the component's activities with funding transferred to them by UNDP. While this reduces UNDP's direct control over implementation with a corresponding risk to the achievement of component outputs, and notwithstanding the capacity gaps identified above, this approach is mandated by the objective of increasing the Government's capacity to formulate and implement disability policy in line with its mandate and international commitments, and Government ownership and accountability for results – and therefore, in the longer term, sustainability of those results.

Whether implemented through grant funding or under national implementation modality (see 2.9.3 below), the cooperation will be governed by an agreed framework clearly linking funding to program results. Implementation by MoSVY/DAC of the component will be subject to UNDP's applicable financial and quality assurance controls. These measures will ensure that funding from the program is used as effectively as possible.

Furthermore, as mentioned above, the recent ratification of the CRPD and the current process to draw up the NDSP provide an indicator of political commitment as well as a key strategic entry point to build capacity. The risks outlined above in terms of both political will and technical capacity will be mitigated by applying the lessons learned in UNDP's institutional capacity-building experience in Cambodia and elsewhere and through the incentives provided by the CRPD ratification process, combined with strong technical support, as follows:

- The CRPD process involves a public and objective discussion of Cambodia's progress in protecting the rights of people with disability through the engagement with the Committee, providing an incentive for the RGC to demonstrate that it is making progress to meet its international obligations. The neutrality of the CRPD system provides a clear and apolitical benchmark against which to measure the RGC's performance, and the UN as guardian of the CRPD is best placed to leverage this into improved quality of life for people with disability in Cambodia through development cooperation.
- The program will support further in-country incentives through:
  - Regular open progress reviews, based on available data, against NDSP targets with the participation of civil society, media etc.
  - Strengthening the capacity of civil society to monitor and support implementation of the CRPD, strengthening its voice both as a partner of government and as a stakeholder in engaging with the CRPD committee, to strengthen the 'push' on Government to implement CRPD and to be transparent in the way it does so.
  - Convening the Annual Partnership Dialogue on Disability, with the UN acting as a neutral convenor between development partners, government and civil society.

### ***How will we know?***

The program's achievements will be measured against key outcome indicators that measure both the results in terms of process (inclusiveness, transparency, evidence-based) and the extent to which the NDSP reflects the CRPD. Because the process of drafting and implementing the NDSP is complex, depending on many stakeholders and with a number of attendant risks which have been identified above, the implementation of the component will need to remain flexible (driven in particular by the results of the framework/capacity assessments) and responding to opportunities and challenges as they arise.



Key outcome indicators reflecting both process (inclusiveness) and substance (compliance with the CRPD) will include:

- Number of consultative workshops/meetings held with representatives of DPOs and people with disability, (including women, children and parents) and development partners in the process of NDSP development
- Extent to which the NDSP reflects inputs from DPOs/CSOs
- Extent to which the NDSP reflects expert technical advice on compliance with the CRPD
- Extent to which baseline data is identified and collected for each major policy area within NDSP, including disaggregation for women and children with disability
- Legal framework review completed and disseminated widely
- Legislative reform plan to revise the Disability Law adopted
- Extent to which legislative reforms are implemented
- Extent to which revisions to the Disability Law adopt the recommendations of the framework review and reflect consultations with DPOs, civil society and development partners
- Extent to which sub-decrees and Prakas to implement the revised Disability Law are adopted following recommendations of the framework review and following consultation with DPOs
- Extent to which data is collected in accordance with the NDSP
- Number of NDSP review meetings held with participation of line Ministries, DPOs and civil society
- Number of Annual Policy Dialogues with DPOs, civil society and development partners held
- Extent to which recommendations from DPOs, civil society and development partners are reflected in revisions to the NDSP and/or disability policy
- Extent to which recommendations of functional/capacity assessment are reflected in DAC's revised strategic plan
- Extent to which mandates of DAC, PWDF, DWPWD are revised in accordance with functional/capacity assessment to clarify roles and functions
- Extent to which recommendations for improvement of disability data are adopted and implemented
- Number of consultative meetings with stakeholders (DPOs, including representatives of women, children and parents, civil society, development partners) during drafting and finalisation of the CPRD report
- Extent to which CDPO/DPO inputs are reflected in the report on the CPRD
- Cambodia's report on the CPRD submitted on time

At this stage, before the NDSP has been drafted and without an assessment of current RGC capacity or capacity gaps, it is not possible to define more detailed targets for indicators, however, after adoption of NDSP and completion of the functional/capacity assessment, more detailed indicators of achievement should be set in agreement between UNDP and DAC/MoSVY, based upon the results of the functional and capacity assessment.

### ***Will the benefits last?***

Supporting the rationalisation of functions and the capacity development of RGC stakeholders, including MoSVY and DAC, as focal points within the RGC for disability, is the most appropriate path to achieve sustainable improvements in the Government's capacity to meet its international commitments under the CRPD. At the same time, the program's strong support to CDPO as the legitimate civil society counterpart to the RGC will strengthen accountability.

## 2.6 Component 2: Supporting DPOs to raise the voice and protect the rights of people with disability

**End-of-Program outcome:** Disabled People’s Organisations effectively represent the needs and priorities and advocate for the rights of people with disability

**Intermediate outcomes:**

1. Increased capacity of the Cambodian Disabled People’s Organisation/Disabled People’s Organisations to fulfil their mandates
2. Effective inclusion and representation of diverse groups of people with disability

**Intended results:**

- 1.1 CDPO and DPOs capacitated to act as effective channel for raising the voice of people with disability
- 1.2 Specific needs and priorities of women and children with disability, people with hearing, visual and intellectual disability and other excluded groups are included and addressed in CDPO/DPO plans and activities
- 1.3 CDPO and DPOs are actively involved in regional networks, exchange of experiences and good practices
- 2.1 Existing DPOs strengthened and new DPOs are established to ensure representation of diverse groups of people with disability
- 2.2 Specific needs and priorities of women and children with disabilities, people with hearing, visual and intellectual disability and other under-represented groups are represented in new DPOs

**Implementing agency:** UNDP

***Why are we doing this?***

A strong civil society to represent the voices of people with disability is a core mechanism for realising disability rights, and a fundamental principle of the CRPD. Cambodia has a relatively strong civil society, with many Cambodian DPOs, INGOs and NGOs active in the disability sector. In addition, the CDPO has increasing capacity and credibility as a peak organisation for DPOs, with a substantial national network of provincial DPOs and local SHGs.

Within this broad picture, however, effective representation of the voice of people with disability is uneven. The Triple Jeopardy research on violence against women and girls with disabilities revealed the relatively poor representation of women and girls with disabilities, while as noted above, there is limited representation of people with visual, hearing and intellectual impairments. There is no overall coordination of the voice of civil society, with many SHGs and provincial DPOs (and one national DPO) sitting outside of CDPO’s membership, and limited interaction between CDPO and NGOs and INGOs in particular.

Traditionally, DPOs have not engaged strongly in policy research or advocacy, although CDPO has been increasing its capacity in this area; (the Triple Jeopardy research is an example). Although CDPO’s Executive Director is a member of DAC, policy dialogue channels between government and civil society need to be strengthened.

While CDPO has taken proactive steps to increase capacity related to management and governance, including support to subnational members, this needs to be maintained and increased in some areas, including in quality monitoring and evaluation systems and other core organisational functions (such as human resources and finance).

Strengthening the capacity of DPOs to represent the voice of people with disability in the design, implementation and monitoring of disability policy and the implementation of the NDSP is therefore a key pillar of this program's design.

### ***How will we do it?***

As articulated in the theory of change, (see 2.3 above), two of the pre-requisites for the program's success are that the RGC and civil society collaborate effectively, and that in turn CDPO is recognised by civil society as a leader for people with disability in Cambodia. Strengthening CDPO's capacities as a policy dialogue and advocacy partner with the RGC, and as a resource for strengthening the voice of DPOs and SHGs and, through them, people with disability, is key to these objectives.

The program will therefore support CDPO's capacity development, anchored around CDPO's 2014-2018 strategy. This support will focus on the key mandates of CDPO to:

- Undertake policy research and advocacy;
- Act as a channel for policy dialogue between the RGC and civil society;
- Strengthen the capacity of DPOs and act as an effective coordinator in the disability sector; and,
- Ensure the representation of a diverse spectrum of people with disability, paying particular attention to those who are currently under-represented including children and women and those with hearing, visual and intellectual disability.

Activities under this component will be implemented by CDPO with funding from UNDP through an agreement signed between both parties, incorporating the relevant outcomes, outputs, indicators and monitoring evaluation framework under the programme. Funds will be transferred for agreed activities subject to UNDP's standard financial and quality assurance control mechanisms, to ensure that resources are used as effectively as possible. This modality supports the objective of strengthening CDPO's capacity to fulfil its mandate, as well as its ownership and accountability for the results achieved, and therefore their longer-term sustainability. The detailed implementation modality will be determined at the outset of the programme following a capacity assessment (see 2.9.3 below).

The program of support will be developed during the inception phase through discussions with CDPO and based around the CDPO 2014-2018 strategy. Subject to those discussions the following indicative list of activities could be considered for inclusion:

- Strengthening CDPO's capacity to undertake policy research and advocacy, including drawing on the knowledge and experiences of member DPOs and SHGs as a source of evidence for monitoring and advocacy with Government.
- Supporting CDPO's capacity to act as a channel for participation of people with disability in designing, implementing and monitoring disability law and policy and the NDSP in particular, through CDPO's engagement in DAC. Ensuring the inclusion and participation of a diverse spectrum of people with disability, including children, women and people with visual, hearing, and intellectual impairments, will be central. This in turn entails strengthening CDPO's own internal capacity to coordinate the disability sector, including its relationships with provincial DPOs and with INGOs, as well as establishing thematic working groups on gender, hearing, visual and intellectual impairments.
- Supporting CDPO to participate at the regional level, in particular through the ASEAN Disability Forum, in order to leverage national change through ASEAN bodies such as the ASEAN Intergovernmental Human Rights Commission and others, and to participate in exchanges with counterpart national DPOs in other countries in the region to identify good practices and common strategic approaches.

- Supporting CDPO's engagement in CRPD mechanisms, through providing inputs and comments to the RGC's report through DAC, and possibly through coordinating the drafting of a CRPD "shadow report";
- Strengthening CDPO's role to develop the capacity of DPOs at national and provincial level, including:
  - supporting the capacity development of the Association for the Blind in Cambodia;
  - strengthening the operations of DPOs at provincial level;
  - Supporting the establishment and capacity development of DPOs for groups who currently are particularly marginalised and/or who have no DPOs representing their interests, such as people with hearing impairments and people with intellectual and psychosocial disability (including through parents associations).

In the inception phase, consideration will be given to supporting CDPO to conduct a mapping of DPOs to provide a clear picture in terms of activities, geographical coverage, capacities and the representation of different disability groups. The mapping would seek to identify areas for priority support to new SHGs and DPOs, and for capacity building of existing members.

***Will it work?***

The achievement of results depends critically upon the capacity and will of CDPO which is given the responsibility to decide what activities to undertake and how to implement them, with corresponding limits on UNDP's ability to control and ensure the achievement of results under the program. However, this approach is mandated by the objectives of building CDPO's capacity to fulfil its mandate, maximising CDPO's ownership and accountability as well as the sustainability of results achieved. Furthermore, through previous phases of AusAID support (which have also been based on a similar modality), CDPO has been assessed as a responsible and committed partner. As stated above, funding to CDPO will take place under a clear framework requiring accountability for results, with ongoing financial and quality assurance controls in line with UNDP policies and procedures (see 2.9.3 below).

A number of capacity gaps have been identified, including a need for more effective engagement with line Ministries at national level, to improve CDPO's capacity to support and coordinate DPO members at provincial level, and to improve its monitoring and evaluation capacity. Like other disability actors in Cambodia, it can benefit from deeper understanding of the CRPD and its mechanisms, (such as reporting), and these will need to be validated and perhaps expanded through a capacity assessment during the inception phase. To date, CDPO has shown good insight into its own development needs and an ability to address them. It currently enjoys committed and dynamic leadership and a high level of trust within the DPO community. Conversely, it has yet to establish itself as an equal and engaged policy dialogue partner with the RGC.

The project will ensure strong linkages between Components 1 and 2, leveraging the entry point of CRPD ratification and the fundamental role of engagement of civil society within the CRPD framework and the development of the NDSP. UNDP will use its convening role to work simultaneously on expanding the space for civil society to engage in the design, implementation and monitoring of disability laws, regulations and policy as well as engagement with CRPD reporting.

***How will we know?***

The program will measure progress against a number of key outcome indicators such as:

- Extent to which CDPO/DPOs regularly and actively participates in DAC/MoSVY working groups

- Extent to which CDPO/DPOs inputs are reflected in development and implementation of the NDSP
- Number of policy research papers published by CDPO
- Activity of working groups addressing the needs of women and children with disability, and the extent to which they are engaged in development and implementation of the NDSP
- Inclusion of people with hearing, visual and intellectual impairments in CDPO's/DPO's work plans and evidence of implementation
- Percentage of women in the governing bodies of CDPO, DPOs, federations and leading SHGs
- Number of regional events attended by or hosted by CDPO and DPOs
- Extent to which CDPO participates in the activities of the ASEAN Disability Forum
- Extent to which lessons learned, exchange of knowledge, and good practices disseminated and translated into capacity development actions in CDPO's/DPO's annual work plans
- Number of DPOs representing the needs and rights of women, children and people with visual impairments, hearing impairments, intellectual impairments

More detailed indicators will be developed in consultation with CDPO during the inception phase of the component. In particular, after baselines have been established, specific targets will be set (for instance, in relation to the percentage of women in the governing bodies of CDPO, DPOs, federations and leading SHGs). These indicators will be reviewed on an annual basis throughout the program and amended, replaced or supplemented as appropriate.

CDPO is currently receiving capacity development support from an Australian volunteer specifically focused on monitoring and evaluation. Support from the program will complement these efforts.

#### ***Will the benefits last?***

CDPO is a well-established institution which has built up substantial credibility within the DPO sector. As with any civil society organisation in a developing country, it will in the medium-to-long term remain dependent on external funding, principally from international development partners. CDPO's longer-term sustainability will depend upon the continued commitment of funding beyond the life-cycle of this program. The risks involved can be mitigated through strengthening CDPO's capacity for resource mobilisation from multiple sources including charitable and other foundations. Given that the CRPD institutionalises a core role for civil society as an accountability mechanism, the international community needs to bear its own responsibility for ensuring the continued viability of a strong civil society in the disability sector at least until such time as private philanthropy and other funding sources have developed sufficiently within Cambodia.

## **2.7 Component 3: Supporting Rehabilitation Systems Strengthening**

**End-of-Program outcome:** Improved rehabilitation services for people with disability

### **2.7.1 Sub-Component 3.1: Rehabilitation sector leadership, coordination and planning**

**Intermediate outcome:** Strengthened rehabilitation sector leadership, planning and coordination

#### **Intended results:**

1. Increase government capacity to lead, regulate and plan the rehabilitation service sector.
2. Establishment of a rehabilitation sector leadership and coordination mechanism.
3. Development of the Ministry of Health's role in rehabilitation sector strengthening and service provision.

#### 4. Development of a national vision for rehabilitation and disability support services provision.

**Implementing agency: WHO**

##### ***Why are we doing this?***

Leadership, planning and coordination are critical for strengthening of the rehabilitation sector in Cambodia. Currently, leadership responsibilities for the rehabilitation sector are unclear and rehabilitation services lie across multiple ministries and stakeholders. To date, key stakeholders such as MoSVY and the Ministry of Health (MoH) have not assumed a strong role in sectoral development. The MoSVY has the potential to play a substantive role in disability sector leadership and is increasingly required to support rehabilitation service delivery but with limited resources and service delivery experience.

Unclear leadership roles and poor coordination are key contributing factors to the sector being relatively weak, with potential to weaken further due to withdrawal of the historically substantial INGO support. The very limited data to inform sectoral analysis contributes to this weakness and prevents informed decision making.

The Cambodian Government is attempting to redress disability and rehabilitation sector support through the creation of the PWDF and upgrading of the DAC. This sub-component of the program presents an opportunity to capitalise on these efforts in a way that will directly benefit service delivery. The program's support will fill gaps in technical capacity, engage key stakeholders in planning, and assist with articulation of a national coherent vision (master plan) for rehabilitation to meet disability service needs in the Cambodian context, with attention to the needs and rights of men, women, girls and boys.

##### ***How will we do it?***

Taking a health systems strengthening approach and working with multiple stakeholders, WHO will support development of the Government's capacity to lead, regulate and plan the rehabilitation sector. WHO will utilise five broad approaches to achieve this component:

1. Building rehabilitation stakeholder capacity and dialogue
2. MoSVY and PWDF partnership
3. MoH disability and rehabilitation partnership
4. Provincial rehabilitation demonstration project
5. Timely support to rehabilitation leaders for development of a national rehabilitation and disability service sector vision (in later years of program).

##### **1. Building Rehabilitation stakeholder capacity and dialogue.**

WHO will deliver five initiatives to build stakeholder capacity and dialogue, as follows:

- a) **Building knowledge and increasing dialogue:** Throughout the program WHO will commission analyses and reports that are designed to better inform rehabilitation stakeholders about the status of rehabilitation service provision in Cambodia. WHO will work closely with the RGC to identify priorities and produce reports that meet their decision making needs. One report is planned for each year. In the first year, the report commissioned will cover rehabilitation sector leadership and financing. Future reports are likely to explore areas such as human resources for rehabilitation, regulatory options for rehabilitation and gender dimensions of rehabilitation. Reports will be translated and shared widely with stakeholders. They will be accompanied by an event jointly facilitated by WHO and RGC partners that increases understanding, dialogue and provides a basis for future decision making. WHO will be proactive in using the information generated from these analyses by providing targeted guidance and clear options to RGC decision makers.

- b) **Leadership and coordination mechanism:** As indicated in previous activity, WHO will develop a report and facilitate exploration and discussion on the need for and nature of a rehabilitation leadership mechanism. A round table discussion will be convened on completion of the report. A DAC 'rehabilitation' committee already exists and this is likely to be the best mechanism for leadership. WHO will participate in the mechanism and offer practical support for regular convening of this group. This mechanism will provide a forum for key decision makers across Ministries to meet on a regular basis and coordinate their efforts.
- c) **Tailored Training:** WHO will initially work closely with key national stakeholders, MoSVY, PWDF and MoH to undertake a capacity needs analysis. This analysis will inform future capacity development and technical assistance activities which will be integrated into the partnerships with these three agencies.
- d) **Forum:** Once every two years an annual national 'Rehabilitation and CBR Forum' is planned in order to bring stakeholders together to share good practices, increase coordination and collaboration, and build sectoral capacity. It is envisaged the event will initially be supported by WHO and run in partnership with the rehabilitation coordination mechanism (once established). Over time this may evolve into a national conference where professionals share practices and research. WHO will work closely with UNICEF during event planning to ensure coordination regarding CBR.
- e) **Study Tour:** On alternate years from the national forum and as part of capacity development initiatives, WHO will arrange and fund a study tour for key rehabilitation sector leaders. This will assist in identification of good practices occurring within the region and help create a future vision for rehabilitation and disability service provision in Cambodia. Participation in the tour will link to initial collaboration and performance on WHO supported activities. It is likely that the second tour will focus on future sectoral leaders. The Australian Awards Fellowship will also be considered for the purpose of contributing to capacity development and sectoral leadership.

## 2. MoSVY and PWDF Partnership

The DWPWD within MoSVY is the focal point for rehabilitation within the ministry and collaboration with them to build capacity in sectoral leadership will occur. After the initial capacity needs analysis, dialogue and planning of priorities and targeted capacity development and technical assistance support will occur. The work in sector regulation will be part of this support but is likely to occur in later years of the program. This partnership includes PWDF as clarity and support regarding their leadership role is developed. This work is part of the same 'partnership' described under sub-component 3.2 below.

## 3. MoH Disability and Rehabilitation Partnership.

Initially, WHO will engage MoH stakeholders, particularly decision makers and the Department of Preventive Medicine which is responsible for disability, in an internal consultation about the current and potential role of MoH in rehabilitation service provision, acknowledging its capacity constraints and competing priorities. Alongside this will be the previously mentioned capacity needs analysis. It is envisaged that the Department of Preventive Medicine, in partnership with WHO, will then develop and implement an internal action plan that increases MoH's rehabilitation capacity, explores the role of MoH in service delivery, and provides strategic direction for further MoH engagement. A degree of flexibility is required for this component based on MoH capacity, prioritisation and the opportunities that may arise. Parallel to this project are WHO global and regional initiatives aimed at guiding and strengthening the role of Ministries of Health in disability. This will strongly complement this component.

#### **4. Provincial rehabilitation demonstration project.**

After initial planning, a group of provincial stakeholders will trial a coordinated and streamlined approach to rehabilitation and disability service provision in one province. The demonstration project will pilot a provincial disability and rehabilitation service coordination mechanism, a set of clinical pathway guidelines and referral mechanisms for common impairments, and dissemination of an up to date local and national service directory. The project is necessary to build clarity between MoH, MoSVY, NGOs and DPOs regarding who sees which clients, when and for what type of services. This demonstration project will pay particular attention to the rehabilitation needs of women and children. This project is important for MoH as it is intended to illustrate the preferred role of MoH and therefore provide a basis for identifying its future involvement in rehabilitation service delivery. The project will be designed so that after evaluation it can be replicated in other provinces. WHO will convene a project committee with agreed and time-bound terms of reference, and support implementation.

#### **5. Development of a national rehabilitation and disability service sector vision.**

Throughout the course of the program it is anticipated that increased analysis, dialogue, and capacity development will produce supporting architecture for the vision of rehabilitation and disability support services in Cambodia. Depending on outcomes in earlier years of the program, WHO may support development of a national strategic plan for the rehabilitation sector, this is most likely to occur in the 4<sup>th</sup> or 5<sup>th</sup> year of the program.

##### ***Will it work?***

WHO has considerable international experience in health systems strengthening approaches and direct experience utilising these in Cambodia with the MoH. This work is always challenging with degrees of success directly linked to government capacity and political will. Evidence supports that improved leadership, planning and coordination of a sector does lead to better services for people. An approach considerate of capacity, politics, incentives for change and that is timely and flexible to capitalise on opportunities is necessary. Senior RGC officials consulted during development of the proposal understood the responsibility of government for sectoral leadership and service delivery, including increasing funding to achieve this.

Targeted WHO technical assistance, capacity development and practical support will increase the visibility and performance of individuals and their organisations and programs and this incentive is therefore more likely to achieve program outcomes. A risk to success is that individuals targeted for capacity development will move to other areas or organisations. Insight into the local situation and careful consideration during selection processes for training will mitigate this risk.

##### ***How will we know?***

WHO will monitor deliverables in close collaboration and engagement with rehabilitation stakeholders. In time it is anticipated that a shared work plan with key deliverables will be developed with three government agencies, namely, DWPWD in MoSVY, Department of Preventive Medicine in MoH and PWDF. Strengthened leadership will take time to produce results but in later years of the program it will also be visible through government statements, resource allocation and action regarding rehabilitation and disability services.

##### ***Will the benefits last?***

There is significant potential for long lasting benefits under this component as building sectoral leadership is likely to lay the groundwork and provide guidance and vision for many years to come. Sustainability will be further enhanced by future sectoral leaders being identified and supported to build their capacity. Government system strengthening approaches, by their very nature lead to longer lasting results than pure service delivery support. Therefore, through building the capacity of individuals, organisations and systems, long terms benefits will occur.



## 2.7.2 Sub-Component 3.2: Access to quality rehabilitation services

**Intermediate outcome:** Increased access to quality rehabilitation services

**Intended results:**

1. Increase capacity of MoSVY and PWDF to effectively and efficiently manage Physical Rehabilitation Centres and support their transition from INGOs.
2. Multiple stakeholders engage in development of cost effective and sustainable disability and rehabilitation services, and under-developed service areas are strengthened.
3. Community based rehabilitation implemented in line with WHO CBR Guidelines.
4. Increased government financial investment in disability and rehabilitation service delivery.

***Why are we doing this?***

Accurate estimations of the rehabilitation and disability service needs of the Cambodian population are difficult as limited quality disability prevalence and service needs data exists. However global estimates of disability indicate that 2.2 per cent of the population experience very significant disability. It is those with more significant difficulties that often require disability and rehabilitation services; in the case of Cambodia this would equate to 320,000 people regularly requiring services. Services for women and children with disability are limited and early childhood intervention programs are developing unevenly across the country.

Historically, five large INGOs have supported the PRCs which have been the backbone of national rehabilitation service delivery, establishing a range of programs in response to the needs of land mine victims. In more recent times, INGOs have wound back activities and in some instances this has led to weakening service provision and an increase in unmet service needs. There are now four INGOs engaged in PRCs (as two INGOs have merged into one) but it is likely that this will reduce further in the coming years.

It is important that the limited resources available for rehabilitation be allocated wisely and that services continue to be provided to support empowerment and inclusion of people with a disability in Cambodia. Under current arrangements, PWDF has management responsibility for PRCs, while MoSVY has technical oversight, and the four INGOs contribute financially and technically. Current rehabilitation services are not always good quality or evenly spread across the country and there is a need to expand underdeveloped areas such as services for people with hearing loss.

The transition of PRCs to MoSVY and PWDF management has experienced significant challenges and supporting both these agencies to play an effective role is a priority for rehabilitation sector strengthening. There is an opportunity to assist in the oversight of PRCs to ensure no further deterioration in service quality, and to ensure that good practices are scaled up and shared, including nascent CBR approaches.

***How will we do it?***

WHO will work closely with partners to achieve the objectives of this sub-component through the following three mechanisms:

1. MoSVY and PWDF Partnership
2. The Priority Rehabilitation Service Scheme (PRSS)
3. Close collaboration with UNICEF in selecting small grantees for CBR and underdeveloped services

**1. MoSVY and PWDF partnership.**

A second component of the WHO Partnership with MoSVY and PWDF will be to provide technical assistance to support transition and effective management of the PRCs. Linked to the capacity needs analysis (undertaken as part of sub-component 3.1) and the PWDF Strategic Plan, WHO will

collaboratively identify priority areas for increasing access to rehabilitation services. This will include support for implementing standardised data management system, exploration of service models that are efficient and close to people's homes, and regular workshops and knowledge exchange opportunities between PRCs. To support transition arrangements for the PRCs, WHO will work with PWDF and MoSVY to increase communication and planning with the INGOs.

## **2. Priority Rehabilitation Service Scheme**

WHO will use \$200,000 of program funds annually to establish the PRSS. The aim of the PRSS is to support transitioning rehabilitation services for the period that the RGC cannot identify necessary funds to prevent further service decreases. Some PRC services have been reduced already due to the transition. Some of the first services to decrease have been the outreach clinics and services for women, girls and children with disability.

WHO will facilitate an annual planning day with the key INGOS, PWDF and MoSVY for agreement on priority needs. The relevant stakeholders (INGOs, potentially PWDF and MoSVY in later years of program) will then be asked to jointly submit a proposal specifying roles and responsibilities for delivering identified outputs based on priorities with approximate budgets. WHO will collaboratively determine final budget allocations and outputs, and the agencies/organisations will subsequently be invited to apply for annual funding. WHO will utilise its routine contracting mechanisms and administer these with current organisational administrative capacity. In the initial year(s) of the program this will mean four individual contracts with the 4 large INGOs undertaking the majority of rehabilitation services. For greater transparency, WHO will work with the Program Coordination Team during this process and a mechanism for this will be determined during inception planning. Funding for agencies and organisations in later years will be linked to previous performance and competitive, output based processes will be utilised.

## **3. Small grants scheme partnership with UNICEF for CBR and underdeveloped services**

UNICEF will administer a small grants scheme (SGS) within the auspices of the program's Component 4, delivered using the CBR framework. WHO will work with UNICEF to maximise synergies to ensure coordination and consistency and to advocate for innovative and sustainable CBR approaches in line with WHO's CBR guidelines. The program will consider the Cambodia National CBR guidelines to encourage greater alignment with international practice. The priorities of PWDF and MoSVY in regards to rehabilitation, identified in relation to the PRSS, will be brought to the attention of UNICEF by WHO to maximise synergies with the RGC.

### ***Will it work?***

Increasing access to rehabilitation services holds many challenges, especially in the context of INGO withdrawal. However service provision is a priority and through direct financial support, utilising the PRSS and the UNICEF-managed SGS, and technical assistance to develop more efficient services, (with a focus on the PRCs), achievement of the end-of-project outcome and sub-set of intended results is feasible. As the RGC increasingly takes on a leadership role it is likely that RGC funding to service delivery will increase. One critical assumption in this program is that the government continues to support disability sector initiatives and further grow the economy in order to mobilise greater funding for services. This program component will collaborate closely with the RGC and intends to negotiate an agreement with the RGC regarding increased funding to services.

### ***How will we know?***

Services in receipt of program funding, whether through the PRSS or the SGS, will be expected to provide baseline service data and then measure service access over time. This is possible as most services already do this and a system of collating this information will be developed. Increased government financial support to the PRCs will be an indicator of success. This information will be sought as part of the program's collaboration with the RGC.

### **Will the benefits last?**

Technical assistance to PWDF and MoSVY to put in place systems and structures that support improved management of the PRCs has potential to last, even with staff turn-over within these agencies. Systems that increase efficiency are more likely to be adopted and sustained, and support to MoSVY and PWDF will be mindful of this.

## **2.8 Component 4: Inclusive governance and inclusive community development**

**End-of-Program outcome:** Increased capacity of and collaboration between subnational decision makers, civil society and communities to achieve the rights of people with disability

### **Intermediate outcomes:**

1. People with disability have access to community-based services and support from their local decision-makers in reducing barriers to participation.
2. Increased capacity of subnational decision-makers in select areas to implement the NDSP, aligned to the CRPD.

### **Intended results:**

1. Government officials in selected provinces, districts and communes have greater knowledge, skills and resources to improve the lives of people with disability.
2. People with disability have increased opportunities to participate and contribute to community life in selected areas.
3. Collaboration between stakeholders in selected provinces, districts and communes as well as across each level of the system is increased.
4. Non-government organisations are able to deliver quality community based services to people with disability, in particular women and children.
5. On-going documentation and dissemination of experiences to influence policy dialogue and contribute to the CRPD reporting process.

**Implementing agency:** UNICEF

### **Why are we doing this?**

In order to effectively improve the lives of people with disability in Cambodia through increased opportunities for participation and the implementation of the CRPD, the program must address, in parallel to national level engagement, the sub-national development context to link actors and create an enabling environment for people with disability.

A key development process and priority for the RGC is the National Program for Sub-National Democratic Development (NP-SNDD); this program is the driver for the decentralisation process in Cambodia and oversees within this process: sub-national institutional development, the development of strong human resource management systems, the transfer of functions and resources, sub-national budget, financial and property systems, support institutions for decentralisation reform process.

As roles, responsibilities and resources (both financial and human) are transferred to the sub-national level, there is a unique window of opportunity to make local decision making processes inclusive, participatory and responsive to people's needs. It is vital that the rights and needs and voice of people with disability are taken into account during the process of formulation and implementation of local plans and budget. However, for many people with disability the main support does not come from government institutions but through organisations such as DPOs,

SHGs and NGOs. The decentralisation process provides a new opportunity to bring together and promote synergies between the government and non-government service providers, to encourage local statutory bodies to take account of the rights of people with disability and to strengthen participation of people with disability in the development of local decision-making. By encouraging, facilitating and institutionalising participation, decentralised governance will be strengthened and more accountable. Decentralisation is a key process in Cambodia and attention to developing the sub-national system and capacities is critical to empowering people with disability. As the decentralisation process takes place, there is an on-going need to support CBOs and NGOs to provide support and deliver services to people with disability at the local level, however, with a broader overarching aim to strengthen the multi-stakeholder engagement in support for people with disability. It is important to strengthen the relationship between stakeholders (government and non-government) to reduce fragmentation, duplication and to respond effectively to the real needs of people with disability in communities. Collaboration and cooperation between the different actors will increase mutual accountability and legitimise at the sub-national level the work of the disability sector within the development process. This approach is consistent with UN Agenda 21 (see Annex 10).

### ***How will we do it?***

UNICEF proposes to achieve its end-of-program outcome of 'increased capacity of and collaboration between subnational decision makers, civil society and communities to achieve the rights of people with disability' through a package of interventions which will ultimately improve on-the ground coordination between disability relevant stakeholders, improve local decision making's disability inclusiveness and reduce fragmentation of support to people with disability by bringing together local government and decision-makers with NGO/CBO service providers.

The component package will consist of: a) capacity development activities for local government including Provincial Governors, provincial, district and commune decision-makers, b) the roll out of a commune contracted community worker to be a commune level disability focal point and to provide outreach support to people with disability and, c) a small grants scheme aimed at strengthening the link between non-government service providers (NGOs/CBOs) and local decision-makers and to provide disability support services to people with disability. The component elements - capacity development, strengthening inclusiveness at the sub-national level and small grants - are mutually reinforcing delivery mechanisms. The component's core activities are not ends in themselves, but a strategic interlinking of delivery mechanisms that will strengthen the institutional system and structure at the sub-national level to ultimately make a difference for people with disability. The results of this component are ultimately aimed at sustainability through the component's engagement with and development of the capacity of the emerging sub-national institutional environment by:

- building the capacity of local decision makers to take disability inclusive actions;
- placing a disability community worker at the grassroots level; and
- nesting the small grants within the decentralisation process.

The program component frames the small grants mechanism and disability inclusiveness within a clear government process. UNICEF experience clearly demonstrates that programs initiated with donor funding, when clearly linked to Government accountabilities, particularly at the sub-national level, once established and delivering results are sustainable as Government has shown willingness to buy-in to the work and take it to scale.

### **Geographic Focus**

In order to effectively monitor, measure and collect evidence for upstream policy development, the component will work in select geographic areas. The select geographic areas for the component will

be applied to all three elements of the component packages – capacity development for local decision-makers, the community worker and the small grants scheme.

For the first two years of implementation the program will focus on six provinces (to be determined during inception), selected from UNICEF focus provinces and key urban areas; there will be a mixture of urban and rural areas and particular attention to high need areas. The component recognises that currently greatest areas of need are found to be in remote rural areas. Two additional provinces will be included from non-UNICEF focus provinces, to help ensure coverage of under serviced areas. Mid-program, UNICEF will review the initial target areas to assess whether the model is working and possibly revisit and/or expand the target areas. Figure 2 in Annex 1 shows the six key urban areas of the component: Battambang, Kampong Cham, Kandal, Phnom-Penh, Siem Reap, Sihanoukville. The map additionally shows the nine UNICEF focus provinces (Battambang, Kampong Cham, Kampong Speu, Kampong Thom, Mondulhiri, Prey Veng, Ratanakiri, Siem Reap, Svay Rieng).

### **Inception**

Implementation will begin with an inception phase. This phase of the component will include:

- Identification of the geographic focus areas in which the work will be implemented during the first two years of the program. The areas will be selected based upon criteria including: the needs of people with disability, the existing capacity of subnational decision makers, activities of non-government service providers and by clearly identifying areas with weak and strong capacities. The intention is to draw specific lessons to inform roll out, and to identify opportunities and methods to work cooperatively with various services providers.
- A detailed review of the realities on the ground for people with disability in the selected focus provinces will be undertaken. UNICEF's focus is on equity for the most vulnerable and deprived members of the community, which includes people with disability, since they are among the poorest 20 per cent of Cambodians<sup>25</sup>. The review will involve a desk review of research and analysis, consultations with key actors at central level (DAC and CDPO), provinces, districts, communes, and NGOs. The review will also focus on capacity diagnostics - training needs, baseline knowledge of trainers and decision-makers, gaps in and barriers to participation and access to services and will identify existing opportunities and support structures such as DPOs. This initial review will provide the baselines to inform the intended results and intermediate outcomes.
- Revision of the community worker model to be disability inclusive.
- Development of the specific guidelines and protocol around the small grants administration and management. The small grants will be designed to be as accessible as possible with Khmer and English language materials to be developed.

### **Sub-national capacity development for disability inclusiveness**

Sub-national capacity development is central to creating an enabling environment and system in which people with disability can have their voices heard and their needs met through inclusive decision-making, planning and implementation. Through capacity development, there will be stronger institutional coordination between key stakeholders for a more disability inclusive system. Capacity development for local decision makers<sup>26</sup> and non-government service providers on disability awareness, specific tools, stakeholder engagement and disability specific interventions will be carried out in consultation and close coordination with other UN agencies and in particular DAC, MoSVY and CDPO. The sub-national capacity building under the UNICEF component will be designed to complement and support efforts led at the national level by MoSVY, DAC and CDPO such as the DAC plans to establish provincial level DACs and CDPOs commitment to strengthen their DPO relationships with local village leaders and commune councils at the sub-national level.

Consultation of people with disability and their families will critically inform capacity development tools and implementation.

For capacity development of sub-national decision-makers on disability and inclusive governance, UNICEF will build from its experience of working closely with the Secretariat of the National Committee for Subnational Democratic Development (NCDD-S) to strengthen the sub-national administrations through the capacity development teams at the Ministry of Interior (MoI) / Secretariat of the NCDD-S, as well as the provincial and district capacity development advisors<sup>27</sup>. Any funds transferred to NCDD-S will be on an output based agreement and will be closely monitored. NCDD-S meets the UN HACT standards; annual audits takes place and UNICEF conducts spot checks.

### **Strategic engagement with Ministry of Interior and NCDD-S for sub-national results for people with disability**

MoI has the mandate from the Royal Government of Cambodia to lead and coordinate decentralisation reform. The Minister of Interior was appointed as chairman of the National Committee for Democratic Development at Sub-national level established by the Royal Decree dated 31 December 2008. MoI is uniquely position to influence sub-national development and decision making processes.

The Department of Local Administration (DoLA) of MoI is instrumental in the design and delivery of capacity building for sub-national administrations together with development partner programs and projects that support decentralisation reform. The training topics include planning, budgeting, finance system, procurement to mainstreaming gender, natural resource and environmental management and social development into planning and implementing process.

There are many skilled and experienced trainers at national (at DoLA/MoI and NCDD-S) and sub-national level (provincial and district administrations) as a result of the past years of reform who could be used to their full potential in further strengthening the capacity and effectiveness of the sub-national administrations in identification and delivery of services to meet the needs of local citizens.

The provincial and district governors (report to MoI) have the crucial role to coordinate and support all government development interventions, including those that are implemented by line departments of national ministries, development partners and CSOs in territory.

Provincial governors and district governors are in better position to than any technical line departments to bring together various actors at sub-national level to cooperate, share information and program resources in an integrated manner.

A yearly District planning integration workshop that involve participation of line departments, DPs, NGOs and CSOs in October- November and organized by district governor offices with support of provincial governor office in coordination with Provincial Department of Planning is an example of how the district administration fulfils its coordination role.

As reforms progress, it is expected that more and more functions and resources (finance and human) will be assigned to local administrations (governments), thus their role will become more and more crucial in understanding vulnerable populations, coordinating the planning and service delivery to meet the needs of citizens. The role of line ministries and department will be more on setting and monitoring technical standard compliance.

This sub-national capacity development will reinforce (rather than duplicate) any capacity development activities organised by DAC/MoSVY on the 2009 *Disability Law*, the NDSP and the CRPD. The focus of capacity building under the component will be on: local solutions to removing

barriers to participation, disability inclusive planning (budgeting and annual work plans), linking and accessing non-government services, and practical low cost high impact local interventions to support people with disability and the community level, (e.g. accessible public infrastructure, transportation to legal services, health services, and vocational training), to improve the lives of people with disability and actively encourage their participation. The capacity development activities will, over the life of the program, be rolled out in the initial eight focus provinces (from provincial level actors down to village level)<sup>28</sup> and the six key urban areas identified for the component; if new geographic locations are identified, capacity development activities will continue into the new areas.

The capacity development of sub-national actors will be sequenced starting with general awareness raising followed by more targeted activities to support decision-makers to implement disability actions – including accessibility of public infrastructure, inclusive budgeting, livelihoods, etc. By increasing awareness and disability inclusive decision-making and action plans, the link between people with disability and non-government service providers will be strengthened, addressing the current gaps that exist between the stakeholders for a more sustainable disability inclusive environment.

Capacity development activities and materials will be developed in coordination with MoSVY and DAC to ensure complementarity to national policies and their approaches to sub-national capacity development. The sub-national capacity development under this component, conducted in cooperation with MoI/NCDD-S, will link and reinforce DAC and MoSVY's activities at the national level related to capacity building, enforcement and implementation of endorsed regulatory frameworks.

Capacity development will be delivered by MoI and NCDD-S capacity development teams and specialists and representatives of people. Activities will be accessible and specifically aim to include women with disability and represent the gender and child specific dimensions of disability in governance. Consultation and cooperation with CDPO will be an integral part of the capacity development work, to complement their plans and support organisations that do not come under their umbrella. Increasing the capacity of the subnational decision-makers and stakeholders to understand the importance of disability inclusiveness and to provide support to people with disability is an element of the work for the sustainability of results).

As a first step, it is envisioned that initial training around disability awareness will be needed. For this, the initial step will be to prepare appropriate resources for trainers and decision-makers in collaboration with DAC, CDPO and other representatives of people with disability and tapping into already existing resources of local NGOs. Specific examples of resources are: training manuals, leaflets, posters, fact sheets, checklists, and advocacy points for information sessions at village level.

In parallel to awareness raising resource development, incentives around capacity development will be assessed during the inception phase and options will be tested in the first two years of implementation. Capacity development and training for trainers will be conducted in the early phase of implementation. Over the following years, capacity development activities such as workshops led by the trained trainers, cascade training, in-country cross visits and other methods such as 'on the job coaching' (provincial and social service focal points will be coached by capacity development advisors; social service focal points will be coaching the members of the Commune Committees for Women and Children [CCWCs]) will be rolled out in the selected geographic areas of the component. UNICEF will work closely with the MoI and its capacity development unit, the provincial/district capacity development advisers, the provincial and district social service focal points, the commune focal points for women and children throughout the capacity development work. It is important to note that representatives of people with disability (including women with

disabilities) and local NGOs implementing CBR will be actively involved in the planning and delivery of these training sessions and participatory M&E.

To complement the capacity building of local decision-makers and to increase participation of people with disability in local decision-making, UNICEF will advocate for and facilitate the participation of a representative of people with disability (DPOs or NGOs) to participate in the Women and Children Consultative Committees (WCCC) and CCWC meetings. During the inception phase of the work UNICEF will engage with people with disability and decision making structures to identify entry points and overcome barriers preventing people with disability participating in these structures, for example, suggesting a revision to the WCCC and CWCC guidelines.

### **The community worker**

To strengthen the links between people with disability, non-government service providers and local decision makers, UNICEF will roll out its community worker model. The community worker model will support local governments and decision-makers capacity to be disability inclusive and will be a critical link in the system at village level.

The community worker model<sup>29</sup> under the program: a commune contracted and supervised community worker focussed on providing support specifically to people with disabilities and their families at the village level. The community worker is a local villager, familiar with the environment and community. The community worker's function will be to: mobilise families, undertake home visits – especially to female headed households or families with women and/or children with disability, provide support and advice for disability inclusiveness to village leaders, and make necessary referrals to services (thus linking beneficiaries, service providers and decision-makers)(see Annex 9).

The community worker will provide direct support through outreach, serve as a link to services by providing referrals, sharing information on availability of services with village members and assist in early identification and screening in children. Over the life of the program, with AusAID funds, it is planned that the model be rolled out in 50% (up to 70%) of communes in the selected provinces. The community worker will serve as an informal disability focal point at the community level, liaising between people with disability and linking local decision-makers and service providers operating in the area. The community worker model is embedded within existing governance structures, the commune, and their function will ensure that the issue of disability is on the agenda and will physically represent and hold accountable the commune's commitment to disability.

As the community workers will be involved with CBR related activities at village level, UNICEF will coordinate with WHO to ensure complementarity of provision and to avoid possible overlap. If there are other CBR workers in the selected areas, UNICEF will pay particular attention to ensure synergies and to rely on the expertise of these professionals to strengthen capacity of other community workers. The component will also explore the possibility of working with pagodas/spiritual leaders to address stigma and discrimination and to strengthen their role in supporting people with disability. UNICEF engagement with faith based leaders will focus on promoting a rights based approach.

### **Small Grants Scheme**

UNICEF lessons and observations in a range of sectors find that in Cambodia, NGOs funded without formal ties to Government operate in a vacuum. They provide valuable services – with little information exchange with the government organisations who should at the very least have oversight and accountability for quality and reach of services. Because of this de-linking, NGOs



make no impact on policy, their data is missed by the Government at all levels so the people and their issues remain hidden; they are often better funded than the local level services so they become resented - rather than supported by the public services system.

To address this vacuum and to enhance coordination and reduce fragmentation within the sector and between actors, the small grants scheme will be used as a mechanism to bridge the relationship between non-government service providers and local decision makers, strengthening knowledge/experience sharing and creating a locally rooted disability network. The small grants scheme (SGS) will provide direct support to non-government service providers for people with disability at the community level within the CBR framework. The small grants scheme will be delivered in the context of its local institutional framework – strengthening mutual accountability and influencing local provision of service delivery.

The SGS will support organisations that meet the necessary requirements (management, fiduciary, etc.) and correspond to grant calls that have demonstrable efforts to strengthen the system locally between people with disability, non-government service providers and local authorities.

### **UNICEF history of support to disability and lessons learned**

1. **Armed Conflict phase** (emergency responses): **1992 to 1995**, UNICEF support to the disability sector was part of Mine Action Programmes with a specific focus on IDPs and refugees returned from Thailand. UNICEF provided direct financial and technical support to Government and NGOs.
2. **Post-Conflict phase** (rehabilitation and socioeconomic reintegration): **1996-2000**, UNICEF provided ongoing support to women and children with disabilities (including child soldiers demobilization). UNICEF provided direct financial and technical support to Government and NGO.
3. **Development phase** (Disability Empowerment and right-based inclusion with greater government leadership, ownership and sustainability [Community-based rehabilitation]): from 2001 to date, UNICEF's support to disability has focussed on policy and legal framework development, empowerment and right-based inclusion. (Government sub-contract NGOs)

### **Lesson learned:**

UNICEF support to children with disability, in particular services, has been implemented in cooperation with government, local and international NGOs. One of the central challenges is sustainability and Government leadership, ownership and accountability in cases where funding is from UNICEF or other donors without any government or commune fund counterpart contribution.

In response to this challenge, UNICEF has been collaborating with MoSVY and the National CBR Committee to deliver coordinated CBR support to people with disability. New guidelines were established with the aim of increasing government accountability and coherence of service delivery. New grant criteria included: a government or commune budget counterpart contribution; NGOs and government must have a clear phasing out and handover strategy in the short, medium and long term (within 5 years maximum); a percentage of staff with disabilities; a good track record of working with government, and; for organizations that establish self-help-groups of PWDs commune council members must be involved. Grant selection was led by MoSVY with participation from other stakeholders. Through this experience, it was observed that the Ministry could harness the public-private service delivery relationship to address needs where there were no CBR services. Lessons from this experience demonstrate that funding support through the Ministry resulted in greater collaboration, oversight, monitoring, accountability, sustainability and ownership. It is important to address the reliance of project-based support (which is finite) and important to involve government in mapping, identifying issues and coordinating of services in their respective provinces both at local and national level. By

linking Government and no-government service providers, evidence and buy-in was achieved and evidence could be used efficiently by the Ministry for policy development.

### **Process around the Small Grants Scheme**

During the inception phase detailed guidelines for the SGS will be developed including: the principles underlying grant scheme; the scope and mechanisms for identifying and revising relevant thematic lines for calls for proposal; application process, drawing upon the previous AusAID small grant scheme (the Cambodia Initiative for Disability Inclusion – CIDI) and its guidelines; frequency for the call; length of funding; the review committee composition, frequency of its meetings; etc. The dissemination of the small grants process in both Khmer and English will be operated under UNICEF’s existing procedures.

The Small Grants Scheme’s selection process will be done by an interdisciplinary panel, with representation of people with disability, participating UN agencies and sector technical advisers. The selection panel will make the final recommendations to UNICEF who will then process the supported applications through their internal screening process. Given that the applications will be assessed carefully by the selection panel, the UNICEF internal process will be primarily to ensure alignment with grant management guidelines. While UNICEF will lead in managing the SGS, regular consultation with WHO will take place to ensure alignment with international CBR guidelines and maximise opportunities on the ground.

Agreements with recipients of the SGS, where possible, will be outputs based. This will minimise and mainstream some of the monitoring and acquittals processes around grants. Additionally, it will hold grant recipients to their stated outputs.

The purpose of the SGS is to improve support to people with disability through the CBR framework through strengthening the link between services (non-government providers) to the local governance system in the selected areas and to encourage collaboration between subnational administrations and non-state service providers. To this end, it is envisioned that to manage the small grants funds, funding streams through which organisations can apply will be established. These streams would have specific foci to ensure that the small grants feed into the component results through the delivery of services to people with disability. Examples of such funding streams could include: participation and empowerment; knowledge sharing and data; support to children with disabilities; support to underserved disabilities; but not limited to these examples.

The SGS will be managed as a coherent part of the whole process of community support for people with disability and the selection of grantees will maximise synergy with the WHO grants for physical rehabilitation in component three and UNDP’s support to CDPO in component two. Potential grantees (especially Khmer speaking organisations) will be supported through capacity development workshops, exchange visits and other activities in order to help them make appropriate and viable applications. Those organisations that meet necessary financial requirements will be given financial support to implement their proposals. Special attention will be given to interventions to improve the lives of women and girls with disability that are in line with the NDSP. A network to support these organisations and share their knowledge among themselves and other subnational actors will be developed, building on lessons learned from the CIDI.

### **M&E for the component**

M&E for the component will commence in the inception phase and will be rooted in UNICEF’s Country Programme M&E framework and in the joint program’s M&E Framework. It is expected that M&E activities will also be carried out by the SGS recipients and feed into the component

framework. The UNICEF field offices will play a critical role in supporting the involvement of local actors in participatory M&E through documenting experience and monitoring results.

All of the component activities will be subject to on-going M&E which will include documentation, dissemination and uptake of lessons learned. There will be a mid-program cycle summative review to assess relevance, effectiveness and efficiency of the model and re-assess the geographic focus areas of the first two years of implementation. All elements of the program component must prove to be effective and responsive to needs.

### ***Will it work?***

Since Cambodia has embarked on and committed to an ambitious decentralisation reform it is essential for local authorities to be responsive to particular needs on the ground. For this to work and to encourage sustainability the actors working in the communes must be involved. By working with local decision makers, in collaboration with MoI and NCDD-S, the program is involving key actors in promoting disability rights. MoI is the lead Ministry in the process and plays a strong role in the development agenda and policy in Cambodia; they are a strategic partner for the program, in addition to the Component 1 and 3's work with MoSVY and MoH.

By targeting geographic areas, the component will be able to pilot and test models of strengthening the institutional context in which people with disability live. The results of the interrelationship of improved capacity of decision makers on disability, increased participation of people with disability and improved coordination between local government and non-government service providers can be explored and refined. Lessons learned and best practice can be incorporated and updated throughout the life of the program. Importantly, this component will link from the sub-national level up to the national level, through the program, to provide evidence and experiences. As a part of the whole program, this component's work will contribute to the feedback loop at the different levels in Cambodia of information, data, experiences and realities of people with disability.

The component sets out to explicitly create linkages between non-government service providers in the disability sector and government, to formalise the relationships, improve information sharing and to harness the work of both for sustainable results for people with disability. The small grants scheme is a mechanism through which the institutional strengthening and coordination at the sub-national level will flow up to the national level with policy framework.

The community worker is an innovative model which has commune buy-in, as they fund the position, and that will deliver grassroots support to people with disability as well as be a unique focal point, linking people, services and local government. As this model is part of the local system (commune contracted), the scalability potential of the model is high. In communes where the community worker model (Annex 9) is implemented, and where low cost high impact interventions have been delivered, there will be lasting changes on the ground<sup>30</sup>.

Co-operation and the development of partnerships between NGO/CBOs with local government and decision-making bodies at the sub-national level will improve local governance, participation opportunities for people with disability and improved coordination in the delivery of services.

### ***How will we know?***

Strong on-going M&E will be a key feature of the component. This will provide important information as the process is unfolding and where corrective actions need to be taken. A full set of indicators will be developed during the inception phase and during the first quarter of 2014. Indicative indicators include:

- People with disability have access to community-based services and support from their local decision-makers in reducing barriers to participation.

- Number of NGOs with strengthened capacity to provide quality services responding to the needs of people with disability and their families at the community level.
- Number of people accessing disability or rehabilitation services through the SGS.
- Number of NGOs/organisations participating in the SGS delivering services.
- Number of grants specifically bringing different stakeholders together (people with disability, service provider, local decision makers).
- Number of people with disability and their families benefiting from the daily interventions of community workers.
- Number of commune interventions carried out collaboratively between local government and non-government service providers. Increased capacity of subnational decision-makers in select areas to implement the NDSP, aligned to the CRPD.
- Number of WCCC and/or CCWC meetings that have a participating (involved in decision-making processes) representative of people with disability, in particular representation of women and children with disability.
- Number of people with disability benefiting from council decisions.
- Number of consultative workshops or meetings held between local authorities and people with disability/parents of children with disabilities.
- Identification of barriers to participation of people with disability and finding solutions.
- Number of commune interventions carried to remove barriers for people with disability.
- Number of people with disability and their families receiving quality support services in selected areas.
- Number of meetings between small grant holders, local councils and district and provincial offices.
- Number of people trained to deliver courses on disability.
- Number of people involved in capacity building events.

### ***Will the benefits last?***

Sustainability is inherently built into the design through sub-national work – with the commune councils, districts, provinces and the ultimately MoI. The component is focussed on the sub-national in order to tie the work of the NGOs together and together with local government and the government’s accountability for protection of the rights of people with disability and the oversight, delivery and quality control of services to people with disability.

In the coming years there will be increased allocation to local budgets (commune and district fund) as part of the decentralisation process and communes will be have a greater capacity as a result of the program to create involve and take account of people with disability in governance processes. The needs of people with disability will be put on the agenda and accountability within the system will be strengthened, from the local to the national level – ultimately supporting Cambodia with its UNCRPD commitments. Local authorities will have developed a consultative working relationship with civil society organisations to respond to and meet the needs of people with disability through inclusive development actions or disability specific actions.

## **2.9 Resources**

### **2.9.1 Budget overview**

Funding will be provided in Australian dollars but the program will budget in US dollars. The program budget has been developed based on an exchange rate of AUD\$1 buying US\$0.9 to reflect the recent depreciation of the Australian dollar. It is possible that further depreciation of the Australian dollar may occur. The risk of further weakening of the Australian dollar will need to be managed (see the Budget Annex (Annex 3) and Risk Management Annex (Annex 6) for further

details). Final amounts will be recorded in US Dollars based on the UN operational rate of exchange upon receipt of contributions.

The budget should be regarded as indicative. The Program Board will have authority to vary budget allocations from year to year, taking a performance based approach. This will allow for flexibility to take advantage of emerging opportunities and accommodate changes in circumstances. This may involve reallocation between components based on performance and absorptive capacity.

Table 1 (below) provides an overview of the budget by category of expenditure by year. A detailed budget is in Annex 3. Total estimated expenditure over the 5.5 years is US\$12.728 million which exceeds the projected available funding of US\$11.629 million. During program design, each of the UN agencies made significant cuts to their proposed budgets in response to the devaluation of the Australian dollar. The budget will need to be further revised during the inception phase and possibly on an annual basis to ensure that it balances with available funding. Due to absorptive capacity issues there may be under expenditure during the inception phase and year 1. Any savings made in these years would help to balance the budget against available funding.

### **2.9.2 UNDP Multi-Partner Trust Fund Office, as the Administrative Agent of the Joint Programme**

This UN Joint Program will use the pass-through fund management modality according to the United Nations Development Group Guidelines on UN Joint Programming. The UNDP Multi-Partner Trust Fund Office (MPTF Office), serving as the Administrative Agent for the Joint Program, as set out in the Standard MoU for Joint Programs using Pass-Through Fund Management, will perform the following functions:

1. Administer such funds received, in accordance with the MoU, including the provisions relating to winding up the Joint Program Account and related matters.
2. Subject to availability of funds, disburse such funds to each of the Participating UN Organizations (PUNOs) in accordance with instructions from the Program Board, taking into account the budget set out in the Joint Program Document, as amended in writing from time to time by Program Board.
3. Consolidate financial reports, based on submissions provided to the Administrative Agent by each PUNO, and provide these to each donor that has contributed to the Joint Program Account and to the Program Board and PUNOs.
4. Provide final reporting, including notification that the Joint Program has been operationally completed, in accordance with Section IV of the MoU.
5. Disburse funds to any PUNO for any additional costs of the tasks that the Program Board may decide to allocate (as referred to in Section I, Paragraph 3 of the MoU) in accordance with Joint Program Document.
6. Receive contributions from donors that wish to provide financial support to the Joint Program.

Prior to the Joint Program launch, a MoU will be signed between PUNOs and the Administrative Agent. The Administrative Agent then concludes the agreement with the contributor.

**Table 1: Budget overview by category of expenditure by year, 2013 - 2018**

Budget category	Total budget US\$	Inception 2013 US\$	Year 1 2014 US\$	Year 2 2015 US\$	Year 3 2016 US\$	Year 4 2017 US\$	Year 5 2018 US\$
<b>Program Coordination Team: Total program costs</b>	<b>1,541,530</b>	<b>70,000</b>	<b>265,806</b>	<b>269,056</b>	<b>307,306</b>	<b>275,556</b>	<b>353,806</b>
Indirect support costs (7% of total program costs)	107,907	4,900	18,606	18,834	21,511	19,289	24,766
<b>Total Budget: Program Coordination Team</b>	<b>1,649,437</b>	<b>74,900</b>	<b>284,412</b>	<b>287,890</b>	<b>328,817</b>	<b>294,845</b>	<b>378,572</b>
<b>Component 1: Supporting Government implementation of the CRPD: Total program costs (UNDP)</b>	<b>1,218,000</b>	<b>50,500</b>	<b>266,500</b>	<b>246,500</b>	<b>221,500</b>	<b>216,500</b>	<b>216,500</b>
Indirect support costs (7% of total program costs)	85,260	3,535	18,655	17,255	15,505	15,155	15,155
<b>Total Budget: Component 1</b>	<b>1,303,260</b>	<b>54,035</b>	<b>285,155</b>	<b>263,755</b>	<b>237,005</b>	<b>231,655</b>	<b>231,655</b>
<b>Component 2: Supporting DPOs: Total program costs (UNDP)</b>	<b>1,992,000</b>	<b>29,500</b>	<b>396,500</b>	<b>391,500</b>	<b>391,500</b>	<b>391,500</b>	<b>391,500</b>
Indirect support costs (7% of total program costs)	139,440	2,065	27,755	27,405	27,405	27,405	27,405
<b>Total Budget Component 2</b>	<b>2,131,440</b>	<b>31,565</b>	<b>424,255</b>	<b>418,905</b>	<b>418,905</b>	<b>418,905</b>	<b>418,905</b>
<b>Component 3: Supporting rehabilitation systems strengthening: Total program costs (WHO)</b>	<b>2,071,000</b>	<b>64,000</b>	<b>395,000</b>	<b>403,000</b>	<b>403,000</b>	<b>403,000</b>	<b>403,000</b>
Indirect support costs (7% of total program costs)	144,970	4,480	27,650	28,210	28,210	28,210	28,210
<b>Total Budget Component 3</b>	<b>2,215,970</b>	<b>68,480</b>	<b>422,650</b>	<b>431,210</b>	<b>431,210</b>	<b>431,210</b>	<b>431,210</b>
<b>Component 4: Inclusive governance and inclusive community development: Total program costs (UNICEF)</b>	<b>4,954,900</b>	<b>148,000</b>	<b>955,380</b>	<b>955,380</b>	<b>985,380</b>	<b>955,380</b>	<b>955,380</b>
Indirect support costs (7% of total program costs)	346,845	10,360	66,877	66,877	68,977	66,877	66,877
<b>Total Budget Component 4</b>	<b>5,301,745</b>	<b>158,360</b>	<b>1,022,257</b>	<b>1,022,257</b>	<b>1,054,357</b>	<b>1,022,257</b>	<b>1,022,257</b>
<b>Total program costs and indirect support costs (Program Coordination Team and Components 1-4)</b>	<b>12,601,852</b>	<b>387,340</b>	<b>2,438,729</b>	<b>2,424,017</b>	<b>2,470,294</b>	<b>2,398,872</b>	<b>2,482,599</b>
<b>Multi-Donor Trust Fund management fee (1% of total funds transferred to MPTF Office by AusAID)</b>	126,018	3,873	24,387	24,240	24,703	23,989	24,826
<b>Total budget (Total program costs, indirect support costs, plus MDTF management fee)</b>	<b>12,727,869</b>	<b>391,213</b>	<b>2,463,116</b>	<b>2,448,257</b>	<b>2,494,997</b>	<b>2,422,861</b>	<b>2,507,425</b>
<b>Available budget from AusAID (US\$)</b>	<b>11,629,000</b>	<b>395,000</b>	<b>2,392,000</b>	<b>2,215,000</b>	<b>2,214,000</b>	<b>2,214,000</b>	<b>2,199,000</b>

### 2.9.3 Budget overview by component

#### **Program Coordination Team**

The Programme Co-ordination Team will be housed in UNDP. The budget was developed based on UNDP's current program costing of similar work and standard cost estimates used in UNDP programming. The budget includes the cost for staffing (one International P-4 level position, one administrative assistant position and one national UN Volunteer); the cost of setting up the office; annual operational costs (rent, utilities, IT support, stationary etc.); travel costs (international and local); monitoring and evaluation costs (external); and communication costs for joint communication activities of the program (publications, brochures, advertisements, web site communication, organisation of events etc.).

#### **Component 1 and 2 (UNDP)**

The budget was developed in consultation with relevant stakeholders, development partners and using standard cost estimates used in UNDP programming.

The implementation modality and potential direct funding of Government (i.e., MoSVY/DAC) and CDPO for these two components will be determined based on the initial capacity assessment of the partner institution and additional fiduciary control assessments (e.g. Harmonized Approach to Cash Transfers (HACT)) which are obligatory under UNDP guidelines and procedures. Based on the above, an appropriate modality for direct funding will be determined. There are two main modalities:

1. Grant – in which the partner institution will receive funding for specific objectives and activities
2. National implementation modality (NIM) – in which partner institutions are given overall responsibility for management of their component of this work with a clear division of tasks, roles and responsibilities, and budget allocations. between partner institutions and UNDP.

In both cases, UNDP will ensure proper monitoring of the activities, quality assurance and transparency of utilization of funds based on standard UNDP rules and regulations. Both modalities require opening of a specific bank account to be used for the utilization of funds with UNDP carrying out regular reviews and periodical financial audits.

Components 1 and 2 will be managed by one National NO-B equivalent funded by the program.

The budget also provides for necessary technical assistance costs from UNDP Asia Pacific Regional Centre and UNDP HQ to be utilised throughout the project.

UNDP 'in kind' contributions will include significant allocation of time from other UNDP staff including the Governance Unit (Project officer, Finance associate and Head of Unit), and UNDP senior management (Deputy Country Director and Country Director). In addition, other UNDP program Units (Poverty, Environment) as well as UNDP Operations (HR, Procurement, Management Support Unit) will provide assistance in implementation of the program as a part of their regular tasks and responsibilities.

#### **Component 3 (WHO)**

During the design and in-country mission the budget for components of the program were discussed with national stakeholders to identify levels of support required and standard costing. The program was developed and activities identified, then based on the standard costing, the budget was developed.

Initially there will be limited direct funding to the RGC, however, in later years of the program there is potential for funding based on work plans. The RGC will be responsible for implementation with clear roles and responsibilities. The decision will be made taking into consideration transparency, accountability and performance of relevant RGC departments. If the RGC is funded

there will be two levels of control mechanism: 1) funding linked to a work plan and deliverables which will be monitored by WHO; and 2) close monitoring by the WHO NPO through communication, monitoring of implementation, support, and accountability for use of funds.

WHO will recruit a National Professional Officer (NPO-C) in Disability and Rehabilitation who will be fully responsible for implementation, with support by the WHO country and regional offices.

The in-kind contribution from WHO will be:

- Office space, utilities, furniture, supplies, security and telecommunication.
- Logistics and administrative support.
- Regular communication and back-up technical support from Western Pacific Regional Office
- Visits from Regional Office and Headquarters.
- Opportunities for NPO Professional Development.

#### **Component 4 (UNICEF)**

The budget for all items, except the SGS, were developed based on UNICEF's current program costing of similar work carried out in communes. Staffing costs are based on standard UNICEF staff scales.

The SGS budget was agreed to by the Design Team with five per cent allocated to activities related to implementing the program including technical support and management for NGOs/DPOs.

Direct support to the RGC will go through the Secretariat of the NCDD-S which channels funds to the various subnational provincial and district administrations and via the MEF for the social service envelope through the commune/sangkat funds to support implementation of basic social services. The framework for providing funds to the RGC is aligned with Sub-decree 10, 2004 (Anukret 10). UNICEF has an internal guideline on daily subsistence allowance, travel, incentives and other allowances for government employees and community structures involved in a UNICEF-supported program. UNICEF will only provide funds to government institutions that have passed the HACT micro-assessment.

The program will fund one international L3 position to manage and provide technical support to the component and two National Officer (NOBs) for supporting implementation of the component.

UNICEF in-kind contribution in Phnom Penh will include office costs, (stationary, rent, utilities), technical support from the UNICEF Representative, Deputy Representative and heads of sections. Locally it will include support from zone staff, program assistants and drivers.

### **3. Implementation arrangements**

#### **3.1 Governance, management arrangements and program structure**

A diagram of program governance and coordination arrangements is in Annex 2.

##### **3.1.1 Program governance**

The program will be governed by a Program Board. Membership of the Program Board will be two RGC representatives (one to be nominated by MoSVY and one by MoH); a senior representative of AusAID; the UN Resident Coordinator and the Heads of the three participating UN agencies (UNDP, UNICEF and WHO) or their senior nominees; and two representatives of people with disability. It is proposed that the Program Board be jointly chaired by the UN Resident Coordinator and the MoSVY representative. The Board will decide on a process for appointment of the representatives of people with disability. For example, one could be nominated by CDPO and the other chosen from any other organisation by the Board on the basis of their skills and qualifications. . One of these positions should be filled by a woman.



The Program Board will:

- Provide strategic guidance for coherent and coordinated program implementation
- Approve the program annual work plan and budget and approve allocation of funds , which triggers the release of funds from the MPTF Office to the participating UN agencies
- Approve frameworks for key high profile program activities (e.g., grants schemes)
- Review progress mid-year and approve annual progress reports, including progress against set targets. The Program Board will review annual consolidated narrative progress reports and annual consolidated financial reports submitted by the MPTF Office, based on narrative and financial submissions from the participating UN organisations.
- Ensure the highest level of fiduciary accountability and closely monitor the Risk Management Register (see section 3.4 and annex 6).
- Review the mid-term and final evaluations of the program

As a member of the Program Board and Program partner AusAID will play a substantive role in the guidance of the program, drawing from its substantial experience and knowledge of the sector and of the program modalities envisaged.

The Program Coordination Team will serve as the Secretariat to the Program Board. The Program Board will meet at least twice a year. Detailed terms of reference for the Board will be developed in consultation with all relevant actors and approved by the Board at its first session.

### 3.1.2 Program management and coordination

#### **Staffing**

The responsibilities of staff assigned to the Program Coordination Team are described below. The responsibilities of other staff members are described in Annex 8. Supervision of program staff outside the Program Coordination Team will be by line management within the UN agency in which they are located. Accountability to the whole program will be through monitoring of deliverables specified in the annual work plan.

The overall staffing of the program is set out in Table 2.

**Table 2: Program staffing for coordination and each UN organisation**

UN organisation	Title	Number	National staff (Y/N)	Level
Program Coordination Team (based in the UNDP Office)	Program Coordinator	1	N	P4
	Administrative Associate	1	Y	ICS6
	Intern for people with disability	1	Y	
UNDP	Program Analyst	1	Y	NO-B equivalent
UNICEF	Inclusion Specialist	1	N	P3
	National Officer	1	Y	NO-B
	National Officer	1	Y	NO-B
WHO	National Officer	1	Y	NO-C

#### **Technical Review Committee**

The Technical Review Committee (TRC) will provide regular technical oversight of the program and will be chaired on an annually rotating basis by a representative from a participating UN agency (UNICEF, UNDP, WHO) at deputy level or equivalent. The Program Coordination Team

will support the convening and recording of meetings. The TRC will meet quarterly in order to review progress in the last quarter and plan coordination of upcoming work. In addition the TRC will:

- Assist in the coordinated development of the progress reports to the Program Board
- Each quarter hold a review of progress (see 3.3 below for more details)
- Coordinate the development of the annual work plan and budget
- Coordinating knowledge management across the program components
- Refer significant issues to the Program Board

Detailed terms of reference for the TRC will be approved by the Program Board at its first session.

### **Program Coordination Team**

The Program Coordinator will be supervised by the Chair of the TRC and physically hosted and contracted by UNDP for the entirety of the program. The Program coordinator will in turn supervise the Program Coordination Team. The key responsibilities of the PCT will be:

1. Provide overall coordination of the joint program
2. Function as key point of contact and high level program interface with the RGC, the DAC and donors
3. Perform strategic representation functions in collaboration with program components
4. Serve as secretariat to Program Board and TRC
5. Ensure program-wide communication in a coordinated and complementary way with the component-specific communication activities carried out by each UN agency
6. Coordination, oversight and quality assurance of program-wide monitoring and evaluation
7. Coordination of the submission of reports to the MPTF Office
8. Conduct knowledge management activities including documentation and communication of good practices
9. Funds mobilisation

The Program Coordinator will be responsible for 1) overall management of the PCT; 2) convening the TRC; 3) be primarily responsible for activities 1-9 in the list above; and 4) providing technical advice to ensure the coherence of the technical components of the program and strategic positioning of the joint program as a whole.

The Administrative Associate will work under the supervision of the Program Coordinator. He/she will be responsible for providing administrative, financial and operational support to the PCT. The Intern will work under the supervision of the Program Coordinator.

### **3.1.3 AusAID's role in the program**

AusAID is committed to working in close partnership with UN agencies in setting the broad strategic direction for the program (through the board) and in program implementation. Within the governance arrangements, policies and other procedures established by the Board, AusAID will be invited to participate in:

- the formulation of guidelines and policies;
- the provision of technical advice for program implementation;
- participation in; program monitoring and evaluation, the Technical Review Committee, sub-selection grant panels, training courses, workshops and forums, etc.; and
- other relevant activities.

## **3.2 Implementation Plan**

An inception phase will commence after the MPTF Office, as the Administrative Agent, has entered into MOU with UNDP, UNICEF and WHO, and AusAID has entered into a formal agreement with

the MPTF Office . It is anticipated that this will occur no earlier than September 2013. The inception phase will run through to 31 December, 2013. Program implementation will occur over five calendar years, from January 2013 to December 2018. An Implementation Plan showing key activities by half-year for the inception phase and Years 1 and 2 has been developed (see Annex 4). The plan shows critical path activities required at an early stage of implementation in preparedness for later stages of programming. Baseline data for all components will be collected during the inception phase and year one (see Section 3.3, M&E). Key components of the Implementation Plan for program governance and management and each program component are outlined below.

### **3.2.1 Program governance and management**

Priority will need to be given to quickly establishing the Program Board so that it can authorise the MPTF Office to release the first tranche of funding for inception activities. As the Program Coordinator will not have been employed at this point, AusAID and the three UN agencies will need to jointly develop draft terms of reference for the Board and the TRC for adoption at its first meeting. UNDP, in collaboration with UNICEF and WHO, and working closely with the Board, will need to give very high priority to recruitment of the Program Coordinator. The primary limiting factor during inception will be the time taken to recruit program staff. Following recruitment of the Program Coordinator and other program staff, priority will need to be given to developing the Year 1 annual work plan and budget. Priority should be given to early identification of a suitably skilled short-term international consultant to develop the M&E Framework, although substantive work should not commence till each UN agency is in a position to commence annual work planning.

### **3.2.2 Component 1: Supporting government implementation of the CRPD**

In the inception period of the program and in first half of Year 1 several activities need to be undertaken in order to set the direction for later stages of the program:

1. Recruitment of the Program Analyst
2. Intensive consultation between UNDP (and potentially other UN agencies) with DAC and MoSVY regarding DAC's annual work plan and the program's support for implementation
3. Capacity assessment of DAC and MoSVY
4. Functional analysis of DAC and MoSVY
5. HACT assessment (if the NIM is chosen as the implementation modality)
6. Existing disability related data assessment and data need analysis
7. Preparation of the component 1 annual work plan for 2014

### **3.2.3 Component 2: Supporting Disabled People's Organisations**

In the inception period of the project and first half of Year 1 several activities need to be undertaken in order to set the direction for later stages of the program:

1. Recruitment of the Program Analyst
2. Intensive consultation between UNDP (and potentially other UN agencies) and CDPO regarding CDPO's annual work plan and the program's support for implementation
3. Capacity assessment of CDPO
4. HACT assessment (if the NIM is chosen as the implementation modality)
5. Consultation with CDPO, DPOs and CSOs on potential creation of new DPOs and strengthening of existing DPOs

### **3.2.4 Component 3: Supporting rehabilitation systems strengthening**

The initial step will be recruitment of the WHO NPO for Disability and Rehabilitation. During the inception phase considerable consultation and relationship building will be required with key stakeholders. As part of this, a testing of planned program activities will occur with potential to

change some aspects of the program in response. Initial contracting of consultants for the training and technical assistance needs analysis and sectoral leadership paper will be required in early program implementation.

Following initial consultations and analysis, more detailed planning with MoSVY, MoH and PWDF will occur. This is anticipated for early 2014 and will be an important foundation to many future potential training and technical assistance activities. Establishment of the leadership and coordination mechanism is a priority as this will be utilised to guide subsequent activities such as the national forum. Determining priorities and services funded under the PRSS and SGS will need to occur early in program implementation and be regularly reviewed.

### **3.2.5 Component 4: Inclusive government and inclusive community development**

There is a staged approach to implementation of this component. First, it is critical to understand the position on the ground from which to develop training materials and to begin the process of finding entry points to include people with disability in decision making systems. The review of the position on the ground will allow UNICEF to identify the target areas for implementation of component 4. There will be on-going formative evaluation to make sure that the targeted innovations being made across the system are on track and that the NGOs/DPOs funded under the SGS are making a difference to the lives of people with disability and that there is comprehensive coverage. After a period of implementing these activities, the processes and outcomes will be subject to a summative review in order to refine the model and to expand the program in new communes and provinces. At the end of the program there will be a full understanding of the barriers that people with disability face and how they can be effectively overcome that can be generalised to other provinces.

## **3.3 Monitoring and evaluation**

The primary source of data will be the program's Monitoring and Evaluation Framework (M&EF). Another key data source will be the M&E Framework for the NDSP. UNDP will provide technical assistance to DAC in the development of this Framework and in the analysis and utilisation of data.

A guiding program principle is to use data and evidence for the purposes of learning and program adaptation. Structured opportunities for reflection on what is working and what is not have been identified. Information on successes and challenges will be used to inform the on-going improvement of program delivery.

While the M&EF serves as an important accountability tool to AusAID, its primary purpose will be to collect and analyse data that will be used as a program management tool to improve performance and inform RGC policy and programs. This will require an on-going effort in data management, rapid analysis and use of that analysis to guide program implementation.

Each of the three UN agencies will be responsible for the collection, quality assurance and analysis of monitoring data for their respective program components. Monitoring reports will be provided to the PCT on a six monthly basis. The UN agencies will draw on their in-house, in-country M&E expertise to assist program staff with quality assurance and analysis.

The Program Coordinator will be responsible for overseeing the effective implementation of the M&EF by each of the UN agencies and undertaking quality assurance checks on the quarterly monitoring reports by each agency. A significant risk to effective M&E is the absence of an M&E specialist within the PCT. Mitigation strategies have been identified in the Risk Management Register (Annex 6).

A consolidated Annual Progress Report (APR) consisting of the consolidated narrative and financial reports of the three participating UN organisations, will be provided to the Program Board by the

MPTF Office. The APR will provide an analytical review of progress and achievements over the previous year, including progress against baselines, which will allow for an assessment to be made about the adequacy of progress. The APR will also detail changes in the implementation approach for the next year, based on lessons learned. The APR will be the primary mechanism for reporting against the M&EF. The PCT will be responsible for coordinating the submission of inputs to the MPTF Office for this purpose. During the inception phase, AusAID and the three UN agencies will agree on a reporting template for the APR, in accordance with UNDG reporting guidelines. An objective should be to achieve streamlined reporting by avoiding parallel reporting to the Board, AusAID, RGC and the MPTF Office.

M&E data collected by the program will be highly relevant to the RGC policies and programs. In addition to provision of M&E reports to relevant parts of government, the PCT and UN agencies implementing each component will engage with relevant parts of the RGC in a dialogue on the analysis and utilisation of M&E data.

Structured opportunities for learning and adaptation will be:

1. Each UN agency, concurrent with preparation of their six monthly monitoring report, will conduct a quantitative and qualitative analysis of data, including reflection on successes and challenges.
2. The TRC will conduct annual program wide substantive analysis of performance drawing on quantitative data from each UN agency's six monthly M&EF reports and qualitative information gleaned from daily implementation practice. This will include use of the internal analysis conducted biannually by each of the UN agencies, as outlined in step 1 above.
3. The Program Board will review performance over the past year and coordinate the development of the next annual work plan and budget, building on lessons from the previous year. This will include an annual review of the ToC and programmatic risks in the Risk Management Register (RMR), with necessary modifications being made. The M&EF will be modified to capture performance data relating to changes resulting from program adaptation. Proposed changes to the program will be approved by the Program Board.

In addition to the M&EF, each UN agency will generate analytical work which will inform program directions. Examples include the functional analysis and capacity assessment of MoSVY, the analysis of the current financing of rehabilitation services, focussed operational research commissioned under the Component 4 SGS, and feedback loops from the subnational level to the national level of lessons learned under Components 2 and 4 to inform both national practice and application in other provinces. This analytical work will inform the work of each UN agency and their partners and be fed into the structured opportunities for learning and adaptation by the program, mentioned above.

Knowledge generated by the program will be actively disseminated to all stakeholders to promote the development of an understanding of effective ways of conducting disability development work. This will include dissemination of information relating to less than optimal performance for the purpose of promoting dialogue on alternative approaches and strategies.

The higher level elements of the program's M&EF are set out in Annex 5. For each program component, end-of-program outcomes, intermediate outcomes, intended results and key indicators have been developed. A full M&EF will be developed by the UN agencies during the inception phase and the early part of Year 1 with the assistance of an international M&E consultant with disability expertise. Development of the M&EF may involve revisions to the program's outcomes. Any revisions would require approval of the Program Board. Advantages in developing the full M&EF early in the life of the program rather than at design are that it will be aligned to more

detailed work planning and it will be informed by the monitoring needs of program staff. The M&EF will incorporate monitoring of key programmatic risks identified in the RMR (Annex 6).

The M&EF will be aligned to relevant components of AusAID's Disability Performance Assessment Framework (DPAF) and will be a source of data for agency wide annual reporting against that Framework. The program will be able to report against AusAID's Headline Result 13 "number of people provided with disability services like prostheses and assistive devices through AusAID supported programs." This program will need to contribute data to the United Nations Development Assistance Framework (UNDAF) in Cambodia, particularly in regard to indicators for people with disability and vulnerable groups. These linkages to UNDAF will be identified as part of the M&EF development. Alignment between relevant aspects of the program's M&EF and the NDSP M&EF will be sought. The program's M&EF will be developed by the end of Quarter one, Year one, and the NDSP M&EF will not be developed till later in 2014. Opportunities for alignment will be sought through UNDP's technical inputs on the development of the NDSP M&EF, under component 1.

The M&EF will need to ensure a focus on development of qualitative monitoring to complement quantitative monitoring, while noting quantitative monitoring needs to, where possible, focus on changes in the lives of people with disability as a result of this program.

Because of the particular disadvantage faced by women and girls with disability, where relevant, monitoring data will be disaggregated by sex. Key service utilisation data for program grants will be analysed for gender differences and, as needed, strategies to deal with gender inequality will be developed in addition to strategies already in place. Monitoring data will also be disaggregated by age, in recognition of the particular issues, challenges and needs of children and adolescents with disability.

Baseline data falls into two broad categories:

1. Disability-related data that is the responsibility of the RGC, where the program will be providing technical assistance to improve data collection, (for example, baseline data for the NDSP and data relating to the rehabilitation sector). In many instances, however, relevant baselines will not be available due to extremely limited national data and inconsistencies in reporting.
2. Baseline data directly related to the program's activities, (for example, baseline data for rehabilitation services receiving program grants). Baseline data will be available from a number of activities undertaken during inception and year one. These include the capacity assessment of DAC, MoSVY and CDPO, the functional analysis of DAC and MoSVY, the analysis of the adequacy of existing disability related data, information from the rehabilitation analytical studies, and information provided by PRCs on existing levels of service provision.

The analysis of existing disability data and the data needs assessment to be conducted as part of Component 1 will identify major gaps and how they can be addressed. For category 1 above, the program will, within available resources, be providing technical assistance for the improvement of data collection capacity, but not collecting data. For category 2, baseline data needs and means of collection will be identified as part of the development of the M&EF.

An independent program evaluation, to be commissioned jointly by the Programme Board and AusAID, has been budgeted for in Year 3 as a mid-term review. This will evaluate whether the program is on-track to deliver against its outcomes and provide valuable guidance for any program modifications that may be needed. Although an end-of-program evaluation would take place only 18 months after the mid-term review, given this program will be AusAID's largest bilateral disability program and the relative newness of disability programming in AusAID, there is a strong

case for an end-of-program evaluation, especially if a follow-on program is intended. One function of an end-of-program evaluation would be to determine whether the program has adequately responded to recommendations by the mid-term review. An independent end-of-program evaluation, to be commissioned jointly by the Programme Board and AusAID, has been budgeted for in Year 5.

### **3.4 Risk assessment and management**

The Risk Management Register (Annex 6) details specific risks and for each risk its potential impact, probability, risk rating, a management response to mitigate the risk, and the residual level of risk after the management response. The RMR indicates one or more owners for each risk. It is the owner's responsibility to monitor the risk and undertake proactive mitigation strategies. The Program Coordinator will monitor overall risk management within the program.

The RMR groups risks into four categories: 1) overarching risks applying across the program; 2) program governance and management risks; 3) component specific risks; and 4) operating environment and external risks.

The program design recognises that risk management is closely related to the program's ToC. Programmatic risks may limit the extent to which change may be realised. The mitigation strategies are therefore an essential part of the ToC.

While risks will be managed on an on-going basis, the RMR specifies points in time when monitoring of particular risks will be important. The RMR also contains 'flags' which are indicators that the mitigation strategy may not be working. When 'flags are raised' this will result in a re-examination of whether a different approach is needed to controlling the risk.

In addition on-going monitoring and management of risks by their owners, the RMR will be reviewed and revised annually as part of the joint annual program review outlined in Section 3.3.

### **3.5 Sustainability**

Disability-inclusive development is a relatively new area for development. This means that those organisations specifically focused on people with disability (both RGC and civil society) have, for the most part, not benefitted from significant financial and technical assistance commensurate with the scale of the issues they are trying to address. While there are some areas of strength (such as CDPO's growing ability to develop quality, evidence-based projects), there is some risk that the outputs and outcomes supported under this program will not continue beyond 2018.

To mitigate this risk, it will be important that the UN agencies work with implementing agencies to develop prioritised and feasible plans of action, and provide appropriate capacity development to support effective implementation. In doing so, UN agencies will need to take care to ensure capacity support, not capacity supplementation (i.e., not doing things for them). Capacity development should be seen as a capacity investment by enabling organisations to seek out information, analyse it, develop partnerships and make informed decisions about priorities. This will help to ensure continuation of outcomes beyond the end of this program.

There will however, be an on-going need for donor funding beyond 2019. While the program will seek to ensure increasing RGC contributions to the sector, it is extremely unlikely the RGC will finance 100 per cent of the disability sector by 2018. This is a long term objective. With regards CSOs, even in developed countries, most disability organisations still rely heavily, if not solely, on government funding. In the case of Cambodia, on-going donor funding of CSOs is likely to be needed.

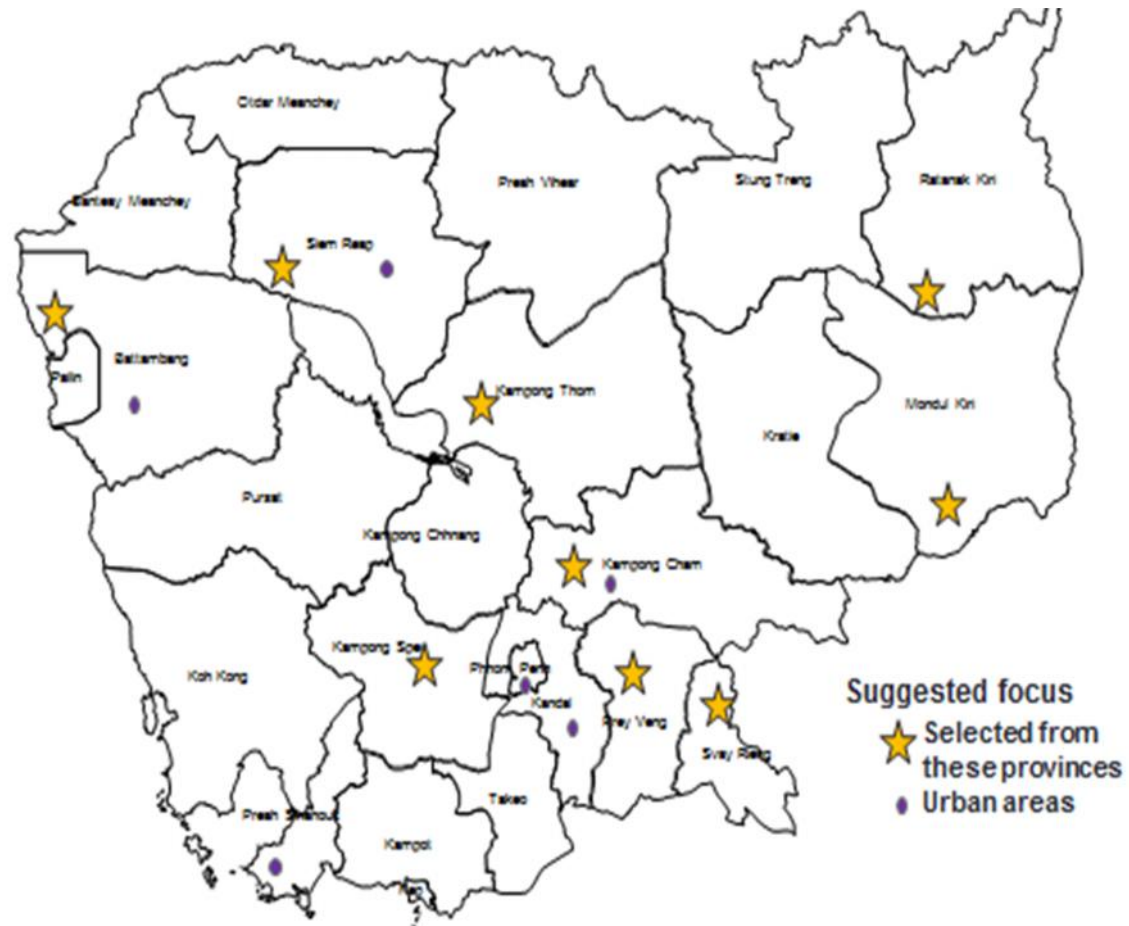
As an AusAID focus country for disability-inclusive development, it is expected that AusAID will continue to contribute towards disability work in Cambodia. This is, however, not guaranteed. Taking this into consideration, and the relatively small financial envelope available for this program, it will be necessary for the UN partners (and AusAID) to try to secure other donor resourcing for this program and into the future. This is likely to depend on two factors, 1) whether other donors prioritise disability and can make resources available; and 2) whether this program is seen as an attractive, aid effective, option for support.

Finally, sustainability will depend on the ability of the program to strike an appropriate balance between supporting direct service delivery and supporting the development of systems that can finance and manage service delivery in future. The program has been designed to provide an appropriate balance between tangible service delivery results and long-term capacity development and systems strengthening.



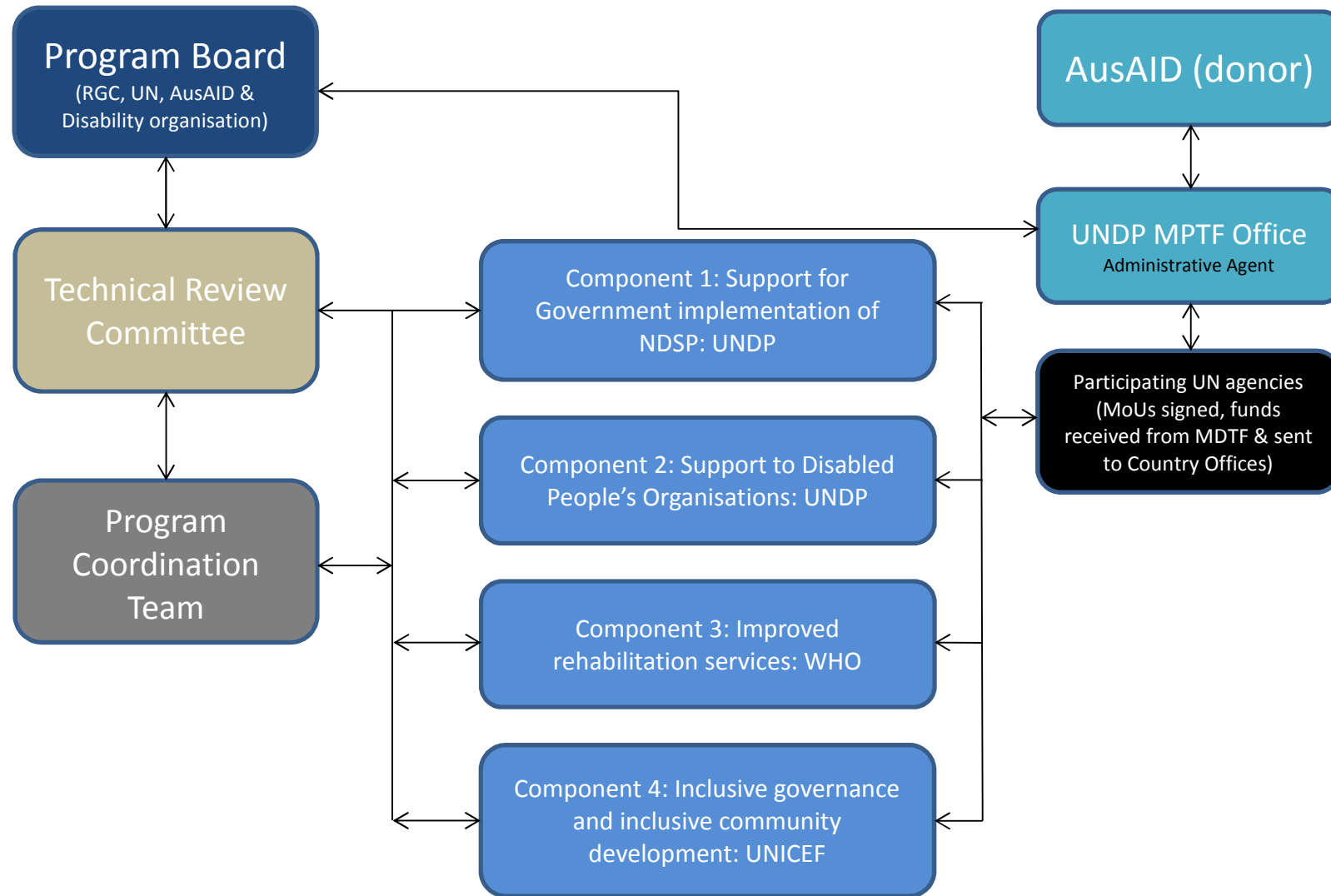
## Annex 1: Potential provinces for Component 4 activities

Figure 2: Map of Cambodia showing selected urban areas and potential provinces for Component 4



## Annex 2: Program governance and coordination arrangements

Figure 3: Program governance and coordination arrangements



## Annex 3: Budget

### **Projected funding by AusAID**

Projected total funding from AusAID over the 3.5 years, 2013 – 2016 is AUD\$7.938 million. AusAID funding will be allocated using the Australian Government’s financial year which runs from 1 July to 30 June. Table 3 sets out the anticipated funding by AusAID’s financial year.

**Table 3: Projected funding by AusAID financial year, 2013 - 2016**

Indicative Date	Tranche Number	Amount of Grant Funds in AUD
Dec-13	1	\$1,846,000
Aug-14	2	\$1,220,500
Feb-15	3	\$1,220,500
Aug-15	4	\$1,216,500
Feb-16	5	\$1,216,500
Aug-16	6	\$1,218,000
Total		<b><u>\$7,938,000</u></b>

As a number of key partners such as DAC and CDPO use a calendar year financial year (January – December), the annual work plan and budget for the program will be developed on a calendar year basis as this makes it easier for partners to report against grants.

The inception phase will commence after AusAID has entered into a formal agreement with the UN Multi-Partner Trust Fund Office and the Office has entered into MoUs with UNDP, UNICEF and WHO. It is anticipated that this will occur no earlier than September 2013. The inception phase will run through to 31 December, 2013. Program implementation will occur over five calendar years, from January 2013 to December 2018.

Table 4 sets out the projected funding by AusAID on a *calendar year* basis from 2013 to 2016. From commencement of the inception phase in 2013, through to 30 June 2014 (i.e., the end of AusAID’s 2013 - 2014 financial year,) projected funding will be AUD\$1.846 million. If, for example, AUD\$0.435 million was spent in the inception phase through to end-December 2013, AUD\$1.411 would be left for expenditure in the first six months of 2014. From the beginning of AusAID’s next financial year, (1 July, 2014), projected funding will increase to AUD\$2.441 million a year. Assuming that AUD\$1.411 million from the 2013 - 2014 allocation was left for expenditure in the first six months of 2014 and that half (i.e., AUD\$1.22m) of the AUD\$2.441 million allocation for the 2014 – 2015 financial year was budgeted to be spent in the last six months of 2014, the total budget for calendar year 2014 would be AUD\$2.631 million. Projected funding for each subsequent calendar year (2015 – 2016), based on the methodology outlined in this paragraph, is set out in Table 4. Funds will be converted into US dollars using the actual UN rate of operational exchange (UNROE) on the date of the receipt of contributions.

**Table 4: Projected funding by AusAID by calendar year, 2013 -2018**

Calendar Year: Jan-Dec	Available funds AUD\$M	Available funds US\$M*
Inception Phase: 2013	0.435	0.413
Year 1: 2014	2.631	2.499
Year 2: 2015	2.437	2.314
Year 3: 2016	2.435	2.312
<b>Total</b>	<b>7,938</b>	<b>7.538</b>

\*UNORE –November 2013

### **Program budget overview**

The program will use US dollars for budgeting purposes as this is the currency used by UN agencies in Cambodia. The program budget has been developed based on an exchange rate of AUD\$1 buying US\$0.9, to reflect the recent depreciation of the Australian dollar. It is possible that further depreciation of the Australian dollar will occur. The risk of further weakening of the Australian dollar will need to be managed (see the Risk Management Annex (Annex 6) for further details).

Independent of this risk, AusAID and the UN agencies will be seeking financial contributions to the program from other donors to support scale up. To the extent that additional funding can be mobilised, the impact of a weakening of the Australian dollar would be minimised. It does, however, need to be recognised that the likelihood of attracting additional funding from other donors, particularly in the short term, is not high. The PCT will monitor Australian-US dollar currency exchange rates so that adjustments to the program’s budget can be made by the Program Board, if needed, without delay.

The program budget is presented in Table 6 below. The budget should be regarded as indicative. The Program Board will have authority to vary budget allocations from year to year, taking a performance based approach. This will allow for flexibility to take advantage of emerging opportunities and accommodate changes in circumstances. This may involve reallocation between components based on performance and absorptive capacity.

The table shows the budget for the MPTF Office Administrative Agent fee, the Program Coordination Team, each of the four program components and the UN overhead of seven percent. The MPTF Office Administrative Agent fee is calculated at one per cent of the total funding made available to the program by AusAID (it is a one-time fee). For example, if the total funding in any one year was US\$2.5 million, the Administrative Agent fee would be US\$25,000 which will be deducted at the time of the contribution receipt. The UN Agencies’ overhead fee of seven per cent is calculated on the total amount of funds the MPTF Office disburses to each of the UN agencies. For example, in Year 1 if the total funds disbursed amounted to US\$2.4 million, the seven per cent overhead fee would be US\$168,000. The UN overhead fee is calculated after the one per cent MPTF Office Administrative Agent fee is deducted. The UN overhead fee is a calculated on a once only basis. UN agencies have provided assurances that they will not be charging any additional overhead at either global or country levels beyond the one-off seven per cent.

Projected total expenditure over the 5.5 years is US\$12.728 million. This exceeds the total anticipated funding of US\$11.629 million. During program design, each of the UN agencies made significant cuts to their proposed budgets to take account of the recent devaluation of the Australian dollar. The budget will need to be further revised during the inception phase and possibly on an annual basis to ensure that it balances with available funding. Due to absorptive capacity issues there may be under

expenditure during the inception phase and year 1. Any savings made in these years would help to balance the budget against available funding.

The percentage of budget allocated to key areas of expenditure over the five years of the program is shown in Table 5 below. (Note: the seven percent UN overhead fee is included in the total for each budget component.)

**Table 5: Percentage of budget allocated to components**

Budget category	Percentage of total budget
Component 1: Supporting Government implementation of the CRPD	10.2
Component 2: Supporting DPOs	16.7
Component 3: Rehabilitation system strengthening	17.4
Component 4: Inclusive governance and inclusive community development	41.7
Program Coordination Team	13
MPTF Office Administrative Agent fee	1
<b>Total</b>	<b>100</b>

**Table 6: Program Budget for inception phase (2013) and for Years 1 – 5, 2014 – 2018 (Calendar Years January – December)**

Item	Total budget US\$	Inception 2013 US\$	Year 1 2014 US\$	Year 2 2015 US\$	Year 3 2016 US\$	Year 4 2017 US\$	Year 5 2018 US\$
<b>Program Coordination Team</b>							
<b>1. Staff and other personnel costs</b>							
Program Coordinator (P4)	1,064,030	40,000	200,806	202,806	204,806	206,806	208,806
Administrative Associate (GS6)	135,000		25,000	26,000	27,000	28,000	29,000
Administrative Assistant (UNV local)	32,500		6,000	6,250	6,500	6,750	7,000
<b>2. Supplies, commodities, materials (no budget provision)</b>							
<b>3. Equipment, vehicles and furniture, including depreciation</b>							
Office establishment costs	20,000	20,000					
<b>4. Contractual services</b>							
Consultant: development of the M&E Framework	10,000	10,000					
Mid-term evaluation and Final Evaluation	110,000				35,000		75,000
<b>5. Travel</b>							
Airfares and provincial travel	40,000		8,000	8,000	8,000	8,000	8,000
<b>6. Transfers and grants to counterparts (no budget provision)</b>							
<b>7. General operating and other direct costs</b>							
Rent; utilities; IT support; stationary	80,000		16,000	16,000	16,000	16,000	16,000
Communications	50,000		10,000	10,000	10,000	10,000	10,000
<b>Total program costs (1-7)</b>	<b>1,541,530</b>	<b>70,000</b>	<b>265,806</b>	<b>269,056</b>	<b>307,306</b>	<b>275,556</b>	<b>353,806</b>
<b>8. Indirect support costs (7% of total program costs for Program Coordination Team)</b>	<b>107,907</b>	<b>4,900</b>	<b>18,606</b>	<b>18,834</b>	<b>21,511</b>	<b>19,289</b>	<b>24,766</b>
<b>Total Budget Program Coordination Team (1-8)</b>	<b>1,649,437</b>	<b>74,900</b>	<b>284,412</b>	<b>287,890</b>	<b>328,817</b>	<b>294,845</b>	<b>378,572</b>
<b>Component 1: Supporting Government implementation of the CRPD</b>							
<b>1. Staff and other personnel costs</b>							

Item	Total budget US\$	Inception 2013 US\$	Year 1 2014 US\$	Year 2 2015 US\$	Year 3 2016 US\$	Year 4 2017 US\$	Year 5 2018 US\$
Program analyst	285,000	10,000	55,000	55,000	55,000	55,000	55,000
<b>2. Supplies, commodities, materials (no budget provision)</b>							
<b>3. Equipment, vehicles and furniture, including depreciation (no budget provision)</b>							
<b>4. Contractual services</b>							
MoSVY/DAC functional analysis	40,000	40,000					
Consultancy and contractual services	85,000		50,000	30,000	5,000		
<b>5. Travel (no budget provision)</b>							
<b>6. Transfers and grants to counterparts</b>							
Grant to MoSVY/DAC	750,000		150,000	150,000	150,000	150,000	150,000
<b>7. General operating and other direct costs</b>							
Training and meeting costs	58,000	500	11,500	11,500	11,500	11,500	11,500
<b>Total program costs (1-7)</b>	<b>1,218,000</b>	<b>50,500</b>	<b>266,500</b>	<b>246,500</b>	<b>221,500</b>	<b>216,500</b>	<b>216,500</b>
<b>8. Indirect support costs (7% of total program costs for Component 1)</b>	<b>85,260</b>	<b>3,535</b>	<b>18,655</b>	<b>17,255</b>	<b>15,505</b>	<b>15,155</b>	<b>15,155</b>
<b>Total Budget Component 1 (1-8)</b>	<b>1,303,260</b>	<b>54,035</b>	<b>285,155</b>	<b>263,755</b>	<b>237,005</b>	<b>231,655</b>	<b>231,655</b>
<b>Component 2: Supporting DPOs to raise the voice and protect the rights of people with disability</b>							
<b>1. Staff and other personnel costs (no budget provision)</b>							
<b>2. Supplies, commodities, materials (no budget provision)</b>							
<b>3. Equipment, vehicles and furniture, including depreciation (no budget provision)</b>							
<b>4. Contractual services</b>							
Technical assistance	106,000	6,000	20,000	20,000	20,000	20,000	20,000
CDPO capacity assessment	17,000	17,000					
<b>5. Travel (no budget provision)</b>							

Item	Total budget US\$	Inception 2013 US\$	Year 1 2014 US\$	Year 2 2015 US\$	Year 3 2016 US\$	Year 4 2017 US\$	Year 5 2018 US\$
<b>6. Transfers and grants to counterparts</b>							
Grants to CDPO and other DPOs	1,650,000		330,000	330,000	330,000	330,000	330,000
<b>7. General operating and other direct costs</b>							
Meeting and training costs (regional)	114,000	6,500	21,500	21,500	21,500	21,500	21,500
Monitoring and evaluation (field monitoring, spot checking on sub-national level)	25,000		5,000	5,000	5,000	5,000	5,000
Support to forming and strengthening new DPOs (capacity development)	80,000		20,000	15,000	15,000	15,000	15,000
<b>Total program costs (1-7)</b>	<b>1,992,000</b>	<b>29,500</b>	<b>396,500</b>	<b>391,500</b>	<b>391,500</b>	<b>391,500</b>	<b>391,500</b>
<b>8. Indirect support costs (7% of total program costs for Component 2)</b>	<b>139,440</b>	<b>2,065</b>	<b>27,755</b>	<b>27,405</b>	<b>27,405</b>	<b>27,405</b>	<b>27,405</b>
<b>Total Budget Component 2 (1-8)</b>	<b>2,131,440</b>	<b>31,565</b>	<b>424,255</b>	<b>418,905</b>	<b>418,905</b>	<b>418,905</b>	<b>418,905</b>
<b>Component 3: Supporting rehabilitation systems strengthening</b>							
<b>Sub-component 3.1: Strengthened Rehabilitation Sector Leadership, Planning and Coordination</b>							
<b>1. Staff and other personnel costs</b>							
National Officer: NO-C	310,000	20,000	58,000	58,000	58,000	58,000	58,000
<b>2. Supplies, commodities, materials (no budget provision)</b>							
<b>3. Equipment, vehicles and furniture, including depreciation</b>							
IT support (for computer and docking station)	2,000	2,000					
<b>4. Contractual services</b>							
Training and TA needs assessment: MoH, MoSVY, PWDF	25,000	25,000					
<b>5. Travel</b>							
Airfares and provincial travel	27,000	2,000	5,000	5,000	5,000	5,000	5,000
<b>6. Transfers and grants to counterparts (no budget provision for this sub-component; See C3.2)</b>							



Item	Total budget US\$	Inception 2013 US\$	Year 1 2014 US\$	Year 2 2015 US\$	Year 3 2016 US\$	Year 4 2017 US\$	Year 5 2018 US\$
<b>7. General operating and other direct costs</b>							
Analysis and reports	90,000	15,000	15,000	15,000	15,000	15,000	15,000
Dialogue events and meeting support	27,000		7,000	5,000	5,000	5,000	5,000
Bi-annual National Rehabilitation and CBR Forum	120,000		40,000		40,000		40,000
Bi-annual Rehabilitation Study Tour	80,000			40,000		40,000	
MoH Rehabilitation Partnership	95,000		15,000	20,000	20,000	20,000	20,000
Provincial Rehabilitation Demonstration Project	150,000		30,000	30,000	30,000	30,000	30,000
<b>Sub-component 3.2 Access to Quality Rehabilitation Services</b>							
<b>6. Transfers and grants to counterparts</b>							
MoSVY and PWDF Technical Partnership for Rehabilitation Support	145,000		25,000	30,000	30,000	30,000	30,000
Priority Rehabilitation Services Scheme (grants)	1,000,000		200,000	200,000	200,000	200,000	200,000
<b>Total program costs</b> (Components 3.1 and 3.2)	<b>2,071,000</b>	<b>64,000</b>	<b>395,000</b>	<b>403,000</b>	<b>403,000</b>	<b>403,000</b>	<b>403,000</b>
<b>8. Indirect support costs</b> (7% of total program costs for Components 3.1 and 3.2)	<b>144,970</b>	<b>4,480</b>	<b>27,650</b>	<b>28,210</b>	<b>28,210</b>	<b>28,210</b>	<b>28,210</b>
<b>Total Budget Component 3 (1-8)</b>	<b>2,215,970</b>	<b>68,480</b>	<b>422,650</b>	<b>431,210</b>	<b>431,210</b>	<b>431,210</b>	<b>431,210</b>
<b>Sub-component 4: Inclusive governance and inclusive community development</b>							
<b>1. Staff and other personnel costs</b>							
L3 – International	876,460		175,292	175,292	175,292	175,292	175,292
National Officer - B	225,220	5,000	44,044	44,044	44,044	44,044	44,044
National Officer - B	225,220	5,000	44,044	44,044	44,044	44,044	44,044
<b>2. Supplies, commodities, materials (no budget provision)</b>							
<b>3. Equipment, vehicles and furniture, including depreciation (no budget provision)</b>							
<b>4. Contractual services</b>							
Review of the current position on the ground	30,000	30,000					

Item	Total budget US\$	Inception 2013 US\$	Year 1 2014 US\$	Year 2 2015 US\$	Year 3 2016 US\$	Year 4 2017 US\$	Year 5 2018 US\$
Revision of the community worker model for disability focus – guidelines, training materials, materials used by community worker	20,000	20,000					
Development of sub-national capacity development resources	95,000	20,000	15,000	15,000	15,000	15,000	15,000
Mid-program component assessment to revisit geographic focus areas and assess progress towards results for the component	30,000				30,000		
<b>5. Travel (no budget provision)</b>							
<b>6. Transfers and grants to counterparts</b>							
Small Grants Scheme	2,500,000		500,000	500,000	500,000	500,000	500,000
Capacity development funds – MoI/NCDD-S and sub-national provincial and district administration	325,000		65,000	65,000	65,000	65,000	65,000
<b>7. General operating and other direct costs</b>							
Development of capacity development resources for sub-national actors	170,000	20,000	30,000	30,000	30,000	30,000	30,000
Community worker	205,000	30,000	35,000	35,000	35,000	35,000	35,000
Meeting and capacity development costs associated with the Small Grants Scheme	125,000		25,000	25,000	25,000	25,000	25,000
Monitoring and evaluation for sub-national activities	128,000	18,000	22,000	22,000	22,000	22,000	22,000
<b>Total program costs (1-7)</b>	<b>4,954,900</b>	<b>148,000</b>	<b>955,380</b>	<b>955,380</b>	<b>985,380</b>	<b>955,380</b>	<b>955,380</b>
<b>8. Indirect support costs (7% of total program costs for Component 4)</b>	<b>346,845</b>	<b>10,360</b>	<b>66,877</b>	<b>66,877</b>	<b>68,977</b>	<b>66,877</b>	<b>66,877</b>
<b>Total Budget Component 4 (1-8)</b>	<b>5,301,745</b>	<b>158,360</b>	<b>1,022,257</b>	<b>1,022,257</b>	<b>1,054,357</b>	<b>1,022,257</b>	<b>1,022,257</b>
<b>Total program costs and indirect support costs (Program Coordination Team and Components 1-4)</b>	<b>12,601,852</b>	<b>387,340</b>	<b>2,438,729</b>	<b>2,424,017</b>	<b>2,470,294</b>	<b>2,398,872</b>	<b>2,482,599</b>
<b>Multi-Donor Trust Fund management fee (1% of total funds transferred to MPTF Office by AusAID)</b>	126,018	3,873	24,387	24,240	24,703	23,989	24,826
<b>Total budget (Total program costs, indirect support costs, plus MDTF management fee)</b>	<b>12,727,869</b>	<b>391,213</b>	<b>2,463,116</b>	<b>2,448,257</b>	<b>2,494,997</b>	<b>2,422,861</b>	<b>2,507,425</b>

## Annex 4: Implementation Plan

The Implementation Plan shows key indicative activities by half year for the inception phase and Years 1 and 2 to indicate critical path activities required at an early stage of implementation in preparedness for later stages or later years of programming.

**Table 7: Implementation Plan: Inception Phase and Years 1 and 2**

Key indicative activities	Inception Jul-Dec 2013	Year 1 Jan-Jun 2014	Year 1 Jul-Dec 2014	Year 2 Jan-Jun 2015	Year 2 Jul- Dec 2015
<b>Program governance and management</b>					
Establish the Program Board and agree on Terms of Reference for the Board and Technical Review Committee					
Biannual meetings of the Program Board					
Approval on the inception phase budget by the Program Board					
Seek release of the first tranche of funding from the UN Multi-Donor Trust Fund for inception activities					
Recruit the Program Coordinator and other Program Coordination Team staff					
Development of the program's M&E framework by an international consultant					
Program Board review and approval of the program's M&E Framework					
Program Coordinator coordinates and quality assures application of the program-wide M&E Framework					
Hold the first meeting of the Technical Review Committee after recruitment of the Program Coordinator					
Monthly meetings of the Technical Review Committee					
PCT and Technical Review Committee coordinates the development of the Year 1 work plan and budget for each UN agency					
Program Board review and approval of a consolidated Year 1 work plan and budget					
Seek release of funding from the UN Multi-Donor Trust Fund for Year 1 activities					
PCT & Technical Review Committee holds an annual retreat to review the past year's performance and coordinate the development of the next year's work plan and budget					
Program Board reviews and approves consolidated annual work plans and budgets					
PCT coordinates preparation of the annual program report to AusAID					
Program Board reviews and approves the annual program report to AusAID					
Program Coordinator develops a program-wide communication strategy, aligned to the communication strategies for each component developed by the three UN agencies					
Program Coordinator develops a funds mobilisation strategy to seek additional funding for the program					

<b>Component 1: Supporting Government implementation of the Convention on the Rights of Persons with Disabilities</b>					
Functional analysis and capacity assessment of DAC and relevant MoSVY departments					
Support to inclusive and participatory development of NDSP					
Capacity development of DAC and relevant MoSVY departments to fulfil their functions with reference to NDSP including on time reporting under CRPD					
Legal framework analysis					
Legal framework harmonisation to comply with CRPD					
Monitoring of NDSP/CRPD implementation across the whole Government					
Analysis of the existing data sources and analysis of data needs for proper implementation of NDSP, with recommendations for appropriate disability related data collection					
Regional networking, exchange of experience, knowledge/best practices					
<b>Component 2: Supporting Disabled People's Organisations to raise the voice and protect the rights of people with disability</b>					
Capacity development of CDPO and DPOs to act as effective channel for raising the voice of people of disability especially women and girls with disability and most vulnerable groups					
Strengthening DPOs and exploring opportunities for establishing new DPOs to ensure representation of diverse groups of people with disability					
Regional networking, exchange of experience, knowledge/best practices					
<b>Component 3: Supporting Rehabilitation Systems Strengthening</b>					
<b>Component 3.1: Rehabilitation Sector leadership, coordination and planning</b>					
Recruitment of WHO NPO					
Meeting of stakeholders & sharing of WHO Program					
Training needs analysis for MOH, MoSVY and PWDF					
Inception meeting with key rehabilitation stakeholders					
Initial report on rehabilitation sector situation and leadership.					
Round table on rehabilitation leadership and coordination					
Second report commissioned and dialogue event					
Third report commissioned and dialogue event					
Fourth report commissioned and dialogue event					
Fifth report commissioned and dialogue event					
Targeted training and technical assistance for PWDF & MoSVY					
Establishment of rehabilitation coordination mechanism					
Bi-annual National Rehabilitation and CBR Forum					
Bi-annual Rehabilitation Study Tour					
MOH Rehabilitation Partnership Consultation and Planning					
MOH Disability and Rehabilitation Partnership Activities					
Provincial Rehabilitation Demonstration Project – stakeholder consultations and					

formation of project committee					
Initial development of clinical pathways & resources for demonstration project					
Provincial Rehabilitation Demonstration Project – inception workshop					
Demonstration Project implementation and evaluation					
<b>Component 3.2: Increase Access to Quality Rehabilitation Services</b>					
MoSVY & PWDF Technical Partnership for Rehabilitation Support Activities					
Information shared regarding Priority Rehabilitation Service Scheme					
PWDF, MoSVY and INGO Planning Day(s) for PRSS and distribution of round funds					
Collaboration with UNICEF for round SGS CBR supports					
<b>Component 4: Inclusive governance and inclusive community development</b>					
Recruit staff					
Stakeholder engagement					
Review position on the ground					
Develop small grant scheme guidelines					
Updating/revision of the community worker for disability inclusive development					
Identify target geographic areas					
Development of capacity development training materials					
Implementation of the community worker					
Implementation and management of small grant scheme					
Implementation of capacity development activities					
Monitoring and evaluation					

## Annex 5: Monitoring and Evaluation Framework

This annex shows the higher level elements of the program’s Monitoring and Evaluation Framework (M&EF) on a preliminary basis. The M&EF will be refined and fully developed during the inception phase and the early part of Year 1. See Section 3.3 for the approach the program will take to M&E and key issues relating to the development of the M&EF.

<b>Program Goal:</b> Improved quality of life for people with disability (long term)			
<b>End-of-Program outcome:</b> People with disability have increased opportunities for increased participation in social, economic, cultural and political life through effective implementation of the National Disability Strategic Plan, aligned to the Convention on the Rights of Persons with Disability			
<b>Component 1: Supporting Government implementation of the CRPD</b>			
<b>Component 1: End-of-Program outcome</b>	<b>Intermediate outcomes</b>	<b>Intended results</b>	<b>Key indicators</b>
MoSVY/DAC effectively coordinates implementation of the National Disability Strategic Plan, aligned to the CRPD	Feasible and inclusive National Disability Strategic Plan developed, aligned to the Convention on the Rights of Persons with Disability	National Disability Strategic Plan complying with CRPD, CRC, CEDAW and other international conventions to which Cambodia is a party, is adopted following a disability- inclusive process	<ul style="list-style-type: none"> <li>• Number of consultative workshops/meetings held with representatives of DPOs and people with disability, (including women, children and parents) and development partners in the process of NDSP development</li> <li>• Extent to which NDSP reflects inputs from DPOs/CSOs</li> <li>• Extent to which NDSP reflects expert technical advice on compliance with CRPD</li> <li>• Extent to which baseline data identified and collected for each major policy area within NDSP, including disaggregation for women and children with disability</li> </ul>

		<p>Law on the Protection and Promotion of the Rights of Persons with Disabilities and implementing legislation revised in alignment with CRPD, CRC, CEDAW and other international conventions to which Cambodia is a party</p>	<ul style="list-style-type: none"> <li>• Legal framework review completed and disseminated widely throughout government and published</li> <li>• Legislative reform plan to revise the Disability Law adopted</li> <li>• Extent to which legislative reforms are implemented</li> <li>• Extent to which revisions of Disability Law adopt the recommendations of the framework review and reflect consultations with DPOs, civil society and development partners</li> <li>• Extent to which sub-decrees and Prakas to implement the revised Disability Law are adopted following recommendations of the framework review and following consultation with DPOs</li> </ul>
	<p>Increased capacity of MoSVY/DAC to coordinate development and implementation of the National Disability Strategic Plan</p>	<p>Implementation of NDSP is monitored comprehensively and transparently across whole of government</p>	<ul style="list-style-type: none"> <li>• Extent to which data collected in accordance with NDSP</li> <li>• Number of NDSP review meetings held with participation of line Ministries, DPOs and civil society based on published data across health, education, employment and other sectors</li> <li>• Number of Annual Policy Dialogues with DPOs, civil society and development partners held</li> <li>• Extent to which recommendations from DPOs, civil society and development partners are reflected in revisions to the NDSP and/or disability policy</li> <li>• Extent to which recommendations of functional/capacity assessment are reflected in revised strategic plan of DAC</li> <li>• Extent to which mandates of DAC,</li> </ul>

			PWDF, DWPWD are revised in accordance with functional/capacity assessment to clarify roles and functions
		In depth analysis of existing disability related data sources performed and recommendations for improvement of comprehensive disability related data collection, analysis and utilisation provided	<ul style="list-style-type: none"> <li>Extent to which recommendations for improvement of disability data adopted and implemented</li> </ul>
		Reporting under CRPD is completed comprehensively and on time following an inclusive process	<ul style="list-style-type: none"> <li>Number of consultative meetings with stakeholders (Disabled People Organisations, including representatives of women, children and parents, civil society, development partners) during drafting and finalisation of CPRD report</li> <li>Extent to which CDPO/DPO inputs are reflected in report on CPRD</li> <li>Cambodian report on CPRD submitted on time</li> </ul>
<b>Component 2: Supporting Disabled People's Organisations to raise the voice and protect the rights of people with disability</b>			
<b>Component 2: End-of-Program outcome</b>	<b>Intermediate outcomes</b>	<b>Intended results</b>	<b>Key indicators</b>
Disabled people's organisations effectively represent the needs and priorities and advocate for the rights of people with disability	Increased capacity of Cambodian Disabled People's Organisation/Disabled People's Organisations and other disabled people's organisations to fulfil their mandates	CDPO and DPOs capacitated to act as effective channels for raising the voice of people with disability	<ul style="list-style-type: none"> <li>Extent to which CDPO/DPO regularly and actively participates in DAC/MoSVY working groups</li> <li>Extent to which CDPO/DPO inputs are reflected in development and implementation of the NDSP</li> <li>Number of policy research papers published by CDPO</li> <li>Quality of CDPO/DPOs monitoring and evaluation framework</li> <li>Number of funding proposals submitted by CDPO/DPOs</li> </ul>
		Specific needs and priorities of women	<ul style="list-style-type: none"> <li>Activity of working groups</li> </ul>



		<p>and girls with disability, people with hearing, visual and intellectual disability and other excluded groups are included and addressed in CDPO/DPO plans and activities</p>	<p>addressing the needs of women and children with disability, and the extent to which they are engaged in development and implementation of the NDSP,</p> <ul style="list-style-type: none"> <li>• Inclusion of people with hearing, visual and intellectual impairments in CDPO/DPO's work plans and evidence of implementation</li> <li>• Percentage of women in governing bodies of CDPO, DPOs, federations and leading SHGs</li> <li>• Number of DPOs representing the needs and rights of women, children and people with visual impairments, hearing impairments, intellectual impairments</li> </ul>
		<p>CDPO and DPOs are actively involved in regional networks, exchange of experiences and good practices</p>	<ul style="list-style-type: none"> <li>• Number of regional events attended by or hosted by CDPO and DPOs</li> <li>• Extent to which CDPO participates in activities of ASEAN Disability Forum</li> <li>• Extent to which lessons learned, exchange of knowledge, and good practices disseminated and translated into capacity development actions in CDPO/DPOs annual work plans</li> </ul>
	<p>Effective inclusion and representation of diverse groups of people with disability</p>	<p>Existing DPOs strengthened and new DPOs are established to ensure representation of diverse groups of people with disability</p>	<ul style="list-style-type: none"> <li>• Number of DPOs representing people with visual impairments</li> <li>• No. of DPOs representing people with hearing impairments</li> <li>• No. of DPOs representing people with intellectual impairments</li> </ul>

		Specific needs and priorities of women and children with disabilities, people with hearing, visual and intellectual disability and other under-represented groups are represented in new DPOs	<ul style="list-style-type: none"> <li>• Specific activities aimed at needs of women and girls with disability and most vulnerable groups are included in DPO's work plans and implemented</li> <li>• Percentage of women in DPOs governing bodies</li> <li>• Number of disabled peoples organisations specifically representing women</li> </ul>
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<b>Component 3: Supporting Rehabilitation Systems Strengthening</b>			
<b>Component 3: End-of-Program outcome</b>	<b>Intermediate outcomes</b>	<b>Intended results</b>	<b>Key indicators</b>
Improved rehabilitation services for people with disability	<b><i>Sub-component 3.1: Rehabilitation sector leadership, coordination and planning</i></b>		
	Strengthened rehabilitation sector leadership, planning and coordination	Increased government capacity to lead, regulate and plan the rehabilitation service sector.	<ul style="list-style-type: none"> <li>• Increased government (MoSVY) convened meetings on rehabilitation</li> <li>• Increased government data and use of data on rehabilitation by stakeholders and in service provision</li> <li>• Rehabilitation sector strengthening initiatives included in future MoSVY and MoH work plans</li> </ul>
		Establishment of rehabilitation sector leadership and coordination mechanism.	<ul style="list-style-type: none"> <li>• Mechanism established and meetings regularly occurring.</li> </ul>
		Development of Ministry of Health role in rehabilitation sector strengthening and service provision.	<ul style="list-style-type: none"> <li>• MOH participating in rehabilitation sector leadership mechanism.</li> <li>• MOH develops and disseminates clinical guidance for rehabilitation.</li> </ul>
		Development of a national vision for rehabilitation and disability service provision.	<ul style="list-style-type: none"> <li>• National rehabilitation strategy developed.</li> </ul>

<b>Sub-component 3.2: Access to quality rehabilitation services</b>			
Increased access to quality rehabilitation services	Increased capacity of MoSVY and PWDF to effectively and efficiently manage Physical Rehabilitation Centres and support transition from INGOs	<ul style="list-style-type: none"> <li>• Service data from PRCs indicates service provision levels increased or maintained in transition.</li> <li>• Systems for PRC management in place and functioning.</li> </ul>	
	Multiple stakeholders engage in development of innovative, cost effective and sustainable disability and rehabilitation services, and under-developed service areas are strengthened.	<ul style="list-style-type: none"> <li>• Expansion of sustainable and cost effective service models.</li> <li>• Service grant recipient reports demonstrating sustainability.</li> <li>• Service grant recipient reports demonstrating increase in service access.</li> </ul>	
	Community Based Rehabilitation implemented in line with WHO CBR Guidelines.	<ul style="list-style-type: none"> <li>• CBR small grants reflect CBR Guideline principles and approaches.</li> </ul>	
	Increased government financial investment in disability and rehabilitation service delivery.	<ul style="list-style-type: none"> <li>• Government investment in rehabilitation increased against baseline.</li> </ul>	

<b>Component 4: Inclusive governance and inclusive community development</b>			
<b>Component 4: End-of-Program outcome</b>	<b>Intermediate outcomes</b>	<b>Intended results</b>	<b>Key indicators</b>
Increased capacity of and collaboration between subnational decision makers, civil society and communities to achieve the rights of people with disability	People with disability have access to community-based services and support from their local decision-makers in reducing barriers to participation.	People with disability have increased opportunities to participate and contribute to community life in selected areas.	<ul style="list-style-type: none"> <li>• WCCCs and CWCCs change processes of decision-making to include people with disability, DPOs and SHGs</li> </ul>
		Improved access to services for people with disability at the community level.	<ul style="list-style-type: none"> <li>• Quality support services are developed for people with disability in selected areas</li> <li>• Community workers include people with disability in their day to day work</li> <li>• NGOs/organisations supported by Small Grants Scheme deliver needed services to</li> </ul>

			people with disability
		Collaboration between stakeholders in selected provinces, districts and communes as well as across each level of the system is increased.	<ul style="list-style-type: none"> <li>Local councils, district and provincial administrations and board of governors office consult among each other and with NGOs/DPOs/SHGs. SGS support this process.</li> </ul>
		On-going documentation and dissemination of experiences to influence policy dialogue and contribute to the CRPD reporting process.	<ul style="list-style-type: none"> <li>Production of reports, case studies, human interest studies.</li> <li>Use of programme documentation by decision and policy makers to influence national policies and plans.</li> </ul>
	Increased capacity of subnational decision makers to implement the NDSP, aligned to the CRPD	Government officials in selected provinces, districts and communes have greater knowledge, skills and resources to improve the lives of people with disability.	<ul style="list-style-type: none"> <li>Training of trainers courses on people with disability developed for sub-national decision-makers. Identification of barriers to participation of people with disability and solutions to their removal.</li> </ul>
		People with disability have increased opportunities to participate and contribute to community life in selected provinces.	<ul style="list-style-type: none"> <li>Strengthened capacity of local decision makers and NGOs to provide relevant and quality services responding to needs of people with disability at community level.</li> </ul>
		Collaboration between stakeholders in selected provinces, districts and communes as well as across each level of the system is increased.	<ul style="list-style-type: none"> <li>Local councils, district and provincial administrations and board of governors consult among each other and with NGOs/DPOs/SHGs. SGS support the collaborative process.</li> </ul>
		On-going documentation and dissemination of experiences to influence policy dialogue and contribute to the CRPD reporting process.	<ul style="list-style-type: none"> <li>Production of reports, case studies, human interest studies.</li> <li>Use of programme</li> </ul>

			documentation by decision and policy makers to influence national policies and plans.
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## Annex 6: Risk Management Register

Note: the 'flags' in the last column are used as indicators that the control may not be working. 'When?' indicates the point in time when the flag will be monitored. If a flag indicates problems this will give rise to a re-examination of whether a different approach is needed to controlling the risk.

Specific risks	Impact	Probability	Risk	Management response	Residual risk	Owner	When? Flags
<b>1. Overarching risks applying across the program</b>							
1.1 The program will involve a significant focus on women and girls with disability. If implementing partners do not have sufficient gender awareness and expertise to inform relevant intervention strategies, there is a risk that women may be excluded from the benefits of the program.	Major	Unlikely	Moderate	Gender equity has been incorporated into the program's design and will be reflected in funding. UN agencies have a strong commitment to promotion of gender equity and considerable experience in this area. Gender equity will be a standing agenda item for policy dialogue with government at all levels.	Low	PCT UNDP UNICEF WHO	On-going
1.2 The program will involve a significant focus on children with disability. If implementing partners do not have sufficient awareness and expertise to inform relevant intervention strategies, including child protection policies and practices, there is a risk that children may be harmed or excluded from the benefits of the program	Major	Unlikely	Moderate	All program components will address the rights and needs of children with disability. The program components that will bring UN and funded civil society organisation staff into direct contact with children will be Component 4 (UNICEF), and to a lesser extent Component 3 (WHO). UNICEF has well established child protection policies and procedures that are consistent with those of AusAID. UNICEF will use is child protection module in training and make this available to WHO for the rehabilitation component. Child protection policies will apply to all counterparts and partners.	Low	PCT UNICEF WHO	On-going
1.3 While the program is specifically focused on people with disability there is a risk that the program does not sufficiently address the diversity of disabilities and in particular the most marginalised, vulnerable and under-served groups, including people with intellectual and psychosocial disability and people who are hearing impaired or deaf.	Major	Unlikely	Moderate	Program planning (e.g. UNICEF's social service mapping) will take account of the diverse needs of people with disability. The small grants under component 4 will include people with disability with diverse needs. Under component 2 the program plans to support the establishment of new DPOs to represent the needs of people with specific disabilities. The program will engage in advocacy to Government and DPOs on the diverse needs of people with disability and capacity assessments of Government under component 1 will also address this issue..	Low	UNDP UNICEF WHO	On-going Small grants are limited in relation to diverse disabilities. No new DPOs are established
1.4 Substantial parts of the program, including activities under each component, will be implemented by third parties receiving grants from the UN. There is a risk that the UN agencies will have a limited ability to ensure effective implementation by third parties.	Moderate	Unlikely	Moderate	Some types of grants will be awarded on a competitive basis. For these grants, criteria are likely to include past performance, capacity of the applicant and the merits of grant applications. Each UN agency will work closely with organisations in receipt of grants to ensure accountability and will take action to address poor performance. Technical assistance will also be provided to grantees. A key strategy for all program components will be to use output based approaches	Low	UN agencies	Ongoing Poor performance by grant recipients

				as part of grant agreements in order to incentivise the achievement of results.			
1.5 Some stakeholders are wary of UN agencies commitment and ability to deliver results that will improve the lives of people with disability.	Moderate	Unlikely	Moderate	The program specialists will consult regularly with stakeholders, keep them informed about progress and outcomes, share knowledge and be transparent and open with them. In essence, this concern will be mitigated by successful implementation of the program, with an emphasis on working effectively with a broad range of stakeholders.	Low	UN agencies	Q4, 2013 Stakeholders openly expressing dissatisfaction and lack of engagement with the program.
<b>2. Program governance and management</b>							
2.1 There are likely to be significant delays during the inception phase as the rate limiting factor will be recruitment of staff. If significant delays in program implementation continue post-inception this will make it difficult to achieve outcomes and have an adverse impact on the reputation of AusAID and the three UN agencies.	Moderate	Possible	High	UN agencies will undertake initial preparations for recruitment of staff (e.g. preparation of advertisements) pending the grant agreement being signed by AusAID. The UN agencies will consider employing short-term contractors to undertake inception work, pending the mobilisation of staff. Annual program work plans will be realistic in relation to timelines and the sequencing of work. The Program Coordinator will closely monitor progress and the Program Technical Review Committee will address delays in implementation. Program communication with stakeholders will be clear on proposed program activities and timelines and not raise expectations beyond what can be realistically delivered. The Program Board will take a performance based approach to funding which will allow re-allocation of funding from under-performing components to components with the ability to absorb additional funding.	Low	Program Board PCT Technical Review C'ttee UNDP UNICEF WHO	On-going Significant delays in recruitment of staff Significant delays in implementation of work plans
2.2 This is the first AusAID disability program which will be managed by UN agencies. AusAID will take an active interest in progress of the program through both its Phnom Penh Post and the Disability Policy Section in Canberra. There is the possibility of tensions between AusAID and UN agencies on program management and implementation issues which could have a negative effect on AusAID – UN relations. In addition AusAID plans to increase its disability policy advocacy to Government. If this is not aligned with the program's advocacy there is the risk of advocacy being at cross purposes and impact may be minimised.	Moderate	Possible	High	AusAID and the three UN agencies will need to put in place suitable partnership arrangements that satisfy the interests of both parties. Advocacy to Government by AusAID and the program will be aligned and well planned.	Low	AusAID Program Board UNDP UNICEF WHO	On-going Dissatisfaction by AusAID, the Program Board or the UN agencies regarding AusAID's role in the program
2.3 While each of the three UN agencies will have responsibility for good quality M&E of their program components, there is no staffing position in the Program Coordination Team to provide technical assistance to each agency on M&E, monitor the quality of M&E data, undertake cross-program analysis and prepare the annual program report for the Program Board and AusAID. The absence of such a position may adversely affect the	Major	Possible	High	During the inception phase and the beginning of Year 1, a short-term international M&E consultant with disability expertise will be engaged to develop the M&E Framework. The consultant will develop templates and systems to facilitate operationalisation of the Framework. Each UN agency will need to ensure that it devotes sufficient resources to operationalising the M&E Framework and utilise	Low	Program Board PCT UNDP UNICEF WHO	On-going The Program Coordinator does not have sufficient M&E skills. The quality of data collection and

quality of the program's M&E.				existing in-house M&E expertise. Use of relevant indicators already being collected by UN agencies will be explored in addition to program specific indicators. The Program Coordinator will need to take on responsibility for monitoring the quality of M&E work and, with the assistance of the three UN agencies, preparing the annual program report to the Board and AusAID. If these mitigation strategies are insufficient, short-term M&E expertise will need to be mobilised, possibly on a periodic basis.			reporting against the M&E Framework is poor
2.4 For efficiency and to maximise outcomes there will need to be a significant level of coordination between the three UN agencies (UNDP, UNICEF and WHO) that will be responsible for managing different program components. These UN agencies have limited experience in working on joint programs and have different approaches to program management which could impact negatively on program implementation. In particular, there is the risk of each UN agency taking an uncoordinated approach to their work with MoSVY, particularly DAC, PWDF and the Department of Welfare for People with Disability. There is also the risk that each of the UN agencies will take an uncoordinated approach to their work with CDPO.	Moderate	Possible	High	A Program Coordination Team will be established to facilitate cross-agency coordination. Monthly meetings of the Technical Review Committee involving key staff from each agency will plan coordination of work. There will be close collaboration between each UN agency in development of annual work plans. Following development of the annual work plan the PCT and the three UN agencies will hold a joint meeting with MoSVY, including DAC, PWDF and the Department, to discuss how the agencies will coordinate their activities with MoSVY. A similar meeting will be held with CDPO. The Program Board will monitor the effectiveness of coordination. The UN Resident Coordinator's Office can facilitate resolution of any disputes.	Low	Program Board PCT Technical Review C'ttee UNDP UNICEF WHO UNRCO	On-going Evidence of program implementation occurring in an un-coordinated way
2.5 The three UN agencies will be the primary providers of technical support to implementing partners. While UN Cambodia staff have expertise in a range of areas that will be beneficial to the program, there is currently limited disability specific expertise amongst UN Cambodia staff. This limitation may impact negatively on the support available to implementing partners	Moderate	Possible	High	The Program Coordinator will have expertise on disability in a development context and be able to provide technical guidance to the program as whole. Each UN agency will be recruiting staff and this should boost their technical expertise in disability. There will also be opportunities for on-the-job and self-guided learning. UN agencies plan to supplement technical support by mobilising short term inputs from staff members in regional and global offices who possess disability specific expertise.	Low	UNDP UNICEF WHO	2013-2015 Program partners indicate the need for more disability specific technical assistance
2.6 The Program Board will take a performance based approach to budgeting to provide flexibility to take advantage of opportunities and accommodate changed circumstances. This may involve reallocation of funds from one component to another, based on performance and absorptive capacity. The risk is that the Board may have difficulty in coming to decisions and that reallocations may cause tension between UN agencies.	Moderate	Possible	High	The Program Board will need to use clear and transparent process for considering funding reallocations involving consultation with all affected parties. Decisions will need to be based on sound evidence.	Low	Program Board	2015-2018 Unresolved disputes regarding funding reallocations
<b>Component specific risks</b>							
<b>3. Component 1: Supporting government to implement the CRPD</b>							
3.1 The RGC has increased its political commitment to disability, demonstrated by the vote of the National Assembly to endorse the CRPD. The elevation of the	Major	Possible	High	The program aims to strengthen the capacity of DAC to effectively coordinate a whole of government approach to promoting disability inclusive development	Moderate	AusAID UN agencies	2016-2018 The capacity of DAC has not



status of its Disability Action Council provides an opportunity to assist the Government to develop a more effective whole of government response to disability to fulfill Cambodia's CRPD obligations. For the program to be successful the political commitment of the RGC to disability will need to be matched by an increase in RGC capacity and funding for disability. Funding will need to be both transparent and predictable. There is the risk that this will not occur.				through the new National Disability Strategic Plan. The NDSP will include strategies for mobilisation of additional funding for disability specific and disability inclusive programming. It is recognised that growth in DACs capacity while needed will be not sufficient. UNDP will work closely with DAC and key Ministries to monitor progress and to address problems. Cambodia is well aware of its reporting obligations in implementing the CRPD. This means the RGC is likely to be more receptive to advocacy by development partners and Cambodia's relatively strong civil society disability movement. The involvement of UN agencies in this program will enable deployment of their convening power with government, thereby strengthen advocacy efforts. The program will advocate to the RGC for transparent funding allocations for disability programming, including disability inclusive programming so progress can be monitored. The feasibility of establishing a baseline for disability funding in MoSVY and selected key line Ministries will be explored. The level of funding will be monitored and linked to advocacy efforts.			increased significantly by 2016. Funding for disability programming has not increased significantly above Cambodia's inflation rate by 2016
3.2 The program's investment concept proposed a discreet component to improve information on the number of people with disability and their quality of life. Data was to be used to inform program planning and in advocacy to Government on key service needs. Due to resource constraints, at design it was decided to limit this work to an assessment of the current (inadequate) disability data and a data needs assessment and not proceed with a proposed data collection exercise. It is unlikely Government will give priority to funding a data collection exercise. The lack of data will limit the evidence base for program planning and effective advocacy to Government.	Moderate	Almost certain	High	The analysis of existing disability data in Cambodia may provide a limited (albeit inadequate) basis for program planning and advocacy. It may also be possible to work with MoSVY and the National Institute of Statistics to improve disability data collection through existing mainstream instruments such as the census and the Cambodian Social and Economic Survey. If additional funds become available from AusAID or other sources support for improved data collection would be a high priority area.	High	UNDP	On-going The effectiveness of advocacy is limited by poor quality data
3.3 DAC/MoSVY fail to accept or act upon major recommendations from the functional analysis. The organizational structures and mechanisms within DAC/MoSVY remain confusing, with a lack of clarity on roles and responsibilities.	Major	Possible	High	The functional analysis will be undertaken in close collaboration with DAC and MoSVY to increase the likelihood of their ownership of the results. Following the assessment, UNDP will work with DAC/MoSVY to draw up an agreed and specific action plan to address the issues raised by the assessment, including a clear and prioritised set of time-bound tasks, with a clear division of responsibilities. The annual work plans for project implementation following the functional analysis should be closely based on this.	Moderate	UNDP/DAC	
3.4 Capacity-building activities implemented under the program do not result in improved quality or effectiveness of DAC's work.	Major	Possible	High	UNDP will assess this situation and provide a report on the reasons why DAC has not improved the quality and effectiveness of its work and what steps can be taken to address the situation, including alterations to the implementation plan. If needed additional TA will	Moderate	UNDP/DAC	4 <sup>th</sup> quarter 2014

				be provided			
3.5 Analysis of the existing data sources for proper implementation of NDSP is not of sufficient quality to properly inform implementation of NDSP.	Moderate	Possible	High	UN Agencies prepare plans/modalities for securing gathering of quality data and undertake fundraising activities	Moderate	UNDP	1 <sup>st</sup> quarter 2014
<b>4. Component 2: Supporting Disabled People's Organisations to raise the voice and protect the rights of people with disability</b>							
4.1 CDPO and DPOs dialogue with RGC faces difficulties preventing inclusive development of NDSP and reporting under CRPD	Major	Possible	High	UNDP in partnership with other UN agencies will use their leverage and convening capacity to bring both parties to the table and ensure the constructive inputs from all stakeholders are incorporated into NDSP	Moderate	UNDP/CDPO	
4.2 CDPO and DPOs are unable to act as an effective channel for advocating for the rights of the most vulnerable of people with disability, especially women and children with disabilities.	Moderate	Possible	High	UNDP will assess other options as to how to empower CDPO and DPOs to carry out these tasks	Low	UNDP/CDPO	
4.3 Civil society does not recognise and support CDPO as a leader in representing interests of people with disability in Cambodia.	Major	Unlikely	Moderate	UNDP works with civil society and CDPOs to ensure synergies and facilitate cooperation between CDPO and civil society	Low	UNDP/CDPO	
<b>5. Component 3: Supporting Rehabilitation Systems Strengthening</b>							
<b>Component 3.1: Rehabilitation sector leadership, coordination and planning</b>							
5.1 Achieving coordination relies on a range of stakeholders working collaboratively and participating in the coordinating mechanism. If relationships between stakeholders break down and/or meetings cease some benefits will be lost.	Moderate	Possible	High	The establishment of a coordination mechanism will need to take into account the potential multiple concerns of different stakeholders. For example MoH may like to play a bigger role than other stakeholders are happy with, or the reverse. Clarifying purpose, delegating responsibility and ensuring stakeholders are appropriately represented will be a priority for establishment of the mechanism. Management of the component will involve on-going high priority to relationship management with key stakeholders and facilitation of productive dialogue between stakeholders.	Moderate	WHO	On-going Relationships between key stakeholders deteriorate Coordination meetings cease
5.2 Stronger leadership in rehabilitation relies to some degree on the government's on-going political support for people with disability and appreciation for the important role rehabilitation plays in enabling people with disability to participate in community life. In the absence of this support it may not be possible to make significant gains in strengthening the rehabilitation sector.	Moderate	Possible	High	Attaining political support for rehabilitation requires understanding of the enabling role it plays in supporting participation of people with disability in community life. Clear information about role and unmet service needs is important for advocacy for this component of the program. Some early analysis will estimate unmet service needs for use in advocacy.	Moderate	WHO	On-going By 2016 there has been no increase in Government funding for rehabilitation services
5.3 Building leadership and capacity in rehabilitation requires individuals trained and supported to remain in the sector and in key organisations. There is the risk that the investment in capacity building will be lost by people moving to jobs outside the rehabilitation sector.	Moderate	Likely	High	A very considered approach to selection of participants in a wide variety of training opportunities will occur in order to identify people most likely to remain engaged in sector and those likely to participate in future sectorial leadership.	Moderate	WHO	On-going Significant loss of trained staff from the rehabilitation sector
5.4 Attempting to increase MoH engagement in rehabilitation, even if modest, has the potential to fail if health sector decision makers are not effectively	Moderate	Unlikely	Moderate	Working with MoH on disability and rehabilitation requires awareness of risks and an incremental and realistic approach. WHO needs to be sensitive to the	Low	WHO	On-going MoH fails to increase its

supported to understand the role health and how health can achieve this role. There is potential for this to 'backfire' with MoH , when prompted, to pull back from rehabilitation services and be explicit about this.				demands on the health sector and nurture their ability to meaningfully engage. WHO needs to demonstrate leadership in this area to ensure withdrawal is not considered an appropriate response, especially in light of increasing global health responses to disability.			commitment to rehabilitation work or withdraws from the sector
<b>Component 3.2: Access to quality rehabilitation services</b>							
5.5 Increasing access to rehabilitation services relies on the ability of the key stakeholders, including MoSVY and PWDF, to mobilise additional financial resources.	Moderate	Possible	High	Advocacy on the need for increased funding, informed by the results of the analytical work commissioned under this component, will be a prominent feature of WHO's work. AusAID and WHO will make it clear that on-going direct donor support for service delivery will be time limited and seek to negotiate agreement for the Government to increase its financial support. Constraints to government funding are, however, clear and AusAID and WHO are aware that increase funds may not be allocated. As part of the systems strengthening work a focus on increasing efficiency and effectiveness is important in order to support increased service provision should additional funding not be allocated by government.	Moderate	WHO	On-going By 2016 there has been no increase in Government funding for rehabilitation services
<b>6. Component 4: Inclusive governance and inclusive community development</b>							
6.1 The Ministry of the Interior will lack the necessary technical knowledge and skills and/or commitment to become involved in the program	Major	Unlikely	Moderate	UNICEF is already using its well established relationships at Mol and its mid-term review process to prepare the ground for this new work and will provide necessary training and support.	Low	UNICEF	Q1, 2014 Mol staff engaged on other matters and not available.
6.2 Communities and decision-makers will not be open to disability inclusive development	Major	Possible	High	UNICEF will be using capacity development, training and other activities with a wide range of stakeholders to raise awareness and take positive action through the engagement of DPOs to tackle stigma and discrimination and to show through concrete examples how people with disability can participate in society.	Low	UNICEF	Q2, 2014 Communities show resistance to using tools to include people with disability.
6.3 Applicants for small grant scheme are unable to meet the needs of people with disability on the ground and/or the NGOs/DPOs are unable to meet needed standards of management, reporting and fiduciary requirements.	Major	Unlikely	Moderate	UNICEF will support NGOs/DPOs through the application process and UNICEF staff will provide capacity development and training to assist NGOs/DPOs to be able to respond to all types of need. UNICEF will monitor small grants to identify problems with performance and take necessary steps to work with NGOs/DPOs to mitigate any problems.	Low	UNICEF	Q2, 2014 It will be clear that NGOs/DPOs are unable to meet standards. Q4 2015 NGOs/DPOs not delivering comprehensive services of an acceptable standard.
6.4 UNICEF is too complex an organisation to deliver SGS efficiently.	Major	Unlikely	Moderate	UNICEF will review procedures to make decision-making as flexible as possible and will explore various mechanisms to facilitate the process. UNICEF has experience of working with NGOs in Cambodia and	Low	UNICEF	Q1-2, 2014 Delays in decision-making and slow disbursement of

				will draw upon this for lessons.			funds for the small grants.
<b>7. Operating environment and external risks</b>							
7.1 Fraud in the program would impact negatively on the reputation of AusAID and the UN as a development partners in Cambodia and reduce the likelihood of other development partners making contributions to enable scale up of the program	Minor	Possible	Moderate	The program will use output based funding agreements to ensure a focus on results rather than complex acquittal processes. Mechanisms that will be used for direct funding of Government are outlined in Section 2.9.3, including fiduciary control checks that will occur prior to funding and accountability mechanisms once funding has been allocated. The UN agencies have well established systems and procedures for financial accountability for sub-grantees and have a long experience in working in Cambodia. This will include HACT assessments, periodic spot checks and internal and external audit, regular monitoring, and a requirement for separate bank accounts. Application of these procedures should significantly reduce the likelihood of fraud. Similar procedures will be applied to funding of civil society organisations. Should fraud be detected appropriate corrective action will be initiated.	Low	PCT UNDP UNICEF WHO	On-going Discovery of fraudulent practices
7.2 Cambodia is a relatively safe and stable environment. The key risks faced by staff are motor traffic accidents, theft and sexual assault.	Moderate	Possible	High	UN agencies in Cambodia have well established policies and procedures to maximise the safety and security of staff. All program staff and consultants will be required to comply with these policies and procedures. Any incidents affecting staff safety and security will be reviewed to identify lessons learned.	Low	PCT UNDP UNICEF WHO	On-going Incidents affecting staff safety and security
7.3 Some aspects of program implementation will bring program staff and organisations funded by the program into contact with children. There is a risk of child abuse or exploitation.	Major	Possible	High	AusAID's due diligence framework requires that all multilateral organisations in receipt of AusAID funding be assessed in relation to AusAID's Child Protection Policy and standards. This includes a review of the multilateral organisation's capacity, systems, policies and processes to determine its child protection strengths and weaknesses. AusAID's Cambodia Post will conduct this assessment if it has not already been undertaken. The UN agencies will be required to act in accordance with the principles set out in AusAID's Child Protection Policy and abide by other relevant international declarations, conventions and agreements. All allegations of child abuse or exploitation involving program staff or staff and volunteers of organisations in receipt of program funding will be properly investigated and the findings acted upon, as needed.	Low	AusAID PCT UNDP UNICEF WHO	On-going Allegations of child abuse or exploitation are not effectively investigated and acted upon
7.4 As AusAID budgets in Australian dollars, its allocation for the program will be denominated in Australian dollars. The program budget will be in US dollars which is the currency used for budgeting by the UN and other partners in Cambodia. At the time of design, the Australian and US	Major	Likely	High	Independent of the risk, AusAID and the UN agencies will be seeking financial contributions to the program from other donors. To the extent that additional funding is mobilised, the impact of a weakening Australian dollar will be minimised. The PCT will	High	PCT Program Board AusAID UNDP	On-going The Australian dollar has depreciated below

<p>dollars were close to parity but by the time the design document was being finalised the value of the Australian dollar in relation to the US dollar had depreciated by more than 10 per cent. Further depreciation of the Australian dollar is possible. If the Australian dollar remains significantly below parity with the US dollar this will have the effect of reducing the funding after currency conversion is applied.</p>				<p>monitor Australian-US dollar currency exchange rates so that adjustments to the program's budget can be made by the Program Board without delay, if needed. If the Australian dollar has further depreciated by the commencement of the inception phase a key initial task for the Program Board will be to revise the program budget in consultation with AusAID and the three UN agencies.</p>		<p>UNICEF WHO</p>	<p>AUD 0.9 to USD 1 by the commencement of the inception phase Significant further weakening of the Australian dollar</p>
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## Annex 7: Situational analysis and strategic context

This annex provides a more detailed version of Section 1.

### 1.1 National Development Context

It is important to situate an understanding of the lives of people with disability in Cambodia within the broader political, economic, social and cultural context within which decisions that affect them take place. This first section provides that broader context, including through illustrative examples.

At a political level, the Royal Government of Cambodia's (RGC) statement of priorities is outlined in the *Rectangular Strategy Phase II* (2008 – 2013). Centred on good governance, it has four focus areas:

1. Enhancement of the agricultural sector;
2. Further rehabilitation and construction of physical infrastructure;
3. Private sector development and employment generation; and,
4. Capacity building and human resource development.

The *National Strategic Development Plan* (NSDP) is the road map for implementation of the *Rectangular Strategy Phase II*. Developed to cover the period 2006 – 2010; it was updated in 2009 and extended to 2013 in order to align with the Rectangular Strategy. The NSDP is in turn supported by a range of other RGC strategies covering lines Ministries and whole-of-government issues.

One of the most important strategies is the *National Program for Sub-National Democratic Government* (SNDD, 2010 – 2019), which also highlights the vision of decentralisation reform. The National Program aims to ensure effective decision-making at local levels, including through the participation of citizens in the development process and through the creation of demand for services. It has five focus areas:

1. Sub-National Institutional Development;
2. The Development of Strong Human Resource Management Systems;
3. The Transfer of Functions and Resources;
4. Sub-National Budget, Financial and Property Systems; and,
5. Supporting Institutions for D & D Reform Processes

The implementation of these strategies and plans in a coherent, linked and prioritised way was emphasised in the NSDP Update (2009 – 2013, p. 3) and is on-going. There are also two other important reform processes underway, on Public Financial Management and the National Public Administrative Reform.

The World Bank's *Cambodia Economic Update for April 2013* noted that the overall macroeconomic situation was positive, largely underpinned by growth in the agriculture and tourism sectors. There has also been a considerable decrease in poverty rates from 34.7 per cent in 2004 to 20 per cent in 2011.<sup>31</sup>

Despite these positive achievements, there are a number of significant challenges facing Cambodia's population of 13,395,682 people.<sup>32</sup> This includes growing inequality between urban and rural settings, provinces, and different social groups.<sup>33</sup> This mirrors trends in other low and low-middle income countries in the Association of South East Asian Nations (ASEAN), which can put both economic growth and social stability at risk.<sup>34</sup>

Although the RGC has ratified several important international treaties, including the International Covenant on Economic, Social and Cultural Rights, Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Violence Against Women (CEDAW),

reporting against the treaties is often delayed with several time periods covered by one report; implementation is also delayed (as demonstrated through submission of combined progress reporting and significant lists of issues from the treaty bodies).<sup>35</sup> A recent visit by the United Nations Special Rapporteur for Human Rights noted several areas of concern, including a culture of impunity and lack of freedom of expression.<sup>36</sup>

While more children are entering Grade 1, and gender disparity at this point is decreasing, keeping children in school and ensuring they receive a quality education remains challenging. These challenges are magnified for children facing additional barriers, such as poverty, remoteness or lack of community support for education (including by ethnic groups).<sup>37</sup>

In health, progress has been made against MDG Four on reducing child mortality. Cambodia does however fare worse than other countries in the region with lower life expectancy, contraceptive prevalence and higher maternal mortality.<sup>38</sup> While there has been a decrease in childhood stunting, in large part due to improvement in economic factors at the household level, further work is required to address inequality, including investments in health and education service delivery.<sup>39</sup>

While Cambodia has made good progress in developing policies and plan to address gender inequality (including through *Neary Rattanak III 2009 – 2013*), girls are still less likely to continue on to higher education and women are more likely to be illiterate than their male counterparts.<sup>40</sup>

A recent study by the World Bank, found that while significant progress has been made in the policy and legislation framework for D & D, there are a number of emerging political economy issues. For example, decisions by Commune Councils were often found to be largely informed by Cambodian People's Party (CPP) politics, formal settings are often ineffective in ensuring representative 'voice' of communities (but were supplemented through other means) and low levels of meaningful participation of women in decision-making.<sup>41</sup>

## 1.2 Lives of People with Disability in Cambodia

The World Health Organisation (WHO) and World Bank's *World Report on Disability* (2011) estimates that 15 per cent of the world's population have a disability, of whom 2.2 per cent have very significant difficulties functioning. Extrapolating this figure to Cambodia would mean there are over 2 million people with disability and over 320,000 of whom have very significant difficulties functioning. For further information on national statistics, refer Section 1.5 of this Annex.

With a predominantly Buddhist population, it is often thought that disability is seen as a result of a sin in a past life. There are however, other cultural norms that impact on people's perception of disability. This includes belief in the connection between mind and body, which may lead to people with mobility impairments being considered to have intellectual impairments as well, people with disability being considered a burden as they are seen as being unable to contribute to the well-being of the family and a culture of pity.<sup>42</sup>

Determining the quality of life of people with disability is a complex task, often dependent upon multiple and interlinked factors requiring both qualitative and quantitative assessment. Preliminary findings (November 2012) from a recent Jesuit Refugee Services study of 2,791 people with disability found the majority self-assessed their quality of life as being reasonable or partially satisfied. There were however, several areas for concern, for example approximately 20 per cent of respondents did not feel they had sufficient income to live their life with dignity.

As a post-conflict country, Cambodia plays host to a number of risk factors which can lead to high prevalence of psychosocial impairments. By way of example, the prevalence of post-traumatic stress disorder is substantially higher than global averages. Little appears to be being done to address this challenge with just 0.2 per cent of the total health budget spent on mental health and no planning

for psychologists and social workers in health sector human resource planning (in addition to psychiatrists and psychiatric nurses). The lack of availability of appropriate and free medication for those who require them is a significant challenge.<sup>43</sup>

The lack of access to appropriate and affordable health, rehabilitation and disability services has a significant impact on the well-being and participation of people with disability in Cambodia. There are several key challenges:

- Eligibility for social protection programs is often determined by the ID Poor poverty assessment tool managed by the Ministry of Planning. While this tool includes a question on disability it is not scored and only relates to the head of household or spouse of the head of household. This reduces opportunity for households with people with disability to be counted as poor, and therefore reduces eligibility for Health Equity Funds (HEF) or Community-Based Health Insurance.<sup>44</sup> Another challenge is that many social protection programs are not universal in coverage.
- The Minimum Package of Activities (MPA, at the primary level) and Complementary Package of Activities (CPA, for referral hospitals), which are covered by HEF, do not include specialised rehabilitation services. This means that even if people with disability were identified as being poor, they still face some challenges in accessing these services due to costs of transport and/or covering living costs while receiving treatment (while the RC covers provides some subsistence allowance, it is extremely low). This creates flow-on effects as rehabilitation services are often a pre-requisite for people with disability to access mainstream health services. By way of example, a woman with mobility impairment might require a wheelchair in order to access sexual and reproductive health services offered at a local clinic.
- In one study, people with disability prioritised barriers to healthcare as follows: 1) financial (e.g. transport costs, user fees), 2) quality of care (e.g. knowledge and skills of healthcare providers, including discrimination on the basis of being able to pay), 3) user knowledge (e.g. not knowing where to go or what they were entitled to), 4) physical (e.g. long distances to travel, inaccessible health centre facilities), 5) socio-cultural (e.g. discrimination on the basis of disability).<sup>45</sup>

For further information on rehabilitation and disability services, refer Section 1.6 of this Annex.

Issues preventing children with disabilities attending school include social discrimination, lack of transport, assistive devices, physical barriers, teachers' lack of skills in appropriate teaching methodologies and the need for children to help with housework.<sup>46</sup> A recent study found that 10.1 per cent of children had one or more disabilities, with cognitive and speech impairments the most common.<sup>47</sup> The lack of early identification, intervention and support for young children with disability can reduce their ability to enter Grade 1 on time and learn effectively later in life.

The 2004 Cambodia Socio-Economic Survey (CSES) found that a head of a household (HoH) who is a person with a disability will earn approx. USD42 per month, compared other HoH earning approx. USD60 per month. When comparing average monthly wages for rural persons with disabilities who are the HoH (approx. 85 per cent of persons with disabilities live in rural areas in Cambodia), then the majority of persons with disabilities earn one third the GDP per working population. It also showed that persons with disabilities are twice as likely to be landless.

A recent study found that most employers surveyed viewed the employment of young people with intellectual disability positively, being only concerned that the right job and training were available. It also noted that more young women with intellectual disability were concerned about safety travelling to and from, and within the workplace, than compared to their male counterparts.<sup>48</sup> Some



young people with disability are already utilising mobile technology to communicate and seek out job opportunities. Expanding access to a variety of technology can assist not just in getting them connected to other young people, but also in securing employment in technology-related fields.<sup>49</sup>

Although adults with disability are often marginalised and vulnerable, children with disability are even more so. In Cambodia, children with intellectual disability and their families face significant stigma and discrimination, with very few organisations providing services and supports.<sup>50</sup>

People who are deaf or have a hearing impairment are particularly marginalised. The word 'deaf' translates into Khmer to mean 'cannot speak', indicating a lack of understanding of the concept of deafness. Many people who are deaf are often misdiagnosed as having an intellectual disability. It is established there are over 50,000 people who are deaf in Cambodia and 500,000 with hearing impairment, however just 1,800 people who are deaf have been taught sign language.<sup>51</sup>

Women with disability face the triple burden of discrimination, on the basis of gender, disability and poverty. It is thought that the intersection of this discrimination has more than simple compounding effect, in that it creates interlinked barriers which are complex to address. Recent research in Cambodia examined prevalence of violence against women with disability compared to their peers without disability. Using a combination of the WHO's Multi-country Study on Women's Health and Domestic Violence Against Women and Self-Reporting Questionnaire (SRQ) and the Washington City Group Questions on Disability, the research found that when compared to their peers without disability, women with disability:

- Experienced significantly higher rates of emotional, physical and sexual violence by household members (other than partners) compared to women without disability;
- Were considered less valuable and more burdensome within the household;
- Were 2.5 times more likely to require permission from a partner to seek healthcare; and,
- Experience higher rates of psychological distress (as a result of partner violence) and are less able to disclose family violence or seek appropriate support (often because communities/NGOs do not seek to include them in prevention/support programs).<sup>52</sup>

### 1.3 Government and People with Disability

The first steps towards RGC action in support of people with disability in Cambodia came as a result of the legacy of landmines and other Unexploded Ordnance (UXO), but also in part due to the first United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) decade for people with disability '*Full Participation and Equality of Disabled Persons in the Asian and Pacific Region*'; (1993 – 2002). RGC's commitment was demonstrated through ratification of the Convention on the Rights of Persons with Disabilities (CRPD) in 2012.

#### *Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY)*

The MoSVY Work Platform (2008 – 2013) includes priority 3: '*Strengthen and Expand Welfare and Rehabilitation Services for People with Disabilities*'. This includes objectives on the National Disability Law, ratification and implementation of the CRPD, International Labour Organisation (ILO) Convention 159 and other policies on disability, continuing and strengthening sustainability of physical rehabilitation services (as well as spinal cord injury treatment services), promoting vocational training, creating jobs and business opportunities for persons with disabilities, strengthening and expanding community-based rehabilitation (CBR)/organising self-help groups, expand and promote Braille and sign-language and their use through information communication technology, and finally to strengthen and expand sports and arts movements for persons with disabilities. The Work Platform does not specify which institution should lead.

### *History of the Disability Action Council*

A National Task Force on Disability, comprising both RGC and civil society representatives, was established in 1993 with the job of identifying common issues and strategies for the sector. One of the recommendations of the Task Force was the establishment of a coordinating body.<sup>53</sup>

The Disability Action Committee was established in 1996 and then recognised as semi-autonomous body by the Ministry of Social Affairs, Veterans and Youth Rehabilitation (MoSVY<sup>54</sup>) in 1999 (refer Prakas #308); the name was also changed to the Disability Action Council (DAC). According to the Prakas, the responsibility of the DAC was to act as in an “*advisory capacity to government, policy-makers and key NGO representatives on all issues affecting the well-being of people with disabilities*”. It was also noted as being the national focal point on disability. At that time, the DAC Executive Board comprised:

- Chair – Secretary of State, MoSVY;
- Deputy Chair – Cambodia Trust Country Representative;
- Members from the Ministry of Education, Youth and Sports, Ministry of Health (MoH), MoSVY (two members); and,
- Five members from civil society, including specifying one representative of women with disability.

In 2003, the Executive Director of the Cambodian Disabled People’s Organisation (CDPO) became the Chair, with this then switching back to the Secretary of State, MoSVY in 2008.

In 2009, RGC finally adopted the Law on the Promotion and the Protection on the Rights of Persons with Disabilities. The need for a disability law was first identified by the Task Force in the mid-1990’s and had already been presented to the Council of Ministers at least twice<sup>55</sup> before it was finally passed. Articles 6 and 7 of the Law concerned the role of the DAC. This was followed by a Sub-Decree (No 59) which established the DAC as an RGC entity, emphasised its role as the national coordination and advisory mechanism on disability and amended the composition of the DAC (previously known as the Executive Board) to include:

- Chair – Minister for Social Affairs, Veterans and Youth rehabilitation;
- Vice-Chairs – Secretaries of State from MoSVY, Council of Ministers, MoH, Ministry of the Interior (MOI), Ministry of National Defence, and a representative from the Disabled People’s Organisation (DPO);
- Other RGC members came from the Cambodian Mine Action and Victim Assistance Authority (CMAA), and the Ministries of Economy and Finance, Education, Youth and Sports, Rural Development, Planning, Information, Public Works and Transportation, Land Management, Urbanisation and Construction, Women’s Affairs, Labour and Vocational Training, and the Secretariat of Function Public, Cambodian Red Cross, Council for Development of Cambodia, Council for Agriculture and Rural Rehabilitation and Development; and,
- Civil society members were: four representatives of DPOs (two female, two male), and one each from an NGO working in the disability sector, employer and the Secretary of the DAC.

Individual members of the DAC were named in Government Decision (No 72 SSR) of December 2010. According to Sub-Decree No 59, the DAC was responsible for providing technical advice on disability and rehabilitation, assisting Ministries and other institutions to development policies etc. related to disability and rehabilitation, promoting implementation of those policies, proposing revisions, amendments or new policies, laws etc. relating to disability, monitoring/evaluating those policies/laws and communicating with relevant national/international communities for the purpose of information exchange and mobilising resources. Finally, the Sub-Decree noted the DAC

Secretariat would be staffed from existing MoSVY civil servants and could also recruit contract workers, and that the DAC would meet twice per year.

A 2011 Prakas (No 561) further outlined the roles and responsibilities of the DAC Secretariat as follows:

- Coordinate directly with and coordinate the efforts of others in working with Ministries and other stakeholders to develop, promote, implement policies, laws etc. relating to disability and rehabilitation;
- Develop an evidence based for amendments, changes, new proposals to policies, laws through research and monitoring and evaluation;
- Manage human resources (including performance-based recruitment), finances and assets of the DAC Secretariat;
- Proposed annual action plans/budgets of the DAC and prepare documents for the Chair to submit to DAC meetings;
- Liaise with national/international stakeholders on sharing lessons learned and mobilising resources; and,
- Prepare reporting and act as 'Disability Resource Centre'.

A new Sub-Decree was signed by Prime Minister on 2 May 2013 (No. 216 ANKr.BK) on '*Sub-Decree on Organisation and Functioning of the Disability Action Council*'. This included several important changes including,

- The Prime Minister is the Honorary President;
- The DAC is be responsible for preparing reports on the Convention on the Rights of Persons with Disabilities;
- The DAC Secretariat is upgraded to a General Secretariat (effectively higher than a Department within the Ministry);
- Each Ministry will establish a Disability Working Group (DWG), responsible for mainstreaming disability into the work of that Ministry (similar to the Gender Mainstreaming Action Groups supported by the Ministry of Women's Affairs; and
- The General Secretariat will comprise five units: Administration and Finance, Rights of Persons with Disabilities, Welfare and Rehabilitation, Integration and Disability Service Development.

Throughout the history of the DAC, provision has been made for several committees, sub-committees and working groups covering areas such as education and Community-Based Rehabilitation (CBR). Based on information collected from stakeholders during the design phase, it is estimated the DAC has met just three times in last five or so years. The DAC Secretariat was recently (2013) nominated as the focal point within RGC for the CRPD.

The DAC has received financial and technical support from a range of development partners since it was established. This included INGOs in the early days, USAID for a period of seven years until 2006 (via Handicap International Belgium) and the most recently AusAID. While some of the challenges in the DAC Secretariat's ability to fulfil its functions may relate to the change in status and staff etc., many can also be attributed to the relatively unstable financing, including from development partners, particularly over the last five years which have seen periods of no financial support and/or periods of short-term contracts.

### *History of the Department of Welfare for Persons with Disabilities*

The Department of Welfare of Persons with Disabilities (herein referred to as the Department) is the responsible entity, on behalf of RGC, to develop and submit for endorsement, national policies, laws relating to disability and rehabilitation (i.e. the DAC Secretariat and other institutions can provide input, but are not authorised to lead).<sup>56</sup>

In January 2010, a Prakas (No 056) established the Disability Rights Administration (DRA), within the Department (this was mandated under the *Disability Law* Article 8). According to the Prakas, the DRA has three offices (administration, consultation, coordination and promotion, and inspection) and is responsible for:

- Promoting, monitoring, inspecting and enforcing policies, laws etc. on disability (including preparing cases for court and instituting fines for non-compliance);
- Being a 'law consultant' to people with disability and public and private sector institutions; and,
- Arbitrating conflict regarding the *Disability Law* on the Promotion and the Protection of the Rights of Persons with Disabilities.

A Prakas from September 2011 defined the six sub-entities within the Department to include

- Statistics and Communication Office;
- Rehabilitation Affairs Office;
- Vocation Training, Job and Conflict Resolution for People with Disability Office;
- Technical Office for Coordinating Disability, Braille and Sign Language;
- Women and Girls with Disabilities, Art and Sport of People with Disability Office; and,
- DRA.

### *History of the Persons with Disabilities Foundation*

Article 46 of the *Disability Law* on the Promotion and the Protection of the Rights of Persons with Disabilities agrees the establishment of the Persons with Disabilities Fund (a public administration institution) that is responsible for 1) funding implementing of programs which assist people with disability and other institutions to receive/provide services such as health, rehabilitation, education etc., 2) to promote and enhance the welfare of people with disability, including in particular those who are poor and who do not receive services/supports elsewhere, and 3) to provide loans and credits for reasonable accommodation.

Further detail on the operations of the Fund is found in Sub-Decree (No 118 ANK-BK) dated September 2010. According to the Sub-Decree, the Fund has a Governing Board, which should meet every three months, comprising:

- Chair – MoSVY Representative; and,
- Members from the Council of Ministers, Ministry of Economy and Finance, DPO, DAC Secretariat, DRA Chair, individual with outstanding social welfare knowledge and experience, Director and one staff representative of the Fund.

The Sub-Decree further elaborates the roles and responsibilities of the Fund as follows:

- Provide and manage rehabilitation services and centres;
- Fund implementation of programs providing services for people with disability including in health, rehabilitation and education etc.;
- Promote improved the welfare of and integrate people with disability into the community;
- Collect fines from institutions that do not comply with the *Disability Law*;

- Manage funding received from various sources (including RGC and development partners); and
- Conduct technical research and human resource development on rehabilitation.

The Fund also has provincial branches based at both at Provincial and District Social Affairs, Veterans and Youth Rehabilitation Offices. Roles and responsibilities for these offices include:

- Managing PRCs within geographic areas of responsibility;
- Managing the pension scheme for people with disability; and,
- Manage information on people with disability receiving the pension and services from the PRCs.<sup>57</sup>

The Fund is now known as the Person with Disabilities Foundation (PWDF).

AusAID engaged the Australian Volunteer International (AVI) to place a well-qualified volunteer to provide strategic advisory support to PWDF. The volunteer commenced her work in August 2012 and will continue through to June 2014. The volunteer has assisted PWDF in the development of their strategic plan and building organisational capacity.

***National Plan of Action for Persons with Disabilities, including Landmine/Explosive Remnants of War (ERW) Survivors (NPA)***

RGC ratified the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and On Their Destruction (known as the 'Anti-Personnel Mine Ban Convention') in 1999. In 2001, CMAA was mandated with responsibility for fulfilling victim assistance obligations under the Convention. This responsibility was transferred to MoSVY and DAC in 2001 via Sub-Decree.<sup>58</sup>

In 2005, the Anti-Personnel Mine Ban Conventions' Standing Committee on Victim Assistance and Socio-Economic Reintegration developed a framework to assist the most-affected countries, including Cambodia, develop victim assistance plans. The DAC developed the draft of the National Plan of Action for Victim Assistance in 2005. In 2007, the DAC started the process of the development of the National Plan of Action for Persons with Disabilities, including landmine/ERW Survivors (NPA) with the support of AusAID (via the Australian Red Cross). UNICEF also participated in this process. During the development it was agreed that the plan of action should be inclusive of all persons with disabilities and not only focus on landmine survivors. The draft of NPA was finalised in 2009 (covering the period to 2011).

While the NPA included all people with disability, it was still guided by the framework for victim assistance as set out in the five priority areas adopted by the states parties to the Anti-Personnel Mine Ban Convention: emergency and continuing medical care, physical rehabilitation, psychological and social support, economic reintegration; and laws, public policies and national planning.<sup>59</sup>

To support coordination and implementation of the NPA, a National Disability Coordination Committee (NDCC) was established by Government Decision on 5 August 2009. Comprising largely the same membership as the DAC, the NDCC was responsible for:

- Monitoring, coordinating, evaluating and promoting the NPA;
- Developing relevant national policies to improve coordination and services delivery;
- Support and collaborate with Ministries and other stakeholders to develop national policies for inclusion of people with disability;
- Cooperate with Ministries, service providers and international development partners to benefit people with disability, and landmine survivors,;
- Collect information on and collate reporting from Ministries and other stakeholders,;

- Support RGC to meet commitments under the Anti-Personnel Mine Ban Convention, and the CRPD (and Optional Protocol) when ratified;
- Assist RGC to implement the *Disability Law*; and,
- Assisting in identifying victims and mobilising resources for disability issues, including victim assistance.<sup>60</sup>

Provision was also made for a series of sub-committees to progress priority areas under the NPA but these were never established. The 2011 review report of the NPA noted that just 12 of 27 objectives had been met. The first meeting of the NDCC was held in March 2010. In light of the need to continue progressing unmet objectives and to allow sufficient time to develop a new NPA, the second meeting was held in February 2012 and it was agreed to extend the NPA to the end of 2013.<sup>61</sup>

### ***Law on the Promotion and the Protection of the Rights of Persons with Disabilities***

The National Task Force on Disability recommended in 1996 the adoption of a national law on disability. After remaining in draft, the *Disability Law* was adopted in July 2009. Cambodia's legal system follows the French system, in that each law is enacted through a series of Sub-Decrees and Prakas. Approximately five Sub-Decrees, six Inter-ministerial Prakas and five (other) Prakas are required to enact the *Disability Law* fully; at the time of writing, four Sub-Decree, one Inter-ministerial Prakas and five (other) Prakas had been finalised.

The *Disability Law* includes an interesting provision (Article 49) which notes that: "*In the case of any provisions that contradict the provisions of this law, the provisions of those international treaties shall be considered as the principle provisions*". While this positively addresses, to some extent, areas where the Law is not aligned to the CRPD (for examples several references to primary prevention) or where there are gaps (such as no mention of access to justice), it provides little in the way of practical expectations and guidance for how the CRPD might be implemented.

### ***Summary***

Compared with other countries in the region, Cambodia has a relatively complex governmental structure focused on people with disability. This includes two inter-Ministerial, multi-stakeholder coordination bodies (the DAC and NDCC), numerous overlapping committees, sub-committees and working groups. As most of these bodies do not meet regularly, their effectiveness is questionable. The three government institutions with responsibility for disability, the DAC Secretariat, Department and the PWDF do not, for the most part, coordinate and cooperate in a functional manner. This is reflected in an overlap of functions between different institutions resulting in unclear accountabilities. Combined with a lack of sound data collection and analysis and limited meaningful engagement of DPOs and people with disability in the shaping, monitoring and implementing of the NPA and *Disability Law* etc., the resulting institutional framework has been historically characterised by unclear prioritisation in disability policy, with blurred lines of accountability, limited feasibility and no clear to evidence-based or participatory assessments of the needs and priorities of people with disability. This is compounded by the relatively low status, and corresponding low levels of resourcing, of MoSVY within RGC.

## **1.4 Civil Society and People with Disability**

Cambodia has a relatively large civil society community focused on people with disability. This is largely result of the landmine legacy, which led to the influx and high levels of support of International NGOs (INGO) in the 1990's. This section is not intended to be an exhaustive description of all organisations working in the disability sector, rather a brief outline of some organisations, in particular DPOs.

Established in 1994, the Cambodian Disabled People's Organisation (CDPO) is an organisation made up of and for people with disability. CDPO has 33 staff at their headquarters in Phnom Penh, and subnational DPO members in all 23 provinces. They have over 10,000 individual members within a member structure as follows:

- CDPO – Phnom Penh office
- Provincial DPOs and Women with Disabilities Forums
- District Federations, formed by several Self-Help Groups (SHG)
- Village-level SHG

CDPO has three areas of focus: advocacy and rights monitoring (which includes research), communication and awareness raising and DPO development. Over recent years, CDPO has been working to increase capacity for informed advocacy based on research and analysis; this includes partnering with other organisations to undertake the seminal Triple Jeopardy research on violence against women with disability. The outputs of this increased capacity include several position papers on education, employment and agriculture.<sup>62</sup>

While CDPO is the peak body representing people with disability in Cambodia, it does not yet appear to be considered the 'umbrella' DPO – i.e. other national DPOs are not members. In recent years, CDPO has made good progress in changing the way it provide capacity development support to subnational members (from approaching this similar to an audit function, to working in a more collaborative/mentoring approach). Despite the good progress, CDPO will need to continue a focus on the most appropriate ways of delivering capacity development support; it appears an emerging challenge is that the often young CDPO capacity development officers are not often viewed with sufficient respect by the older DPO leaders (at provincial/district levels), thereby constraining the mentoring approach. While there has been some attempt to focus the capacity building of subnational members in a more targeted manner, there are still areas for improvement. For example, it could be useful for CDPO to consider building the capacity of some subnational members to a sufficient level on particular topics (either related to organisational strengthening, advocacy skills or within a particular sectoral technical area), which would then enable them to provide capacity development support to their peers. This would then free up the CDPO staff to concentrate capacity development efforts on new subnational members and/or emerging issues.

The Association of the Blind in Cambodia (ABC) is for the most part, the only other national DPO. Established in 2000, it is a member of the World Blind Union and the International Council for Education of Visually Impaired. ABC operates a library of resources (such as Braille books and sound devices), and computer training programs for people who are blind and vision-impaired. It also managed a CBR program which assists in training on income generation, referring children who are blind to special schools and referring people with vision impairment to appropriate services.<sup>63</sup> It is unclear to what degree ABC focuses efforts on advocacy, including combining efforts with CDPO.

There is no DPO for people who are deaf or hearing impaired. NGOs like the Maryknoll Deaf Development Program and Krousar Thmey have been working to support establishment of such a DPO for many years. One of the key constraints is that there are just 15 Cambodian adults who are deaf and know sign language and can read and write. The two main organisations working with people who are deaf and hearing impaired (Krousar Thmey and the Maryknoll Deaf Development Program) have recently agreed to work together to develop a common Khmer Sign Language, which will also assist in the development of DPO for people who are deaf/hearing impaired. (As a school and with no Khmer Sign Language, Krousar Thmey used American Sign Language).

There are also several other smaller DPOs, including the Phnom Penh Centre for Independent Living Initiative and the Disabled Students Association.

There is no robust information on the total number of SHG's in Cambodia, although one estimate puts it at just over 2,000, supported by 16 disability-focused NGOs. Approximately 800 of those SHG's are members of CDPO. Many SHG's were supported by CDPO, INGOs and local NGOs originally as a way of supporting income generation (e.g. through cow and rice banks, pig-raising), often because they were unable (due to poverty, lack of confidence etc.) to access mainstream micro-credit schemes.<sup>64</sup> Later, the advocacy concept has been introduced, however this is not yet well understood by many SHG's. Many SHG's still represent some of the poorest people in Cambodia, and it is therefore understandable that their priorities are focused on meeting basic needs, before becoming self-advocates.<sup>65</sup>

Many children, young people and adults with intellectual disability often rely on parents association to represent their views. There are very few of this type of SHG in Cambodia; there is the Parents Association of Children with Intellectual Disability (PACHID) in Phnom Penh and several groups supported by NGOs like Komar Pikar Foundation. There are no DPOs/SHG's comprising only people with intellectual and psychosocial disability.

While there are many women with disabilities working for DPOs (at all levels), gender equality within the DPO movement ('movement' is used here to describe all DPOs/SGH's at all levels) appears to have some way to go. This is illustrated by the low representation of women with disability in DPO leadership positions, and the lack of knowledge and awareness on the different situation of women with disability (in particular given the stark findings from the Triple Jeopardy research). There appears, to some extent, to be a view within the DPO movement that gender equality is an issue that women with disability need to address (e.g. through the formation of Women with Disabilities Federations) as opposed to being addressed through both specific initiatives aimed at empowering women and girls with disability, and tacking practical steps within all programs (including advocacy) to ensure equal and meaningful representation of women with disability.

Finally, a challenge facing the disability-focused civil society sector is lack of clarity regarding the differing roles and responsibilities of DPOs and NGOs. For many years, it was NGOs (often INGOs) that defined the priority agenda for civil society efforts on disability and provided support for DPOs to participate. This paradigm needs to be changed, putting DPOs in the driving seat in terms of defining the agenda and facilitating cooperation within civil society. It is unclear to what degree this conversation within civil society has taken place and in fact whether there is even acknowledgement of the need for there to be dialogue. There are likely to be two key challenges with this changing dynamic: 1) NGOs feels sufficiently confident in the ability of DPOs to lead advocacy efforts (including acknowledging that making mistakes is part of the learning process), and 2) NGOs are able to develop other areas of value-added in the changing context.

Civil society organisations currently manage the majority of specialised and support services for people with disability

## **1.5 Information on People with Disability**

In general, there are four possible sources of national data on people with disability:

1. General population surveys – such as census;
2. Sample surveys – such as labour force or socio-economic surveys; and,
3. Administrative data – such as through health or education services.
4. Cambodia Mine/ERW Victim Information System (CMVIS)



More detailed information on people with disability (including their quality of life) can also be gathered through specialised sample surveys (e.g. National Disability Survey) and administrative data (e.g. from rehabilitation and disability services providers, or national disability registries). Good quality information on people with disability can be difficult to gather because:

- the significant stigma and discrimination which often surrounds disability means some people may feel too ashamed to identify as having a disability;
- the word 'disability' and 'impairment' often don't translate easily into local languages, or locally used words have negative or offensive connotations;
- a person may not consider themselves to have a disability, if for example, they consider their impairment a normal part of aging or have never had a health condition and/or impairment formally diagnosed; and,
- enumerators can influence responses by not asking questions in ways that are sensitive and/or culturally appropriate.

There are however, established international good practice with regards inclusion of disability censuses (known as the Washington City Group on Disability Statistics 'Short Set of Six Questions' – refer: ) which can also be applicable to other sample surveys. The Washington City Group on Disability Statistics and UNICEF are currently updating the childhood disability module (known as the 'Ten Questions Screening Instrument', TQSI) which has often been included in UNICEF's Multiple Indicator Cluster Surveys (MICS).

In general, good quality information on people with disability should be based on the WHO's International Classification of Functioning, Disability and Health (ICF)<sup>66</sup>. The ICF considers the interrelationship between a health condition, impairment, functional limitations<sup>67</sup> (i.e. difficulties in daily life), and external factors (such as environmental accessibility); this is known as the 'bio-psycho-social model'. While this can be a somewhat complex concept upon which to base data collection, it is the foundation for proven models as noted above.

However, many developing countries adopt disability classification systems predominantly reliant on diagnosis of health conditions. With a low ratio of skilled healthcare workers to population, and low or no specialised professionals required to perform good quality diagnosis, this approach is fundamentally flawed.

MoH and MoSVY issued the Inter-ministerial Prakas on the Classification of Types and Levels of Disabilities in November 2011. This Prakas classifies disabilities into four types namely: physical, intellectual, mental and other disabilities. Each type is divided into four levels of severity namely: profound, severe, moderate and mild. Clear descriptions for each type and level disability are provided. These classifications are based on the type and level of impairment.

Cambodia has information on people with disability from all three of the above sources as follows.

### *General Population Surveys*

#### *Census*

Every 10 years the general population census is undertaken. The 1998 census did not include any variables relating to disability. The 2008 census include one question on disability whether the person has any "*physical/mental disability*" and whether it was acquired "*since birth or after birth*". Five categories are available for selection: seeing, speech, hearing, in movement and mental. The census found **1.4 per cent** of the population had a disability, with data disaggregated since birth/after birth and by 'type' of disability. Data has not been sex-disaggregated<sup>68</sup>.

### *Commune Database*

The Commune Database (CDB) is the RGC's primary tool to monitor progress towards the Millennium Development Goals (MDG). Information is collected on each village by Commune or Village Chiefs based on a standard survey collecting economic and demographic information. Information is then collated by the Provincial Office of Planning. The survey includes two questions on people with disability: "number of people with disability in village", and whether the disability was as acquired at "birth, because of other accidents, war, mine/UXO's". Information can be disaggregated by sex and to some extent by age (due to sub-sequent follow-up questions relating to people with disability over the age of 18 years old who don and don't work, and those under 18 years old).<sup>69</sup>

### *UNICEF Social Service Mapping*

First piloted in 2009, the Social Service Maps for Commune Committees for Women and Children (CCWC) complements the ID Poor data and the Commune Data Base, by identifying the most vulnerable women and children, as well as mapping village resources (such as education and sanitation facilities). The Social Service Mapping Tool has two questions related to disability.

### *Sample Surveys*

#### *Cambodia Socio-Economic Survey (CSES)*

Undertaken on an annual basis since 2007, the CSES provides information on the living conditions and poverty status of a representative sample of households (this includes information on income, education, labour force participation etc.). Data is used to monitor the NSDP and MDGs. The CSES routinely includes two questions on disability: "Does X have any disability?" and whether the person had "any major problem with his/her body, mind or behaviour that limits his/her participation in work, school or ordinary social life?" Responses should relate only to permanent or long-term conditions. It also provides a list of impairment types to guide respondents.

Both the 2004 and 2007 CSES's estimated approximately **4 per cent** of the population have a disability. Data is sex-disaggregated, age-disaggregated (but only for those over 65 years old) and broken down into nine disability 'types' (seeing, hearing, speaking, moving, feeling, psychological and learning difficulties, people who have fits and other/don't know).<sup>70</sup> At the time of writing, data from the 2009 CSES is not available online.

#### *Cambodia Demographic and Health Survey (CDHS)*

Cambodia has undertaken three CDHS' – 2000, 2005 and 2010. Data from the 2000 and 2010 surveys were not available online at the time of writing. The primary purpose of the CDHS is to provide information on the health status and health-seeking behaviour of the population (e.g. fertility preferences, health expenditure). The survey included one question on disability "Do any living household members have a disability?" Follow-up questions related only to physical impairments, and cause. The 2005 CDHS reported **2.2 per cent** disability prevalence, information is disaggregated by age and sex.<sup>71</sup>

#### *Cambodia Childhood Disability Survey 2011*

In 2011, MOES implemented the first step of the TQSI, where parents/carers responded to questions for over 21,000 children. Those that screened 'positive' were referred to a Multi-Professional Assessment Team (supported by Handicap International Belgium, which included a range of health professionals which diagnosed health conditions and assessed impairments and disability. The survey was supported by the Global Partnership for Education. Results indicate that **10.1 per cent** of children have a disability, with cognitive and speech impairments being the most common.<sup>72</sup>

## **Administrative Data**

### *Education Management Information System*

The Ministry of Education, Youth and Sport (MOEYS) Special Education Office (SEO) captures data on children with disability in school through the Education Management Information System (EMIS). Data is collected by Principals and teachers based on 8 disability types, those with seeing, hearing, speaking, moving, feeling (tactile), psychosocial and learning difficulties, and fits/epilepsy. Data from 2006/07 noted that **3 per cent** of children in school had a disability.<sup>73</sup>

### *Physical Rehabilitation Centres*

Physical Rehabilitation Centres (PRC's) collect information on clients at the point of service provision and also through outreach; this includes some general demographic information (age, sex, employment status) as well as type of service provided. Key challenges for the physical rehabilitation sector include collecting information on cases as opposed to clients (thereby making it impossible to monitor total number of clients receiving services) and the absence of standardised system of data collection (which mean different PRC's collect information in slightly different ways).

### *ID Poor*

The ID Poor is a poverty assessment tool which combines a proxy means test (PMT) with community-based poverty assessment. It is used to inform eligibility for social protection programs. The ID Poor includes one question on disability but this is included in the non-scoring part of the questionnaire. While it is possible for the Village Chief to override the scoring component of the questionnaire (PMT) based on information from the community-based poverty assessment, it is not known whether this has occurred on the basis of household disability status. Data from the ID Poor on people with disability is not routinely collated and analysed.

### *Cambodia Mine/ERW Victim Information System*

In 1994, the Cambodian Red Cross (CRC) created the Cambodia Mine/ERW Victim Information System (CMVIS), with the technical and financial support of Handicap International Belgium and UNICEF. CMVIS aimed to provide systematic collection, analysis, interpretation and dissemination of information about civilian and military casualties of landmines, unexploded ordnance and other explosive remnants of war in Cambodia. In 2009, the management of CMVIS was handed over to the Cambodian Mine Action and victim Assistance Authority (CMAA).

According to CMVIS, there have been a total of 64,247 mine/ERW casualties recorded for the period from 1979 through April 2013. Among them, 19,666 people (31%) were killed, 35,669 people (55%) were injured and 8,912 people (14%) had amputations<sup>74</sup>.

To summarise, Cambodia has a range of data sources on people with disability. Other than the Cambodia Childhood Disability Survey 2011 and CMVIS, all data is not considered to be reliable based on the four key challenges outlined above, and also because it is not sufficiently based on the ICF. Further challenges include the lack of disaggregation, analysis and reporting of existing information and absence of feasible plan to improve the quality of data. This is likely to be a result of several factors: the lack of capacity within NIS, the low levels of knowledge within the disability sector relating to current data collection processes (e.g. it appears CDPO and its members are largely unaware of the existence of the CDB) and what factors influence good quality data collection and the absence (to date) of opportunities for the two groups to come together. Some of these issues could be addressed, in the first instance, but supporting a governance mechanism for disability data collection (managed by NIS). This model has been used in other countries (like Australia) successfully.

Positively, Cambodia does have a wide range of smaller-scale qualitative and quantitative studies on people with disability – most of which is undertaken by NGOs working with and for people with disability. These studies cover a range of different areas, from examining the particular situation of children with intellectual disability, to examining the quality of life of PRC clients, to assessing mental health issues. However these valuable resources do not appear to be informing policy and programming to the degree to which they should; this may be attributed to the variable methodology and quality of dissemination/communication of research findings and because key decision-makers are often not involved in the research process, nor fully aware of the outcomes.

## **1.6 Rehabilitation, Disability Services and Community-Based Rehabilitation**

Cambodia's landmine legacy of landmines, the RGC's commitment to disability and a strong civil society sector focused on people with disability have significantly contributed to the establishment of physical rehabilitation services and Community-Based Rehabilitation (CBR) programs in Cambodia. This section provides brief background information on work to date and key challenges facing rehabilitation (for all groups of people with disability), disability services and CBR.

### *Rehabilitation for People with Mobility Impairments*

In the early 1990's five international organisations started providing physical rehabilitation services; International Committee of the Red Cross (ICRC), Cambodia Trust, Handicap International (HI) Belgium and Handicap International France and Veterans International Cambodia (VIC). These organisations have supported the establishment of eleven Physical Rehabilitation Centres (PRC).

- Handicap International (HI) was founded on the border between Cambodia and Thailand in 1982. It eventually split into two operations (Belgium and France) but these were merged in Cambodia in 2013. Both organisations have supported seven PRC's to date: Banteay Mean Chey, Kampong Thom, Kampong Cham, Siem Reap, Pursat, Kampot and Takeo. However the just Siem Reap, Kampong Cham and Takeo remain, the others were closed in 2003.
- ICRC began working in Cambodia in 1965. Since 1992, ICRC managed the Battambang Regional Physical Rehabilitation Centre, Phnom Penh Orthopaedic Component Factory; and since 2004, the Kompong Speu Regional Physical Rehabilitation Centre formerly run by the American Red Cross.
- The Cambodia Trust was established in 1992, with support from the British Department for International Development and now supports three PRC's (Phnom Penh, Kampong Chhnang and Kampong Som).
- Veterans International Cambodia was established in 1992 with support from the Vietnam Veterans of America Foundation (VVAFA) from the United States Agency for International Development's (USAID) Leahy War Victims Fund. Veterans International Cambodia now support three PRC's: Kien Khleang (Phnom Penh), Kratie and Prey Veng.

An evaluation of the PRC's in 2006 recommended that the RGC take greater responsibility in oversight and management of the rehabilitation sector. In recognition of MoSVY's low capacity/resourcing, a 'contracting-out' option was recommended (i.e. MoSVY retains oversight/macro-management without administrative burden). In 2008, it was agreed via a Joint three-year Memorandum of Understanding (MoU) that the five international organisations would 'handover' management to MoSVY by end of 2010. However there was no detailed agreement between the international organisations and MoSVY specifying expectations and plans for the handover, e.g. how MoSVY might ensure increased financial support from the Ministry of Economy and Finance, and how the issue of low civil servant salary (compared to international organisation salaries) would be managed. While some stakeholders note positively increasing RGC financial contributions to the sector, the handover as originally envisaged did not work.

Subsequent to this, each international organisation developed separate Bilateral MoUs with MoSVY specifying differing expectations and plans for a handover of their PRC's, often informed by the availability (or otherwise) of their own donor funding sources. There does not appear to be agreement with the international organisations and MoSVY as to how discussions for a feasible handover might recommence.

Following the Bilateral and Joint MoUs, HIB handed over the Takeo and Siem Reap centres to MoSVY end of 2010. However, HIB continued to provide financial support (staff incentives and imported raw materials) to Takeo and Siem Reap centres during 2011. Beginning 2012, HIB maintained its support to the Siem Reap centre only. Starting 2013, HIB discontinued the support to both centres. After the merger of HIB and HIF in 2013, they have not yet handed over their centre in Kampong Cham to MoSVY. VIC handed over the Kien Khleang, Prey Veng and Kratie centres to MoSVY at the beginning 2013, while continuing to provide support on general management, quality assurance, clinical mentoring, staff incentives and imported raw-materials to those centres. VIC still manages its CBR activities in Kandal, Prey Veng, Svay Rieng and Kratie provinces. ICRC has handed over the two rehabilitation centres and the orthopaedic component factory to MoSVY at the end of 2010, while continuing to provide the financial and technical support to those centres. CT has not officially handed over any centres to MoSVY. In addition, MoSVY contributes financial, technical, managerial and human resources supports to all rehabilitation centres including small rehabilitation workshops in Cambodia. The amount of support has increased steadily.

During the design phase, the team was presented with varying and complex explanations of how RGC financing to the PRC's works. A few examples of the explanations include:

- Some funding goes from the Ministry of Economy and Finance (MEF) to their Provincial offices, and is then transferred to Provincial Social Affairs, Veterans and Youth rehabilitation Offices, and then onwards to the PRC's'
- Other funding from MEF to their Provincial offices remains with the office who undertake procurement of supplies on behalf of the PRC's; and,
- The PWDF also pays some salaries and incentives direct to PRC's.

There is no coverage of rehabilitation within RGC's social protection programs, including Health Equity Funds.

There are two professional associations for people working in the rehabilitation sector; the Cambodia Physical Therapy Association (CPTA), and the Cambodian Association of Prosthetists and Orthotists (KHAPO). CPTA was established in 1994 by qualified Cambodian physical therapists who graduated from the Technical School for Medical Care, University of Health Sciences, Cambodia. The association aims to increase the quality of physical therapy in Cambodia through developing national standards and supporting professional development. It has worked with Curtin University in Australia and the Singapore General Hospital Postgraduate Allied Health Institute to provide regular in-service training modules.<sup>75</sup>

Cambodia does have a specialised training institute for P and O technicians, the Cambodian School for Prosthetic and Orthotics (CSPO). Established by the Cambodia Trust in 1994,<sup>76</sup> CSPO now offers International Society for Prosthetics and Orthotics (ISPO) accredited Category II qualification for P and O technicians from Cambodia and all around the world. It has an on-going relationship with La Trobe University in Australia.<sup>77</sup>

In 2010, ICRC worked with MoSVY to establish standardised database systems for the PRC's. This resulted in the successful integration of a Stock Management System (SMS) into all 11 PRCs. However, Patient Management System (PMS) still encounters several issues related to compatibility, which required further investigation, fixing and training. The new PMS is currently

functioning in Kampong Speu, Battambang, and Kampong Cham centres. ICRC plans to support MoSVY to work on Takeo and Siem Reap centres in 2013. It is expected that the new PMS is successfully integrated into the 11 PRCs by 2015. The lack of standardised client information system makes it difficult to monitor total client numbers.

### ***Rehabilitation for People with Vision Impairment***

In addition to the MoH, there are several NGOs working in the eye health sector (including Fred Hollows Foundation, CBM, Rose Charities, Children's Surgical Centre. Their work focuses predominantly on the prevention and treatment of avoidable blindness, however they do provide glasses. There are some services at referral hospitals. ABC is the only a key organisation that provides support to people who are blind or vision impaired for assistance with daily living (such as learning how to use a white cane). They have limited outreach. ***Rehabilitation for People with Hearing Impairment***

There are very limited services for people with a hearing impairment in Cambodia, the key is only one NGO that provides services for people who have a hearing impairment in Cambodia – is All Ears Cambodia. There are some services at provincial and referrals hospitals.

### ***Rehabilitation for People with Intellectual and Psychosocial Impairment***

As noted above (refer section 1.2 of this Annex) there are few services for people with intellectual and psychosocial impairments. There is only one service provider for children with intellectual or mental disabilities, the Centre for Child and Adolescent Mental Health (CCAMH) run by Caritas. Other NGOs like HAGAR, Rabbit School, Komar Pikar Foundation etc. have some activities will aim to improve the life skills of children with intellectual disability. There is no planning for psychologists in health sector human resource planning (in addition to psychiatrists and psychiatric nurses). The lack of availability of appropriate and free medication for those who require them is a significant challenge.<sup>78</sup>

### ***Support Services***

People with disability require a range of 'disability support services' that assist their function and participation in everyday activities. An example of this is sign language interpreters and assistive technologies, such as those that support people with vision impairments access print media. Support services that enable individuals to participate are under-developed in Cambodia, as with many other low and middle income countries.

### ***Community-Based Rehabilitation***

Community based rehabilitation (CBR) has a long history in Cambodia predominated by local NGOs developing a range of varied programs in a variety of locations. Cambodia has had limited opportunity to implement a shared national vision of CBR, especially since release of the WHO CBR Guidelines in 2010, which conceives CBR programs across a broad framework. This is despite the existence of national CBR guidelines which are based on the WHO CBR Guidelines and a CBR Committee supported by the DAC Secretariat. CBR is a flexible, dynamic approach which is reliant on programs linking and referring to ensure people with disability access the variety of services needed and participate fully in community life.

There is one pilot project supporting the deployment of social workers to hospitals in Phnom Penh. If successful, this may be extended to other hospitals although it's not clear whether this is within current MoH plans.

## Annex 8: Position descriptions for program staff

Note: Position descriptions have been developed based on the different formats used by each of the three participating UN agencies.

### Program Coordination Team

The Program Coordination Team will be hosted by UNDP and staff will be contracted to UNDP.

#### Program Coordinator: Key responsibilities and competencies

##### Responsibilities

The Program Coordinator will work under the supervision of the (rotating) Chair of the TRC and will be responsible for the following:

- Overall management of the Program Coordination Team
- Technical advice and oversight
- Providing management advice and coaching to the TRC
- Develop and strengthen partnership and coordination between the three UN agencies and between the UN agencies and government, DPOs and donors
- Facilitate knowledge building activities
- Secretariat for the Technical Review Committee and lead on the following key TRC functions:
  - Coordinate the development of the six monthly and annual progress reports to AusAID
  - Organising an annual meeting to review performance as a basis for developing the next annual work plan
  - Coordinate the development of the annual work plan and budget
- Lead on the following key Program Coordination Team functions:
  - Donor relations and coordination of joint reporting requirements
  - Funds mobilisation
  - Provide overall coordination of the joint program
  - Coordinate, oversight and quality assurance of program-wide M&E
  - Function as key point of contact and high level program interface with the Royal Government of Cambodia, the Disability Action Council and the Ministry of Social Affairs, Veterans and Youth Rehabilitation
  - Perform strategic representation functions in collaboration with program components
  - Serve as secretariat to Program Board and TRC
  - Ensure program-wide communication in a coordinated and complementary way with the component-specific activities carried out by agencies
  - Assist in facilitation of dialogue between various stakeholders (government, DPOs, CSOs, DPs and UN agencies) to ensure inclusive and synergetic development of policy and strategic plans

##### Key Qualifications

###### *Competencies:*

- Ability to communicate effectively orally and in writing in order to communicate complex, technical information to technical and general audiences
- Skill in negotiating effectively in sensitive situations
- Skill in effectively coordinating program inputs from different organisations
- Skill in monitoring program performance, including quality assurance of monitoring data
- Skill in achieving results through persuading, influencing and working with others
- Skill in facilitating meetings effectively and efficiently and to resolve conflicts as they arise

- A high level of technical knowledge and expertise on disability in a development context

*Qualifications and experience:*

- Advanced university education (MS or PhD) with expertise in the area of disability rights;
- At least 10 years of relevant professional experience, of which at least five are at international level
- Strong skills in project management and previous experience of managing large scale projects
- Extensive experience in the monitoring and evaluation of programs
- Ability to effectively coordinate a large, multidisciplinary team of experts and consultants.

**Job code title:** Administrative Associate, Program Coordination Team

Pre-classified Grade: ICS-6

Supervisor: Program co-ordinator/Chief Technical Adviser

**II. Organizational Context**

Under the overall guidance and supervision of the Program Coordinator, the Administrative Associate assists in the overall management of administrative services, administers and executes processes and transactions ensuring high quality and accuracy of work. The Administrative Associate promotes a client, quality and results-oriented approach.

The Administrative Associate works in close collaboration with the Operations, Program and projects staff in the CO and other UN agencies staff to exchange information and ensure consistent service delivery.

*The functions/duties/ key results of this job description are generic and not all duties are carried out by all Administrative Assistants.*

**III. Functions / Key Results Expected**

**Summary of Key Functions:**

- Implementation of operational strategies
- Efficient administrative support
- Support to supply and assets management
- Support to administrative and financial control
- Support to common services
- Coordination of Registry and Receptionist functions
- Support to knowledge building and knowledge sharing

1. Ensures **implementation of operational strategies**, focusing on achievement of the following results:

- ❑ Full compliance of administrative activities with UN/UNDP rules, regulations, policies and strategies.
- ❑ Provision of inputs to the CO administrative business processes mapping and implementation of the internal standard operating procedures (SOPs).
- ❑ Preparation of administrative team results-oriented work plans.

2. Ensures **efficient administrative support**, focusing on achievement of the following results:

- ❑ Organization and coordination of shipments and customs clearance
- ❑ Coordination of travel arrangements. Performing a Buyer role in Atlas for preparation of POs for travel and other administrative expenses.
- ❑ Organization of procurement processes including preparation of RFQs, ITBs or RFPs



<p>documents, receipt of quotations, bids or proposals, their preliminary evaluation. Preparation of POs.</p> <ul style="list-style-type: none"> <li>❑ Organization of workshops, conferences, retreats</li> <li>❑ Coordination of DSA, travel agencies, and other administrative surveys, surveys for organization of common services.</li> <li>❑ Support with protocol matters, registration of staff, coordination with local authority on space and other administrative matters.</li> <li>❑ Supervision of cleaning services.</li> <li>❑ Coordination of transportation services, regular vehicle maintenance and insurance.</li> <li>❑ Checking and certifying of vehicle daily log and gas consumption, update and maintenance of vehicle history report.</li> <li>❑ Prompt reporting and investigation of cases of vehicle accidents, damage, loss or theft of items; update and maintenance of vehicle history report.</li> <li>❑ Research and retrieval of statistical data from internal and external sources; preparation of statistical charts, tables and reports.</li> </ul>
<p>3. Provides <b>support to proper supply and assets management</b>, focusing on achievement of the following result:</p> <ul style="list-style-type: none"> <li>❑ Coordination of assets management in the CO, timely preparation and submission of periodic inventory reports.</li> <li>❑ Coordination of the provision of reliable and quality office supplies</li> </ul>
<p>4. Provides support <b>for effective administrative and financial control in the office</b>, focusing on achievement of the following results:</p> <ul style="list-style-type: none"> <li>❑ Maintenance of administrative control records such as commitments and expenditures.</li> <li>❑ Confirmation of availability of funds prior to review by supervisor; creation of vendor set-up information in Atlas;</li> <li>❑ Maintenance of data integrity in the database, control program; analysis of results and initiation of corrective actions when necessary.</li> <li>❑ Coordination of common premises/services cost-recovery arrangements.</li> <li>❑ Proper control of supporting documents of funds and activities.</li> <li>❑ Provision of the information for the audit.</li> </ul>
<p>5. Ensures proper <i>common services</i> focusing on achievement of the following result:</p> <ul style="list-style-type: none"> <li>❑ Maintenance of common services/office space management to ensure integrated activities on common services and implementation of the UN reform.</li> </ul>
<p>6. Coordinates implementation of <b>Registry and Receptionist functions</b>, supervises Registry Clerk and Receptionist, focusing on achievement of the following results:</p> <ul style="list-style-type: none"> <li>❑ Provision of efficient general reception and information services.</li> <li>❑ Provision of reliable registry services.</li> </ul>
<p>7. Supports <b>knowledge building and knowledge sharing</b> in the CO, focusing on achievement of the following results:</p> <ol style="list-style-type: none"> <li>1. Training of staff on the administrative procedures</li> <li>2. Briefing/debriefing of staff members on issues relating to area of work</li> <li>3. Sound contributions to knowledge networks and communities of practice.</li> </ol>
<p><b>IV. Impact of Results</b></p>
<p>The key results have an impact on the efficiency of the unit. Accurate analysis and</p>

presentation of information, thoroughly researched and fully documented work strengthens the capacity of the office and facilitates subsequent action by the supervisor. Incumbent's own initiative is decisive in results of work and timely finalization.

## V. Competencies and Critical Success Factors

### Functional Competencies:

#### Building Strategic Partnerships

##### Level 1.1: Maintaining information and databases

- Analyses general information and selects materials in support of partnership building initiatives

#### Promoting Organizational Learning and Knowledge Sharing

##### Level 1.1: Basic research and analysis

- Researches best practices and poses new, more effective ways of doing things
- Documents innovative strategies and new approaches

#### Job Knowledge/Technical Expertise

##### Level 1.1: Fundamental knowledge of processes, methods and procedures

- Understands the main processes and methods of work regarding to the position
- Possesses basic knowledge of organizational policies and procedures relating to the position and applies them consistently in work tasks
- Strives to keep job knowledge up-to-date through self-directed study and other means of learning
- Demonstrates good knowledge of information technology and applies it in work assignments

#### Promoting Organizational Change and Development

##### Level 1.1: Presentation of information on best practices in organizational change

- Demonstrates ability to identify problems and proposes solutions

#### Design and Implementation of Management Systems

##### Level 1.1: Data gathering and implementation of management systems

- Uses information/databases/other management systems
- Provides inputs to the development of simple system components
- Makes recommendations related to work procedures and implementation of management systems

#### Client Orientation

##### Level 1.1: Maintains effective client relationships

- Reports to internal and external clients in a timely and appropriate fashion
- Organizes and prioritizes work schedule to meet client needs and deadlines
- Establishes, builds and sustains effective relationships within the work unit and with internal and external clients
- Responds to client needs promptly

#### Promoting Accountability and Results-Based Management

##### Level 1.1: Gathering and disseminating information

- Gathers and disseminates information on best practice in accountability and results-based management systems
- Prepares timely inputs to reports

### Core Competencies:

- Demonstrating/safeguarding ethics and integrity
- Demonstrate corporate knowledge and sound judgment
- Self-development, initiative-taking
- Acting as a team player and facilitating team work

- Facilitating and encouraging open communication in the team, communicating effectively
- Creating synergies through self-control
- Managing conflict
- Learning and sharing knowledge and encourage the learning of others. Promoting learning and knowledge management/sharing is the responsibility of each staff member.
- Informed and transparent decision making

<b>VI. Recruitment Qualifications</b>	
Education:	Secondary education. Certification in administration desirable. University Degree in Business or Public Administration desirable, but it is not a requirement.
Experience:	6 years of relevant experience in administration or program support service. Experience in the usage of computers and office software packages (MS Word, Excel, etc.). Experience in handling of web-based management systems.
Language Requirements:	Fluency in the UN and national language of the duty station.

## Components 1 and 2: UNDP

<b>I. Position Information</b>
Job Code Title: <b>Program Analyst</b> Pre-classified Grade: ICS-9 Supervisor: DCD, ACD (Program )
<b>II. Organizational Context</b>
<p>Under the guidance and direct supervision of the UNDP ACD(P), the Program Analyst is responsible for management of the UNDP program within the thematic/sectoral areas assigned. The Program Analyst analyses political, social and economic trends and leads formulation, management and evaluation of program activities within his/her portfolio, provides policy advice services.</p> <p>The Program Analyst supervises and leads program support staff, coordinates activities of the projects' staff. The Program Analyst works in close collaboration with the operations team, program staff in other UN Agencies, UNDP HQs staff and Government officials, technical advisors and experts, multi-lateral and bi-lateral donors and civil society ensuring successful UNDP program implementation.</p>
<b>III. Functions / Key Results Expected</b>
<p><b>Summary of Key Functions:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Implementation of program strategies</li> <li><input type="checkbox"/> Management of the CO program</li> <li><input type="checkbox"/> Creation of strategic partnerships and implementation of the resource mobilization strategy</li> <li><input type="checkbox"/> Provision of top quality policy advice services to the Government and national</li> </ul>

partners and facilitation of knowledge building and management
<p>1. Ensures <b>implementation of program strategies</b> focusing on achievement of the following results:</p> <ul style="list-style-type: none"> <li>❑ Thorough analysis and research of the political, social and economic situation in the country and preparation of substantive inputs to CCA, UNDAF, CPD, CPAP and other documents.</li> <li>❑ Identification of areas for support and interventions within the thematic/sectoral areas assigned.</li> <li>❑ CO business processes mapping and preparation of the content of internal Standard Operating Procedures in Results Management.</li> </ul>
<p>2. Ensures effective <b>management of the CO program</b> within the thematic/sectoral areas assigned focusing on quality control from formulation to implementation of the country program achieving the following results:</p> <ul style="list-style-type: none"> <li>❑ Effective application of RBM tools, establishment of management targets (BSC) and monitoring achievement of results.</li> <li>❑ Design and formulation of CO program within the area of responsibility, translating UNDP's priorities into local interventions. Coordination of program implementation with the executing agencies. Introduction of performance indicators/ success criteria, cost recovery, targets and milestones.</li> <li>❑ Initiation of a project, presentation of the project to PAC, entering project into Atlas ( in small offices), finalization of contribution agreement; determination of required revisions; coordination of the mandatory and budget re-phasing exercises, closure of projects through review. Program Analyst can perform functions of Manager Level 1 in Atlas for POs and vouchers approval, participates in recruitment processes for projects.</li> <li>❑ Financial and substantive monitoring and evaluation of the projects, identification of operational and financial problems, development of solutions. Participation in audit of NIM projects.</li> <li>❑ Follow up on audit recommendations. All exceptions are timely reported.</li> <li>❑ Aggregate reports are regularly prepared on activities, outputs and outcomes. Preparation of donor reports.</li> </ul>
<p>3. Ensures <b>creation of strategic partnerships and implementation of the resource mobilization strategy in cooperation with the Management Support and Business Development Team</b> focusing on achievement of the following results:</p> <ul style="list-style-type: none"> <li>❑ Development of partnerships with the UN Agencies, IFI's, government institutions, bi-lateral and multi-lateral donors, private sector, civil society in the specific thematic areas based on strategic goals of UNDP, country needs and donors' priorities.</li> <li>❑ Analysis and research of information on donors, preparation of substantive briefs on possible areas of cooperation, identification of opportunities for initiation of new projects, active contribution to the overall office effort in resource mobilization.</li> </ul>
<p>4. Ensures <b>provision of top quality advisory services and facilitation of knowledge building and management</b> focusing on achievement of the following results:</p> <ul style="list-style-type: none"> <li>❑ Identification of sources of information related to policy-driven issues. Identification and synthesis of best practices and lessons learnt directly linked to program country policy goals.</li> <li>❑ Support to development of policies and institutions that will address the</li> </ul>

countries problems and needs in collaboration with the Government and other strategic partners.

- ❑ Sound contributions to knowledge networks and communities of practice.
- ❑ Organization of trainings for the operations/ projects staff on program issues.

#### **IV. Impact of Results**

The key results have an impact on the success of country program within specific areas of cooperation. In particular, the key results have an impact on the design, operation and programming of activities, creation of strategic partnerships as well as reaching resource mobilization targets.

#### **V. Competencies and Critical Success Factors**

##### **Functional Competencies:**

##### Advocacy/Advancing A Policy-Oriented Agenda

##### **Level 1.2: Preparing information for advocacy**

- ❑ Identifies and communicates relevant information for a variety of audiences for advocating UNDP's mandate

##### Results-Based Program Development and Management

##### **Level 1.2: Contributes to results through primary research and analysis**

- ❑ Assesses project performance to identify success factors and incorporates evidence based best practices into project work
- ❑ Researches linkages across program activities to identify critical points of integration
- ❑ Monitors specific stages of projects/program implementation
- ❑ Analyses country situation to identify opportunities for project development
- ❑ Participates in the formulation of project proposals and ensures substantive rigor in the design and application of proven successful approaches and drafts proposals accordingly

##### Building Strategic Partnerships

##### **Level 1.2: Maintaining a network of contacts**

- ❑ Maintains an established network of contacts for general information sharing and to remain up-to-date on partnership related issues
- ❑ Analyses and selects materials for strengthening strategic alliances with partners and stakeholders

##### Innovation and Marketing New Approaches

##### **Level 1.2: Enhancing processes or products**

- ❑ Generates new ideas and proposes new, more effective ways of doing things
- ❑ Documents and analyses innovative strategies/best practices/new approaches
- ❑ Resource Mobilization (Field Duty Stations)

##### **Level 1.2: Providing inputs to resource mobilization strategies**

- ❑ Analyses information/databases on potential and actual donors
- ❑ Develops a database of project profiles. Identifies opportunities for project proposals for presentation to donors

## Promoting Organizational Learning and Knowledge Sharing

### Level 1.2: Basic research and analysis

- Generates new ideas and approaches, researches best practices and proposes new, more effective ways of doing things
- Documents and analyses innovative strategies and new approaches

## Job Knowledge/Technical Expertise

### Level 1.2: Fundamental knowledge of own discipline

- Understands and applies fundamental concepts and principles of a professional discipline or technical specialty relating to the position
- Possesses basic knowledge of organizational policies and procedures relating to the position and applies them consistently in work tasks
- Strives to keep job knowledge up-to-date through self-directed study and other means of learning
- Demonstrates good knowledge of information technology and applies it in work assignments
- Demonstrates in-depth understanding and knowledge of the current guidelines and project management tools and utilizes these regularly in work assignments

## Global Leadership and Advocacy for UNDP's Goals

### : Preparing information for global advocacy

- Identifies and communicates relevant information for advocacy for UNDP's goals for a variety of audiences
- Identifies and takes advantage of opportunities for advocating for UNDP's mandate

## Client Orientation

### Level 1.2: Establishing effective client relationships

- Researches potential solutions to internal and external client needs and reports back in a timely, succinct and appropriate fashion
- Organizes and prioritizes work schedule to meet client needs and deadlines
- Anticipates client needs and addresses them promptly

### Core Competencies:

- Demonstrating/safeguarding ethics and integrity
- Demonstrate corporate knowledge and sound judgment
- Self-development, initiative-taking
- Acting as a team player and facilitating team work
- Facilitating and encouraging open communication in the team, communicating effectively
- Creating synergies through self-control
- Managing conflict
- Learning and sharing knowledge and encourage the learning of others. Promoting learning and knowledge management/sharing is the responsibility of each staff member.
- Informed and transparent decision making

<b>VI. Recruitment Qualifications</b>	
Education:	Master's Degree or equivalent in Business Administration, Public Administration, Economics, Political Sciences, Social Sciences or related field.
Experience:	2 years of relevant experience at the national or international level in providing management advisory services, hands-on experience in design, monitoring and evaluation of development projects with specific focus on human rights. Previous experience in working on disability related issue is an advantage. Experience in the usage of computers and office software packages, experience in handling of web based management systems.
Language Requirements:	Fluency in the UN and national language of the duty station.

### **Component 3: WHO**

<b>Position Title:</b>	Technical Officer (Disability and Rehabilitation)
<b>Grade:</b>	National Professional Officer C
<b>Organization:</b>	World Health Organization, Western Pacific Regional Office
<b>Duty Station:</b>	Phnom, Penh, Cambodia
<b>Unit/Team:</b>	Non-Communicable Diseases/Disability and Rehabilitation
<b>Nature of Position:</b>	Fixed-term
<b>Effective Date:</b>	01 August 2013

#### **POST DESCRIPTION**

##### **Purpose of the Post:**

To work together with the NCD team leader in the area of disability and rehabilitation, including primarily implementation of the Joint UN - AusAID Cambodia Disability Program. The incumbent will work in close collaboration with the UN - AusAID Program Coordination Unit as well as relevant government ministries, departments, agencies, non-government organizations, research institutions and other relevant stakeholders.

##### **Objective of the Programme and of the immediate unit or field activity:**

The main objective of the programme is to support implementation of the Government of Cambodia's national disability legislation, policies and programme commitments. In particular, to support the development of rehabilitation service provision and the inclusion of people with disabilities in mainstream services, in particular health.

##### **Organization Context:**

Working under the supervision of the NCD team leader and under the guidance of the WHO Representative and Technical Officer (Disability and Rehabilitation) at the regional office, the incumbent will assist in the country level coordination for all disability and rehabilitation activities, and primarily the UN - AusAID Disability Programme.

The National Professional Officer (NPO) works independently as an expert and as part of the technical team within the WHO office and will contribute to the overall collaboration with the Government of Cambodia. The NPO will work closely with technical colleagues and is expected to exercise good judgement in the application of WHO policy guidelines and programme objectives as approved through the resolutions of the World Health Assembly, the WHO Executive Board and the Regional Committee for the Western Pacific and other relevant documents.

#### **Summary of Assigned Duties:**

Under the supervision of the NCD team leader and the WHO Representative, and in close collaboration with the UN - AusAID Programme Coordination Unit, WHO/WPRO and WHO/HQ, government counterparts and other relevant stakeholders, the incumbent will:

1. Assist in the implementation of all disability and rehabilitation related programme activities, in particular the UN - AusAID Disability Programme.
2. Lead implementation of the UN – AusAID Disability Programme 'Support Rehabilitation Sector Strengthening' component, including development of annual work plan and budget preparation, commissioning reports and analysis, organising and conducting training courses, workshops and forums, providing and facilitating technical assistance, contracting partners to support rehabilitation service delivery, working with the Ministry of Health, Ministry of Social Affairs, Veterans and Youth Rehabilitation and the People with Disability Foundation to undertake shared activities, working in collaboration with UNICEF for determination of the small grants scheme and fulfilling all administrative and reporting requirements for the UN – AusAID Disability Programme.
3. Develop and maintain close working relationships with programme partners for both formal and informal collaborations, especially with the government and local and international development partners, as required.
4. Assist in fully implementing the work plan for disability and rehabilitation and other activities as may be required, including routine reporting for WHO as well as technical and financial reporting for donors and partners.

#### **RECRUITMENT PROFILE**

##### **Competencies : (with reference to WHO competency model):**

1. Producing results
2. Communicating in a credible and effective way
3. Moving forward in a changing environment
4. Knowing and managing yourself
5. Fostering integration and teamwork

##### **Functional Skills and Knowledge (specific to the post):**

1. Proven skills in planning, monitoring and evaluation of interventions.
2. Ability to guide and implement projects.
3. Ability to communicate effectively with the government and partner agencies.
4. Good management and leadership abilities and experience.
5. Familiarity with the goals and procedures of international organizations (United Nations system, donors, nongovernmental organizations).
6. Ability to think strategically and work under tight deadlines and achieve results.
7. Ability to build partnerships and work in multi-cultural and multidisciplinary settings.
8. Ability to work harmoniously as a member of a team, adapt to diverse educational and cultural backgrounds and maintain a high standard of personal conduct.



**Education (Qualifications):***Essential:*

University Degree in Medicine, Diploma of Physiotherapy (allied health) or other disability or health-related field.

*Desirable:*

Master's degree in Public Health, Social Sciences or International/Community Development.

**Experience:***Essential:*

Minimum 5 years' experience in disability or rehabilitation sector.

Minimum 2 years' experience in project management, including project development, planning, monitoring and evaluating, writing financial and technical reports.

*Desirable:*

Experience working with international organizations. Experience in training, teaching and advocacy. Proficiency in data collection and analysis. Extensive experience in the disability and rehabilitation sector an additional advantage.

**Language:**

Excellent knowledge of English and Khmer (both written and spoken)

**Other Skills (e.g. IT):**

Proficiency in standard MS office applications.

**Component 4: UNICEF**

**Position Title:** Specialist, P-3, Phnom-Penh

**Job Level:** L-3

**Section:** Local Governance for Child Rights program

**Funding source:** AusAID (2014-2018)

**Estimated cost:** USD 175,000 per annum

**Purpose of the Position:** Under the supervision and guidance of the Chief, LGCR, the incumbent will be responsible for the strategic planning, implementation, coordination of activities, and monitoring and evaluation related to the UN-AusAID joint program on disability. The incumbent will orchestrate activities with other UN agencies and other UNICEF programs to maximize synergies. By paying special attention to results achieved at subnational level by forging effective partnership with local duty bearers and civil society representatives, the incumbent will also be expected to contribute to solid partnership building and policy development related to the disability sector and the subnational democratic development (decentralisation) reform.

**Required qualifications and competencies:**

**a) Education:** Advanced university degree in Health Sciences, Public Health, Public Administration, Public Policy, Social Policy, Social Development, or other relevant disciplines. Post-graduate qualifications in disability-related disciplines is advantageous.

**b) Work experience:** Five years of progressively responsible professional work experience at the national and international levels in program management, monitoring and evaluation, in a

related field. Experience in disability program management and community development is an advantage

**c) Languages:** Fluency in English is required and knowledge of another language would be an asset. Knowledge of the local working language of the duty station is an asset.

**d) Competencies:** Highest-level **communication skills**, including engaging and informative formal public speaking; and excellent writing skills to produce high quality documents, including donor reports; **Team work:** Able to work effectively in a multi-cultural environment; **Drive for results:** Sets high standards for quality and consistently achieves program goals; **Translates strategic** direction of the joint UN-AusAID program on disability into concrete results to improve the life of children with disability; **Maintains and extends an effective network** of individuals across UNICEF programs, UN agencies, civil society and government representatives; **Coaching and Supervision** of two national professionals (NOB) to encourage greater integration of community based interventions to improve the lives of children with disability. **Effective negotiator** who explores a range of possibilities and who is able to safeguard UNICEF's reputation and credibility in the disability sector. Demonstrates and shares detailed **technical knowledge and expertise on disability**, especially at the grass-root level. Seeks and proposes opportunities for advancing UNICEF's mission.

**Position Title:** Community Development Officer, NOB, Phnom-Penh

**Job Level:** NO2 (2 positions)

**Section:** Local Governance for Child Rights program

**Funding source:** AusAID (2014-1018)

**Estimated cost:** USD 45,000 per annum

**Purpose of the Positions:** Under the supervision and guidance of the Disability Specialist, Local Governance for Child Rights program, the incumbents will be responsible to support the implementation, coordination of activities, and monitoring and evaluation related to the UN-AusAID joint program on disability. The incumbents will liaise with technical staff of UN agencies, UNICEF Zone Offices, the secretariat of the Disability Action Councils, civil society organisations to create synergies in focus areas of interventions. Special attention will be paid to accompany civil society organizations to submit quality proposals for the small grant scheme. Incumbents will provide on-going support to maximize implementation of these schemes by ensuring thorough monitoring of results achieved at subnational level. The incumbents will particularly liaise with the Ministry of Interior and Zone offices to encourage the establishment of effective partnerships with local duty bearers and civil society representatives. In the context of subnational democratic development (decentralisation) reform, the incumbents will continue to provide technical support related to capacity development of subnational duty bearers to strengthen quality early childhood development interventions with a strong focus on the needs of children with disabilities at local level.

**Required qualifications and competencies:**

**a) Education:** Advanced university degree in any of Social Sciences, Public Administration, International Relations, Business Administration, Public Health, Education, or other related field.

**b) Work experience:** Minimum five years progressively responsible professional work experience in social development, project administration, monitoring and evaluation, including field work experience.

c) **Languages:** Fluency in English and Khmer is required and knowledge of another UN language would be an asset.

**d) Competencies:**

The scope of the job is to provide support for the implementation of the Local Governance for Child Rights program. The job requires **commitment, high level of integrity and strong drive for results** for the achievement of the established program goals and objectives. The work requires some expertise for technical program management, requiring **initiative, problem solving, creativity and innovation, especially in the area of disability and early childhood development. Sound judgement, planning and resource management expertise** and creative approach are required for advising management and making recommendations on program implementation, alternative approaches, and optimal utilization of resources, to ensure achievement of stated objectives. Decision making includes timely and effective decision on planning, and implementation, requiring **conceptual/analytical thinking, judgement, planning, monitoring, decisiveness, flexibility, resource management and communication** skills. The work makes resource management and planning & monitoring expertise essential for managing the overall allocation and disbursement of funds to ensuring they are properly coordinated, monitored and liquidated in accordance with the allotments.

## Annex 9: The community worker model

### Integrated community-based early childhood care and development (ECCD) through contracting community assistant at village level

The aim of this UNICEF innovation is to implement integrated community-based early childhood care and development (ECCD) interventions through community assistants recruited in each village and contracted by the commune council. It is envisioned that the work will demonstrate the feasibility of an integrated approach to service delivery for the early years, from conception to six years of age, along a continuum of prevention and care to maximize the development outcomes of young Cambodians. Results and lessons learnt from this work will be used to advocate for policy change, notably within the context of strengthening service delivery at commune approach.

Currently the work is limited to three communes in order to be able to closely follow the implementation by subnational counterparts and UNICEF. Selection criteria for the pilot areas included (a) the existence of ECCD-related interventions, (b) established community-participation structures and capacities (even if limited and not fully functioning), (c) commune council's commitment to collaborate. Thus, two communes in Svay Rieng were selected because there are on-going health outreach services, screening for malnutrition and distribution of sprinkles<sup>79</sup> in all villages, and community pre-school and home-based parenting education in some villages. Furthermore, in an attempt to develop a model that takes ethnicity into account, a third commune from Mondulkiri was added. All three communes have been part of a recent UNICEF-supported assessment on ECCD practices<sup>80</sup>. Commune councils are offered an operational model for delivering an integrated package of services through a contracted assistant who will be responsible to follow up on a number of important stages of child development. The work contributes to the realization of the National Action Plan on Early Childhood Care and Development. It is implemented in the context of decentralization reforms, which provide an opportunity for modeling new cross-sectoral functions by local authorities that call for integration at the community level. It also aims to offer commune councils an operationalised package of services through a contracted assistant who will be responsible to follow up on a number of important stages of child development. The practical approach of the pilot contributes to the realization of the National Action Plan on Early Childhood Care and Development.

The strategies associated with this tool include social mobilization with a strong emphasis on inter-personal communication and service delivery. The main features of the community worker model are:

- Focus on the most critical periods of life - pregnancy and early childhood – for child survival and development (including early screening/identification of disabilities)
- Community-based approach – facilitated by local authorities, implemented by people living in the community
- Integrated approach – ensuring that the information and services provided by various sectors are integrated at the community, family and child level
- Blend traditional child-rearing practices and cultural beliefs with evidence-based approaches

It is envisioned that the contracted community worker will work part time (4 hours x 5 days per

week) and will have responsibilities including:

1. Conduct a monthly education session (whenever possible in collaboration with the staff from health centre or other relevant government representatives) to inform parents, grand-parents and other care givers on birth registration, maternal, newborn, child health and nutrition, early child stimulation and education, early identification/screening of disabilities, child protection, the importance of safe drinking water, improved sanitation and hygiene practices, prevention of injuries.
2. Mobilize parents and caregivers and facilitate timely utilization of early childhood care and development related services such as birth registration, antenatal and postpartum care, immunization, breast-feeding support group, deworming, micro-nutrient supplementation, home-based education mothers group, community preschool
3. Assist Health Centre staff in planning and conducting health outreach services and other field work.
4. Liaise with CPS teacher to help the enrolment of 3 years old children in community preschool (CPS) and 6 years old children in primary school.
5. Identify the most vulnerable children in the village (poor, orphans, those with disabilities, exploited) and carry out home visits for follow-up. Referrals are made to appropriate services (including specialized services such as physical rehabilitation, audiology etc.).
6. Detect problem/crisis happening to any child 0-6 years old in the village and report to village chief and CCWC.
7. Collect basic data on the situation of mothers and children in the village and report to the commune council, commune committee for women and children, health centre to improve monitoring of the situation of young children in the village.
8. Contribute to planning and budgeting of ECCD interventions such as those related to child protection.

The community-based assistants will work under direct supervision of the commune focal person for women and children and report to her; will assist the village leaders (village chief, deputy and assistant), and closely collaborate with others village volunteers on maternal and child issues; they will assist the community preschool teacher with the enrolment of 3-5 years old children and encourage regular attendance.

This project is conducted in close collaboration with the Ministry of Interior who will be the main partner and play a coordination role for other line Ministries who will provide technical inputs: Ministries of Health, Education, Youth and Sports, Social Affairs, Veteran and Youth Rehabilitation, Women's Affairs and of Rural Development.

The central institutions will provide guidance and technical inputs to the subnational levels where the commune councils are the direct implementer of the project with support from district and provincial levels.

The provincial and district administrative authorities will provide technical and managerial support and supervision, to the commune councils through their designated focal staff (in principle the social services focal points). Staff from provincial and district line departments will provide technical support to the commune councils as well as directly to the community-

workers when relevant.

UNICEF will provide technical and financial support to the commune council in three communes to contract one community ECCD assistant in every village of the commune. These communes are selected for the program because they already have some functioning ECCD services such as a functioning health centre with active network of village health support group, community preschool in some villages; mothers support groups for home based education, micronutrients supplementation for children etc.

## Annex 10: UN Agenda 21

Chapter 27:

Strengthening The Role Of Non-governmental Organizations: Partners For Sustainable Development

10. Governments should take measures to:

- a) Establish or enhance an existing dialogue with non-governmental organizations and their self-organized networks representing various sectors, which could serve to: (i) consider the rights and responsibilities of these organizations; (ii) efficiently channel integrated non-governmental inputs to the governmental policy development process; and (iii) facilitate non-governmental coordination in implementing national policies at the programme level;
- b) Encourage and enable partnership and dialogue between local non-governmental organizations and local authorities in activities aimed at sustainable development

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