



កិច្ចសហប្រតិបត្តិការ  
អាល្លឺម៉ង់

DEUTSCHE ZUSAMMENARBEIT

អនុវត្តដោយ:

**giz**

Deutsche Gesellschaft  
für Internationale  
Zusammenarbeit (GIZ) GmbH

## The intimate worlds of men and women with disabilities in Cambodia

Disability, sexual and reproductive health & rights

**Dr Alexandra Gartrell**

**November 2015**

## Table of Contents

<b>List of Tables .....</b>	<b>4</b>
<b>List of Figures .....</b>	<b>4</b>
<b>Abbreviations.....</b>	<b>5</b>
<b>Executive Summary .....</b>	<b>6</b>
<b>Research participants .....</b>	<b>6</b>
<b>Findings.....</b>	<b>6</b>
<b>Limitations .....</b>	<b>10</b>
<b>Recommendations .....</b>	<b>10</b>
1 – Knowledge of sexual and reproductive health .....	10
2 – Daring to love .....	11
3 – Marriage, risk and vulnerability .....	11
4 – Contraception, reproduction and childbirth .....	11
5 – Access to and experiences of health services .....	12
<b>Background .....</b>	<b>15</b>
<b>Disability and sexual and reproductive health policy contexts in Cambodia.....</b>	<b>17</b>
<b>Current sexual and reproductive health practices in Cambodia.....</b>	<b>18</b>
<b>Research rationale .....</b>	<b>21</b>
<b>Research aims .....</b>	<b>21</b>
<b>Research methodology .....</b>	<b>22</b>
<b>Participant recruitment .....</b>	<b>23</b>
<b>Key Findings .....</b>	<b>25</b>
<b>1 - Knowledge of sexual and reproductive health .....</b>	<b>25</b>
Information sources.....	26
Deaf people’s access to health and sexual and reproductive health information .....	31
Key points.....	32
Recommendations .....	33
<b>2 - Daring to love and marry .....</b>	<b>34</b>
Men with disabilities experiences of love and finding a spouse .....	34
Key points: Men with disabilities .....	37
Recommendations .....	38
Women with disabilities experiences of love and finding a spouse .....	38
Key points: women with disabilities .....	43
Recommendations .....	44
<b>3 - Marriage, risk and vulnerability .....</b>	<b>45</b>
Women making their own decisions .....	46
Changing employment opportunities, migration and sexual risk.....	47
Physical, verbal and sexual abuse .....	48
Women who remain single and are childless .....	50
Key points.....	51

Recommendations: .....	52
<b>4 – Contraception, pregnancy and childbirth .....</b>	<b>53</b>
Learning about contraception .....	53
Decision-making about contraception .....	56
Patterns of contraception use .....	56
Contraception and side-effects.....	57
Misconceptions about contraception .....	58
Pregnancy and childbirth .....	59
Ante-natal and post-natal care .....	61
Child mortalities.....	61
Unwanted pregnancies .....	62
Pre-marital and extra marital sex .....	63
Key points.....	64
Recommendations .....	64
<b>5 - Access to and experiences of health services .....</b>	<b>66</b>
Physical access .....	66
Hierarchy of health seeking and decision-making .....	70
Men and women with disabilities suggestions for improvements.....	72
Key points.....	73
Recommendations .....	74
<b>Conclusion.....</b>	<b>75</b>
<b>References .....</b>	<b>80</b>
<b>Appendix 1 .....</b>	<b>82</b>
<b>Appendix 2 .....</b>	<b>82</b>
<b>Appendix 3 .....</b>	<b>83</b>
<b>Appendix 4 .....</b>	<b>85</b>
<b>Appendix 5 .....</b>	<b>87</b>
<b>Appendix 6 .....</b>	<b>93</b>

## List of Tables

Table 1: Summary of Interviewees: Women with disabilities .....	82
Table 2: Summary of Interviewees: Men with disabilities .....	82
Table 3: Demographics of female interviewees .....	83
Table 4: Focus Group Discussion Participants: Women with Disabilities* .....	84
Table 5: Focus Group Discussion Participants: Deaf Women .....	84
Table 6: Demographics of Male Interviewees .....	85
Table 7: Focus Group Discussion Participants: Men with Disabilities .....	85
Table 8: Focus Group Discussion Participants: Deaf Men.....	86

## List of Figures

Figure 1: Women with disabilities by type.....	12
Figure 2: Women with disabilities by age (relative distribution).....	13
Figure 3: Men with disabilities by type .....	13
Figure 4: Men with disabilities by age (relative distribution) .....	14

## Abbreviations

ANC	Antenatal care
CDHS	Cambodia Demographic and Health Survey
CDPO	Cambodian Disabled People's Organisation
DPO	Disabled people's organisation
FGD	Focus group discussion
ICPD	International Conference on Population and Development
IUD	Intrauterine device
NIS	National Institute of Statistics of Cambodia
MOH	Cambodian Ministry of Health
MOP	Cambodian Ministry of Planning
MOSAVY	Cambodian Ministry of Social Affairs, Veteran and Youth Rehabilitation
PI	Principal Investigator
PNC	Postnatal care
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infections
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNFPA	United Nations Population Fund
WHO	World Health Organization

## Executive Summary

Although specific Articles in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) recognise the reproductive rights of persons with disabilities (Article 23), the right to access sexual and reproductive health information and services (Article 25) and the need to empower women with disabilities (Article 6), these rights continue to be unattainable for many. The sexual and reproductive health of persons with disabilities have been widely and deeply neglected in a historical pattern that includes denied information about sexual and reproductive health, denied rights to establish relationships and to decide whether, when and with who to have a family (WHO/UNFPA, 2009). They are not excluded however, from physical, emotional and sexual abuse and other forms of gender-based violence, with a systematic review of the literature finding that children with disabilities are 130 per cent more likely to experience domestic and sexual violence than those without a disability (Jones, 2012, see also Astbury and Walji, 2013, WHO/WB, 2011). Research on the sexual and reproductive experiences of men and women with disabilities in the Global South is sparse, and an evidence-base is urgently required to inform the implementation of disability inclusive sexual and reproductive health policy and programming (Lee et al, 2015). This research examines the sexual and reproductive health experiences of men and women with mobility, visual and hearing impairments in rural Cambodia,<sup>1</sup> and is the first research to specifically examine disability, sexual and reproductive health in Cambodia.

### Research participants

A total of 58 men and women with disabilities participated in this study. More than half of participants were women with disabilities (33 or 56%). Of these, 25 women participated in in-depth interviews and 8 in focus group discussions (FGD). The average age of female participants was 35 years. Almost half had mobility impairments (42.5%), just under a third had visual impairments (27%), 15% were deaf and the remaining women had a combination of physical, developmental and multiple disabilities (see Figures 1 and 2). Of the men with disabilities, 11 participated in in-depth interviews and 14 in FGDs. Male participants had an average age of 33 years; 40% has mobility impairments, 36% were deaf, 8% had visual and 8% physical impairments, a further 4% had intellectual and 4% had multiple impairments (see Figures 3 and 4).

### Findings

This research found that whilst disability shapes women's and men's sexual and reproductive lives, in rural Cambodia disability fundamentally reduces women's potential to marry, bear children and acquire the socio-economic security that marriage can entail. In this study, 15 of 33 (45%) of women with disabilities were married compared to the national average of 68% (NIS/MoP, 2015); two-thirds (10 of 15) had a disability at the time of marriage. Women with disabilities in the reproductive age range (15-49 years) have a significantly lower total fertility rate: an average of 1.26<sup>2</sup> children per woman, compared to the national average of 2.7 children per woman and 2.9 children per woman for rural women (NIS/MoP, 2015). Furthermore, 19 of 33 (57%) of the women interviewed were

---

<sup>1</sup> Although two informants had developmental and an intellectual impairment, this report does not claim specific insights into the sexual and reproductive health of men and women with these impairments.

<sup>2</sup> Amongst the 30 women in the reproductive age range there was a total of 38 children.

childless.<sup>3</sup> With few or no children, women with disabilities have reduced access to potential carers and support currently and in old age and thus experience increased vulnerability across the life cycle. Men with disabilities rates of marriage in this study were also below national averages. Of the 25 men who participated, 14 were married (56%) and 11 (44%) were still single, compared to the national average of 66% of married men (NIS/MoP, 2015). Ten of the married men (10 of 14) had a disability at the time of marriage and those in the reproductive age range had an average of 1.13 children.<sup>4</sup>

It is not surprising that men and women with disabilities knowledge of contraception and reproduction is limited given the overall low levels of education among persons with disabilities and the poor quality of education in Cambodia generally. Informants in this study had an average of 3.6 years of education: 4 years for women with disabilities, 5.1 years for men with disabilities, 3.2 years for deaf woman and 2.3 years for deaf men (see Tables in Appendix 3 and 4). This compares to an overall average number of years of schooling in the working-age population in Cambodia of 4.8 years (Jeong 2014:5). The Cambodia Demographic and Health Survey (CDHS) 2014 (NIS/MoP, 2015) found that 47% of women and 42% of men had attended some primary school without having gone onto secondary school. Only one in every two men (52%) has attended secondary or higher education and two in five women (40%) (NIS/MoP, 2015). Still 13% of women and 6% of men have never attended school (NIS/MoP, 2015).

Systematic inclusion of sexual and reproductive health in school curriculum is important but given the low completion rates in upper levels where teaching about sexual development usually occurs, additional non-school-based avenues to teach men and women are needed. Men and women with disabilities in this study identified the need for greater access to information at the village level, particularly in face-to-face formats. Such information must be made available to both single and married couples, with and without children, with and without disabilities and particularly in remote rural areas. Furthermore, teachers and health professionals require greater confidence in appropriate communication with persons with disabilities, particularly deaf men and women. Health professionals also require access to communication aides to support them to be able to communicate effectively with deaf men and women.

Men, but particularly women with disabilities in this study were concerned about their marriageability and their attractiveness to a potential partner. When men with disabilities were single and not independently supporting themselves and/or contributing to their natal households, they and their families worried about their ability to support a wife and children. Women with disabilities were not confident that men would fall in love with them because as women with disabilities, they felt unattractive. Women with disabilities and their families were often fearful that husbands would mistreat and /or abandon them, leaving them to raise children on their own. Although these fears were not realised in any of our interviewees, these are widespread social narratives that need to be replaced with positive stories of women with disabilities as capable wives and mothers. Families and women with disabilities themselves tend to respond to these fears by choosing to remain single and by

---

<sup>3</sup> Three of these were married women; two married in their 40's and never became pregnant and the third never got pregnant despite her and her husband's desire for children.

<sup>4</sup> 7 of the 11 men interviewed were married and they had a total of 26 children.

doing so ensure their safety. However this strategy exposes women to a different set of vulnerabilities associated with being single and childless, including the potential absence of carers and support as they get older and being an easy target for verbal, physical and sexual abuse.

Although positive images of men with disabilities as husbands and fathers are also required, men with disabilities in this study faced fewer barriers to marriage than women. Men with disabilities and their families are able to approach the families of potential spouses, whereas women and their families have to wait to be approached. This fundamentally shifts the power differential in the favour of men. Women with disabilities are triply disadvantaged by gender, disability and poverty, as is widely recognised in international and national research literature. Employment and being able to earn their own income would greatly increase men and women with disabilities self-confidence, quality of life, social power and value within their families, access to health services and ultimately increase their potential to marry.

When married, women with disabilities were able to access contraception alongside their able-bodied counterparts. Different types of contraception are locally available and cheap and women gain information about contraception through their social networks of relatives, neighbours and friends and call upon these networks if they have any problems. However, men and women have little understanding of how contraception works in the body and are concerned about negative side effects of contraception. Health care professionals encourage women to change contraception type if they experience negative side effects and tend to rely upon natural methods as the contraception of last resort, but these methods are not always effective. Women and men with disabilities would like more information on natural methods. Increasing women's confidence to use natural methods – particularly the calendar method is required. Although women stated that they discuss contraception decision-making with their husband, men felt that women make the ultimate decision regarding contraception. Men's support for their wives in regard to family planning needs to be strengthened, as does the use of condoms, which are poorly utilized nationally (see CDHS 2014, NIS/MoP, 2015).

Men play a key role in supporting their wives to attend antenatal and postnatal care (ANC and PNC) and their access to sexual and reproductive health (SRH) services more generally. Women with disabilities in this study were keen attenders of ANC and PNC visits to the health centre and were supported to do so by their husbands and families who were keen to ensure new babies were healthy and free of impairments. Women's birthing patterns reflect those of the general population with the majority of women giving birth in the presence of a trained health professional and at a health facility. However, the CDHS 2014 (NIS/MoP, 2015) shows that poorer women are the least likely to birth at the health centre and given the institutionalised disadvantages faced by persons with disabilities, particularly women, it makes sense to sensitize health professionals to disability rights and to the provision of appropriate supports. Furthermore, men and women with disabilities would like to see persons with disabilities employed as health professionals in their local health centres. This would greatly enhance the inclusivity of health services.

Training health care professionals in disability awareness and the delivery of non-discriminatory services has improved men's and women's experiences at the health centre. Such training needs to be extended geographically and should include access to communication aides (visual, auditory and pictorial). Travel, asking for help and costs are significant barriers to access health services. Women, particularly who require assistance to travel and those without husbands, can find it difficult to ask others for help particularly if it requires the outlay of financial resources. Greater awareness of any travel assistance that is locally available is required. Positive experiences at the health centre are even more important given the challenges that men and women with disabilities may encounter when negotiating the trip to the health centre.

Cambodian society and economy have rapidly changed over the past twenty years with poverty rates declining from 53.2% in 2004 to 20.5% in 2014 (World Bank, 2014); inequality has significantly increased over this period. This research illustrates the trend of more and more young Cambodians migrating away from rural areas to work in garment factories, in the construction industry, and to engage in residential NGO disability specific skills training programs. These employment and training opportunities expose women with disabilities to a new set of sexual and reproductive health risks including unsafe sexual practices and gender-based violence (see also Samandari et al, 2010). Living away from family and the social restrictions of village life, they make new friendships including with men. Pre-marital sex is on the increase and it is increasingly important that women and men are well informed about contraception, know how and where to access it, and most importantly have the confidence to initiate its use. It is widely recognised that increased use of family planning is linked to improved economic and social development of families and broader communities (Samandari et al, 2010). Women who use contraception have a better quality of life, higher social status and great autonomy (ibid) – attributes that are particularly important to offset the cultural and institutionalised disadvantages faced by women with disabilities. In this study, unmarried women with disabilities who have children felt ashamed, hide themselves from social interactions within village and tend to stay at home, all detrimental to her emotional, social and economic wellbeing.

Abortion is also increasing in Cambodia and is being used as a particularly unsafe form of birth control. The women in this study who had had abortions, had had multiple abortions which suggests that family planning information is not being routinely provided to women post abortion. Furthermore, these women all experienced complications following the abortion and required repeat visits to health professionals that incurred significant direct financial costs, and indirectly caused the loss of productive work time and reduced health and wellbeing. Health professionals need to be trained to routinely provide family planning information to all women in a non-stigmatising manner, in facilities where multiple contraception types are available (Mc Dougall et al, 2009).

Disability shapes men and women's sexual and reproductive health albeit in different ways. Cambodian culture constructs disability as inability and it is assumed that men and women with disabilities are unable to work and contribute to their households and communities. Although in reality men and women with disabilities do make valued contributions, many particularly women and those with sensory, intellectual, multiple and severe disabilities continue to face discrimination and institutionalised disadvantages. For women, these

disadvantages are manifest in the difficulties they encounter when they want to marry and bear children alongside their able-bodied counterparts, in the difficulties they face in securing the support – financial and practical – that they need to access health services, and in the culturally-based stigma that exposes women with disabilities to greater rates of physical, verbal and sexual abuse than their able-bodied counterparts.

Broad social and attitudinal changes are required to ensure that SRH services are readily available and accessible to all and that Cambodian villages are disability inclusive. Disability rights, disability confidence and the provision of appropriate practical and emotional support by health professionals, teachers, families and community members need to be promoted. Furthermore, men and women with disabilities self-confidence and skills to be able to contribute - both financially and non-financially - to their families need to be built as these changes will give those with disabilities greater social power to be able to shape their own health and wellbeing, including their SRH.

### **Limitations**

Participants in this research were selected based selection criteria of women and men with disabilities between the ages of 15 and 49 years. Participants tended to be those who were most readily accessible and geographically closest to the district town or to the houses of disabled people's organizations (DPOs). Some participants had milder impairments (such as loss of vision in one eye, or birth deformity to the hands) that would not be expected to significantly impact daily functioning, they are however considered to be a person with disability by villagers because of their bodily difference.

### **Recommendations**

#### **1 - Knowledge of sexual and reproductive health**

- Promotion of inclusive education and disability friendly school environments is the first critical step to improve girls and boys with disabilities access to basic education.
- Sexual and reproductive health programs need to be developed and consistently taught as part of the school curriculum. It needs to be checked to what extent inclusive schools/ classes already provide SRH lessons and if there is a need to support the further extension of the school curriculum.
- More frequent (quarterly) face-to-face meetings at the village level are required to improve men and women with disabilities knowledge of sexual and reproductive health, and in turn informed sexual and reproductive decision-making. Accessible SRH information material should be made available, taking the communication needs of hard of hearing and blind people into account.
- Village level face-to-face meetings need to be inclusive of all and particularly target remote rural villages. Single and married men and women with and without children, with and without disability need to be invited and supported to attend as required. Information also needs to be presented in appropriate formats.
- Multiple strategies are required to raise knowledge among men and women with different impairments. Deaf persons need dedicated communication strategies due to poor knowledge of sign language and high levels of illiteracy.

- Men and women with disabilities need to be made aware that SRH is relevant to them, irrespective of their marriage status.
- Support and encourage men and women with disabilities to ask questions and to seek out information about SRH.
- Build the communication skills of teachers, parents and health centre staff to feel comfortable to discuss SRH issues in a non-discriminatory and stigmatising manner particularly with adolescents, single men and women and those with disability.

## **2 – Daring to love**

- Promote social and human rights-based understandings of disability.
- Men and women with disabilities need to be supported into formal and informal sector employment to build their self-confidence, independence, desirability as husbands and wives, and their overall quality of life.
- Build men and women with disabilities’ skills and employability.
- Promote non-discrimination and employment opportunities for all.
- Disseminate positive images and role models of men and women with disabilities as husbands, fathers, wives and mothers to change culturally dominant stereotypes. Particular focus must be given to the families of persons with disabilities themselves.
- Deaf men and women require visual communication aids to ensure they understand information being shared with them.
- Counsel men with disabilities on family planning, HIV prevention and condom use.
- Greater understanding of men’s attitudes to, and experiences of family planning particularly men with hearing, visual and more severe disabilities is needed.
- Men’s understanding of their role and responsibilities in family planning needs to be strengthened.

## **3 – Marriage, risk and vulnerability**

- Support SRHR education through role model approach enabling persons with disabilities to provide good examples among their peers and to challenge common stereotypes and misconceptions about the sexuality of persons with disabilities.
- Promote women with disabilities knowledge of and access to appropriate sources of support by local authorities, the police and the law if and when domestic and other forms of violence occur.
- Promote women with disabilities’ knowledge of their rights as women to safety and freedom from fear.
- Raise awareness of men and women with disabilities’ right to love, marry and parent.

## **4 – Contraception, reproduction and childbirth**

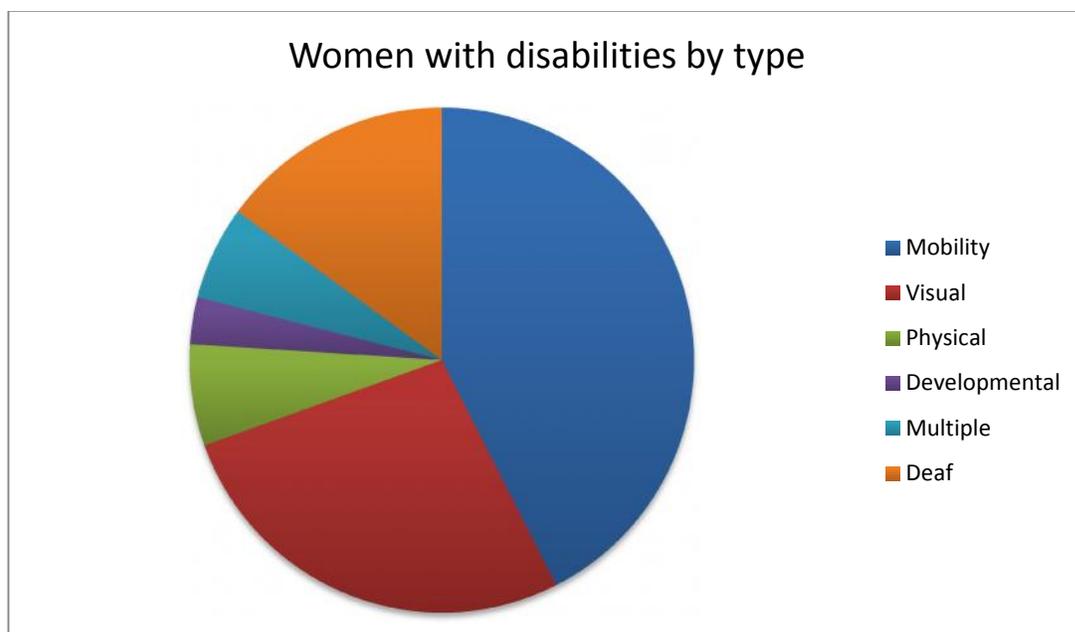
- Promote women’s and men’s knowledge of how contraception works in the body to prevent pregnancy as well as basic understanding of reproduction and bodily anatomy to countervail myths about side-effects of family planning methods.
- Promote condom use and knowledge of HIV and STI prevention.
- Raise men’s awareness of their role and responsibilities in family planning and to support their wives’ decision-making.

- Raise awareness of SRH at the village level through face-to-face activities and ensure wide participation of married and not married couples, persons with and without disabilities and single persons.
- Increase women’s knowledge of different types of contraception so that they can make informed decisions as to which is most suitable for them.
- Provide women with more information on safe abortions and post-abortion follow-up and family planning.
- Train health care professionals to consistently provide all women with family planning information and follow up post abortion care.
- Address men’s and women’s concerns with the side-effects of contraception on women’s health.

### 5 – Access to and experiences of health services

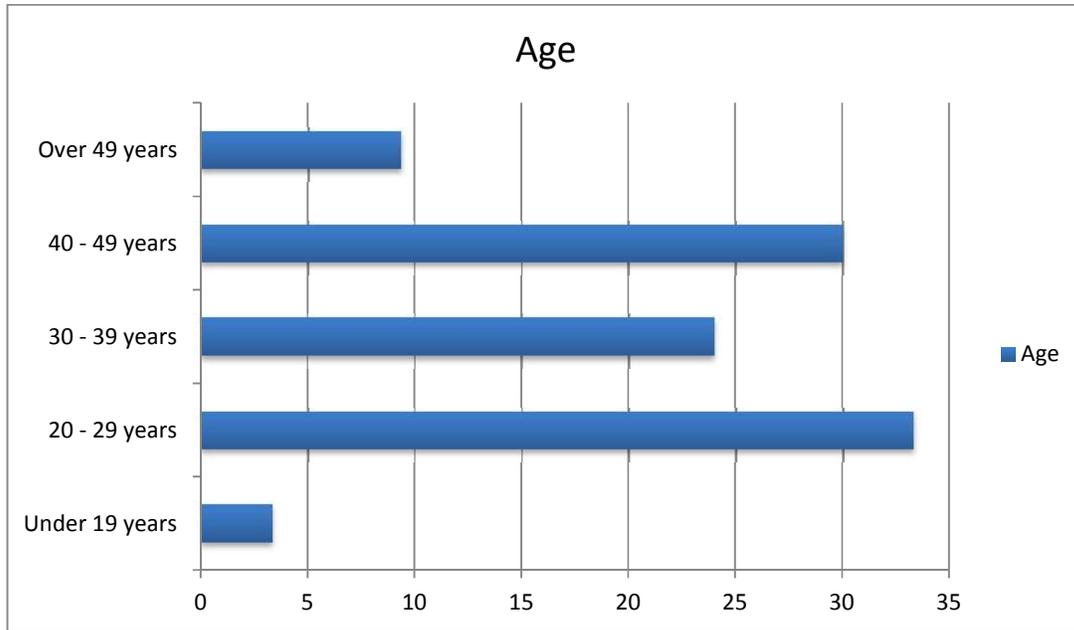
- Raise persons with disabilities awareness of any travel funds or vouchers that may be able to improve their access to health services.
- Ensure wheelchair access and ramps are present at all health centres.
- Train and employ persons with disabilities as health professionals.
- Facilitate communication between health staff and persons with disabilities (e.g. with regard to deaf persons) through training including the use of visual aides.
- Ensure visual aides and other assisting communication means are available at all health centres.
- Raise awareness of disability and disability rights among health professionals and teachers so that they encourage children with disabilities when they are young.
- Improve access to information and understanding of sexual and reproductive health particularly in remote areas and among the poorest including men and women with disabilities.

Figure 1: Women with disabilities by type



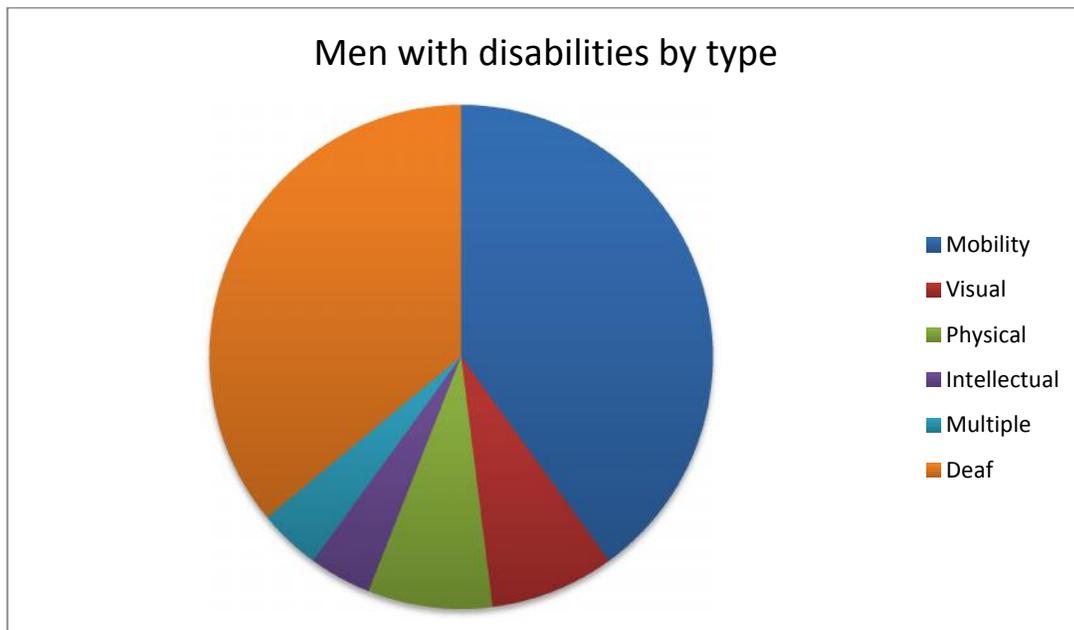
\*This includes all 33 female participants: interviewees and FGD participants.

Figure 2: Women with disabilities by age (relative distribution)



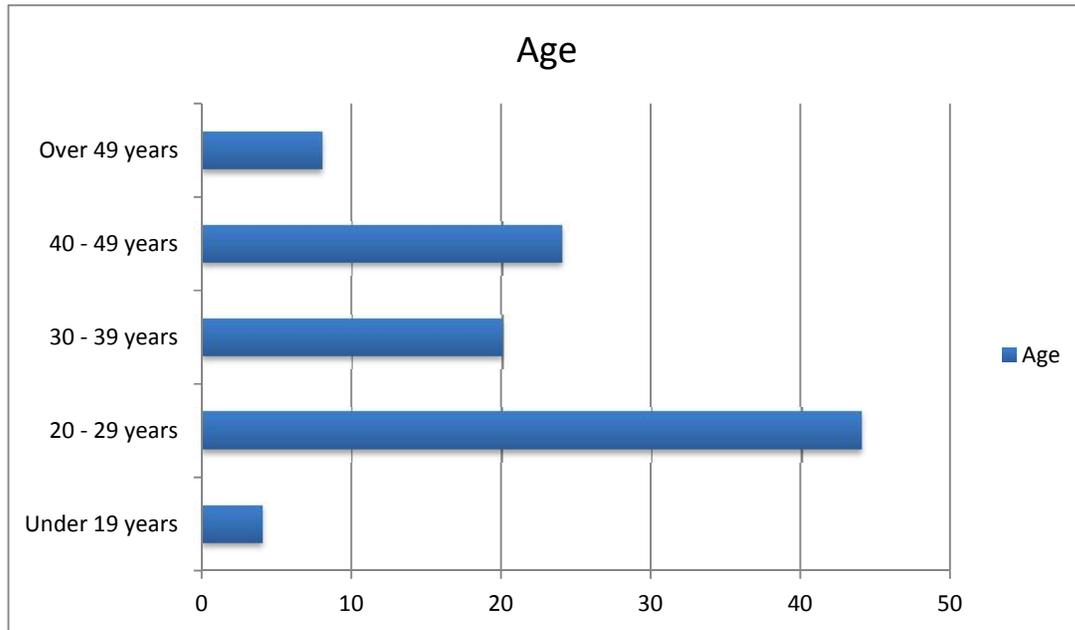
\*This includes all 33 female participants: interviewees and FGD participants.

Figure 3: Men with disabilities by type



\*This includes all 25 male participants: interviewees and FGD participants.

Figure 4: Men with disabilities by age (relative distribution)



\*This includes all 25 male participants: interviewees and FGD participants.

## Background

In the international development arena the rights of all to sexual and reproductive health are well articulated and have been for the past two decades. The UNFPA International Conference on Population and Development (ICPD) *Beyond 2014 Global Report*, for example recognises the rights of all couples and individuals to decide upon the number, spacing and timing of their children, to have access to the information required to do so, and to attain the highest standard of sexual and reproductive health (Paragraph 7.3). However, government, international and national disability and mainstream organisations have consistently overlooked the sexual and reproductive health rights of persons with disabilities, and they are the most marginalised group in relation to sexual and reproductive health issues and services (WHO/UNFPA, 2009, Dutch Coalition on Disability and Development, 2013). The adoption of the UNCRPD in 2006 galvanised global attention on disability-based discrimination and human rights violations, and was closely followed by greater attention on the sexual and reproductive health rights of persons with disabilities by organisations such as the WHO and UNFPA (WHO/ UNFPA, 2009). The ICPD reiterated the UNCRPD recognition of disability as a specific issue requiring attention and called for all governments to eliminate discrimination against persons with disabilities in regard to their reproductive rights, household and family formation (UNFPA, 2014).

Men and women with disabilities have the same desires for intimate relationships, marriage and parenthood as others, and despite popular perceptions of their asexuality, they are sexually active (World Bank, 2004). The challenges they face in relation to their sexual and reproductive health are not necessarily part of having an impairment, but reflect their poor social status and the lack of legal protection, understanding and support (WHO/UNFPA, 2009:6). In the absence of even very basic information on sexual and reproductive health, persons with disabilities do not understand how their bodies work, and their rights to define what they do and do not want (ibid). Despite the limited information on the sexual and reproductive health of persons with disabilities, particularly the gender dimensions (Frohman and Ortoleva, 2013), it is widely thought that persons with disabilities have significant unmet needs and are more likely to be excluded from sex education programmes (WHO/WB, 2011:85). In fact, their needs for sexual and reproductive services may be greater than others due to their increased vulnerability to abuse, to become infected with HIV and other sexually transmitted infections (WHO/UNFPA, 2009). They may have little experience relating to and negotiating with potential partners (WHO/UNFPA 2009:6), which further heightens their vulnerability.

The common misconception that persons with disabilities are sexually inactive means health professionals fail to offer sexual and reproductive health services to them (WHO/WB, 2011:77-78). Reproductive health service providers have limited awareness of the sexual and reproductive needs of persons with disabilities, have poor understanding of their rights and limited access to resources and training on disability that would enable them to establish inclusive services (Lee et al, 2015,). Persons with disabilities thus face specific structural, institutional and individual barriers that limit their opportunities to establish intimate relationships and to access services and other sources of support that they may require to realise their rights, once they are indeed aware of them.

Women with disabilities experience unique disadvantages that are the result of the intersectional discrimination associated with gender and disability (Mac-Seing and Boggs, 2014; Lee et al, 2015; Frohmader and Ortoleva, 2013, WHO/WB, 2011;). Rates of disability prevalence are higher for women (19.2%) than men (12%) (WHO/ WB, 2011), and women with disabilities are more likely to live in poverty than men with disabilities and their non-disabled counterparts (ibid). They face particular barriers to their economic, social and political participation that are related to gender and disability stereotypes, which are often multiple and mutually reinforce one another. They are also less likely to be engaged in paid employment which in turn diminishes their social power and access to material and non-material resources (ibid).

Although the UNCRPD advocates the incorporation of a gender perspective in all efforts to promote the full and equal enjoyment of human rights, disability and development programs worldwide consistently fail to apply a gender and/or a disability lens (Frohmader and Ortoleva, 2013:3-4). Women with disabilities also have reduced access to health services and information, screening, prevention and care services and thus have greater unmet health needs, particularly in relation to sexual and reproductive health (Lee et al, 2015). International and regional human rights bodies recognise that worldwide women and girls with disabilities experience, and are more vulnerable to all forms of violence, abuse, exploitation and neglect (Frohmader and Ortoleva, 2013; WHO/WB, 2011, WHO/UNFPA, 2009). Persons with disabilities are up to three times more likely than non-disabled people to be physically and sexually abused or raped, with women, and those with intellectual and mental disabilities the most vulnerable (WHO/UNFPA, 2009). Research on gender-based violence in Cambodia found that 52.5% of women with disabilities reported emotional violence, 25.4% physical violence and 5.7% sexual violence from family members (Astbury and Walji, 2014).

Persons with disabilities are a highly diverse group and although at a population level disability correlates with disadvantage, not all persons with disabilities are equally disadvantaged (WHO/WB, 2011). Gender, age, socio-economic status, ethnicity, sexuality, rural or urban residence, disability type and severity each shape the experience of disability. For example, persons with intellectual and mental impairments, particularly severe impairments are more disadvantaged than those with physical and sensory impairments (WHO/WB, 2011). Together, these differences amplify or ameliorate disadvantage – for example, a young women living with visual impairment in a remote rural area experiences multiple disadvantages when compared to a wealthy, middle-aged man with mild physical impairment living in the city, only some of which directly relate to impairment. Wealth and social status can overcome activity limitations and participation restrictions (WHO/WB, 2011), and highlight that impairment does not always and necessarily lead to disability, as noted by social models of disability (see Oliver, 1990).

## **Disability and sexual and reproductive health policy contexts in Cambodia**

In Cambodia, respect for individual and collective rights is a key principle that underpins sexual and reproductive health policy and strategy (MoH, 2006). Cambodia adopted a rights-based approach to reproductive health in line with the United Nations Declaration at the International Conference on Population and Development in Cairo, Egypt, in 1994 (Huy, 2011) and the Fourth World Conference on Women in Beijing, 1995. The Cambodian National Population Policy (2003) further affirmed these rights and adopted a personal empowerment strategy to enable people to make free and informed decisions about their reproductive lives in a context where many people have very little control over reproductive or sexual health-related choices (MoH, 2006:1). The National Strategy for Reproductive and Sexual Health in Cambodia (2006-2010), and the more recent Strategy (2013-2016), recognised the need to support and give visibility to gender-specific issues, such as gender-based violence, and to promote male involvement as a means to reduce gender inequity. Although the National Strategy for Reproductive and Sexual Health aims to address gender inequities, disability and its gender-specific impacts are invisible, although anecdotal evidence suggests disability is recognised as a key gap in current policy and programs (pers. comm, 2015).

The Cambodian National Disability Strategic Plan 2014-2018 states that it presents “an age and gender-sensitive and rights-based approach to addressing the rights and needs of adults and children with disabilities in Cambodia” (Government of Cambodia, MoSAVY, 2014). Ten key strategies are identified two of which are most relevant to this study: Strategy 1 to reduce discrimination, violence, abuse, neglect and exploitation of persons with disabilities, and Strategy 8 to ensure all persons with disabilities, particularly those in rural areas, have access to affordable and accessible quality health services. While the gender and disability specific vulnerabilities to violence, abuse and discrimination are recognised at the policy level, sexual and reproductive health issues are not specifically identified in the National Disability Strategic Plan.

The absence of disability in sexual and reproductive health policy (see for example Racherla et al, 2013), and of sexual and reproductive health in disability strategy and policy, suggests the need for greater inter-Ministerial collaboration and advocacy on these long neglected issues particularly given their multiple, often inter-generational impacts. Moreover, there is limited empirical evidence available to inform policy makers’ efforts to respond to the particular barriers that women and men with disabilities continue to face to sexual and reproductive health services in Cambodia. The Cambodian Demographic and Health Survey (CDHS) 2014 (NIS/MoP, 2015) is the most recent survey of current sexual and reproductive health patterns in Cambodia, and yet data is not disaggregated by disability and gender, place of residence, education level and wealth quintile. The national trends identified in the CDHS 2014 (NIS/MoP, 2015) can be compared with data collected in this current study to disentangle the disability specific factors that shape the sexual and reproductive health of men and women with disabilities. This study contributes to filling this knowledge. This study is qualitative and does not provide statistically meaningful and representative data but reveals current trends, cultural patterns and barriers to sexual and reproductive health services.

## **Current sexual and reproductive health practices in Cambodia**

In Cambodia, women's age, education and socio-economic status are key determinants of sexual and reproductive health practices and access to SRH services, including contraception (Samandari et al 2010). A situational analysis of state health financing found that the most vulnerable populations have poor access to health services, including sexual and reproductive health services (Racherla et al, 2013). Although men and women with disabilities are not explicitly identified in policy and research literature on sexual and reproductive health in Cambodia (see for example MoH, 2012), it is widely recognised that persons with disabilities are one of the most marginalised and poorest social groups (MoSAVY, 2014). Many families with a member with disability have limited education and knowledge and struggle to access government services (Cambodian Government, MoSAVY, 2014). Cambodian women in general continue to face labour discrimination and earn approximately 30% less than men, the literacy rate is 40% higher for men and school enrolment is 50% higher for boys by age 15 (MoH, 2012:18). Women and girls with disabilities are particularly disadvantaged as gender stereotypes and institutionalised discrimination reinforce social misconceptions that associate disability with inability (Gartrell, 2010).

Cultural beliefs that disability is the result of karma from bad actions in previous lives, underpin negative attitudes and behaviour toward persons with disabilities (Gartrell, 2010). The hierarchical social structure reinforces these cultural beliefs and specific terminology is used to differentiate status, such as older (*bong*) and younger (*poon*) (Gartrell 2013). Persons with disabilities are positioned at the bottom of the social hierarchy with lesser status than their able-bodied peers (Gartrell, 2010); gender, age and wealth are other key determinants of status (Ebihara, 1968) and can ameliorate or amplify status differentials (Gartrell, 2004). In the Cambodian context, persons with intellectual, psychiatric, visual and hearing impairments, autism, multiple and very severe disabilities are the most vulnerable and marginalised from their communities, social activities, services and even the disability movement (Cambodian Government, MoSAVY, 2014). The socio-cultural norms of hierarchy and karma underpin the multiple forms of discrimination that persons with disabilities encounter in their economic lives, and they are most likely to engage in poorly paid, unskilled, informal sector work (Cambodian Government, MoSAVY, 2014; Gartrell, 2010). With limited financial resources, access to health services, including sexual and reproductive services, is poor and compounded by a lack of locally available inclusive services and costly, often inaccessible transport.

Current knowledge of sexual and reproductive health in Cambodia illustrates that Cambodian women who are older, are more educated, have higher income and live in urban areas are more likely than others to use modern methods (Samandari et al 2010:123). The most marginalised groups - including women, women who have no, or very little education, are in the lowest wealth quintiles and who live in rural and remote areas - have the poorest access to services (NIS/MoP, 2015, Racherla et al, 2013). These women experience the greatest inequalities in fertility - they are the most likely to have higher fertility rates and to attend few ANC and follow up PNC visits. Rural and low parity women are more concerned about their need to work physically hard and to earn money, and wish to avoid side-effects and complications that reduce their productive capacity (Sadana and Snow, 1999). Women with disabilities' poor access to health services in general is likely to extend into their access to sexual and reproductive health services, as they are often in lower wealth quintiles and

have little or no education. Racherla et al (2013) conclude that all behaviour change communication interventions regarding sexual and reproductive health practices should be intensified among these marginalised populations, including men (ibid).

### ***Fertility rates***

Over the past fifteen years in Cambodia, fertility rates – the estimated number of children the average woman would bear in her lifetime - have declined from 3.8 in 2000 to 3.0 in 2010, and 2.7 in 2014 (NIS/MoP, 2015). While the median age at first childbirth is 22.8 years (MoH, 2012), teenage fertility is a major health concern with significant health consequences for women. Of women aged between 15 and 19 years, 12% have become mothers or are currently pregnant and incidence varies significantly by wealth: 11.2% of women aged 15-19 years who have had a live birth are in the lowest wealth quintile versus 4.9% in the highest wealth quintile (NIS/MoP, 2015:10). Adolescent reproductive and sexual health is a focus area in national SRH policy and programs.

### ***Contraception***

Of currently married women, 56% are currently using some method of contraception, with the majority using a modern method - mostly the pill or injectables (NIS/MoP, 2015:11). Over the past ten years, use of modern methods has increased from 27% of currently married women in 2005, to 39% in 2014 (NIS/MoP, 2015). Only 4% of women without children are using a modern method of contraception because generally women do not start to use contraception until they have had at least one child (ibid). Women feel pressure not to use contraception in the early stages of their fertility (Samandari et al, 2010). In the past, women also tended to use contraception to cease childbearing rather than to space births, and perceived it is inappropriate to use contraception before at least two live births (Sadana and Snow, 1999).

Available research suggests that men's attitudes, and women's beliefs about their husband's attitudes, are an important determinant of women's contraception use. Women who believe that their husband has a positive attitude toward contraception are more likely than those who did not to use a method, and women who felt nervous when speaking with their husband about contraception were less likely to use a method (Samandari et al, 2010). Women whose husband's made the final decision about contraception were less likely to use a method (ibid). Furthermore, male responsibility for fertility control is low with only 2.7% of males using condoms and no males choosing sterilization; the burden of contraception thus falls largely on women (Racherla et al, 2013). Men, however, do play an important role in facilitating their wives' access to follow-up care and services (Sadana and Snow, 1999). Increasing men's approval of, and partner communication about contraception and family planning, and building women's confidence in their own reproductive decision-making are the best ways to promote contraceptive use (Samandari et al, 2010, Sadana and Snow, 1999).

Women's decision-making regarding contraception are also influenced by her social network and social attitudes within those networks (Samandari et al, 2010). When women are uncertain about using modern contraception, they make decisions about method on the basis of discussions within their social networks, particularly with husbands, neighbours and

other women (ibid:123). Local attitudes about women's sexuality shape negotiations of women's sexual behaviour and fertility choices (Sadana and Snow, 1999).

### ***ANC and delivery***

Nearly all (95%) of pregnant Cambodian women who gave birth in the five years prior to the latest CHDS (2014) attended ANC at least once from a health professional (NIS/MoP, 2015). Level of education is a critical determinant of attendance at ANC, with 99% of those who have more than secondary education attending ANC. However, only 76% of women attended four or more ANC visits – the WHO recommended number of visits – and level of education was positively correlated with the number of visits. Urban women are also more likely to attend at least four times than women living in rural areas (85% compared to 74% respectively) (NIS/MoP, 2015).

In the last ten years the number of babies delivered in the presence of a health professional has increased dramatically from 44% in 2005 to 89% in 2014, and at a health facility from 22% in 2005 to 83% in 2014 (NIS/MoP, 2015). The number of women delivering at health centres increases with the mother's level of education and is higher for urban (96%) than rural women (81%). Only 68% of births to women with no education were at the health centre, compared to practically all births to women with more than secondary education (NIS/MoP, 2015).

### ***Abortion***

Abortion is increasingly common in Cambodia. Limited access to safe terminations, particularly outside of Phnom Penh, lack of awareness of abortion rights, costly procedures and stigma all contribute to women's reliance on unsafe means to terminate a pregnancy (Hemmings and Rolfe, 2008). Many women (10-50%) require post abortion care for complications related to unsafe abortion, and have to visit more than one health care facility to gain post-abortion care or a contraceptive method (McDougall et al, 2009). Most importantly, after abortion many women want to prevent future pregnancies, but were not offered post-abortion contraception, and those who were, often refused family planning (Ibid:129). Post abortion, the majority of women did not receive contraception information and services, rendering them at risk of another unwanted pregnancy and unsafe abortion (ibid:131). Training health centre staff – nurses and midwives – to be able to provide abortion and post-abortion services, particularly training and information to change attitudes and assumptions about those who accept contraception is critical to remove service provider barriers (Delvaux et al, 2008; McDougall et al, 2009). Disability inclusion should be mainstreamed into all sexual and reproductive health care reforms and this research contributes a knowledge base on which to base such activities.

## **Research rational**

The Rights Based Family Planning and Maternal Health Project (Muskoka) of the German Development Cooperation in Cambodia is conceptualised within the framework of the G8 Muskoka Initiative to improve mother and child health and commenced in August 2012. The project focuses on improving quality, access, and use of services in the area of rights-based family planning and maternal and child health in four target provinces: Kampot, Kampong Thom, Kampong Speu and Kep. The project aims to reduce barriers to access sexual and reproductive health and rights needs of persons with disabilities at individual, family, community and health service level, among other activities.

In 2013, the Muskoka project undertook steps to identify disability inclusive interventions. A literature review was commissioned which made general recommendations to promote sexual and reproductive health and rights of persons with disabilities. It suggested comprehensive consultation with persons with disabilities at all stages of program implementation and sensitisation of persons with disabilities as well as health personnel about human rights, sexual and reproductive health (Hörmansdörfer/Olson 2013). In the remaining time of the current phase (until the end of 2015), and considering the final phase of the project (until the end of 2018), the Muskoka project wants to expand activities on disability and sexual and reproductive health and rights. Moreover, it intends to cooperate with DPOs, including the national disabled people's organisation (the Cambodian Disabled People's Organisation [CDPO]), who will play a key role in increasing knowledge about sexual and reproductive health among their target groups. In particular, it is part of Muskoka's project activities to raise awareness and knowledge on sexual and reproductive health and rights among members of DPOs.

To explore persons with disabilities' current sexual and reproductive health knowledge and practices, the project commissioned this qualitative research. The aim is to provide foundational understanding of persons with disabilities' current sexual and reproductive health care and needs, and for this knowledge to inform future project interventions. Results of the qualitative research will provide the background of a subsequent baseline study to inform one of Muskoka's project indicators on persons with disabilities' sexual and reproductive health knowledge.

## **Research aims**

This research aims to provide foundational understanding of persons with disabilities' current sexual and reproductive health care and needs, and asks three specific questions:

- 1 – what are persons with disabilities current knowledge, attitudes and behaviour toward their sexual and reproductive health and rights?
- 2 – what barriers do persons with disabilities face when accessing reproductive and sexual health care services?
- 3 – what strategies do persons with disabilities identify to address these barriers?

## **Research methodology**

Fieldwork was conducted in Kampot province for eight days – September 3-11, 2015. GIZ have provided a maternal and child health project for three years in Kampot and have pre-established relationships with the health centre staff, disability focused NGOs (EPIC Arts and Deaf Development Program) and with local disabled people’s organisations (Women and Children with Disability Forum Kampot). The Principle Investigator (PI) led a six person research team made up of three representatives from CDPO (two female and one male), and three provincially-based DPO representatives from Chhuk and Angkor Chey Districts (two female and one male) in Kampot province. Together, the team constituted three pairs of interviewers – two female pairs and one male pair, who interviewed women and men with disabilities respectively.

A total of 36 in-depth interviews (25 women with disabilities and eleven men with disabilities) were conducted in four districts: Angkor Chey, Chhouk, Teouk Chhou and Duong Tong. Five focus group discussions (FGD) were also held with a total of 25 participants. Three FGD were held with deaf men and women (two with nine men and one with six women) and two FGD with members of DPO self-help groups (one five female and one five male participants).

Interviews were conducted in Khmer by staff from the Cambodian Disabled People’s Organisation and the Kampot-based DPOs, as described above. All interviewers were trained by the PI in how to conduct in-depth interviews and were familiarised with the interview questions including examination of the information that each question is designed to collect. The one-on-one interviews followed an interview checklist (see Appendix 5) and asked open-ended questions that allowed the interviewer to follow the interviewees’ lead and examine issues that they identified as important. Interviews examined knowledge and attitudes in relation to reproduction, sex education and sexual interaction, marriage, family planning and pregnancy (contraception, abortion, and childbirth), access to health services and information, current decision-making regarding sexual and reproductive health. The collection of qualitative data enabled comprehensive insights into current knowledge, attitudes and behaviours, to barriers to services and strategies to address these based on the experiences of persons with disabilities themselves.

All interviews were tape recorded with interviewees’ permission and then transcribed verbatim from spoken Khmer into written English. The content of all interviews was analysed thematically by the PI. Analysis entailed the PI reading all interview transcripts three times, coding key pieces of text – that is data, and then grouping the data into key themes which now form the different sections of this report. Written consent was gained from all interviewees’ prior to the collection of any data (see plain language statement). All data that is information collected has been de-identified and given a code number. The Cambodian Ministry of Health Research Ethics Committee approved this research on June 26, 2015.

The FGD also followed a checklist of questions (see Appendix 6) that were all asked to participants. The discussions followed the lead of participants and issues they raised were explored before moving onto the next series of questions on the checklist. A sign language interpreter translated between spoken Khmer and sign, whilst a CDPO team member translated from English into Khmer. Male and female sign language interpreters were used

in the FGD with deaf men and women respectively. However, the English-Khmer interpreter was female. As all of the deaf men were friends with one another and with the sign language interpreter, the presence of a female interpreter did not stifle conversation. The need to interpret between sign, Khmer and English meant that discussions took longer than anticipated and different levels of sign language proficiency amongst participants mean detailed and multiple explanations were required in some cases. FGD with hearing men and women with disabilities followed the same format. All FGD discussions lasted between two and two and a half hours. The PI took detailed notes in all FGD and four of the five FGD were transcribed verbatim. Transcripts do not differentiate between speakers. The fifth FGD was not transcribed for logistical reasons. Analysis of FGD data followed the same methodology as for interview data.

### **Participant recruitment**

Provincially-based DPO staff in each of the four districts invited members of the self-help groups<sup>5</sup> that they facilitate to participate in an in-depth interview. This study aimed to interview men and women in the reproductive age range (15-49 years). However, three of our 36 informants were outside of this age bracket (two men and one woman) as DPO staff faced several challenges in recruitment.<sup>6</sup> Firstly, many younger men and women with disabilities had migrated away either alone or with their spouse and children to work in Phnom Penh and other provincially-based factories. Secondly, fieldwork was done in the middle of the rice transplanting season – a busy period in the annual agricultural cycle and some persons with disabilities were too busy to participate. Thirdly, in the absence of pre-arranged participants within the 15-49 year old age range, the three over age participants who were physically present and ready to be interviewed were interviewed.

Finally, given the time limitations of the fieldwork period, DPO staff selected persons with disabilities who lived in locations that were the easiest to access. Given these difficulties, a second return visit was made to Angkor Chey to conduct an additional four interviews (two men and two women) who lived more remotely.

In Angkor Chey and Duong Tong interviews were conducted in the house compound of the DPO Director. DPO staff made this decision to ensure that our target of interviews with nine persons with disabilities in each district was achieved. In Chhouk and Teouk Chhou interviews were conducted in the homes of participants' as they were easy to get to. Interviews lasted between 30 - 60 minute depending on the age, marital status and sexual and reproductive history and experiences of interviewees.

Participants in the focus group discussions were recruited through the provincially-based DPOs. DPO staff invited members of their self-help group and EPIC Arts invited staff and former students of their program to participate in a FGD. Deaf men and women had greater awareness of sexual and reproductive health issues because of their engagement with EPIC Arts and other NGO schools and programs. It is thus reasonable to expect that they are exceptional when compared to deaf men and women who live in rural villages. FGD were held at EPIC Arts, in the compound of a local pagoda and in the home compound of the DPO leader's house in Angkor Chey.

---

<sup>5</sup> In this study the term "self-help group" refers to village-based chapters of DPOs.

<sup>6</sup> An additional informant was HIV positive and was interviewed although HIV is not typically to be a disability.

### **Reproductive health and rights defined**

Reproductive health was first defined at the ICPD in Cairo in 1994, and later by the World Health Organization (WHO) and others as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity in all matters related to the reproductive system and to its function and processes” (quoted in MoH, 2012:5). Reproductive rights, also defined at the ICPD, recognise the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, to have the information and means to do so, and to attain the highest standard of sexual and reproductive health. It includes the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights document (UNFPA, 1994).

### **Disability defined**

There is no universally agreed upon definition of disability (Groce et al, 2011). The UNCRPD defines disability as “an evolving concept... that... results from the interaction within persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others” (UNCRPD, 2006).

An impairment is the mind-body difference that may or may not lead to a disability. Disability refers to the discriminatory embodied social and environmental processes that together turn an impairment into a disability. The relationship between impairment and disability can be thought of as the difference between sex and gender where sex is the biological condition and gender the socialised and culturally specific manifestation of sex.

## Key Findings

### 1 - Knowledge of sexual and reproductive health

Men and women with disabilities' knowledge of their sexual and reproductive health was low mirroring patterns in the general population. Marital status is a key determinant of men and women with disabilities' knowledge of sexual and reproductive health, especially knowledge of contraception. Single men and women with disabilities had very limited knowledge, particularly those under 30 years of age, and they were shy when speaking about sexual and reproductive health.

The overall level of education in Cambodia is relatively low and partly underpins low levels of knowledge about body physiological processes, general health and reproduction. For example:

*“General health education [is poor], not specifically on sexual and reproductive health but women with and without disability do not have a lot of information” (F09, 49 year old woman with mobility impairment).*

*“We are illiterate... so it seems like we don't understand [about contraception]” (F01, 42 year old woman with mobility impairment).*

While a few informants reported that they had learnt a little about sexual development and contraception (condoms) at school, they were recent graduates or had attended specialist NGO disability schools and programs, such as Krousar Thmey, the Deaf Development Program, Marist Solidarity Cambodia or Epic Arts. For example:

*“Krousar Thmey taught us about reproduction and condoms so I knew how they worked” (FGD, deaf women).*

The education of informants who were school age in the 1970's was disrupted because of the civil war and Pol Pot regime and they studied very little, if at all:

*“I didn't study... because of the war...it was always war” (M11, 58 year old man with mobility and visual impairment).*

Informants who attended public schools in the 1980s and the 1990s explained that reproduction was not part of the curriculum at that time. Men and women with disabilities reported that their parents did not talk to them about reproduction, puberty, sexuality and marriage. These data reflect cultural patterns of little discussion of sexual and reproductive health between parents and their children. The few exceptional parents who did speak with their children were mothers who spoke with their daughters about menstruation and fathers who encouraged their children to use contraception to avoid having too many children. For example:

*“My Mum was old already and the older generation did not know much about menstruation... and she did not tell me ‘oh daughter, it is like this or that’... she never told me. The older generation did not know much about this compared to today...*

*now people [parents] know how to give advice and educate... I knew it by myself and from my friend.” (F09, 49 year old woman with mobility impairment).*

As F09 notes above, nowadays parents are more informed and able to advise their children when compared to previous generations. However, among our informants in their 20s, few reported their parents had spoken to them about sexual and reproductive health. Only one 21 year old woman who had just finished Grade 12 had learnt about SRH at a public school. Men with disabilities in their 40s explained that they do have ways of sharing information about reproduction within the family:

*“We have different ways of telling [our children]... indirect ways... for example if the mother has a child and you don’t want to have another sibling, you use the pill...we don’t speak about it directly and we don’t explain the details.” (FGD, men with disabilities).*

The cultural assumption that disability equates to a reduced ability to work and produce income to support a family meant that parents were concerned that their children with disabilities had fewer children. Several male informants did tell their own children about contraception and sexually transmitted diseases. For example:

*“I told them [my children] to protect themselves, don’t let viruses get transmitted ... use condoms and they asked me ‘how can we control births father?’ I told them ‘buy pills for your wife to take or use an IUD ... don’t have too many children because it will be difficult’” (M11, 58 year old man with mobility and visual impairments).*

*“When it comes to children, I’ve told them [my children] ... [I told them] about the methods ... like my married son, I told him that if his wife couldn’t take the pill, she should try injections to avoid having children too quickly” (M02, 46 year old man with mobility and visual impairments).*

Increasing young people’s knowledge and understanding through conversations with their parents could be explored further in reproductive health programs and awareness raising activities.

### **Information sources**

Men and women with disabilities, and villagers in general learn about sexual and reproductive health from three main sources: through their social networks of family, friends and neighbours; village-based information sharing meetings organised by Village Health Support Volunteers and/or NGOs, and directly from health centre staff and/or doctors. Other research has also identified that villagers, particularly women, learn about sexual and reproductive health through trusted social networks of female friends, neighbours and relatives (Vathiny and Hourn, 2010, Samandari et al, 2010, Sadana and Snow, 1999).

#### **1 – Social networks of family, friends and neighbours**

Informal conversations among family members, peers and neighbours are the first key source of information for men and women. For example, young women learnt about their periods by listening to the conversations of older women:

*"I heard my mother and other women talking about periods and I learnt this way" (F11, 48 year old woman with mobility impairment).*

Married women and men learnt about contraception and sexual and reproductive health care by talking with family members, peers and neighbours. Married men for example learnt about contraception from conversations with one another, neighbours and relatives:

*"We hear about contraception from each other" (FGD, men with disabilities).*

*"The neighbours told [me] '[you] have to use birth control'...don't have too many children...we are poor" (M09, 31 year old married man with physical impairment).*

*"My mother-in-law told me about contraception" (M09, 31 year old married arm with physical impairment).*

Men often gain information about contraception from their wives, who in turn learnt from conversations with other women in the village:

*"She [my wife] receives more information [on contraception] than me... from the women around here" (M13, 46 year old married man with mobility impairment).*

Married and even single women with disabilities similarly learnt from one another:

*"[We learn] from one to another. Someone says something and then shares this information with others" (F23, 35 year old single women with mobility impairment).*

When men and women with disabilities have sexual and reproductive health problems, family and friends are the first place that they turn to for help and advice. For example:

*"I felt that my belly was getting a little big and I wondered [about this]. I asked other people 'why is my belly big like a pregnant woman?'... I asked my mum and older sister and my neighbour"<sup>7</sup> (F09, 49 year old married woman with mobility impairment).*

*"My friend told me to take the contraceptive pill and that this would stop the bleeding. I followed her advice, took the pill and the bleeding stopped" (F05, 43 year old married blind woman).*

*"I told my niece from Phnom Penh about this problem [vaginal discharge] and she told me what to do" (F01, 42 year old married woman with mobility impairment).*

Of the married women with disabilities in their 20s and early 30s who had had SRH problems, they spoke less about consulting with family about SRH problems and more about health services. This 25 year old married woman with a mobility impairment for example:

*"I had convulsions when I was pregnant... pain and convulsions ... about 15 times a month ... until the doctor was afraid that it will affect the baby" (F19, 25 year old married woman with multiple impairments)*

---

<sup>7</sup> F09 was not pregnant but had a cyst.

Furthermore, if women want to find out information about very private matters, such as sex, they will ask a family member, such as an older sister:

*“I felt shy to others and myself... this is our personal issue, if I tell other people it is not right... so whatever issue we just keep it in our family and so I asked my older sister. honestly speaking, like me, [I am] just married and still shy” (F09, 49 year old married woman with mobility impairment).*

Face-to-face social networks at the village level are a vital source of information but rumours and misconceptions are also spread through these networks (see Section 4 Misconceptions about Contraception). Improving the quality of information circulating through these networks is critical and an important avenue for action.

## **2 – Village-based meetings on SRH**

Once married, it is socially acceptable for men and women with disabilities to gain information about sexual and reproductive health. However, not all married men and women are equally able to access information, particularly at village meetings. Married couples without children and those with older children were not systematically invited by Village Health Support Volunteers and/or the village head to attend information sharing meetings with Village Health Support Volunteers and / or NGOs. Furthermore, village level meetings only occur once or twice a year and informants considered this number of meetings to be inadequate. This data suggests that only married couples with young children are systematically invited to attend these meetings, which are inadequate in both their population coverage and frequency.

Even though single young people, married couples with older children and those married without children were not invited to attend these meetings, they learnt little bits of information by listening in:

*“They just gather people to share information with them right after they have children. For single people and those who have older children... they never get educated [because they are not invited]” (M14, 42 year old man with mobility impairment).*

*“They were just talking with each other [about the withdrawal method]... the old people... and I just listened to them from afar” (F08, 44 year old married woman with visual impairment).*

Parents and other elders sent young people away if they were seen to be listening:

*“They [my parents] are afraid that the children are listening when older people and neighbours are talking about family planning....older people say that we should not know about this... this is better (F22, 21 year old woman with mobility impairment).*

Cultural norms discourage open and particularly public conversations about sexuality and reproduction. Interviewees explained that to initiate such conversations could be considered impolite, even older married men are reticent to start talking about contraception and sex:

*“I dare not to talk about it (sex/contraception)... I am afraid that they would think I am looking down at them” (M11, 58 year old man with mobility impairment).*

Single women, particularly young women, felt that it was inappropriate for them as unmarried women to learn about reproduction and sexuality, let alone ask questions at village level meetings:

*“When they [participants during village meeting/training] are talking about sexual and reproductive health, I walk away... I don’t stay to listen... it’s not suitable for me... I feel shy to hear this and [I] walked out” (F18, 36 year old single woman with physical impairment).*

*“I was too young that’s why I didn’t join them... I was not married yet” (F02, 25 year old married woman with mobility impairment).*

*“I don’t ask for details because I am afraid of blame. The point is that I am single, so why would I ask such questions... asking a lot about such a topic is not good. I am single... If I ask the questions, it may cause trouble and people may make fun of me and say that I am anxiously wanting to have a husband” (F23, 35 year old single woman with a mobility impairment).*

*“I thought I should not look at it [demonstration of condom use] because it was not what I needed to see... it may not be appropriate... so I didn’t pay much attention as I have no husband” (F24, 45 year single woman with mobility impairment).*

Single women with disabilities make the assumption that sexual and reproductive health information is not relevant to them because they are disabled, unmarried and unlikely to marry, and thus they do not want to know about these matters. Being disabled increases young women’s feelings of insecurity and uncertainty about their marriageability, and is an additional factor that makes them even shyer than non-disabled women. For example:

*“My body looks like this [disabled]... so that is why I do not want to know [about sexual and reproductive health]” (F18, 36 year old single woman with physical impairment).*

*“I am the one who doesn’t have a husband or wife like other people, so I don’t pay much attention [to sexual and reproductive health information]” (F04, 23 year old single woman with a mobility impairment).*

Single men with disabilities also showed a reluctance to learn about sexual and reproductive health, and like women with disabilities this is probably because they do lower expectations of their ability to find a spouse:

*“I do not want to know more about this... I am shy” (M04, 35 year old man with mobility impairment).*

In contrast, married men and women are able to legitimately ask questions and to proactively learn about their sexual and reproductive health and how to protect themselves. For example, with encouragement, a 25 year old married woman with a mobility and neurological impairment asked questions of a teacher (also her cousin), when he came to the village to teach about sexual and reproductive health:

*“My cousin taught here [in the village]... and at that time he taught a young lady here [about natural methods]... he is a primary school teacher and he come to teach us... he taught young teenagers... male and female. At that time I asked the teacher the methods for preventing pregnancy and he told everyone... he told everyone we don't need to be shy. Be brave and ask a question and so I did” (F19, 25 year old married woman with a mobility and neurological impairment).*

Deaf men also took the opportunity in the focus group discussions in this research to ask questions and to learn. For example:

*“When a woman has her periods can you still have sex? ... Where can I get information on sexually transmitted diseases and child birth?” (FGD, deaf men)*

The population coverage and frequency of Village-based meetings needs to be improved to ensure that all young and potentially sexually active men and women are well informed and able to actively protect their SRH.

### **3 – Health centre staff and doctors**

Married informants also gained information about their sexual and reproductive health including contraception by visiting the Commune Health Centre and private practitioners. For example:

*“The doctor just told me that an injection can protect me from getting pregnant” (F15, 41 year old woman, HIV positive).*

*“When we meet the doctor, she asked us about this and that. Its seems that we have more discussion and talking than when we buy medicine at a small shop in the village where we just buy it and go back and we don't talk at all. ...at the health centre we can meet and talk to each other about this and that” (F06, 45 year old woman with mobility impairment).*

*“We learn about these things... sexual health from the health centre... learnt about family planning and reproductive health and [the] prevention of children... we have this conversation with health centre staff after we were married” (FGD, men with disabilities).*

Village visits by health centre nurses were also a source of information about family planning for villagers:

*“The nurse comes to the village and brought medicine for them if they wanted family planning” (FGD, men with disabilities).*

Informants noted that after the birth of their first but also later babies, health centre staff spoke with them about contraception:

*“[We] had conversations after the birth of the first baby at health centre” (FGD, men with disabilities).*

Young men and women both with and without disabilities, married and single, need to be encouraged to ask questions and to seek out information about SRH from their parents,

teachers and health care professionals. Training and awareness raising of teachers, health care professionals and parents in how to relate to, and communicate about these issues with young people is required to ensure that young people are well received, feel safe and are not stigmatised for seeking such information. Furthermore, health professionals' knowledge also needs to be improved to ensure that they consistently share accurate information. Young men and women with and without disabilities will then be more able to make informed decisions.

### **Deaf people's access to health and sexual and reproductive health information**

Information gained through networks of family, friends and neighbours is not available to deaf men and women at the village level because neither party knows sign language. Although they use 'natural' sign and body language that they have developed themselves to communicate with one another at home, it is not always effective and can leave deaf people feeling confused and uninformed. For example:

*"My dad tried to explain things [sexual and reproductive health] to me, but it was difficult" (FGD, deaf men).*

Deaf informants explained that they learnt about sexual and reproductive health care from books and pictures, including those seen at the health centre. One deaf woman's mother took her to the health centre so that she could look and learn from the available visual information (posters and brochures), and one young man's father brought condoms home. The lack of information in accessible, visual formats means that in the absence of contact with specific NGOs like Epic Arts or Deaf Development Program, the majority of deaf men and women have very little knowledge of sexual and reproductive health. For example:

*"Deaf Development Program taught us about contraception when I studied with them... we learnt about women's sexual development and reproduction and condoms" (FGD, deaf men).*

*"I don't talk about sex... I don't know anything about sex. I have never known anything about that" (FGD, deaf women).*

*"I did not know that it is important for women to have reproductive health check-ups" (FGD, deaf women).*

*"I didn't know about it... but I saw my sibling [having sex] and I was very angry... I did not know anything and others do... parents do not teach you" (FGD, deaf women).*

Consultations with health service staff and doctors about general health issues were confusing because health professionals and parents are sign language illiterate:

*"My parents took me to the clinic... my parents tried to talk to the doctor but I didn't really get any information about what was happening with me... And the doctor can't sign... my parents can't sign and so it is quite difficult for me to understand what is going on. My parents tried to do home sign ... body language... it was confusing... and I can't write and my parents can't write ... so I didn't really understand" (FGD, deaf women).*

*“Even my parents only know a little sign and they struggle to explain things to me [when we go to the health centre]” (FGD deaf men).*

Furthermore, in the absence of a means of direct communication between health centre staff and deaf men and women, staff spoke to their parents about them. As a consequence deaf men and women are not included in conversations about them:

*“The doctor explains things to my parents... and not to me” (FGD deaf men).*

*“My mum took me to the doctor and she spoke to the doctor and I didn’t know anything” (FGD deaf men).*

Communication difficulties and deaf men’s and women’s experience of receiving none or at best very little information about their sickness, discourages them from visiting the health centre. For example:

*“I have never been to the health centre because I know that nobody can understand me... so I don’t know anything... we can’t communicate... [so] I just stay at home” (FGD, deaf women).*

Literacy facilitates communication with hearing people and when deaf men and women, and/or their parents can read and write, communication is easier and they are able to gain more information in consultations about their health. Education levels among our informants were limited however, with an average of 2.3 years of schooling for deaf men, and 3.2 years for deaf women, which removes the opportunity to communicate through writing. For example:

*“I can’t get information from the doctor or my parents... it was confusing... both my mum and dad can’t write either, so I can’t really understand” (FGD, deaf women).*

Promotion of deaf men’s and women’s access to education and basic literacy is vital to their general health and is a key foundation to build their knowledge about sexual and reproductive health and service access. Deaf informants in the FGD were all friends, sign literate and would share information together and are thus a very atypical group.

## **Key points**

### **Individual level barriers to SRH knowledge**

- Single men and women with disabilities themselves do not believe that SRH knowledge is relevant to them because they see their disability as a barrier to marriage. Many do not expect to marry and have children.
- Being disabled increases young women’s feelings of insecurity and uncertainty about their marriageability, and is an additional factor that makes them even shy than non-disabled women in the area of SRH.

### **Family / societal barriers to SRH knowledge**

- Parents and elders teach their children very little, if anything about sexual and reproductive health.
- Parents and elders can be a barrier to unmarried young people learning about family planning, sexual and reproductive health.

- Young men and women with disabilities learn very little about sexual and reproductive health at school.
- Information about sexual and reproductive health is not available in visual formats for Deaf people and auditory formats for those with visual impairments.

#### **Individual level facilitators of SRH knowledge**

- When men and women with disabilities are encouraged to feel comfortable and confident to ask questions, they direct their own learning about SRH.

#### **Family / societal level facilitators of SRH knowledge**

- Once married, it is socially acceptable for men and women with disabilities to gain information about sexual and reproductive health.
- Only married couples with young children are systematically invited to attend these meetings, which are inadequate in both their population coverage and frequency.

#### **Recommendations**

- Promotion of inclusive education and disability friendly school environments is the first critical step to improve girls and boys with disabilities' access to basic education.
- Sexual and reproductive health programs need to be developed and consistently taught as part of the school curriculum.
- More frequent face-to-face meetings at the village level are required to improve men and women with disabilities' knowledge of sexual and reproductive health, and in turn informed sexual and reproductive decision-making.
- Multiple strategies are required to raise knowledge among men and women with different impairments. Deaf persons need dedicated communication strategies due to poor knowledge of sign language and high levels of illiteracy.
- The relevance of SRH information to men and women with disabilities' needs to be strengthened irrespective of their marriage status.
- Support and encourage men and women with disabilities to ask questions and to seek our information about SRH in tandem with building the communication skills of teachers, parents and health centre staff to feel comfortable to discuss these issues in a non-discriminatory and stigmatising manner.

## 2 - Daring to love and marry

*“We have the right to love but we do not dare”*

*(FGD, women with disabilities).*

Marriage is a critical turning point in the life trajectories of persons with and without disabilities. Our data demonstrates that men with disabilities were more likely to get married than women with disabilities. However, both men and women with disabilities face challenges, albeit different challenges, when seeking to get married. Men and women with disabilities described their fears of being rejected, which in some cases were realised when families of potential spouses refused marriage proposals either by or to a person with a disability. The majority of male informants eventually found spouses and married, but women with disabilities were less able to negotiate the disability specific, socio-cultural barriers to marriage. In some cases, women chose to remain single as a safer option to the risks that marriage may entail, but in fact these women faced a different set of risks and vulnerabilities that play out across the life cycle.

### **Men with disabilities experiences of love and finding a spouse**

More than half - 14 of 25 (56%) of men with disabilities in this study were married. Men with disabilities felt it was difficult to find a wife because they encountered the negative attitudes of young women’s parents who are concerned a man with disability would not be able to work and earn an income, as the following quotes illustrate:

*“The parents of the woman would think that I am not capable of earning an income and feeding a wife... and that we can’t work like others” (FGD, men with disabilities).*

The social perception men with disabilities are unable earn an income to support a family causes the families of potential spouses to reject men with disability because they would be poor and of low status:

*“Other girls did not accept me and did not like me because I am a man with a disability... her family did not accept me” (FGD, men with disabilities).*

*“If she [my wife] cannot endure what other people would say to her like ‘you chose a husband who has very low [status]’, then it would be difficult (M08, 25 year old man with visual impairment).*

Men were also concerned about providing for a wife and family because they felt that their disability narrows their employment opportunities and limits their income. For example:

*“It is difficult to find a wife... we are a disabled person and so it is difficult to find income and to support a wife and family (FGD, men with disabilities).*

*“In rural areas, we usually do farming or gardening, if we have disabled legs like this, it’s hard to do labour work and farming, and they [families of potential spouses] don’t have any hope in us because we are not strong like others [and so they do not want to marry us]” (M14, 42 year married man with mobility impairment).*

*"I have no job ... and so she [my wife] would be higher-level [status] compared to me... so I am lower... my body is not strong ... so I do not dare to approach any girl ... I am afraid she will look down on me and say 'polio man, he can't do anything'" (M04, 35 year old single man with mobility impairment).*

*"It is hard to move around and to get work outside of the village like in construction [so our income is low and they do not want to marry us]" (FGD, men with disabilities).*

Although the families of several women did reject offers of marriage by men with disabilities, the parents of these men ultimately arranged marriages for them or in a few cases, the men chose their own wife. For example:

*"I had a previous engagement [before my wife] but when she saw I was a person with disability, she broke it off ... and then I married my wife" (M07, 38 year old married man with mobility impairment).*

*"My current wife thinks I am not capable of earning money but she saw that I am honest and a good person [and married me]" (FGD, men with disabilities).*

*"I chose my wife ... I even forced the elders [my parents] to go and engage her" (M07, 38 year old man with mobility impairment).*

For men with intellectual, sensory and more severe impairments, parents do not always consider marriage a possibility, and in these cases the provision of a carer for men with disabilities when parents die is a cause of great concern to parents. For this reason, the parents of some single men with disabilities encouraged their sons to marry and have children to ensure they have a carer in the future, particularly when they get old themselves. For example:

*"My parents say to me 'take a wife and hurry up ... have children so that your children can take care of you" (M08, 25 year old man with physical impairment).*

The surprise of a deaf informant's mother when he told her that he wanted to marry is indicative of the broader social attitude that marriage is not assumed for men with intellectual and hearing impairments. Of the nine deaf men who participated in focus group discussions, only two were married. They were however, a young group with an average age of 24.6 years with plenty of time to marry.

*"I meet my wife<sup>8</sup> [at Epic Arts] and told my parents [we wanted to get married] and they went to visit her. My mum was surprised that I wanted to get married but they arranged our marriage (FGD, deaf men).*

Deaf men discussion of the marriage experiences of deaf men with hearing women illustrate the communication challenges that hearing and deaf couples can encounter. Rumours and anecdotal information about the experiences of others is shared via face-to-face social networks and can reinforce negative stereotypes and promote fear. For example:

---

<sup>8</sup> His wife is also deaf.

*“There was a deaf man who married and had two children. His wife did not sign and they got divorced, because it was very difficult for them to communicate with one another” (FGD, deaf men).*

In relationships and marriage, communication difficulties can leave deaf men feeling confused and disempowered as they are unable to clearly understand what is going on around them.

### ***Daring to love***

Men spoke about their reticence to love a woman because they feared being rejected because of their disability. For example, one man described that prior to meeting this wife he did *“not dare to love as a person with a disability [because he] was afraid of being rejected” (FGD, men with disabilities)*. Single men described feeling timid and shy to find a spouse:

*“I don’t dare to love anyone....I am afraid that if I get [fall in love with] this girl she will not even look after me... I want to get married... but I dare not to find anyone... or ask anyone... because my body is not quite well enough... I think if I love her maybe she will not love me too... so I didn’t love... I wait for someone’s daughter to look at me first and then I will go after her... let the bride see me first... I do not dare to love anyone first, they will say ‘look at your body like this [disabled] and you dare to love a girl” (M04, 35 year old single man with mobility impairment).*

*“I am afraid that if I get married, my wife would not be honest with me. I am afraid that marriage is not my fate and that they [a wife] will not choose me” (M08, 25 year old man with physical impairment).*

As the men above state, they will wait for the family of a potential wife to approach them and their family. This is highly unlikely however, as in Khmer culture it is not possible for young women to approach the man. For men with disabilities who do not work and depend upon their parents, it is the parents who would choose a wife, but without work they are less desirable husbands:

*“I cannot do anything... my parents are still helping to take care of me... [I] let the parents choose [a wife]” (M04, 35 year old man with mobility impairment).*

For men earning an income is critical to autonomous decision-making including in the area of finding a spouse. As one deaf man stated:

*“I am not worried about the future and marriage because I have work” (FGD, deaf men).*

Although individual and social level attitudes do shape men with disabilities experiences of love and marriage, they are not insurmountable. The majority of men with disabilities did find a spouse despite their concerns and fears, and the reluctance of some families to marry their daughter to a man with disability. Men with intellectual, psychological and severe impairments, such as bad cerebral palsy or total blindness, are the least likely to marry as their parents are concerned about their ability to care for and support their children.

Furthermore, men with these types of disabilities are the least desirable husbands and likely to face the most social and environmental barriers to earning an income.

### **Family planning**

Some men with disabilities expressed the desire to have fewer children than they would have if they did not have a disability. They felt that disability reduced their capacity to do the physical work required to feed their families:

*“I said [to my wife] we should stop having children because I am disabled and cannot earn a lot to support many children. If I was not disabled, I would have 4 or 5 children because I would be able to work and look after the children” (39 year old man with mobility impairment).*

In contrast, other men did not consider their disability when deciding how many children to have, but talked about their employment situation and access to contraception as key factors in making family planning decisions. When a disability does not affect the capacity to earn an income, as was the case with one man with a mobility impairment who worked as a hair dresser, disability did not influence the number of children a couple had. For example:

*“[I want] the same number of children whether I am disabled or not” (FGD, men with disabilities).*

*“We did not know about birth spacing but decided two children was enough” (FGD, men with disabilities).*

Greater understanding of men’s attitudes to and experiences of family planning, particularly men with hearing, visual and more severe disabilities, is needed.

### **Key points: Men with disabilities**

#### **Individual level barriers to finding a spouse**

- Men with disabilities fear rejection by potential spouses and their families.
- Men with disabilities who do not work and support themselves, are less desirable as husbands.

#### **Family / societal level barriers to finding a spouse**

- In the absence of communication aids, communication difficulties in relationships and marriage can leave deaf men feeling confused and disempowered as they are unable to clearly understand what is going on around them.
- Men with intellectual, severe and multiple disabilities are the least desirable as husbands because of social stigma and cultural assumptions that disability means inability.

#### **Individual level facilitators to finding a spouse**

- When men with disabilities are able to work to support themselves, they feel more confident to find a spouse.

- Men with disabilities who have an independent source of income can arrange their own marriages.

### **Family / societal level facilitators to finding a spouse**

- Men with disabilities employment situation and access to contraception are key factors in making family planning decisions.
- Supportive families who arrange marriages for men with disabilities facilitate men finding a wife.

### **Recommendations**

- Men with disabilities need to be supported into employment (formal and informal sector) to build their self-confidence, independence, desirability as a husband and overall quality of life.
- Promotion of non-discrimination and employment opportunities for all and dissemination of positive images and role models of men with disabilities as husbands and fathers.
- Build men with disabilities' skills and employability for informal and formal sector jobs.
- Counsel men with disabilities on family planning, HIV prevention and condom use.
- Greater understanding of men's attitudes to and experiences of family planning, particularly men with hearing, visual and more severe disabilities, is needed.
- Deaf men require visual communication aids to ensure they understand information being shared with them.
- Men's understanding of their role and responsibilities in family planning needs to be strengthened.

### **Women with disabilities experiences of love and finding a spouse**

Women with disabilities face disability and gender specific socio-cultural stigmas to marriage. Just over a third of the women (18 of 33) (54%) in this study were single (see Appendix 1, Table 1), compared to 32% of all women (NIS/MoP 2015). Cambodian women, including women with disabilities, are unable to approach the families of a potential husband. Women have to wait for a potential husband to fall in love with them and/or for the family of the potential spouse to approach their family to ask for marriage. As a 48 year old married woman with a mobility impairment explained:

*"Khmer woman, whether able or disabled, if she wants to get married, she needs to wait for a man to come and ask to engage her first... how can we go and ask them? We must wait for them to ask" (F11, 48 year old woman with mobility impairment).*

*"They have to come to us... we can't find them for marriage" (FGD, women with disabilities).*

*"Even if we love them, we don't know if they will love us back... we are disabled... so how can we choose them?" (FGD, women with disabilities).*

Women with disabilities explained that it is difficult for them to marry because their disability means they are “unable to do anything” (F10, 48 year old single women with visual impairment) and are unattractive to men. For example:

*“I am not able to do anything ... and it is difficult ... I look like this so I didn’t get married” (F10, 48 year old single women with visual impairment).*

*“I’m blind like this, who would marry me? ... if he would accept me, I would accept him” (F26, 30 year old woman with visual impairment).*

*“I’m a disabled person... no one sees [is attracted to] me ... they think that I can’t do much work ... so nobody wants me and my appearance looks bad ... they only want to marry pretty girls who are not disabled... (F23, 35 year old single women with mobility impairment).*

Only one of the deaf women who participated in the focus group discussion had been married, although they are now separated.<sup>9</sup> They had difficulties communicating with one another. Deaf women were particularly concerned about communication difficulties if they marry a hearing husband:

*“I am worried because I am deaf and maybe I can’t talk with my husband” (FGD, deaf women).*

*“I am deaf and if I marry, I want a deaf man, not a hearing man” (FGD, deaf women).*

Although deaf women may prefer a deaf partner, their parents tend to want them to marry a hearing husband because it would be easier for the parents to communicate with him, or for their daughters not to marry at all. Deaf women explained their parents’ attitudes in the following ways and reveal different attitudes towards the marriage of their deaf daughters:

*“My parents do not want me to have a boyfriend who is deaf like me because it is difficult to communicate” (FGD, deaf women).*

*“My parents have asked me if I want to get married and I said not yet ... they are angry at me because I do not want to marry ... some husbands are violent and drunk” (FGD, deaf women).*

*“One man asked my parents to take me to a ceremony and then we spent time together ... my nephew saw us and told my father and he said ‘you should not have a partner’ and he was angry to see me with a man ... he just wants me to stay home [and not marry]” (FGD, deaf women).*

Furthermore, parents have low expectations of their daughters’ marriageability and offer potential husbands who are less desirable to other non-disabled women. For example:

*“My parents introduced me to a man who had children already and wanted me to marry him but I didn’t want to” (FGD, deaf women).*

---

<sup>9</sup> Her husband was a hearing man who had many girlfriends and drank every day. He did not provide her with any income to support her and their two children.

Deaf women expressed the desire to work and to wait before they marry, reflecting the more general trend for women to marry older, particularly those in urban areas. The participation of these women in NGO programs has exposed them to new opportunities, including paid employment. For example:

*“I think maybe one more year [and I will marry] wait until I find a job” (F04, 23 year old woman with mobility impairment).*

Women with disabilities themselves are not confident in their attractiveness to men as a wife and these feelings are an individual level barrier to their marriage. Women with disabilities internalise dominant social attitudes.

### **Family attitudes**

Social attitudes of parents and others are a significant barrier to women with disabilities entering marriage. A 49 year old woman with a mobility impairment, who is now separated, explained that it was only possible for her and her husband to marry because both families agreed to their union, a situation that would be the same for women with and without disabilities:

*“All the families and relatives liked each other and that’s why we were able to get married” (women with disabilities focus group participant, 49 year old woman with mobility impairment).*

*“If my parents and relatives agree, I also agree ... it’s too brave to decide without asking permission” (F23, 35 year old single woman with mobility impairment).*

Women with disabilities encounter cultural barriers to marriage, just as non-disabled women do. If the families do not agree to the union, it is not possible for the marriage to go ahead:

*“I had a relationship ... but his parents didn’t need me ... his parents were not satisfied with me because I am disabled ... so they didn’t ask for marriage” (F24, 45 year old single woman with mobility impairment).*

*“We are women with disabilities; we are discriminated by non-disabled people. Sometimes, both sides – the man and the woman love each other but the parents say [to the man] ‘why do you have to marry her? If your wife is like that [disabled] after you get married, you will have to serve her’. So there is discrimination from the external surrounds ... so then we women with disabilities have great difficulties in finding a partner ... unless that man commits to love us, we can marry him ... only if the man volunteers himself, then we can accept him” (FGD, women with disabilities).*

Marriage was not discussed as a possibility by the parents of an informant with Down syndrome:

*“[My mother] doesn’t talk about marriage because my mother said that I am crazy ... but I’m not ... well a little” (F20, 18 year old woman with Down syndrome).*

The mothers of some women with disabilities interviewed did not want their daughters to marry because they feared they would be treated badly and/or abandoned by their

husbands. They thus did not arrange for the marriage of their daughters. The mother of two daughters with intellectual disabilities explains that her decision not to let her daughters marry is because of her concern for the care of any children if they were to arise from the marriage:

*“While we [parents] are still alive, it’s ok, but latter on if we are not here ... I don’t know who will look after them ... I don’t know what will happen ... my husband and I worry on this point and can’t fall asleep whenever I think about this. I don’t want [them to marry]. If there is a man with a disability who has a job and is gentle [I will agree]. There are some people who have come to ask too, and they were also good people ... but how can I agree? ... if they have children how can they take care of them in the future. It is very difficult this point. I am afraid they can’t take care of their baby” (F14, 53 year old woman with visual impairment).*

By not allowing daughters to marry as a strategy to keep them safe, parents such as this mother expose her daughters to a different set of vulnerabilities associated with remaining single and childless (see Chapter 3, Section *Women with disabilities who remain single and Childless* below). Other families did not stop their daughters from marrying but made it clear that they thought marriage for a woman with disability was problematic:

*“They [my family] give me advice ... they do not prohibit me [from marrying], but they are afraid that in the future I will have problems ... If my husband abandoned me, my parents and family will not take care of me in the same [way] as they would if I am single [and never marry]. A married life is not the same as a single life. I will have a lot of difficulty to earn [money] and support my children alone ... if he runs away from me ... I will be neglected from my family” (F23, 35 year old woman with mobility impairment).*

If a woman marries without her parents’ consent, she risks her long-term security. Firstly, husbands could abandon them, leaving them to raise children and possibly support elderly parents alone. Secondly, as the young woman above explains, if an independently made decision goes wrong, parents and other family members may not support them and any children arising from the marriage. As the woman quoted above explains herself:

*“I cannot decide on my own because I am afraid that if there is a wrong thing, I will get blamed ... I just see my mother is old and I am afraid that if we have one child and he leaves me, then I will have more difficulty” (F23, 35 year old woman with mobility impairment).*

Women themselves also expressed that they did not want to get married and worried about being treated badly by husbands. They are concerned their husbands would not love and care for them:

*“[I am] afraid my husband will not pay attention to me” (F22, 21 year old single woman with mobility impairment).*

*“I am disabled and I am afraid that if he is not disabled that after he got me [marries me] he might leave me or treat me badly ... something like that” (F11, 48 year old married woman with mobility impairment).*

*“I do not want to get married because I have heard stories about couples breaking up” (F20, 18 year old single woman with Down syndrome).*

Despite these fears, none of our informants had been abandoned by their husband, and only one woman had separated, although an additional woman wanted to divorce. Five (20%) informants experienced physical, verbal or sexual abuse and of these two from their husbands (see Section 3 *Physical, Verbal and Sexual Abuse* below).<sup>10</sup> The fear of abandonment is a popular misconception that not grounded in a solid evidence-base. Awareness raising campaigns should directly target these social stereotypes and replace them with positive and empowering stories of women with disabilities as wives and mothers.

### ***Daring to love***

In intimate relationships, women with disabilities experience limited social and decision-making power. Whether they marry or not depends upon a man loving them. Women who participated in the FGD noted that their ‘rights’ do not translate into the social freedom to choose a spouse:

*“We have the rights, but in our minds ... we dare not to [love]. We can’t show [love]. If we talk about rights, we have them ... we have the right to love” (FGD, women with disabilities).*

*“Even if we are not disabled, we still cannot choose them if the man does not love us ... unless they commit to us” (FGD, women with disabilities).*

Women with disabilities, like some men with disabilities, do not ‘dare to love’. Women with disabilities explained that men do not find them desirable and attractive, assume they will be unable to work and earn an income, and for this reason they feel they are likely to be rejected. Together with the cultural norm of women having to wait for men to choose them, they do not dare to love a man first. Some women believe that they have “no right to love someone” (35 year old single blind woman) because of their disability:

*“We are disabled ... we have no rights to love anyone ... they won’t love us” (FGD, women with disabilities).*

Other women know they are rights holders, but still they do not love, because potential husbands may not or do not love them. For women with disabilities, loving is even more contingent on their partner’s love and acceptance of them first, than it is for women without disabilities. In the absence of this love, women with disabilities do not experience intimate love and marriage:

*“We have the right to love, but we do not dare to love” (FGD, women with disabilities).*

Female informants continue to understand disability as a medical issue only, with one woman explaining that the challenges that women have to face are an inherent and fixed part of disability. For example:

---

<sup>10</sup> Women were not directly asked about their experience of physical, verbal and sexual abuse and the incidence could have been greater than our data suggests.

*“We are not as brave as normal people. We are disabled so we have to do something according to our condition” (FGD, women with disabilities).*

Such discourses of disability naturalise and individualise socio-cultural discrimination rather than recognising these attitudes and practices as changeable. Greater understanding of social models of disability as relational and based upon discrimination at the village level is thus required as a first step toward transformation.

Although both men and women with disabilities face disability specific socio-cultural barriers to marriage, men with disabilities and their families are able to choose and approach potential spouses and their families. Women with disabilities and their families on the other hand, have to passively wait to be approached by the man’s family. This gendered power differential doubly disadvantages women with disabilities as dominant social stereotypes construct disability, and particularly women with disabilities, as unable to do anything. The reality however, is that many women with disabilities actively support others as wives, mothers, daughters and sisters.

### **Key points: women with disabilities**

#### **Individual level barriers when finding a spouse:**

- Women with disabilities are not confident in their attractiveness to men as a wife; they fear being treated badly and not loved; or, even worse, being abandoned by their husband.
- In intimate relationships, women with disabilities experience limited social and decision-making power.
- If women marry without her parents’ consent, she risks her long-term security.
- Some women with disabilities continue to believe that the challenges they face are inherent to their impairment.

#### **Family / societal level barriers when finding a spouse:**

- Parents have low expectations of their daughters’ marriageability and offer potential husbands who are less desirable to other non-disabled women.
- In the absence of communication aids, deaf women were particularly concerned about communication difficulties if they marry a hearing husband.
- Although deaf woman may prefer a deaf partner, their parents tend to want them to marry a hearing husband because it would be easier for the parents to communicate with him, or for their daughters not to marry at all.
- If the families do not agree to the union, it is not possible for the marriage to go ahead.
- The mothers of some women with disabilities interviewed did not want their daughters to marry because they feared they would be treated badly and/or abandoned by their husbands. They thus did not arrange for the marriage of their daughters.
- Families believe that marriage is problematic for women with disabilities.

#### **Individual level facilitators when finding a spouse:**

- Deaf women expressed the desire to work and to wait before they marry.

**Family / societal level facilitators when finding a spouse:**

- The families of both the potential husband and wife must agree to their union.

**Recommendations**

- Promote social and human rights-based understandings of disability among villages and communities, including families of persons with disabilities.
- Deaf women men require visual communication aids to ensure they understand information being shared with them.

### 3 - Marriage, risk and vulnerability

The decision to marry fulfils socio-norms and is a key rite of passage that brings women in particular much status as wives and mothers. Marriage and the alternative of not marrying, however, bring new opportunities, but also risks and potential threats to personal security and wellbeing. Men and women with disabilities typically have less personal, social and cultural resources to draw upon to navigate these uncertainties, and whilst a spouse can be an added source of support, love and care, they can also be abusive, unsupportive and unloving. For this reason, marriage marks a critical turning point in men and women with disabilities' lives and the absence of a husband exposes women with disabilities specific vulnerabilities.

Women with disabilities who did marry followed the wishes of their parents and accepted the husbands that were chosen for them:

*“One of my cousins introduced us and said ‘you should accept him’ ... My siblings and other people ... facilitated our marriage and so I just followed them ... I felt that he looked alright, too, so okay ... my mother and older sibling said ‘let [them] get each other and they can do something [work] together to survive, because when mother is not around it will not be easy’, they said like that. So I followed them and then I started to love him” (F11, 48 year old woman with mobility impairment).*

*“I didn’t meet him till the engagement day ... I felt nothing [when I saw him] ... I just follow my parents and he follows his parents, too ... but he loves me too much” (F19, 25 year old woman with mobility and neurological impairment).*

Marriage changes women’s status as they establish their own households and must support themselves. Some women were fearful of not being able to depend upon family in the future should they again find themselves single and as women with disabilities, the daily challenges they face are heightened thus amplifying their concerns:

*“I am afraid that if I marry and he died, without his presence my relatives will not longer take good care of me” (F23, 35 year old woman with mobility impairment).*

Adherence to the wishes of parents is not only the cultural norm, one that is slowly changing, but provides women with disabilities with a safety net in case anything should go wrong:

*“If I follow her [mother] and I have any problems [with the husband] she [mother] will help, but if I decide on my own and problems arise, she will not help ... so I follow her” (F05, 35 year old woman with visual impairment).*

Women with disabilities recognise the difficulties that living without the support of natal family, relatives and/or a husband would entail. Consequently maintenance of these sources of social support provides them with some security. In the absence of familial support and if they are unable to support their own livelihood, they would literally be dependent upon others for their food. As these women explain:

*"It will be very hard [if we have no relatives or niece and nephew] because we don't know who we can depend on ... if we have no relatives, who can we depend on? It is so hard. It will be so hard until you die because outsiders wouldn't help you. If we can still walk, we can earn a little money, but if you can't get up, who would help you. It's so hard" (37 year old single woman with mobility impairment).*

*"Outsiders won't help us ... If the relatives are careless about us, it'll be hard for us ... we don't know if other people would give us rice to eat" (FGD, women with disabilities).*

Other informants were happily married and pleased that their husbands take good care of them, in one case even more so than before she acquired her disability.

*"My husband thinks that I am disabled and I can't do and work as well as before. In summary now he is more open minded with me ... what I want to do, I do ... he feels ok. That's much easier than before I was disabled ... before I was disabled in fact it was more difficult and after disabled it is easier" (F06, 45 year old woman with mobility impairment).*

*"I said that if he [my husband] would ask his parents, I would agree with him [to get married]. And he asked his parents and I agreed with him ... but I told him I am a disabled person, you shouldn't marry someone like me. I even fall down when I try to walk but he told me that he would do everything for me. I have never carried water once, he does everything for me. I only wash the clothes" (F25, 34 woman with mobility impairment).*

The stories of these women demonstrate that there are exceptions to the stigma and discrimination that many women with disabilities encounter. These positive examples need to be shared widely to begin to change culturally dominant stereotypes and to paint new positive and inclusive images of women with disabilities as wives and mothers.

### **Women making their own decisions**

Women with disabilities also made their own decisions regarding whether to marry or not, once they had received a proposal. Parents did not force their daughters to accept a husband because they recognise that their daughters have a disability. Such a rationale associates disability with inability, rather than capability. For example:

*"A man came to marry me but I didn't take him ... he [my father] understands how my body looks [disabled] and he didn't force me to take him" (F18, 36 year old single woman with physical impairment).*

In this case, she cares for her father, a widower with mobility impairment, and if she married, he may be without assistance. It is her long-term livelihood security that is diminished however, as she would clearly be able to care for a husband and any children, as she currently does for her father. It is the cultural norm for women to remain with their natal families rather than follow accompany their husbands' to their birthplace for fear of being rejected by in-laws:

*“We separated because I didn’t go and live with his family ... I didn’t go. Because I wasn’t able to serve the mother-in-law properly like others [non-disabled people] ...” (FGD, women with disabilities).*

Women, including women with disabilities are increasingly making decisions that challenge cultural norms around relationships and marriage. As women with disabilities leave their villages to study with NGO programs, they form friendships, meet boyfriends and potential husbands. One informant has had a boyfriend for the last two and a half years who she met whilst studying at a residential disability specialist school. Whilst on the one hand conforming to social norms by not spending time with him alone, simply having a boyfriend and stating that if she had her own income she would marry him regardless of family acceptance is evidence of the changing nature of relationships and love. For example:

*“We never spend time alone ... never at all ... we speak but we don’t dare to speak just the two of us alone ... afraid my father and mother ... but I still speak with him, too, but I am afraid my neighbour looks [at me] in a bad way, not a good look” (F04, 23 year old woman with mobility impairment).*

*“I don’t have money or effort to marry myself [so] it is up to my older siblings ... I depend on my siblings. If I have work to do myself, I will not wait for them, I will not depend on them” (F04, 23 year old woman with mobility impairment).*

Deaf men and women too have boyfriends and girlfriends as engagement in NGO programs creates a different social space and brings young people together away from families and the social restrictions of village life. The most fundamental difference for deaf men and women is being able to communicate with peers and form new friendships:

*“When I’m at home [in the village] it is so different ... but in Kampot [I am] happy ... at home it is just me and it is a very sad life ... I am happy now because I can communicate and sign” (28 year old deaf woman).*

All but one of the nine deaf men have or have had girlfriends, both hearing and deaf, in the past compared to two of the five deaf women. The remaining three deaf female informants explained that their parents, and/or themselves do not want them to have a boyfriend.

### **Changing employment opportunities, migration and sexual risk**

As more and more single young women with and without disabilities migrate to Phnom Penh and other regional towns to work in factories, they face particular sexual risks and vulnerabilities in their relationships with men. One informant, a 24 year old woman with a visual impairment, went to work in a factory in Phnom Penh, where she met a man who also worked at the factory. She describes how they initially met on the telephone, a common way of meeting girlfriends and boyfriends in Cambodia. A friend will either give the telephone number of the person of interest or men call numbers randomly – ‘wrong numbers’:

*“At the beginning we met each other on the phone ... then we made an appointment to meet one another ... at first my parents did not know about this” (F07, 24 year old single woman with visual impairment).*

After one month, he invited her to stay with him in the room he rented alone, which she did. She became pregnant and is now the mother of a 2 year old child. Although the father provides her with 100 US-Dollar each month, he has never met his child and is not in relationship with the mother, who is now looked down upon by her neighbours and villagers. She feels that she has made a “big mistake,” is ashamed and “hides herself under hat” (field notes, 8/9/15). Initially, her parents did not know about their relationship, very risky behaviour for a young woman. She explains:

*“When they [my parents] knew, they blamed me and I hate myself” (F07, 24 year old woman with visual impairment).*

Furthermore, she wanted to get an abortion, but the young man advised her against this course of action. Now he has transferred workplace and she is carrying the social cost of having a baby outside of marriage:

*“I said [to him] that I want an abortion ... but he said ‘don’t do that to the baby ... it is bad.’ And so I did not. It was an accident ... I didn’t want [a baby] (F07, 24 year old woman with visual impairment).*

Another informant described how her daughter also met her now husband whilst she was working in a garment factory, but in this case they married. Initially her daughter said:

*“Why [do we] need to have relationships with a man and make the parents worry?’ He [her now husband] worked there too ... then they love each other for almost one year and after I asked to know everything ... so I was called ... to go there and then they didn’t say anything [but] they gave me money to marry them ... they decided themselves ... she was getting old [28 years] too so I didn’t keep her ... what can I do ... nowadays is different from before” (F03, 52 year old woman with mobility impairment).*

Access to information about safe sex, informed decision-making and sexual rights is particularly important for young women who are migrating for work.

### **Physical, verbal and sexual abuse**

Among our informants, five women had experienced verbal and physical abuse, and unwanted sexual attention including being touched inappropriately and kissed. Women with disabilities are easy targets for abuse and violations by men, as an informant said herself:

*“The man thought I would not be able to tell my father ... he told me not to tell anyone ... I told another man not to kiss me too ... because I am very shy ... I am scared when I am at home alone ... men know that I am a person with a disability and my parents know that he [this particular man] wants to rape me ... the man [also] harassed me when I was 16 or 17 ... he touched my breasts and someone saw this and told my father and my father went to his house and hit him and warned him” (F20, 18 year woman with Down syndrome).*

This young woman’s parents are concerned that she will be raped. Men have touched her breasts and kissed her on numerous occasions and now her parents do not allow her to go beyond their neighbours’ house. Rape was reported by other villagers to be a common experience for young women generally, and women with hearing, visual and developmental

disabilities are particularly vulnerable as perpetrators think they are unable to retaliate, scream or tell others. Women with disabilities are afraid, feel vulnerable and maybe without financial resources and social support to call upon when required:

*“I’m scared because I don’t know who has good intentions and who has bad ... because I stay alone and I can’t see ... I’ve heard that disabled people got raped ... harmed ... and so I get scared and worried for myself to have such things happened to me ... I don’t know how I could ring someone because my phone has no credit ... so I may have to call the neighbours” (35 year old woman with visual impairment, FGD).*

Non-disabled husbands and family members can get frustrated at their wives and daughters with disability for the difficulties that their disability presents to them. For example, a deaf woman described how her father hits her because he gets frustrated at not being able to communicate effectively with her:

*“My father gets angry at me ... he is on drugs and hits me because he can’t communicate so he hits me ... I run away to my friends” (27 year old deaf woman).*

Another blind informant described how although she is able to fulfil her sexual obligations as a wife, it is her inability to work that frustrates her husband and results in him verbally abusing her:

*“For sexual side of things ... [it is] no problem ... but outside ... I can’t work and he got mad at me ... when he curses me, I have no feeling to sleep with him ... He [my husband] curses me ... he feels ashamed ... he curse me ‘you will always be blind’ ... This made me get so mad at him (F08, 42 year old woman with visual impairment).*

In two other cases women with disabilities responded to inappropriate physically abusive and threatening behaviour proactively and assertively, demonstrating they are aware of their rights as women:

*“My cousin in law ... he hugged me, but in a way he wants to touch me and I cried ... it was Pchumn Ben last year ... we invited monks to my house to conduct religious chanting ... and my cousin-in-law always played with me and I don’t like the way he played with me ... and I know he has a wife and as a woman he should not play with me like that. He often comes to hug me and touch me. And I am angry with him and cry and I told him ‘you should never play like that with me because I am a woman and you are a man and already have a wife ... I told you many times already why are you stubborn?’ But he only smiles but since then he stops playing with me. I said if he speaks to me that’s ok but if he touches my body, he cannot” (F04, 23 year old woman with mobility impairment).*

*“He [my husband] said things like ‘don’t you dare think you can live without me just because you have others help you’ and sometimes he is almost violent with me ... I called the police but they said they would only help me if I have scars or bruises that are caused by my husband ... It was very embarrassing for me whenever we have an argument ... so I have become determined that I would never let others look down on me anymore because I’m earning my own living ... [he has never been violent] but he*

*has threatened me and I also filed a complaint at the village and commune” (F17, 30 year old woman with mobility impairment).*

Irrespective of whether women with disabilities experience abuse, single women with disabilities felt unsafe and are afraid of rape:

*“I am afraid of bad rumours from my neighbours ... they may laugh at me ... I am afraid of rape” (F23, 35 year old woman with mobility impairment).*

### **Women who remain single and are childless**

Just over a third (9 or 25 women or 36%) of female informants were single and childless. If they remain single when they are past the age of marriageability, they are exposed to a range of risks and vulnerabilities across the lifecycle, including physical and verbal abuse, violence and rape. Being unmarried and childless has significant life-long implications for women’s social and economic wellbeing and quality of life. Among our informants, women with disabilities who never married, are childless and without social support experienced the greatest vulnerability and were most at risk of violence, poverty and social discrimination. When disability combines with lack of natal family support, the absence of a husband and children, landlessness and poverty, women with disabilities depend upon the pity and kindness of others to help them. The experience of a 58 year old woman with mobility and visual impairments demonstrate the multiple stigmas and disadvantages she experienced prior to her marriage in her late 40s. As she explains:

*“I married at an old age. If I married when I was young, I may have children ... but because I am looked down on, that’s why I got married at an old age ... just to support ... while I stay alone, I was looked on and didn’t have a house ... the neighbours used to speak ill about me, they looked down on me as I am weak and stay alone at night ... they often violated me ... stole my earrings ... but I didn’t know where to go as I am poor and struggle to live alone ... and the one who stole my chickens at night, they came to hit me...” (F12, 58 year old woman with mobility and visual impairments).*

Although this woman was one of thirteen siblings, all but two disappeared and have not been heard of since the Khmer Rouge regime in which 1.5 – 2 million people died<sup>11</sup>. In the early 1980’s, she had to sell her families’ land when both her parents were seriously ill and later died. She was left landless, and without parents, siblings or a spouse, and migrated to Kampot to work as an agricultural labourer living on someone else’s land, where she stayed for 20 years. Living alone as a poor, single, disabled woman made her an easy target for abuse by fellow villagers:

*“While I was alone, they wanted to curse me ... accuse me ... they [villagers] call me ‘blind’<sup>12</sup> and I don’t dare to come out [from the house] ... I knew who they were [those who came to verbally abused me], but I dare not say [anything] to them ... because I am alone and afraid they will [further] abuse me ... I am disabled and alone” (F12, 58 year old woman with mobility and visual impairments).*

---

<sup>11</sup> The Khmer Rouge regime last for 3 years, 8 months and 4 days between 1975 and 1979. All cities were evacuated as part of a radical Maoist plan to transform the country into an agrarian society. Educated people were targeted for killing as they were seen to be enemies of the regime and many died due to starvation, disease and torture.

<sup>12</sup> “Qua” is a derogatory term for blind.

Three or four years ago she made the decision to marry as a second wife as one of the few strategies available to protect herself from the verbal and physical violence, and social discrimination she was experiencing as a poor woman with disability living alone. She described that as a married woman she feels more secure and villagers have stopped looking down at her:

*"[I] have no feeling of loneliness ... I feel stable with him [my husband], I am not afraid ... if there is a male in the house, thieves do not dare to do such things" (F12, 58 year old woman with mobility and visual impairments).*

Her husband is known to have other women in addition to his first wife and currently requires full-time care following a stroke two years ago. Even though she is now married and caring for her husband, she still worries about having land to live on when he dies because she continues to live on land that is not her own:

*"I live on someone's land, and in the future, I may not have a place to stay" (F12, 58 year old woman with mobility and visual impairments).*

Marriage provides all women, including women with disabilities, with a sense of economic, social and physical security that they do not have when alone. To achieve this, women, particularly older women with and without disabilities, have few options and may choose marriage to men that others would not accept as a pragmatic solution to their vulnerability. For example:

*"Maybe she is a bit old, poor and no one helps her ... her children have moved away ... that why's she lives with him (woman who married man with HIV) ... she wants someone to help her to do rice farming and that man loves her (F15, 41 year woman who is HIV positive).*

These cases demonstrates that when poverty, being unmarried and childless combines with disability, women are particularly vulnerable and at greater risk of violence and abuse than others.

## **Key points**

### **Individual level barriers that increase risk and vulnerability**

- Women, who remain single when they are past the age of marriageability, are exposed to a range of risks and vulnerabilities across the lifecycle.
- Women with disabilities, who never married, are childless and without social support experienced the greatest vulnerability and were most at risk of violence, poverty and social discrimination.
- When poverty, being unmarried and childless combines with disability, women are particularly vulnerable and at greater risk of violence and abuse than others.
- Women with disabilities are afraid, feel vulnerable and maybe without financial resources and social support to call upon when required.
- Single women with disabilities felt unsafe and are afraid of rape.

### **Family / societal level barriers that increase risk and vulnerability**

- Verbal and physical abuse happens on different levels (spouse, other family members and fellow villagers).
- Women with disabilities are seen to be easy targets for abuse and violations by men.
- Women with hearing, visual and developmental disabilities are particularly vulnerable as perpetrators think they are unable to retaliate, scream or tell others.

#### **Individual level facilitators to reduce risk and vulnerability**

- Women with disabilities also made their own decisions regarding whether to marry or not, once they had received a proposal.
- Access to information about safe sex, informed decision-making and sexual rights is particularly important for young women who are migrating for work.
- When women with disabilities respond to inappropriate physically abusive and threatening behaviour proactively and assertively, they demonstrate that they are aware of their rights as women.

#### **Family / societal level facilitators to reduce risk and vulnerability**

- Not all women with disabilities encounter stigma and discrimination. Poverty, age and marital status amplify stigma
- When spouses and other family members support of men and women with disabilities, they have greater socio-economic and cultural security.

#### **Recommendations:**

- Positive and inclusive images of women with disabilities as wives and mothers need to be shared widely to begin to change culturally dominant stereotypes.
- Support SRHR education through role model approach.
- Promote women with disabilities knowledge of and access to appropriate sources of support by local Authorities, the police and the law when domestic and other forms of violence occur.
- Promote women with disabilities' knowledge of their rights as women to safety and freedom from fear.

## 4 – Contraception, pregnancy and childbirth

Men and women with disabilities could name different types of contraception that are available locally, and that their wives, they and other women in their village use: the pill, injections, implants, intrauterine devices (IUDs), condoms, natural methods and less often tying tubes. They did not know how the different types of contraception work in the body to prevent pregnancy but generally knew how to use contraception effectively, a pattern mirrored in men and women more generally.

### Learning about contraception

Men and particularly women with disabilities learn about different types of contraception, their usage, advantages and disadvantages through their social networks of family, friends and neighbours, just as their non-disabled counterparts do:

*“We often talk about birth control when we have gathering for chatting ... like when someone knows some information about IUD, they come and share it with us and we are able to learn like that. And we got to know information about people who used IUD” (49 year old woman with mobility impairment).*

*“Other people [women] were also using the contraception method [injections] ... same as me ... and they told me that if you want to guarantee [not getting pregnant] you should go to the Doctor too” (F03, 52 year old married woman with mobility impairment).*

On marriage, women and men learnt about sexual and reproductive health. For example:

*“When I had a husband I learnt about sexual and reproductive health ... before I felt shy. Even my age was old already [she was over 40 when she married], I did not know much about that ... I did not know at all. I only know since I have a husband” (F09, 49 year old married woman with mobility impairment).*

*“I didn’t know yet (about contraception) until I was married. After [I was married for] 1 or 2 years, I heard there is a contraceptive pill ... I never used it” (F11, 48 year old married woman with mobility impairment).<sup>13</sup>*

Following the birth of the first child is the first occasion when information about family planning and different types of contraception is routinely provided to new parents. It is a common time for couples to start using contraception, but older informants tended to start using contraception after the birth of their final child. For example:

*“I did not use contraception between pregnancies ... I didn’t use anything because I didn’t know” (F01, 42 year old woman with mobility impairment who had her children in the early 1990s).*

---

<sup>13</sup> This particular woman never used contraception and never got pregnant.

*"I never used contraception after our first and second child ... but I took the pill after our third child ... my husband told me to take space between our children" (F15, 41 year old HIV positive woman).*

Informants in their 40s recalled that when they got married and started having children, there was no contraception or health centre, and they did not know how to space their births:

*"At that time [1980s] there was no contraception at all ... [I had] three kids in three years and two kids in two years ... when contraception came it was too late already..." (F03, 52 year old woman with mobility impairment).*

*"There was a time [when I didn't want to get pregnant] but I didn't know how to control it (F14, 53 year old woman with visual impairment).*

In contrast, of the three married female informants in their 20s, one knew how to birth space prior to marriage:

*"I knew about contraception before I got married ... [I was] educated at the pagoda by an NGO" (F19, 25 year old married women with mobility and neurological impairments).*

One married informant in her twenties started using contraception prior to the birth of her first child, whilst the other two women waited until after their first child was born. For example, a 24 year old woman started having injections five or six months after she married, and two informants having just given birth, are planning to recommence using contraception as soon as they start menstruating again.

Women often based their choice of contraception on the advice and experiences of family and friends:

*"My sister-in-law told me about injections so I chose this way" (F02, 25 year old married woman with mobility impairment).*

*"[I am] taking the contraceptive pill ... following my friend" (F05, 43 year old woman with visual impairment).*

The advice of health centre staff and other health professionals is also important to women's choice of contraception:

*"The doctor just told me that an injection can protect me from getting pregnant" (F15, 41 year old HIV positive woman).*

When asked how contraception works, respondents explained how they use them:

*"I have a shot (injection) every three months" (F02, 24 year old woman with mobility impairment).*

*"I only know how to use the pill ... I know the others [contraception] and that when I use contraception I will not have a baby" (F01, 42 year old woman with mobility impairment).*

*“You take the pill every month ... but I do not know how it actually works” (27 year old deaf woman).*

*“I shot (injections) every three months for ten years ... I stopped using contraception now ... I have no more periods ... they finished 2 years ago” (F03, 52 year old woman with mobility impairment).*

Women did not always use contraception correctly however. For example:

*“I got 4 injections ... I didn’t get injections every 3 months. But the 4 injections were for 2 years” (F01, 42 year old woman with mobility impairment).*

*“If I took pills, I was afraid I would forget to take them ... I heard they said this ... [natural method] is easy ... we don’t have to take any medicines ... just do not miss” (F08, 44 year old woman with visual impairment).*

Very few informants knew how at least one type of contraception actually works in the body to prevent pregnancy, a finding that is likely to be the case for non-disabled men and women too. Men and women had the greatest understanding of how the withdrawal method works to avoid pregnancy. No informants had knowledge of how the pill, injections or implants or the calendar method work. For example:

*“I know that it can prevent pregnancy, but I do not know how ... that is what people said ... that is all I know” (F09, 49 year old married woman with mobility impairment).*

*“The pill is 100 percent effective ... we do not have to worry whether we will have kids or not. We don’t know how they [contraception] work but they work” (FGD, men with disabilities).*

While women were clear on how the withdrawal method works, they were less certain about the calendar method, and did not feel confident using it. In fact, only one woman reported using it:

*“I said [to my husband] about using condoms because I don’t know how to calculate [calendar method] but he says no need to use condoms ... wait and use calendar method ... when I asked him he says he doesn’t want to use [condoms] ... I don’t understand him ... he says it is not comfortable ... I just feel afraid of having a baby [when not use condoms]” (F06, 45 year old woman with mobility impairment).*

Condoms are not widely used and only one informant reported regularly using condoms. This informant and her husband are both HIV positive and only started to use condoms after they were diagnosed. Condoms are associated with sex workers and some informants stated that they do not use them with their husbands because they trust their husbands:

*“I never use [condoms] and my husband never used [them] too because he only stays at home and never goes to other places ... I never use it so I don’t know what the advantage of it is” (F06, 45 year old woman with mobility impairment).*

Our data reflects men’s reported preference for natural methods as they are concerned other ‘modern’ types of contraception negatively impact on women’s health:

*“Husbands prefer natural methods and are afraid that modern methods affect women’s health” (FGD, women with disabilities).*

Both men and women expressed interest in learning more about natural methods of birth control.

### **Decision-making about contraception**

Men and women with disabilities reported that they discuss which contraception they will use with their spouse but men see contraception as their wives responsibility. The male DPO staff member who participated in this study described how men are *“not so interested in contraception as it is a woman’s decision” (field notes, 11/9/15)*. Although men and women with disabilities state that they discuss contraception with their spouse and that they decide together which type the woman will use, women ultimately decide:

*“Let the wife decide ... because decisions about contraception are hers” (M04, 35 year old single man with mobility impairment).*

*“I think I [would] follow my wife [choice of contraception]” (M08, 25 year old single man with visual impairment).*

*“My wife decided upon conception” (M07, 38 year old married man with mobility impairment)*

*“She decided by herself. After we discussed it, I said to her ... whatever you want ... pills or injection” (M09, 31 year old married man with physical impairment).*

*“My wife made the decision” (M13, 46 year old married man with mobility impairment).*

*“I talked to my husband about contraception I said ‘I think I want to use pills’ ... he didn’t say anything ... he said ‘if you want to use them, use them’ (F19, 25 year old married woman with mobility and neurological impairments).*

### **Patterns of contraception use**

Among our 15 married female informants, most women had used injections (23%), the pill (14.8%) and natural methods (14.8%), while 23% (6) had never used contraception. Of those who have never used contraception, one woman and her husband have never been able to get pregnant and are childless (F11); two married when they were over 40 years of age (F09, F12), one woman was sterilised after complications with her last birth (F06); one will commence contraception when her periods return after just giving birth (F19) and the remaining woman has given birth 5 times is now post menopausal (F14).

At the time of interview, 11 married women were using no contraception at all partly reflecting the average age of informants as 36.96 years. Of the remaining four informants one is using each of the following: the pill, injections and an IUD, and one has been sterilized. Of those not currently using contraception, four are menopausal, two have just given birth, two want to get pregnant, one does not have sex with her husband as he works away from home, and two are in their early 40s. These findings suggest that women with disabilities are less likely than non-disabled women currently be using contraception. The

CDHS 2014 found that 40.2% of urban women and 44.3% of rural women were not using any contraception (NIS/MoP, 2015:12).

### **Contraception and side-effects**

Women change contraception type if they experience negative side effects and health service providers encourage women to swap methods if they are experiencing too many side effects. Natural methods seem to be advocated for by health providers as the contraception choice of last resort when other contraceptives are causing women problems:

*“They [health centre staff] said if you don’t have result from pill or injections ... you should use natural methods” (F16, 27 year old woman with mobility impairment).*

*“I tried the pill and injections but they didn’t work for me ... [The] doctor [at the Commune Health Centre] said I don’t have to use any birth control method ... I can use natural methods” (F25, 34 year old woman with mobility impairment).*

Many women experienced problems with contraception, primarily bleeding, which women found diminishes their ability to perform hard physical work. Women identified different patterns of contraception use in rural and urban areas, where village women use injections and the pill more than IUDs as these contraception types enable them to continue the heavy agricultural work that they must do. IUDs were associated with bleeding and other problems including dizziness. Women who live near the market (i.e. urban areas), mostly use IUDs and implants, rather than the pill,<sup>14</sup> as they do not do the same amount of heavy work as rural women:

*“Very few of them [women with disabilities] use IUDs and implants ... for disabled women who have prosthetics ... they don’t like to use IUD and implants because they are rice farmers and have to do rice farming and work hard, carry water and chop firewood ... and people near the market, they mostly use IUD and implants, not the pill ... IUDs and hard work do not mix and it affects women’s health” (FGD, women with disabilities).*

*“[After I starting using] the IUD, I bled constantly ... and I could not work was I am constantly washing my clothes ... I bled for two months ... with the IUD ... I felt hot at night” (F05, 43 year old woman with visual impairment).*

*“I used an IUD and I had to work hard, and it affected my health ... and then I bled ... and sometimes I ached all over my body. So many people do not really use IUDs because most of them have bleeding ... near my house there are many...” (FGD, women with disabilities).*

*“If we use the pill it doesn’t affect our health” (FGD, women with disabilities).*

Women reported other side effects with contraception the last one of which – weight gain was viewed positively by rural-based informants in this study:

---

<sup>14</sup> Women’s perceptions of contraception use equate with findings from the CDHS (NIS/MoP, 2015:12) that found more urban than rural women use IUDs (5.0 versus 4.3% respectively), less urban and more rural women use the pill (13.3 versus 18.3% respectively).

*“After I used the pill, I bled so I changed and used injections ... I used injections and I had no periods for about 2 years ... I felt difficult in my body. I had no strength ... I felt tired” (F01, 42 year old woman with mobility impairment).*

*“When I had my youngest child, I took the pill ... then the doctor recommended me to get injections because I was bleeding a lot” (F15, 41 year old HIV positive woman).*

*“Injections made me skinny ... it [the injections] eat up my blood and made me dizzy” (F16, 27 year old woman with mobility impairment).*

*“I took the pill but my body had a reaction with the pill too. It made me vomit and dizzy so I decided to stop taking it ... the doctor said if I couldn’t take the pill then I should stop ... use natural methods the doctor said” (F25, 34 year old woman with mobility impairment).*

*“The pill makes her fat ... it is good health and have no negative side effects” (M07, 38 year old man with mobility impairment).*

*“I got fat with injections and lost my sex drive” (F03, 52 year old woman with mobility impairment).*

Women want greater access to knowledge about which type of contraception is most likely to suit their needs.

### **Misconceptions about contraception**

There are many misconceptions about contraception that demonstrate poor understanding of how the body works physiologically, of health generally and particularly of reproduction and sexual health. The following quotes illustrate the range of beliefs from contraception having an overall negative effective on health to causing illness and difficulty giving birth. These myths circulate through social networks of family, friends and neighbours at the village level:

*“I am afraid that [with an IUD] our health is not healthy ... so [I am] afraid to use an IUD and I get side effects” (F08, 44 year old woman with visual impairment).*

*“I heard from older people that you shouldn’t use contraception the first time [you have sex] because it causes difficulty with delivery” (M04, 34 year old man with mobility impairment).*

These misconceptions shape women’s and men’s behaviour and increase men’s and women’s reticence to use types of contraception they are worried will have negative side effects. There is also misconceptions and poor understanding about condom use with some men and women unaware that condoms can be used for birth control. Women with disabilities who participated in the FGD had particularly poor understanding of condoms, which is not surprising given that all of them were single and only one had ever been married but had divorced more than 20 years ago:

*“[I] did not know condoms work to prevent pregnancy” (FGD, women with disabilities).*

*“Condoms can cause inflammation of the uterus” (FGD, women with disabilities).*

*“Condoms spread AIDS and they are not so good and affect the ovaries” (FGD, women with disabilities).*

*“I know about condoms to prevent illness but not for birth control” (M09, 31 year old man with physical impairment).*

Furthermore, there is confusion around condom use and infection with HIV/AIDS, and no doubt other sexually transmitted illnesses:

*“When people are talking and someone comes and says that using condoms is not good because you will get HIV/AIDS ... when people hear things like this, they are afraid of using condoms ... Condoms are not widely used now and not so much information [is around] about them as there was before when HIV/AIDS awareness raising was big ... so people are more knowledgeable and they have started to reduce their use of condoms” (FGD, women with disabilities).*

Men and women with disabilities consistently suggested that more regular village-based face-to-face information sharing for men and women is required. Face-to-face delivery of information is the preferred method of communication as it allows men and women to ask questions and to fully understand the information being delivered. These sessions should be for men and women generally, and not just for persons with disabilities or married persons with children. Information on all forms of contraception, their use, how they work in the body to prevent pregnancy, needs to be included, as well as information on the management of side effects and general health information.

### **Pregnancy and childbirth**

The multiple impacts of disability on capacity to work, earn an income to feed and support children is an important factor that women consider when making decisions about the number of children they will have:

*“I discussed with my husband ... I said ‘I am disabled if we have kids we only have two ... and he replied ‘I am okay with that’” (F11, 48 year old woman with mobility impairment).*

*“I’m a disabled person and I don’t know what I can do to feed them [children] ... it’s hard to raise them ... so [I] only want three kids” (F25, 34 year old woman with mobility impairment).*

*“[I] want two children and then we will stop ... my husband also wants this many” (F02, 25 year old woman with mobility impairment).*

When pregnant, some women with disabilities were not even aware they were pregnant. They did not realise the symptoms they were experiencing were those of pregnancy as they had never learnt about sexual and reproductive health, and being deaf meant they had not learned by listening to the informal conversations of others. For example:

*“With my first baby, I didn’t even know that I was pregnant ... I was really busy and sleeping a lot and sick and my tummy was growing but I didn’t really know that I was pregnant (FGD, deaf women).*

Pregnancy and childbirth were a physical challenge and when babies were young carrying them was difficult, for those with mobility impairments:

*“When I was pregnant, it was so difficult ... my hands and legs couldn’t do anything ... they were all painful” (F19, 35 year old woman with neurological impairment).*

*“As I’m a disabled person like this, getting pregnant and giving birth is not an easy thing to do. I have no legs to support me during labour and it was too hard for me” (F17, 30 year old woman with mobility impairment).*

Other women worked too hard whilst pregnant and one informant had a miscarriage at five months:

*“I was working too hard when my husband was not at home ... carting water and splitting wood ... then I felt pain and bled and went to private clinic” (F16, 27 year old woman with mobility impairment).*

Women’s birthing practices have rapidly shifted from women delivering their babies with traditional birth attendants at home, to delivering with trained midwives in health centres or hospitals. Women who gave birth up until the late 1990s and early 2000s were likely to have delivered at home, and women with disabilities’ experiences replicate this trend toward away from home births to health centre and hospital-based birthing:

*“I saw other people and they were delivering their babies at home too, so I thought there is no need to go to the hospital” (F08, 44 year old married woman with a visual impairment).*

Older informants, which are women who are now in their 40s, reported that there was no health centre to go to when they gave birth in the late 1980s and 1990s. They had no choice but to birth at home. For example:

*“All [my] children were born at health centre ... but with first child there was no health centre ... so I gave birth at home” (F05, 43 year old woman with visual impairment).*

Since 2000 however, the Cambodian Government has actively encouraged women and given incentives to health centre staff for each delivery (MoH, 2012). More recent births have thus taken place at health centres or district hospitals, and in cases of complications, women tend to go to the private hospitals in the provincial capital:

*“All of my births were with the traditional birth attendant at home ... but the last one [I] had a caesarean at Takeo hospital when the baby was seven 7 months’ ... the doctor said I have to cut open and get foetus out. I can’t keep this foetus ... because I bled – this was in 1994” (F06, 45 year old woman with mobility impairment).*

As with other decisions around sexual and reproductive health, information is gained through social networks and information from the health centre, and decisions are based upon this information. For example:

*“I told my neighbours that my wife is pregnant and they had delivered at Kampot hospital, so we will go there too” (FGD, deaf men).*

### **Ante-natal and post-natal care**

Women with disabilities attended antenatal and postnatal care (ANC/PNC) at the health centre and they were adequately supported by their husbands and relatives to do so. They wanted to ensure that their babies were healthy, immunised and did not develop impairments and thus were keen attendees at ante and post-natal care:

*“Women with disabilities go [for ante-natal care] not matter how hard it is. They have to go because we are disabled so we can’t let our children get disabled and be like us” (FGD, women with disabilities).*

*“The first baby ... I also checked ... When I was pregnant, I went three or four times ... they checked our health and gave me iron tablets. I saw my aunty went to the health centre for checking when she was pregnant, so I went too ... I also saw ads on the TV and heard it on the radio” (F08, 44 year old woman with mobility impairment).*

*“I visit the doctor every month [for ANC] ... and [after gave birth] they [health centre staff] instructed me to get an injection every month ... after the baby was born we took it to health centre ... to get my child an injection” (F02, 25 year old woman with mobility impairment).*

*“Three months ... three times (ANC) ... I visited the health centre and they gave me iron pills ... I went four times during nine months of pregnancy” (F05, 43 year old woman with visual impairment).*

*“When I was pregnant I went three times” (F19, 25 year old woman with neurological impairment).*

Older women who gave birth with traditional birth attendants did not attend antenatal or postnatal checks, but may have attended for their most recent birth or if they had a problem:

*“I went to the health centre almost every month [for ANC] with the last pregnancy after death of my second baby ... [I was] afraid to [lose another] baby ... we had lost one already” (F08, 44 year old woman with mobility impairment).*

*“I didn’t do checks for all my four kids ... just the last one I went to hospital when I got pain” (F06, 45 year old woman with mobility impairment).*

### **Child mortalities**

Of the 25 women in this study, a total of 38 children were born, of which 5 died within 2 months of delivery. Our female informants have an average of 1.26 children per woman, well below the national average of 2.7 children per women and 2.9 in rural areas (NIS/MoP, 2015). Three women had babies who died (two women both had two babies die); just under a third (5 of 38 children or 13%) of babies born to women with disabilities died. This high figure reflects high national child mortality rate during the late 1980s and early 1990s.

The three women who had child mortalities are all in their early 40s now, and their babies died in the late 1980s and early 1990s. Three babies died because there was no doctor available or the baby died on route to the hospital:

*“[There was] no doctor ... only the Khru Khmer<sup>15</sup> ... he treated my child with medicine but it still did not work and the baby died at 12 days ... it was said that a piece of rice was on the edge of the baby’s mouth ... [The Khru Khmer said it was] same for both babies” (F05, 43 year old woman with visual impairment).*

*“[My] second baby died when [it was] two days old ... [the baby] didn’t get to the hospital in time” (F08, 44 year old woman with visual impairment).*

*“One died at two months from measles in 1987” (F06, 45 year old woman with mobility impairment).*

The remaining baby died from pregnancy complications when the mother was seven months pregnant. She experienced bleeding and was taken to hospital for a caesarean. She lost consciousness on her journey to the hospital and on arrival the doctor advised her husband and mother that she should be sterilised at the same time, which they consented to on her behalf. The doctor had explained to them that if she did not have a hysterectomy, she would likely die. She explains:

*“[The] second death was in 1994 at seven months pregnant ... I was sterilised when I had the caesarean ... so I can’t have babies anymore ... I didn’t know anything because I was in a coma for two days but after the caesarean my mother told me that the doctor had sterilised me already. ... [B]efore the caesarean the doctor asked my mother and husband and they decided to let the doctor sterilise me ... I didn’t know what sterilisation was ... [After this] I thought I wanted more kids if I could ask the doctor to undo it ... I talked to the doctor and asked if I can have any more children ... and I told her that I am sterilised already a year ago ... can I undo the sterilisation? And she said I couldn’t have kids anymore because I was sterilised ... and my husband said that if the doctor can undo the sterilisation, let the doctor undo and we have more kids” (F06, 45 year old woman with mobility impairment).*

### **Unwanted pregnancies**

Women knew where to go if they had an unwanted pregnancy that they wanted to abort. They learnt from other women and through their networks. Furthermore, the local NGO Reproductive Health Association of Cambodia has an office in Kampot that some informants had visited with relatives for other reasons. Two informants had had abortions; one woman has had three abortions in two years following the birth of her fourth child, a clear indication that she was not given adequate and effective information on contraception after her last birth and during abortion services. After her last birth she and her husband used natural methods:

*“I had three abortions after my four children were born ... he [my husband] didn’t do anything bad to me just about we are poor and lacked things ... I think I am a disabled person ... I am afraid I can’t feed my kids and if they are sick ... it is so difficult and I pity my children [so I had an abortion]” (F01, 42 year old woman with mobility impairment).*

---

<sup>15</sup> A Khru Khmer is a traditional Khmer healer.

After her first abortion, she followed the doctors' advice and used natural methods of contraception, had an accident, got pregnant and had another abortion.

*"The doctor advised us to use natural methods during sex [withdrawal] and I have to be careful not to let the sperm in ... but sometimes we missed our plan ... so the doctor advised me again to use the pill but I was bleeding the whole month so I stopped taking the pill ... then the doctor said I should use injections ... after the abortion ... I felt pain ... and vaginal discharge, cervical metritis and I got sick ... the doctor said because I had too many abortions so it caused cervical metritis ... I went for treatment at hospital and when I recovered from these problems the doctor told me to use injections" (F01, 42 year old woman with mobility impairment).*

Furthermore, she feared that their baby would contract Hepatitis B from her husband and again decided to have an abortion:

*"My husband was sick very often and then after we did a blood test we found out that he had Hepatitis B ... the reason [I had an abortion] is that I was afraid that this virus will transmit to the baby in my womb ... whether it transmits or not I am not sure" (F01, 42 year old woman with mobility impairment).*

Poverty was also the reason another informant took the abortion pill:

*"I took that abortion pill by myself and I was very sick ... I took the abortion pill because we have nothing to eat, we were so poor. The doctor told me to buy it and she/he told me that if I was only one month pregnant, I could just take the pill but I got sick since that time" (F15, 41 year old HIV positive woman).*

Women required more information on safe abortions:

*"[Women] take the pill when they have an unwanted pregnancy or they don't want to keep it. Mostly they have a lot of bleeding ... now people go to the health centre ... but sometimes the foetus did not come and they become disabled ... when people go for abortion [with the traditional birth attendant] at 6-7 months pregnant (F09, 49 year old woman with mobility impairment).*

### **Pre-marital and extra marital sex**

The majority of our informants had their first sexual experience with their spouse on marriage. There was only a few examples of pre-marital sex among interviewees, and in all cases it were men with disabilities who had either sex prior to or outside of marriage. In these cases the men involved were working as policeman or soldiers at the time, and both professions are associated with the use of prostitutes and carry considerable social power and prestige. The promotion of safe sex and condom use among this group would be useful to prevent sexually transmitted diseases including HIV.

Only one informants' husband had slept with another woman and she consequently contracted HIV from him. She was not angry or upset with him, but rather accepting his behaviour:

*“I knew that my husband had other partners but I couldn’t stop him as we love each other and he couldn’t stop it either if he was still working ... I am okay with it ... and I didn’t get angry” (F15, 41 year old HIV positive woman).*

## **Key points**

### **Individual level barriers to contraception and reproductive health services**

- Travel is a barrier. For example it is hard to get information if you have to go to the health centre and get the different types of contraception explained to you. They have to depend upon others to give them a lift to the health centre.
- Women’s and men’s knowledge of how contraception works in the body to prevent pregnancy was poor.
- Women did not feel confident using the calendar method.
- Condoms are not widely used and women do not use them because they trust that their husbands are not having sexual relations outside of marriage.
- Men are concerned about negative impact of modern contraception on their wives health.

### **Family / societal level barriers to contraception and reproductive health services**

- Contraception is seen as a woman’s responsibility and women make the final decision regarding choice of contraception, even though women and men discuss contraception decisions together.
- Misconceptions about contraception demonstrate poor understanding of SRH.

### **Individual level facilitators to access contraception and reproductive health services**

- Women with disabilities attended antenatal and postnatal care at the health centre and they were adequately supported by their husbands and relatives to do so. They wanted to ensure that their babies were healthy, immunised and did not develop impairments and thus were keen attendees at ante and post-natal care.

### **Family / societal level facilitators to access contraception and reproductive health services**

- Following the birth of the first child is the first occasion when information about family planning and different types of contraception is routinely provided to new parents.
- Women often based their choice of contraception on the advice and experiences of family and friends, and recommendations from health centre staff and other health professionals.

## **Recommendations**

- Women’s and men’s knowledge of how contraception works in the body to prevent pregnancy as well as basic understanding of reproduction and bodily anatomy could be improved.
- Promote condom use and knowledge of HIV and STI prevention.
- Raise men’s awareness of their role and responsibilities in family planning and to support their wives’ decision-making.

- Support awareness raising on village level, specifically through face-to-face activities and ensure wide participation of married/non-married couples, persons with and without disabilities and single and non-single persons.
- Increase women's knowledge of different types of contraception so that they can make informed decisions as to which is most suitable for them.
- Women require more information on safe abortions.
- Health care professionals need to consistently provide women with family planning information follow abortion care.

## 5 - Access to and experiences of health services

Men and women with disabilities access to and experience of health services depends upon an individual's capacity for independent movement, access to financial resources and the availability of support. For men and women who require assistance to get to the health centre the availability of others - a spouse, children, siblings, parents, relatives and/or friends to accompany them is critical.

Our data suggests that single women with disabilities, particularly those over 30 years of age, and who in the absence of disability would likely be married already, have the greatest difficulty in getting to the health centre and thus have the poorest access to health services. Several female informants had never even been to the health centre and if they are sick they buy medicine in a local shop, take traditional herbs or are patients with their pains. Male informants with mobility impairments, the majority of whom were married or in their early 20s and living with parents, were able to get to the health centre when and if they required.

Although deaf men and women could physically access health services, communicative accessibility was absent as the majority of deaf people are generally both sign and Khmer language illiterate. Without sign language interpreters and in the absence of written Khmer, consultations with health centre staff were confusing, and deaf men and women gained little information or understanding. Some of our deaf informants had been to the health centre once or twice, but decided not to return again as they gained so little. Others had never been to the health centre.

Informants suggested the provision of a travel fund to cover travel costs, ramps and the employment of persons with disabilities and sign language interpreters at health centres would enhance access and the effectiveness of health services. Given low levels of sign language literacy at the village level however, visual sign boards would also be a useful communication aid.

### Physical access

Men's and women's health seeking behaviour reflect patterns in the general population: they will only visit the health centre if they are sick and are not aware of the need for check-ups, particularly in the area of sexual and reproductive health. For example:

*"I was fine in my body, so I didn't go [to the health centre]" (F08, 43 year old woman with visual impairment).*

The first barrier men and women with disabilities encounter when they want to go to the health centre is transportation to get there. If they are able to walk or have means of transportation such as a motorbike or bicycle, they can go alone even though this may be difficult. For example:

*"I dare not to walk a lot ... we are not brave ... I shake ... normally if they have legs they can ride a bicycle ... I can't ride anything..." (F01, 42 year old woman with mobility impairment).*

If they require assistance to get to the health centre, they are dependent upon others to help them. Only two of our male informants were in this situation; most (9 of 11) had mild mobility impairments that did not impact upon their capacity for independent movement.<sup>16</sup> Female informants who required assistance to get to the health centre found this difficult:

*“If you are a person with a disability ... [we have] difficulty travelling to the health centre ... and many difficulties ... [I] need to find someone to take me” (F04, 23 year old woman with mobility impairment).*

Women found finding someone to take them to the health centre was difficult because others were busy and asking for help is not easy and nor always forthcoming. The following quotes illustrate the multiple individual and social barriers women face when they want to get to the health centre: they are unable to travel alone because of their impairment; family members are often busy and unavailable to help them as guides, and they do not like to ask for what they feel is too much:

*“If no one drives us there, and in our mind we really want to do it and go today, and we haven’t seen anyone around we could ask to drive us, then we still cannot go because we are unable to travel” (FGD, women with disabilities).*

*[When I go to the health centre] I follow other people when they walk there ... if there are no other people, I do not go ... I ask my younger siblings to take me to the health centre ... and if not ... I ask my older sibling instead ... I can’t go by myself ... if I am alone I don’t go” (F08, 43 year old woman with visual impairment).*

*“It is difficult to get help ... it is difficult in everything frankly speaking. If we have to travel from home ... [it is] difficult having to wait for a time that suits the driver, like my brother or whoever” (FGD, women with disabilities).*

*“Nobody brings me [to the health centre] ... they are busy with their business. I can only ask them for a little bit of help ... sometimes yes, sometimes not” (F23, 35 year old woman with mobility impairment).*

*“If we are blind, we can’t travel by ourselves. And when we ask for a driving service/ assistance, sometime the motodop is busy so they can’t drive us ... and they just drop us at the front entrance and leave us. I also need a guide ... we need children or someone to guide us ... and these are hard to find ... so we just try to stay home” (FGD, women with disabilities).*

In the absence of help to travel, women explained that they try to stay home, as the last quote above from the FGD illustrates. Staying at home means that women will purchase medicine locally, drink traditional Khmer medicine and “try to be patient” and bear the discomfort that they may be experiencing. For example:

---

<sup>16</sup> One of these two men was a wheelchair user who lived next door to a doctor and the other a man with intellectual impairment who lived with his elderly widowed mother and brother who also had an intellectual impairment.

*“When [I] was sick, [I] just bought medicine ... 1,000 ... 2,000 riel from the little health shop in the village” (FGD, women with disabilities).*

*“I do not want to trouble those who guide me ... I’m embarrassed, I don’t want to trouble them and so when [I’m] in pain [I] drink Khmer traditional medicine ... Persian lilac” (FGD, women with disabilities).*

*“If I have money, I buy [medicine] ... If I have no money, I just have to bear the pain” (FGD, women with disabilities).*

*“If [I] have no money ... [I] just have to live with my illness” (FGD, women with disabilities).*

*“[If it is] just a little pain ... I am able to be patient” (F01, 42 year old woman with mobility impairment).*

Even women who are able to travel to the health centre by themselves, prefer to buy medicine locally as it is convenient and cheap:

*“The health centre is very far and it is hard for me to travel back and forth ... so I only go the place near here where they sell medicine” (FGD, women with disabilities).*

*“When we get sick, to have a person to drive us ... we have to wait too long ... so we buy medicine [locally] to drink on our own...” (FGD, women with disabilities).*

Women also noted that their family, siblings and others prefer to purchase medicine for them at local shops as it is easier than taking them to the health centre to purchase medicine. Alternatively, the village doctor brings medicine to them:

*“My sister will buy medicine for me to and give it to me” (FGD, women with disabilities).*

*“They [relatives] prefer buying us medicine rather than driving us to the health centre” (FGD, women with disabilities).*

*“[The] health centre is far ... so village Doctor brings pills from the health centre” (F05, 43 year old woman with visual impairment).*

Poverty is also a barrier to accessing health service. Informants noted that even though health care services may be free, they still have to expend money to get to the health centre. For example:

*“It was difficult ... I thought that even though I got an interview [with the NGO] still I don’t have money to go [to the health centre] ... and they still charge us at health centre when we go ... I heard some people say that. So for the poor we face difficulty. They [NGO staff] said go without paying. But it is not true ... no money, how can we go? Like no money ... we have no money ... the poor don’t even have 1,000 riel. If we*

*have nothing [no money] ... we also can't go" (F01, 42 year old woman with mobility impairment).*

Another informant explained how money enables women to purchase the support that they require and thus work is critical to their ability to access resources, services and other opportunities:

*"They need someone to accompany them because they cannot walk and they need someone to hold them. And if they want to go far, they need to hire a motodop. If they have money they can hire one and it is easy. Money can bring us everything we want, as long as we have money we can hire people to go anywhere such as the market, hospital or other places ... it is most important that they have a job ... they have money and money can help them to do many things ... if they want to ask a nephew to take them somewhere ... just give a little money..." (F09, 49 year old woman with mobility impairment).*

Women with disabilities access to health services is thus poor, with some informants stating that they have never been to the health centre and/or hospital:

*"I have never been there ... to the hospital never once" (FGD, women with disabilities).*

*"[I haven't been to the health centre] I only stay at home. And when I was informed I have this stomach problem, it was when there was a group of medical doctors who came to the village, so I went there for a check up" (FGD women with disabilities).*

*"Because I am a disabled person ... I have never got any tetanus injections. I never got the injection or went to hospital at all before. And when I was pregnant I never went to the doctor for checking ... when I got sick most of the time I bought Amoxicillin pills or something like that, I heard other people [they] called it [an] antibiotic" (F01, 42 year old woman with mobility impairment).*

*"[I have] never been to the health centre ... no one understands me and so I don't understand anything ... so I just stay at home ... I have never been to the health centre before" (FGD, women with disabilities).*

Furthermore, for deaf men and women the lack of sign language interpreters and their illiteracy is an additional barrier. If deaf men and women have basic reading and writing skills, they could at least communicate a little with health professionals:

*"It is difficult because the doctor can't use sign language and we need a translator too ... and sign when we go to the doctor ... [otherwise] we don't really know what is going on" (FGD, deaf women).*

Deaf men and women left consultations not knowing what had gone on. In contrast, when a sign language interpreter was available, as was the case when visiting health clinics accompanied by NGOs staff such as Krousar Thmey, communication was easy:

*“It was kind of easy because Krousar Thmey had a centre that we could go to ... and it was accessible and had sign language interpreters” (FGD, deaf women).*

Greater access to learn sign language and Khmer, and then to sign language interpreters and to health providers who are willing and able to communicate with deaf men and women using written Khmer or visual communication methods, is urgently required to enhance deaf men’s and women’s access to health and other services. Improving deaf children’s school attendance to ensure they have basic literacy and numeracy skills would also assist them to communicate with others through writing.

Informants suggested that in order to address the challenges associated with having to travel to the health centre a budget to also cover return travel costs could be given to villagers on arrival at the health centre. Informants felt that this would make accessing health services much easier:

*“If there is budget for transport to the health centre that would be great ... to make it easier” (F11, 48 year old woman with mobility impairment).*

If transportation vouchers or other reimbursement schemes are available, there is a need to make eligible persons with disabilities aware of them.

### **Hierarchy of health seeking and decision-making**

Informants explained that financial resources, place of residence, severity of the illness and quality of care shape men’s and women’s, including those with disabilities, health seeking behaviour:

*“People from communities in remote places, if they have no money they go to the health centre, but for those who can afford it, they would go to the referral hospital ... and for those who live near the market, they don’t go to the referral hospital, they go the provincial hospital” (F09, 49 year old woman with mobility impairment).*

*“For those who are poor, [they] go to the health centre” (F10, 48 year old woman with mobility impairment).*

Men and women with and without disabilities choose private sector health care providers because they are seen to provide better services: you do not have to wait; they have better facilities, offer a broader range of services and medicines and are more attentive. Furthermore, they are very convenient and will come directly to the house if required:

*“For those who don’t want to wait, they go to the private clinic” (F10, 48 year old woman with mobility impairment).*

*“That medicine is not available at the public hospital” (F09, 49 year old woman with mobility impairment).*

*“I wondered what the cause of that was and so I went to a private clinic for an ultra sound ... I was in a lot of pain and didn’t want to wait” (F09, 49 year old married woman with mobility impairment).*

*“I never went to the health centre, but the big private hospital. The health centre can not heal my illness, I never got better when I went to the health centre [for her convulsions] ... private follow up is better for our illness than the health centre ... the doctor did not care so well [at the health centre], and they [private doctor] have more medicine to take to relieve the pain. When I was pregnant, I took the iron pill and it really made me feel a lot of pain, I did not sleep well at night ... The health centre doesn't have the equipment to do X-rays or ultrasound like private” (F19, 25 year old woman with neurological impairment).*

*“The health centre near here only has the service of inserting the IUD but they do not have a withdrawal service. For example when there were medical students/interns came, they would insert an IUD for us, but the health service has no withdrawal ... so we have to go to Kampot” (F17, 30 year old woman with mobility impairment).*

Women had also received inaccurate information and advice from public commune health service providers and consequently chose to go to the provincial hospital or to disregard the advice of public sector doctors altogether. For example:

*“When I went to check [the baby] at the health centre, the doctor said I couldn't deliver the baby at the (public hospital in Kampot) because I had cyst in my womb. But when I went to the public hospital in Kampot, the doctor said I didn't have a cyst at all. And also our health centre said that I will not give birth for another 2 weeks, so they sent me to the provincial hospital and when I arrived, I gave birth that night ... health centre said I had cyst and that I can't give birth” (F19, 25 year old woman with mobility and neurological impairments).*

*“The doctor only gave Paracetamol pills and it did not work. I didn't get better. I was sick and my weight was under 40 kilograms ... I asked the doctor ‘why am I not getting better?’ I told her ‘even though I took the medicine you gave me, I am still not getting better, it is still bleeding and now the blood seems to turn a white colour and it's a bit smelly ... she [the doctor] seemed quiet ... so I threw the OK Pill away” (F01, 43 year old woman with mobility impairment).*

*“When I didn't get pregnant for 3 years [after marriage] I went to the doctor and asked about this and the doctor said ‘your womb is very difficult to get pregnant...I never went again after that” (F10, 48 year old woman with mobility impairment).*

*“The doctor (at the health centre) did not give me any advice for me bleeding. The doctor also felt scared as the doctor was not experienced with putting in IUDs and then bleeding come and never stopped” (F05, 43 year old woman with visual impairment).*

If an illness is not treated effectively in the public system, a private health care provider will be sought. For more serious conditions private providers tend to be preferred:

*“For four or five years it [the seizures] were not so serious, but just these last two years, it was so serious, my mum took me to a big private hospital with a well recognised doctor in Kampot” (F19, 25 year old woman with neurological impairment).*

*“The IUD made me bleed ... the doctor said they would not take responsibility if I have any problems, but I still had them take out the IUD ... After it was out, I bled a lot and I went to private hospital and they gave me an injection and it stopped ... the doctor said bleeding would stop after [getting the] IUD out but it didn’t so went private” (F17, 30 year old woman with mobility impairment).*

Despite the misinformation and difficulties the women above have experienced, overall informants feel that they now receive more attention from public health care providers than they were given several years ago. They explained that following the work of NGOs, health providers are more aware of disability. For example:

*“When health centre staff see us at the health centre, a woman with disability, they rush to sell drugs to us – they prioritise us...even me, I arrived last but I got served first” (F05, 43 year old woman with visual impairment).*

*“They said [health centre staff] ‘I’m a disabled person and they’ve learned the rules and so they didn’t charge me” (F25, 34 year old woman with mobility impairment).*

Other informants recalled previous negative experiences at the health centre when their impairment has not been recognised illustrating that service providers had poor understanding of disability:

*“I told the doctor that I couldn’t see but they said “aunty, do not cheat the doctor”. Then the people who I went to the doctor with said, she is not cheating, she has a visual impairment ... it is true, she was planting rice by searching with her hands ... they were quiet and said ‘her eyes are open as normal’” (F08, 44 year old woman with visual impairment).*

*“When I went to the health centre they [health providers] didn’t believe that I’m a disabled person ... and they charged me .... I want them to acknowledge me as a disabled person ... they don’t believe that I am disabled person unless I have not arms or legs” (F02, 25 year old woman with mobility impairment).*

### **Men and women with disabilities suggestions for improvements**

Informants noted the need to raise awareness of disability and disability rights at the health centre and among teachers so that they encourage children with disabilities when they are young. Both men and women with disabilities requested that health information and sexual and reproductive health information is provided at the village level. For example:

*“If they would come to educate us in our village, we can make time if they tell us the date they would come to educate us ... because it is near, so it is easy for us to participate” (F17, 30 year old woman with mobility impairment).*

*“I want more information about birth spacing because ... some disabled women have a partner and they are so shy and they’re afraid to go the health centre ... And they live so far from the health centre, so we need information to come to the village level (FGD, women with disabilities).*

*“If there are village health agents it would be easier” (FGD, women with disabilities).*

*“I think we should promote it directly with them, so that sometimes, if they have a question, they can ask it and get an answer directly and we can explain it to them. Most important, to train them and do awareness raising them with directly – teach and train them how to use...” (F09, 49 year old woman with mobility impairment).*

Furthermore, access to information and understanding of sexual and reproductive health is poorer in rural but particularly remote areas and these areas must be prioritised.

*“We need awareness raising at the community level in remote communities because if we talk about people living around here [the district town] ... mostly, they understand ... and if they don’t understand they will ask each other about this and that. But for those in [the] community, if they sometimes don’t understand what the benefits are from that [brochure] ... even though they receive information, they don’t understand, they just throw it away ... they need brochures **and** face-to-face [discussions] ... mainly for people living in rural areas, they don’t understand about sexual and reproductive health” (F09, 49 year old woman with mobility impairment, emphasis added).*

## **Key points**

### **Individual level barriers to reproductive health services**

- Single women with disabilities, particularly those over the age of marriageability have poor access to SRH and health services, more generally.
- Women with disabilities found asking for help from others difficult. They often stay at home when they are sick.
- Poverty is a barrier to health services as even though health care services may be free, they still have to expend money to get to the health centre.

### **Family / societal level barriers to reproductive health services**

- Family, siblings and others prefer to purchase medicine for men and women with disabilities at local shops as it is easier than taking them to the health centre.
- In the absence of communicative accessibility, deaf men and women experience health services as confusing places where they gain little information about their health.
- Some health professionals have poor understanding of disability.
- Women receive inaccurate information and advice from public commune health service providers and choose to go to private providers.

### **Individual level facilitators to access reproductive health services**

- An individual's capacity for independent movement greatly enhances their access to health services.
- Money enables women and men with disabilities to purchase the support that they require and thus work is critical to their ability to access resources, services and other opportunities.

### **Family / societal level facilitators to access reproductive health services**

- Access to financial resources and the availability of someone to support a person with disabilities to get to the health centre facilitates access to health services.
- Men and women with disabilities feel that health centre staff have become more disability friendly in the last few years.
- Access to sign language interpreters and visual communication aid mean visits to the health centre are meaningful and effective for deaf men and women.
- Improving deaf children's school attendance to ensure they have basic literacy and numeracy skills would also assist them to communicate with others through writing.
- Private sector health care providers are chosen because they are seen to provide better services: there is no wait time, they have more welcoming facilities and offer a seemingly broad range of services and medicines and pay more attention to their patients.

### **Recommendations**

- Raise persons with disabilities' awareness of any travel funds or vouchers that may be able to improve their access to health services.
- Ensure wheelchair access and ramps are present at all health centres.
- Train and employ persons with disabilities as health professionals or facilitate information exchange between health professionals and DPOs.
- Facilitate communication between health staff and persons with disabilities (e.g. with regard to deaf people) through training and the use of visual aids.
- Raise awareness of disability and disability rights at the health centre and among teachers so that they encourage children with disabilities when they are young.
- Improve access to information and understanding of sexual and reproductive health particularly in remote areas.

## Conclusion

The sexual and reproductive health of men and women with disabilities in rural Cambodia is shaped by social misconceptions that disability means inability - to marry, to attend to a spouse, to bear and care for children, and to work. These misconceptions operate in socially nuanced ways, and together with the impairment type, the level of personal, social and economic resources and support available, shape the SRH of men and women with disabilities. Men and women with disabilities however, are husbands and wives, mothers and fathers, and have the same needs for and rights to SRH as their non-disabled counterparts. This research demonstrates that men and women with disabilities knowledge of and access to information about SRH, patterns of contraception use and birthing practices broadly follow trends in the general population, but men and women with disabilities also face disability and gender specific barriers and require various supports to meet their SRH.

### **Socio-cultural, familial and individual barriers to marriage**

This research demonstrates that men and women with disabilities encounter disability specific socio-cultural barriers to finding a spouse. Rate of marriage for the men and women in this study were below national averages<sup>17</sup> at 56% and 45% respectively. Individually, men and women internalise negative social misconceptions about their capability and worthiness to marry. They lack confidence, and women in particular fear rejection, not being loved and ultimately being abandoned by their spouse. Socially, family, relatives and neighbours may question, laugh or completely deny men and women with disabilities desire to marry, particularly if they have sensory, intellectual or severe impairments that preclude independent movement. Families of men and women with disabilities can have low expectations of their child's marriageability.

Whilst men and their families are culturally able to approach potential spouses and their families to ask for marriage, women and their families do not possess this cultural agency. Consequently, women with disabilities and their families are unable to actively seek a spouse, and this cultural denial renders women with disabilities passive and at risk of a lifetime without the key source of women's social status – marriage and motherhood.

In this cultural context, men and women with disabilities described their reticence to "*dare to love*" because they fear rejection because of their disability. They see their disability as a barrier to marriage and maybe unsure as to how and if their impairment affects their physical ability to bear children. These are disability specific feelings that are the result of men and women with disabilities' internalisation of dominant socio-cultural attitudes towards disability. These attitudes fundamentally shape the intimate worlds of men and women with disabilities, particularly women and those with sensory, intellectual, multiple and severe disabilities that prevent independent movement. These groups have the least social resources to draw upon to negotiate the most negative and stigmatising social and physical environments.

---

<sup>17</sup> Nationally 66% of men and 68% of women are married (CDHS 2014, NIS/MoP, 2015).

Although marriage can bring women and men with disabilities greater social and material security and wellbeing, research shows that women with disabilities are more at risk of verbal, physical and sexual abuse by spouses and other family members than those without disability (see Astbury and Walji, 2013). Parents and other family members endeavour to keep their daughters with disabilities safe from this potential risk by preventing their marriage. But as parents age and siblings marry and establish their own families, women with disabilities can be left with little daily support and care, leaving them vulnerable to a different set of risks and vulnerabilities. In the absence of family members to support them, they may have little choice but to live alone dependent upon the goodwill of others. When parents die and siblings move away, men with disabilities who remain single may find themselves in a similar predicament, but research to date in the Cambodian context has not examined men as targets of gender-based violence and sexual abuse.

In this research, women with disabilities who never married, were childless and without social support experienced the greatest vulnerability and were most at risk of violence, poverty and social discrimination. It can be concluded that women without disabilities do not encounter these social stigmas and risks to the same extent as those with disabilities. Women with disabilities who were single felt afraid and vulnerable, and some were without financial resources and social support to call upon when required. Single women with disabilities are seen to be easy targets for rape and other forms of violence and abuse, and women themselves feared rape. Parents were particularly concerned about daughters with hearing, developmental and intellectual disabilities being raped and made sure they never ventured far from home. When women with disabilities responded proactively and assertively to physically abusive and threatening behaviour, they demonstrate awareness of their rights as women to safety and freedom from persecution. This knowledge and proactive action needs to become the norm.

When men and women with disabilities do not support themselves or contribute to their household economies, they are less attractive and desirable as a spouse, and potential spouses question their ability to support and raise children. When women with disabilities who are in intimate relationships do not make a financial contribution to their household they experience limited social and decision-making power. Building men's and women's confidence and skills to earn an income, would enhance their quality of life as well as their marriageability and ability to access health including SRH services.

Some men and women with disabilities continue to believe that the challenges they face are inherent to their impairment and not to the socio-cultural and environmental barriers that they face. These beliefs require urgent attention; dissemination of rights-based understandings of disability would empower men and women with disabilities, particularly if accompanied by broader village-based awareness raising.

### **Socio-cultural, familial and individual barriers to sexual and reproductive health knowledge**

Men and women with disabilities face individual, family and social level barriers to their sexual and reproductive health. Like men and women without disabilities, persons with disabilities' knowledge of their sexual and reproductive health is poor, particularly for unmarried, single people. Underlying socio-cultural beliefs about disability, gender and

sexuality inform when and who is deemed appropriate to learn about SRH. Marriage is the key turning point where access to knowledge about SRH is culturally acceptable and transferred socially through informal networks of family, friends and neighbours, and via health centre professionals, and in some cases NGOs. Whilst marriage is the social marker that men and women can learn about SRH, information about family planning is not consistently and systematically provided until after the birth of the first child. Given the multiple barriers that men and women with disabilities face to marriage, they may never enter this institution. If they also have very little schooling and are disconnected from village-level social networks and spend much time at home, they are likely to miss out on learning about SRH altogether.

Young single men and women, and even married couples without children, are often excluded from village-level opportunities to learn about SRH. Parents and elders teach their children very little about sexual and reproductive health and can actively prevent young people learning by sending them away from public meetings on such matters. Deaf men and women do not have the opportunity to learn through these informal methods and were only able to learn little bits about SRH from posters at the health centre or books, or from NGOs. Furthermore, young people learn very little about SRH at school, if they indeed attend secondary and high school at all. Furthermore, men and women with disabilities themselves do not always believe that information about SRH is relevant to them because they believe that as a person with disability they are unlikely to marry.

The presence of a disability increases men's but particularly young women's feelings of insecurity about their marriageability, as noted above, and they are thus shy to learn about sexual and reproductive health. Men and women with disabilities were only able to direct their own learning about SRH when they were married and were explicitly encouraged to ask questions of teachers, health professionals and others including NGOs. Even if they do possess knowledge of their SRH, the translation of their understanding into actively seeking health services can be difficult because they again encounter multiple barriers – individual, institutional and physical to access SRH services.

### **Socio-cultural barriers and facilitators to contraception, reproduction and childbirth**

Even though women and men with disabilities found access to contraception easy, locally available and cheap, culturally women are reluctant to use contraception until they have demonstrated their fertility through the birth of at least one child. These patterns are changing however, and married women in their 20s, particularly those who are educated are starting to use contraception shortly after marriage. In this study, women mostly used injections and the pill and frequently changed contraception type if they experience too many negative side effects. Condoms were infrequently used, and men predominately viewed family planning as the woman's responsibility.

Both men and women would like more information on natural methods because they are concerned about the negative impacts of modern contraceptives on women's health. Health care providers tend to suggest the use of natural methods when other types of contraception have too many negative side effects. These data support findings from other research on sexual and reproduction health in Cambodia (see for example Samandari et al,

2010, McDougall et al, 2009, NIS/MoP, 2015). Furthermore, women with disabilities are increasingly giving birth in health centres with a trained health professional, as are women more generally. They are good attenders of ANC and PNC as they and their families are concerned to keep their babies healthy and free of impairment.

Most important for women with disabilities continued access to contraception, health centre births, ANC and PNC is the support of families to accompany women to the health centre as required, and awareness of disability inclusive service provision among health care providers. In the absence family support and if visits to the health centre are not considered worthwhile – as was often the case for deaf men and women, women with disabilities simply stay at home or buy contraception locally and not attend the health centre at all.

### **Socio-cultural, individual and family level barriers to access to and experience of health services**

Women with disabilities experienced physical, social and economic barriers to accessing health services, including SRH services. Single women with disabilities, particularly those over the age of marriageability have the poorest access to health services. They tend to have the least social power within their households to command the use of social and financial resources. Women with disabilities – both married and particularly single women - found asking for help from others difficult and for this reason often stay at home when they are sick. Family, siblings and others prefer to purchase medicine for men and women with disabilities at local shops rather than taking them to the health centre. Additionally, deaf women and men experience communication inaccessibility at the health centre and gain little, if any information if and when they visit. For those who do gain information from health professionals, it is often inaccurate and delivered by staff who may have very little understanding of disability.

An individual's capacity for independent movement greatly enhances their access to health services. Furthermore, economic resources enable women and men with disabilities to purchase the support that they require if it is unavailable within their household. Work is thus critical to men and particularly, women's ability to access resources, services and other opportunities.

As Cambodian society and economy rapidly change, new risks are emerging to men and women with disabilities SRH. Many young men and women migrate from their villages for work and reside with friends outside of the social restrictions of village life. In the absence of knowledge about SRH, risky sexual behaviour including non-consensual sex, unwanted pregnancy and unsafe abortion are more likely. Access to information about safe sex, informed decision-making and sexual rights is particularly important for young women and men who are migrate for work. It is vital that young women know their rights, how to initiate the use of contraception and protect themselves, and that young men are aware of their responsibilities in relation to contraception and family planning. Cambodia has a youthful population with young people in the age group 10-24 years making up 36% of the population (Samandari et al, 2010), heightening the importance of dissemination of SRH information to adolescents and young people (MoH, 2012). Such dissemination needs to be

inclusive and present information in accessible formats to ensure that it reaches men and women with disabilities.

For men and women with disabilities to be able to safeguard their sexual and reproductive health socio-cultural attitudes towards disability, gender and sexuality must change. The cultural assumption that disability means inability - particularly for those with the most stigmatised impairments, and is an individual problem rooted in bodily difference needs to be unsettled through the widespread dissemination of positive and empowering stories of men and women with all sorts of disabilities as wives, mothers, husbands, fathers, leaders and role models.

Negative socio-cultural beliefs about disability are the social norm and are internalised by persons with disabilities, enacted by family members, fellow villagers, health care professionals and teachers. As a consequence, men and women with disabilities encounter multiple individual, social and environmental barriers that prevent their access to the support and SRH services they require. Although Cambodian society now has increasing awareness of disability, greater understanding of how to appropriately support men and women with disabilities' inclusion in all facets of daily life, including SRH is required. Disability confidence in health care professionals and teachers is particularly required for those with sensory, intellectual, mental health and developmental disabilities as these are the most stigmatised and poorly understood of all disabilities. Whilst this research has provided valuable insight into the SRH experiences of men and women with mobility, hearing and visual impairments, additional research that examines other impairment types, especially in remote locations where overall socio-economic living conditions are poorer is required. It is these health care providers and men and women with disabilities who require the greatest support to be able to meet their SRH needs and rights.

## References

Astbury, J., and Walji, F. (2013) *Triple Jeopardy. Gender-based violence and human rights violations experiences by women with disabilities in Cambodia*, AusAID Research Working Paper 1.

Government of Cambodia, Ministry of Health (MoH) (2006) *National Reproductive Health Programme 2006-2010*. Ministry of Health, Royal Government of Cambodia: Phnom Penh.

Government of Cambodia, Ministry of Health (MoH) (2012) *National Strategy for Reproductive and Sexual Health in Cambodia, 2012-2016*. Government of Cambodia: Phnom Penh.

Government of Cambodia, Ministry of Social Affairs, Veterans and Youth Rehabilitation (2014) *National Disability Strategic Plan, 2014-2018*. Ministry of Social Affairs, Veterans and Youth Rehabilitation, Government of Cambodia: Phnom Penh.

Government of Cambodia, National Institute of Statistics (NIS)/ Ministry of Planning (MoP) (2015) *Cambodian Demographic and Health Survey, 2014*. Government of Cambodia: Phnom Penh.

Ebihara, M. (1968) *Sway, a Khmer Village in Cambodia*. Ph.D Dissertation. University of Ann Arbor: University Microfilm International [1971].

Frohman, C. and Ortoleva, S. (2013) *The Sexual and Reproductive Rights of Women and Girls with Disabilities*. ICPD Beyond 2014 International Conference on Human Rights. Issues Paper. July 1<sup>st</sup>, 2013.

Gartrell, A., (2004) *Flying on Hope: The lived experience of disability in rural Cambodia*. Ph.D., School of Geography, Anthropology and Environmental Studies, Melbourne: The University of Melbourne.

Gartrell, A., (2010) 'A frog in a well': The exclusion of people with disability from work in Cambodia. *Disability and Society*. 25(3), pp.289-301.

Groce, N., Kett, M., Lang, R., and Trani, JF. (2011) Disability and Poverty: the need for a more nuanced understanding of implications for development policy and practice. *Third World Quarterly*, Vol. 32(8): 1493-1513.

Hörmansdörfer, Cindy/ Olson, Meghan (2013): Inclusion of Persons with Disabilities in the Social Health Protection Project of GIZ in Cambodia.

Huy, L. (2011) (ed) Family Planning. *Health Messenger*, Issue 45:1-92.

Jeong, H. (2014). Legacy of Khmer Rouge on Skill Formation in Cambodia. *Journal of International and Area Studies*, 1-19.

Jones, L. (2012) Prevalence and risk of violence against children with disabilities: a systematic review of the literature and meta-analysis of observational studies. *The Lancet*,

Lee, K., Devine, A., Marco, MJ., Zayas, J., Gill-Atkinson, L. and Vaughan, C. (2015) Sexual and reproductive health services for women with disability: a qualitative study with service providers in the Philippines. *BMC Women's Health*. 15:87.

Mac-Sieng, V. and Boggs, D. (2014) Triple discrimination against women and girls with disability. *Medicus Mundi Schweiz (MMS) Bulletin* #130, October 2014.

Oliver, M. (1990) *The Politics of Disablement*. MacMillan, London.

Racherla, SJ., Bophea, S., Sisokhom, S. (2013) *On Universal Access to Sexual and Reproductive health: Cambodia. Country Profile*. RHAC, EU, SIDA. Phnom Penh.

Samandari, G., Speizer, I. O'Connell, K. (2010) The Role of Social Support and Parity on Contraceptive Use in Cambodia. *International Perspectives on Sexual and Reproductive Health*. Vol 36(3):122-131.

UNCRPD (2006) *Convention on the Rights of Persons with Disabilities: Resolution / adopted by the General Assembly*. In: Assembly UG (ed) A/RES/61/106. United Nations General Assembly.

UNFPA (1996) Reproductive Rights and Reproductive Health, in *International Conference on Population and Development (ICPD) Programme of Action*. UNFPA.

UNFPA / International Conference on Population and Development (ICPD) (2014) *Beyond 2014 Global Report*. UNFPA.

Vathiny, O. and Hourn, K. (2010) *Barriers to contraceptive use in Cambodia: A study in selected sites in Takeo and Siem Reap*. Reclaiming and Redefining Rights Thematic Studies Series 3: Reproductive Autonomy and Rights in Asia. Asian-Pacific Resource and Research Centre for Women. Kuala Lumpur, Malaysia.

WHO/ UNFPA (2009) *Promoting sexual and reproductive health for persons with disabilities*. WHO/UNFPA Guidance Note. Geneva: WHO, UNFPA.

WHO/WB (2011) *World Report on Disability*. WHO and World Bank.

World Bank (2014) *Where have all the poor gone? Cambodia poverty assessment 2013*. Washington D.C: The World Bank.

World Bank. (2004) *HIV/AIDS and disability: capturing hidden voices: Report of the World Bank/Yale University Global Survey on HIV/AIDS and Disability*. The World Bank, Washington, DC.

## Appendix 1

Table 1: Summary of Interviewees: Women with disabilities

Age Range	Total number in age bracket	Single	Married	Number of Children	Childless
Under 19	1	1		0	1
20 – 29 years	11	8 <sup>^</sup>	3	5	6
30 – 39 years	8	6	2	2	6
40 – 49 years	10	3	7 <sup>^^</sup>	5	5
Over 49 years	3	0	3 <sup>*</sup>	2	1
<b>Total</b>	<b>33</b>	<b>18</b>	<b>15</b>	<b>14</b>	<b>19</b>

\*One widow.

\*\* An average of 1.26 child per woman in the reproductive age range.

<sup>^</sup> Two women are single and have children.

<sup>^^</sup> 3 of these women are married and without children

## Appendix 2

Table 2: Summary of Interviewees: Men with disabilities

Age Range	Total number in age bracket	Single	Married	Number of Children	Childless
Under 19	1	1		0	1
20 – 29 years	11	9	2	0	11
30 – 39 years	5	1	4	4	1
40 – 49 years	6	0	6	6	0
Over 49 years	2	0	2	2	0
<b>Total</b>	<b>25</b>	<b>11<sup>^</sup></b>	<b>14</b>	<b>14</b>	<b>11</b>

\*Mine accident impacted leg, arm and eye.

\*\* An average of 2.36 children per man (for all 11 informants) or 3.25 children per man in reproductive age range.

<sup>^</sup>36.3% of men are single.

## Appendix 3

Table 3: Demographics of female interviewees

ID	Age	Disability Type	Marital Status	Number of children	Education	Living w who	Work
F01	42	Mobility	M	4	G1	Spouse and children	Farmer
F02	25	Mobility	M	1 (pregnant)	G9	Spouse and children	Raises pigs
F03	52	Mobility	M	5	G3	Spouse and children	Farmer; raising animals
F04	23	Mobility	S	0	G12 (MSC)	Parents*	At home; domestic work
F05	43	Visual^	M	5	G2	Spouse and children	Farmer
F06	45	Mobility	M	2	G8	Spouse and children	
F07	24	Visual	S	1	G6	Parents	Look after child at home
F08	44	Blind	M	2	G7 (Diploma)	Spouse and children	Farmer/ construction
F09	49	Mobility	M	0	G7 Diploma	Spouse	NGO staff, market seller
F10	48	Visual	S	0	G6	Parents	No paid work
F11	48	Mobility	M	0	G7	Spouse	NGO staff
F12	58	Visual	M	0	None	Spouse	Small business
F13	28	Blind	S	0	None		Domestic work
F14	53	Visual	M	5 ***	G4	Spouse and children	Sells second hand clothes
F15	41	HIV	M	4	G4	Spouse and children	Farmer and small business
F16	27	Mobility	M	2	G1	Spouse and children	Farmer
F17	30	Mobility	M	1	G12	Spouse and children	Small shop at home
F 18	36	Physical	S	0	?	Parents	Animal raising, farming
F19	25	Mobility	M	1	G7	Spouse and	Farming, domestic

						children	work
F20	18	Developmental	S	0	0	Parents	Domestic work
F22	21	Mobility	S	0	G12	Parents	Study
F23	35	Mobility	S	0	0	Widowed father (also a man with disability)	Home; farming; raising animals
F24	45	Mobility	S	0	0	?	Tailor
F25	34	Multiple	M	3	0	Spouse and children	Raise chicken; home
F26	30	Blind	S	0**	0	Parents	Sells cakes

^ Of those with visual impairments, 5 were blind in one eye.

\*Parents includes siblings

\*\*Total of 36 children

\*\*\* 3 of her 5 children have an intellectual impairment.

*Table 4: Focus Group Discussion Participants: Women with Disabilities\**

ID	Age	Marital status	Disability type	Education	# Children	Living with whom	Work
P1	35	S	Blind	G3	0	Older brother's family	Agriculture
P3	49	M (divorced)	Mobility	G4	0	??	Small business
P4	37	S	Multiple (physical/mobility)	G3	0	Sister	Raising pigs

\*Two additional women participated in this FGD but were in their 60's and have been removed from the data.

*Table 5: Focus Group Discussion Participants: Deaf Women*

ID	Age	Marital status	Education*	# of Children	FGD #	Year EPIC Arts
P1	28	Separated	?	2	1	200
P2	22	S	G12	0	1	200
P3	27	S	G6	0	1	200
P4	31	S	G5	0	2	200
P5	28	S	G1	0	2	200

## Appendix 4

Table 6: Demographics of Male Interviewees

ID	Age	Disability	Marital status	Education	# kids	Work
M02	46	Mobility	M	G4	5	Agricultural labourer
M04	35	Mobility	M	G2	3	At home; parents look after him;
M05	21	Visual*	S	G12	0	Currently at school
M06	56	Mobility	M	G3	1	Farmer
M07	38	Mobility	M	G3	3	Farmer
M08	25	Visual (low vision)	S	G7	0	Farmer
M09	31	Physical	M	G9	2	Small business
M11	58	Physical and visual	M	0 (war)	6 (all married except youngest)	Raising animals
M12	27	Intellectual	S	1	0	At home; no work
M13	46	Mobility	M	G9	3	NGO
M14	42	Mobility	M	G7	3	Farmer

\* Of the men with visual impairments two were blind in one eye and the third had low vision.

Table 7: Focus Group Discussion Participants: Men with Disabilities

ID	Age	Marital status	Disability type	Education	# Children	Living with whom	Work
P1	40	M	Mobility (polio)	?	3	Wife and children	Hairdresser
P2	48	M	Mobility	G8	2	Wife and children	Farmer
P3	45	M	Mobility (amputee)	?	3	Wife and children	Farmer
P4	39	M	Mobility	?	2	Wife and children	Farmer
P5	15	0	Physical	G10	0	Parents and siblings	School

Table 8: Focus Group Discussion Participants: Deaf Men

ID	Age	Marital status	Education	# of Children	FGD #	Year EPIC Arts
P1*	27	S	None	0	1	2015
P2	20	S	G3	0	1	2003
P3	27	S	G2	0	1	2013
P4	23	S	G8	0	1	2013
P5	23	M	G2	Wife pregnant	2	2009
P6	22	S	G1	0	2	2009
P7	25	M	G3	Wife pregnant	2	2009
P8	25	S	G1	0	2	2009
P9	30	S	G1	0	2	2009

\* P1 – P4 participated in one FGD and P5-P9 were in another FGD.

# Appendix 5

## Interview Checklists

### Married Women with Disabilities

**Respondent characteristics** (age, marital status, disability status, highest level of education, livelihood, number of children)

- Please tell me about your husband's background (age, highest level of education, livelihood)
- Please tell me about your work (paid and unpaid)

**Reproduction:** Complete birth and death history of respondents' live births:

- year of births
- Where is each child currently living,
- the number of children living with the mother
- year of child's death; age of child at time of death; cause of death

**For your last birth** – Did you attend antenatal care?

- Where did you obtain antenatal care during pregnancy
- How many times? (if not 4, why not?)
- Can you describe the care that you received and your experience with the staff?
- Where did delivery take place?
- What type of assistance did you receive during delivery?
- Why did you give birth at this place?
- Can you tell me about your experience of giving birth at this place?
- Did you face any difficulties in giving birth here?

**Contraception** (are you or your partner currently using a family planning method?)

- If so, which method are you using? Why?
- What other methods do you know about?
- How does this method work in your body to prevent pregnancy?
- How did you find out about this method?
- How did you decide to use this method? (what factors did you consider)
- Was this your decision or your husband's?
- Was it easy for you to get information about contraception? Why/ why not?
- Where did you purchase / get this method?
- Was it easy to access? Why / why not?
- If not, why not?
- What barriers do you face in accessing your preferred method?
- How effective is this method in preventing pregnancy?
- Have you ever use condoms? Why/ why not?

**Pregnancy, pre and post-natal care** (did you receive a check up after the delivery of your last birth ie in the first 2 days after birth?)

- If so, can you tell me about the visit and your experience of it?
- Did you attend post-natal care? Why/ why not? (should be 3 visits)

- How was your pregnancy?

**Marriage:** Please tell me about how you meet your husband and how you came to marry.

- Did you choose your husband? If not, who did?
- Can you tell me about your communication with your husband?

**Fertility preferences-** Did you and your husband/wife discuss how many children you would like to have and how you would space your births? Yes/ No

**Tell us about this decision** – Did you decide together or did your husband or you?

- What is your husbands' attitude toward contraceptive use?

**Attitudes to contraception:** Do most couple you know use a contraceptive method? Why / why not?

- If an elder says not to use a contraceptive method, would you use it?

**First sexual activity:** How old were you when you first engaged in sexual activity?

- Why this age?
- Have you ever had sex when you have not wanted to?

Have you even had any **unwanted pregnancies**? What did you do about it?

- If you had an abortion, where did you go to? Why?
- Can you tell me about your experience
- Can you please tell me about your experience of **health centre staff**?
- What needs to change to make health care services more accessible for PWD?
- As women with disabilities do you face specific challenges in meeting your sexual and reproductive health needs?
- What are these challenges and how do you try to address these?
- How successful are you in addressing these challenges?
- What changes would you like to see?
- Is there anything else you would like to add?

## Unmarried Women with Disabilities

**Respondent characteristics** (age, disability type, highest level of education, livelihood; number of siblings; are your siblings married?)

What do your parents do?

What is your mothers/fathers' highest level of education?

**Attitudes to contraception:** Do most couple you know use a contraceptive method?

- What methods do they use?
- Do you know of any other methods of contraception?
- Do you know how these different types of contraception work to prevent pregnancy?
- How did you get information about these methods?
- Was it easy to get this information?
- Do you know if these methods of contraception are available in this village?
- Would they be easy to get? Why / why not?
- Do you talk to anyone about contraception / marriage and sex? If so, who?
- Have your parents ever talked to you about marriage/ sex/ family planning?
- If an elder says not to use a contraceptive method, would you use it?
- What information would you like to know but you do not currently?

Would you like to get married and have children? Why?

When would you like to get married – what is a good age to take a husband / wife?

Why then?

How do you feel about finding a husband?

Who will choose your husband? (your parents or you?)

- When you get married, how will you decide which method of contraception to use?
  - Will you decide or your husband or will you decide together?
- Has anyone ever touched you or treated you in an intimate way that you did not want?
  - If so, what happened?
  - When? Where? Who?
  - What did you do about this?
- Have you ever had any unwanted pregnancies?
  - What did you do about it?
  - If you had an abortion, where did you go to? Why?
  - Can you tell me about your experience
- Can you please tell me about your experience of health centre staff?
- For general health care and for sexual health care
- What needs to change to make health care services more accessible for PWD?
- As women with disabilities do you face specific challenges in meeting your sexual and reproductive health needs?
- What are these challenges and how do you try to address these?
- How successful are you in addressing these challenges?
- What changes would you like to see?
- Is there anything else you would like to add?

## Unmarried Men with Disabilities

**Respondent characteristics** (age, disability type, highest level of education, livelihood; number of siblings; are your siblings married?)

What do your parents do?

What is your mothers/fathers' highest level of education?

**Attitudes to contraception:** Do most couple you know use a contraceptive method?

- What methods do they use?
- Do you know of any other methods of contraception?
- Do you know how these different types of contraception work to prevent pregnancy?
- How did you get information about these methods?
- Was it easy to get this information?
- Do you know if these methods of contraception are available in this village?
- Would they be easy to get? Why / why not?
- Do you talk to anyone about contraception / marriage and sex? If so, who?
- Have your parents ever talked to you about marriage/ sex/ family planning?
- If an elder says not to use a contraceptive method, would you use it?
- What information would you like to know but you do not currently?

Would you like to get married and have children? Why?

When would you like to get married – what is a good age to take a wife?

Why then?

How do you feel about finding a wife?

Who will choose your wife? (your parents or you?)

- When you get married, how will you decide which method of contraception to use?
  - Will you decide or your husband or will you decide together?
  - What do you think about the use of contraception?

**First sexual activity:** How old were you when you first engaged in sexual activity?

- Why this age?
- Who with? How often?
- Did you use a condom?
- Why / why not?
- Have you ever had an **unwanted pregnancies**?
  - What did you do about it?
  - Why?
- Can you please tell me about your experience of **health centre staff**
- For general health care and for sexual health care
- What needs to change to make health care services more accessible for PWD?
- As women with disabilities do you face specific challenges in meeting your sexual and reproductive health needs?
- What are these challenges and how do you try to address these?
- How successful are you in addressing these challenges?
- What changes would you like to see?
  
- Is there anything else you would like to add?

## Married Men with disabilities

**Respondent characteristics** (age, marital status, disability status, highest level of education, livelihood, number of children)

- Please tell me about your wife's background (age, highest level of education, livelihood)
- Please tell me about your work (paid and unpaid)

**Reproduction:** Complete birth and death history of respondents' live births;

- year of births
- Where is each child currently living,
- the number of children living with the mother
- year of child's death; age of child at time of death; cause of death
- For the birth of your last child, where did your wife give birth?
  - Why here?
  - Who made this decision?
- **Pregnancy, pre and post-natal care** (did your wife attend pre-natal check ups at the health centre? Why / why not?
  - Did your wife receive a check up after the delivery of your last birth ie in the first 2 days after birth? Why / why not?
- **Marriage:** Please tell me about how you meet your wife and how you came to marry.
  - Did you choose your wife? If not, who did?
- **Fertility preferences** – did you and your wife discuss how many children you would like to have and how you would space your births?

**Attitudes to contraception:** Do most couple you know use a contraceptive method?

- What methods do they use?
- Do you know of any other methods of contraception?
- Do you know how these different types of contraception work to prevent pregnancy?
- How did you get information about these methods?
- Was it easy to get this information?
- Do you know if these methods of contraception are available in this village?
- Would they be easy to get? Why / why not?
- Do you talk to anyone about contraception / marriage and sex? If so, who?
- Have your parents ever talked to you about marriage/ sex/ family planning?
- If an elder says not to use a contraceptive method, would you use it?
- What information would you like to know but you do not currently?
- What do you think about your wife using contraception?
  - Who do you think should make decisions regarding your wife's use of contraception?
  - What is your preferred mode of birth control?
  - Why?
- How old were you when you first engaged in sexual activity?
  - Why this age?
  - Have you ever had sex when you have not wanted to?
- Have you engaged in sex with a partner other than your wife?
  - If so, with who?
  - How often?
  - Does your wife know? Why / why not?

- Did you use a condom?
  
- Can you please tell me about your experience of health centre staff?
- What needs to change to make health care services more accessible for PWD?
- As men with disabilities do you face specific challenges in meeting your sexual and reproductive health needs?
- What are these challenges and how do you try to address these?
- How successful are you in addressing these challenges?
- What changes would you like to see?
  
- Is there anything else you would like to add?

# Appendix 6

## Focus Group Discussion Checklist

### Women with Disabilities

- As women with disabilities do you face specific challenges in meeting your sexual and reproductive health needs?
- What are these challenges and how do you try to address these?
- How successful are you in addressing these challenges?
- What changes would you like to see?

### Attitudes to contraception

- Do most couple you know use a contraceptive method?
- What methods do they use in this village?
- What other methods of contraception are available in this village?
- Do you know how these different types of contraception work to prevent pregnancy?
- Can you explain how they work?
- How do you get information about these methods?
- Is it easy to get this information?
- Do you know if these methods of contraception are available in this village?
- Would they be easy to get? Why / why not?
- Where can you purchase this method?
- Is it easy to purchase this?
- As women with disabilities do you have specific needs in relation to your sexual and reproductive needs and access to these services?
- What challenges do WWD face in meeting these needs?

### Communication about sexual and reproductive health

- Do you talk to anyone about contraception / marriage and sex? If so, who?
- Do parents talk to their children about marriage/ sex/ family planning?
- If an elder says not to use a contraceptive method, would young people use it?
- How do couples decide which method of contraception to use?
  - Will you decide or your husband or will you decide together?

### Do women with disabilities in this village attend ANC and receive PNC?

- Why or why not?
- How many times do women need to attend antenatal care during pregnancy?
- Is it the same for women with disability and women without disabilities?
- Why /why not?
- Is there anything else you would like to add?

## **Focus Group Discussion Checklist**

### **Men with Disabilities**

- As men with disabilities do you face specific challenges in meeting your sexual and reproductive health needs?
- What are these challenges and how do you try to address these?
- How successful are you in addressing these challenges?
- What changes would you like to see?

### **Attitudes and knowledge to contraception**

- Do most couple you know use a contraceptive method?
- What methods do they use in this village?
- What other methods of contraception are available in this village?
- Do you know how these different types of contraception work to prevent pregnancy?
- Can you explain how they work?
- How do you get information about these methods?
- Is it easy to get this information?
- Do you know if these methods of contraception are available in this village?
- Would they be easy to get? Why / why not?
- Where can you purchase this method?
- Is it easy to purchase this?
- What about condoms – do men in this village use condoms?
- Why / why not?

### **Communication about sexual and reproductive health**

- Do you talk to anyone about contraception / marriage and sex? If so, who?
- Do parents talk to their children about marriage/ sex/ family planning?
- If an elder says not to use a contraceptive method, would young people use it?
- How do couples decide which method of contraception to use?
  - Will you decide or your husband or will you decide together?
- Is there anything else you would like to add?

---

Published by Deutsche Gesellschaft für  
Internationale Zusammenarbeit (GIZ) GmbH  
Registered offices Bonn and Eschborn, Germany  
  
Improving Maternal and Newborn Care  
GIZ Office Phnom Penh  
# 17, Street306, P.O. Box 81, Phnom Penh, Cambodia  
T +855 (23) 860 110  
F +855 (23) 21 27 83  
giz-kambodscha@giz.de  
www.giz.de

Author Alexandra Gartrell

Layout Jenny Nickisch

As at November 2016

GIZ is responsible for the content of this publication.

In cooperation with



Embassy  
of the Federal Republic of Germany  
Phnom Penh

On behalf of

Federal Ministry for Economic  
Cooperation and Development (BMZ)

Division

Embassy of the Federal Republic of Germany

Addresses of  
the BMZ offices

<b>BMZ Bonn</b> Dahlmannstraße 4 53113 Bonn, Germany T +49 (0)228 99 535-0 F +49 (0)228 99 535-3500	<b>BMZ Berlin</b> Stresemannstraße 94 10963 Berlin, Germany T +49 (0)30 18 535-0 F +49 (0)30 18 535-2501
---	--

poststelle@bmz.bund.de  
www.bmz.de