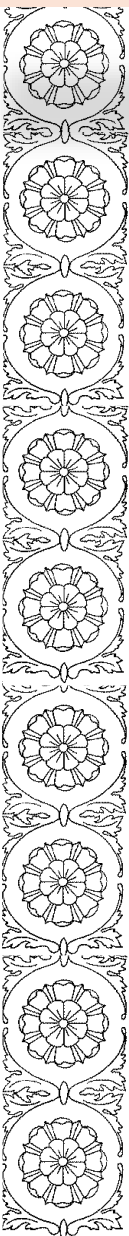


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C.M.A.A

**REPORT ON
QUALITY OF LIFE SURVEY OF MINE/ERW
SURVIVORS AND PERSONS WITH DISABILITIES
IN BANTEAY MEANCHEY PROVINCE**



December 2025

Supported by

**គម្រោងបោសសម្អាតមីនដើម្បីលទ្ធផល ដំណាក់កាលទី៤
Clearing for Results Project - Phase IV**



ACRONYMS

| | |
|-----------|---|
| APMBC | Anti-Personnel Mine Ban Convention |
| ARMAC | ASEAN Regional Mine Action Center |
| CCBL | Cambodia Campaign to Ban Landmines and Cluster Munitions |
| CCM | Convention on Cluster Munitions |
| CCCW | Convention on Certain Conventional Weapons: A United Nations treaty that restricts or bans weapons considered excessively injurious or indiscriminate (important in humanitarian and disarmament contexts). |
| CDHS | Cambodia Demographic and Health Survey |
| CIPS | Cambodia Inter-censual Population Survey |
| CMAA | Cambodian Mine Action and Victim Assistance Authority |
| CMVIS | Cambodian Mine/ERW Victim Information System |
| CRPD | Convention on the Rights of Persons with Disabilities |
| DAC | Disability Action Council |
| ERW | Explosive Remnants of Wars |
| EO | Explosive Ordinance |
| HEF | Health Equity Fund |
| ICBL | International Campaign to Ban Landmines |
| ICRC | International Committee of the Red Cross |
| IDPoor | Identification of Poor Households Program (IDPoor) |
| IMAS | International Mine Action Standards |
| JRS | Jesuit Refugee Service (Cambodia) |
| KOICA | Korea International Cooperation Agency |
| Luxemburg | Luxembourg's Aid and Development |
| MoSVY | Ministry of Social Affairs, Veterans, and Youth Rehabilitation |
| NGO | Non-Government Organization |
| NDSP | National Disability Strategic Plan |
| NMAS | National Mine Action Strategy |
| NSAF | National Social Assistance Fund |
| NSSF | National Social Security Fund |
| OAP | Oslo Action Plan |
| QLS | Quality of Life Survey |
| QoL | Quality of Life |
| SPSS | Statistical Package For The Social Sciences |
| SVN | Survivor Volunteer Networks |
| UNDP | United Nations Development Program |
| VA | Victim Assistance |
| MOP | Ministry of Planning |
| NIS | National Institute of Statistics |
| CDHS | Cambodia Demography and Health Survey |
| CSES | Cambodia Socio-Economics Survey |
| CLFS | Cambodia Labor Force Survey |

KEY TERMS USED

| | |
|---|---|
| Victim Assistance (VA) | This term refers to mine actions and other stakeholder responses as broader and specific efforts to address victims' needs and rights. |
| Explosive Ordnance (EO) | This term refers to mine action's response to the following munitions: mines; cluster munitions; unexploded ordnance; abandoned ordnance; booby traps; other devices (as defined by CCW APII); and improvised explosive devices. |
| VA services | It is a set of activities addressing the needs and rights of people who are victims of explosive weapons and ordnance. VA services include emergency and continuing medical care, rehabilitation, psychological and psycho-social support, socio-economic inclusion, laws and policies, and data collection. However, victim assistance efforts or programs should not discriminate against persons impaired through other causes, persons with disabilities, or other people with similar needs. |
| Explosive Remnants of War: ERW | It is an unexploded ordnance and abandoned ordnance. Under the International Mine Action Standards (IMAS), "Explosive Remnants of War" (ERW) refers to explosive devices that remain after armed conflict and pose risks to civilians, communities, and post-conflict recovery efforts. ERW encompasses two primary categories: <ol style="list-style-type: none"> Unexploded Ordnance (UXO): These are explosive devices such as bombs, grenades, mortars, rockets, and shells that were launched or deployed but failed to detonate as intended. UXO can remain volatile and dangerous long after conflicts have ended. Abandoned Explosive Ordnance (AXO): These are explosives that were left behind or stored by armed forces but were not used or disposed of before they departed an area. AXO may include stockpiles of ammunition, grenades, and other munitions. |
| Victims (of explosive weapons and ordnance) | People who have been killed or suffered either individually or collectively physical, emotional, and/or psychological injury, economic loss, social marginalization, or substantial impairment of the realization of their fundamental rights through acts or omissions related to the use of explosive ordnance and/or weapons with wide-area effects in populated areas. Under the International Mine Action Standards (IMAS), <i>Victim Assistance</i> (VA) refers to a comprehensive set of activities aimed at addressing the needs and rights of individuals injured by landmines, explosive remnants of war (ERW), or other explosive ordnance, as well as their families and communities. IMAS defines Victim Assistance as focusing on the following core components: <ol style="list-style-type: none"> Emergency and Continuing Medical Care: Providing immediate medical response and sustained health care to support the physical recovery of survivors. Physical Rehabilitation: Ensuring access to services such as prosthetics, orthotics, and physical therapy to help survivors regain mobility and functionality. |

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| | <p>3. Psychological and Psychosocial Support: Offering mental health services and community-based support systems to assist survivors in coping with trauma and rebuilding their lives.</p> <p>4. Socioeconomic Inclusion: Facilitating access to education, vocational training, employment, and social protection services to empower survivors and reduce socioeconomic barriers.</p> <p>5. Laws and Public Policies: Promoting the development and enforcement of policies and legislation that protect the rights of survivors and other persons with disabilities.</p> <p>6. Data Collection: Data collection gathers and shares information by compiling SADDD (sex, age, disability, and diversity disaggregated data) on victims with tested tools and service availability data to support referrals. Supporting participation of survivors during initial data collection to identify victims, including survival outcomes, type of injuries, age, gender, pre-existing impairment, civilian or military personnel status and specific needs.</p> <p>IMAS emphasizes a survivor-centered, rights-based approach to Victim Assistance, advocating for the full inclusion of survivors in society and ensuring that assistance programs are accessible, equitable, and culturally appropriate.</p> <p>While identification and referral are not mentioned in the APMBC, CCM or CCW, related services are important if victims are to access available services. Victims tend to live in rural and remote areas, far from capitals where most services are provided. Many barriers exist, including time and cost to reach services that tend to be based in urban areas, absence of childcare and accommodation, lack of information or physical access, and discriminatory attitudes. Identifying victims where they live and supporting them to access services is a vital step in ensuring increased participation and improved quality of life.</p> |
| <p>Law on The Protection and Promotion of The Rights of Persons with Disabilities Chapter 1: Article 2.</p> | <p>The purposes of this law are as follows:</p> <ul style="list-style-type: none"> • To protect the rights and freedoms of persons with disabilities; - - - • To protect the interests of persons with disabilities; • To prevent, reduce and eliminate discrimination against persons with disabilities; <p>To rehabilitate physically, mentally and vocationally in order to ensure that persons with disabilities are able to participate fully and equally in activities within society.</p> |
| <p>Article 3.</p> | <p>The scope of this law applies to persons with disabilities and any activities related to persons with disabilities within the Kingdom of Cambodia.</p> |
| <p>Article 4. Key terms used in this law are defined as follows:</p> | <ul style="list-style-type: none"> • Persons with disabilities: refers to any person who lacks, loses, or damages any physical or mental functions, which result in a disturbance to their daily life or activities, such as physical, visual, hearing, intellectual impairments, mental disorders and any other types of disabilities toward the insurmountable end of the scale. • Public Place: refers to any premises, location, building and means of transportation in either state, public or private ownership that are open |

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| | <p>to and provide services for the general public; for instance, ministries, institutions, departments, roads, leisure and cultural centres, sport centres, recreational resorts, educational establishments, hotels, hospitals, health centres, restaurants, and transportation networks. Public Educational Establishment: refers to public schools that provide education and training to students of all ages.</p> <ul style="list-style-type: none"> • Public Educational Establishment includes all levels of education from kindergarten upwards. - Private Educational Establishment: refers to any schools run by either private or any organisation authorized to provide education and training to students of all ages. • Public Educational Establishment includes all levels of education from kindergarten upwards. • Private Educational Establishment: refers to any school run by either a private or any organization authorized to provide education and training to students of all ages. |
| <p>Chapter 2: Disability Action Council and Disability Rights Administration. Article 6. The Disability Action Council carries out the following duties:</p> | <ul style="list-style-type: none"> • To provide technical advice on disability and rehabilitation issues; • To assist the relevant ministries, institutions, and organizations in developing policies, national plans, and strategies related to disability and rehabilitation. • To promote the implementation of policies, laws, and other regulations related to disability and rehabilitation issues; • To propose revisions, additional completion, or amendments of policies, laws, or other regulations related to disability issues; • To monitor and evaluate the implementation of policies, national plans, laws, and regulations related to disability issues; • To communicate with national and international communities to exchange experiences and mobilize resources from both internal and external sources. |
| <p>The Cambodia Mine Action Standards on Victim Assistance (CMAS-23): Principle</p> | <p>The principles of landmine victim assistance are non-discrimination, participation, and inclusion of victims in decision-making. Other key principles include ensuring accessibility to services, considering vulnerability and diversity (like age, gender, and disability), promoting sustainability through national ownership, and providing integrated, comprehensive services that address the long-term needs of victims.</p> |
| <p>Royal Decree No. 160 on September 4, 2000, established CMAA</p> | <p>The Cambodian Mine Action and Victim Assistance Authority (CMAA), was established under Royal Decree No. 160 with the Prime Minister as the President, assisted by two Vice-Presidents and a Secretary-General who is responsible for day-to-day management. The role of CMAA is responsible for regulating, providing licenses and accreditation, coordinating, and monitoring all mine action activities, i.e., mine/ERW clearance, risk education and assistance to mine/ERW victims, as well as for formulating national mine action strategies and plans to achieve the priorities identified by RGC’s development policies.</p> |

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Sincerely,

Mr. PHAN CHINDA
National Consultant

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EXECUTIVE SUMMARY

This Quality of Life Survey (QLS) was conducted among 4,260 Mine/ERW survivors and persons with disabilities across seven districts in Banteay Meanchey Province, Cambodia, representing one of the most mine-affected regions in the country. The survey aimed to assess service availability, social participation, economic inclusion, psychosocial well-being, and awareness of disability rights, providing evidence to guide policy and program interventions.

Purpose and Scope

The survey sought to:

- Identify gaps in health care, rehabilitation, and assistive technology services.
- Examine levels of social participation and inclusion in community decision-making.
- Evaluate economic conditions, including food security, employment, and access to social protection.
- Understand psychosocial well-being and sources of emotional support.
- Measure awareness of disability laws and rights among survivors and persons with disabilities.

Methodology

Data collection combined quantitative surveys using digital tools (ArcGIS Survey123) and qualitative insights from Focus Group Discussions (FGDs) with 51 participants (5 females, 45 males). Respondents were selected through purposive sampling, covering 473 villages in seven districts. The analysis applied descriptive statistics and thematic interpretation of qualitative data.

Key Findings

- **Demographics:** The population is predominantly male (66.2%) and older (71.7% aged 45+), reflecting historical exposure to mine-related risks and increasing dependency on care.
- **Healthcare and Social Protection:** While 89.9% feel welcomed at health centers, only 5.4% report feeling healthy. Access to ID Poor cards (32.2%) and NSSF (22.5%) remains limited, constraining financial security.
- **Rehabilitation and Assistive Devices:** Only **27.9% use assistive devices**, mainly prosthetics (50.2%). Access is centralized at Battambang PRC, with minimal outreach to remote areas. Additional needs include eyeglasses, hearing aids, and mobility aids.
- **Psychosocial Well-being:** Emotional support relies heavily on family (87.5%), with negligible NGO involvement. Trust in friends and family acceptance is moderate, and 19% express negative feelings about being alive, signaling mental health concerns.
- **Social Participation:** Engagement in community life is uneven. 54.8% attend village meetings and 66.2% attend social events, but women participate far less (35.6% vs. 64.4% for men). Education access is low (34.6%), and satisfaction with training opportunities is only 22%.
- **Economic Inclusion:** Food security is moderate (76.7%), but income sufficiency is extremely low (4.2%). Employment is limited (37.8%), mostly informal and agricultural. Pension coverage is only 20.3%, with stark gender gaps.
- **Rights Awareness:** Awareness of human rights (42.6%) and disability law (40.3%) is low, particularly among women, indicating systemic gaps in outreach and advocacy.

Interpretation

The findings reveal structural barriers in service delivery, economic empowerment, and awareness of rights. Gender disparities are pronounced across all domains, limiting women's access to education, employment, and participation in decision-making. While community engagement and basic health services exist, gaps in rehabilitation, livelihood opportunities, and psychosocial support hinder progress toward inclusive development.

Conclusions

Mine/ERW survivors and persons with disabilities in Banteay Meanchey face multidimensional vulnerabilities, including health, economic, and social. Addressing these requires a rights-based, gender-sensitive approach that integrates health, rehabilitation, livelihood, and advocacy interventions.

Recommendations

- **Health and Rehabilitation:** Decentralize rehabilitation services, expand assistive device provision, and integrate mental health support.
- **Economic Empowerment:** Scale up vocational training, micro-credit access, and inclusive employment programs.
- **Education and Skills Development:** Improve adult education and training opportunities, with a focus on women and marginalized groups.
- **Social Participation:** Promote inclusive community governance and strengthen women's participation.
- **Rights Awareness:** Intensify outreach on disability law and human rights through local authorities and community networks.
- **Monitoring and Advocacy:** Institutionalize regular quality-of-life assessments and advocate for increased funding and technical support.

1. INTRODUCTION

1.1 Organization background

The Cambodian Mine Action and Victim Assistance Authority (CMAA) plays a crucial role in improving cooperation among various stakeholders to support Mine/Explosive Remnants of War (ERW) survivors and their families. CMAA coordinates efforts from government, NGOs, and the private sector to provide a support network from emergency response to long-term medical care and rehabilitation, aiding survivors' social reintegration. The CMAA emphasizes physical, psychological, and socio-economic support, offering vocational training to enhance survivors' employability and financial independence. Additionally, CMAA advocates for the rights and inclusion of Mine/ERW survivors and persons with disabilities, ensuring survivors can fully engage in society. By addressing immediate and long-term needs, CMAA and its partners aim to reduce the impact of landmine incidents and help survivors rebuild their lives.

1.2 Project background

The Mine Ban Treaty and the Convention on Cluster Munitions recognize Victim Assistance (VA) as vital to action [1]. The victim assistance framework in Cambodia is made up of components from treaty review conferences focusing on VA, as well as a 12-point plan developed by Cambodian survivors themselves to better the lives of Mine/ERW survivors and persons with disabilities [2]. The Convention on the Rights of Persons with Disabilities (CRPD) and its implementation in mine-affected countries, including Cambodia, has been instrumental in advancing the rights and support of Mine/ERW survivors and persons with disabilities. This convention has also made significant progress in supporting and assisting Mine/Explosive Remnants of War (ERW) survivors based on the Oslo Action Plan 2020-2024.

The Cambodian Mine/ERW Victim Information System (CMVIS) recorded 65,124 casualties from 1979 to November 2025, and extensive surveys and the Survivor Volunteer Network are in place to assess survivor living conditions. According to Cambodia's statement at the Inter-sessional meeting in June 2024, 27,000 Mine/ERW survivors and persons with disabilities, including those who have received medical and physiotherapy services, and 25,000 Mine/ERW survivors and persons with disabilities have access to assistive devices [3].

Despite these efforts, Cambodia continues to face significant challenges in allocating resources for emergency support, ongoing medical care, rehabilitation, and training services. In 2021, the Cambodian Mine Action and Victim Assistance Authority (CMAA) launched the 25 Survivor Volunteer Network (SVN) to collect quality-of-life survey data from July 2021 to November 2025 in 25 districts across Battambang, Banteay Meanchey, and Pailin, supported by UNDP under the project Clearing for Result Phase IV.

Quality of Life surveys for landmine survivors and persons with disabilities in Cambodia are conducted to gather evidence-based data on their needs and well-being, evaluate the impact of national and international commitments like the Mine Ban Treaty and the CRPD, and identify barriers such as limited income, employment, healthcare, and rights awareness. These assessments also help humanize the issue, highlight the continuing effects of landmines and ERW, and support advocacy for technical and financial assistance from development partners.

Quality of life for landmine victims and persons with disabilities goes beyond survival, emphasizing dignity, independence, and full participation in society. It includes physical and mental health, social inclusion, economic opportunity, and personal autonomy. In Cambodia, this concept is grounded in a comprehensive, rights-based approach that prioritizes equal opportunities and meaningful inclusion, shifting the focus from basic aid to enabling individuals to live independently and contribute fully to their communities.

1.3 Cambodia context

In Cambodia, the most recent and comprehensive population-based data on disability is provided by the 2021–22 Cambodia Demographic and Health Survey (CDHS). This nationally representative survey revealed that 24.4% of individuals aged five years and older reported experiencing some level of disability. This marks a significant increase from the 9.4% reported in the 2014 CDHS, indicating a growing recognition and reporting of disability across the country. Of the total population affected, approximately 3.4 million people live with some form of disability. Among them, 20.3% experience mild to moderate disability, while 4.1% report severe disability, which includes serious limitations in functioning across one or more domains [4].

Cambodia has established a robust legal and policy framework to protect and promote the rights of persons with disabilities. Key national instruments include the Law on the Protection and Promotion of the Rights of Persons with Disabilities (2009). The Disability Law mandates the prevention and elimination of discrimination against persons with disabilities and ensures their full and equal participation in society [5].

Cambodia ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD) in 2012, affirming its commitment to uphold the rights and dignity of persons with disabilities [6]. In alignment with this commitment, the National Disability Strategic Plan 2024–2028 (NDSP3) was developed to enhance the health and well-being of persons with disabilities. This plan emphasizes equitable access to quality health services, rehabilitation, and assistive technologies, and was formulated through inclusive consultations with organizations of persons with disabilities and relevant stakeholders [7]. Complementing this, the Health Strategic Plan 2025–2034 (HSP4) outlines Cambodia’s broader health agenda, prioritizing universal health coverage (UHC), health equity, and system resilience. It focuses on people-centered primary health care and targets vulnerable populations, including persons with disabilities [8]. These efforts are further supported by Cambodia’s UHC Roadmap 2024–2035, which aims to reduce disparities in health access and improve service quality across the country [9].

Cambodia signed the Mine Ban Treaty, known as the Ottawa Treaty, on 3 December 1997 and ratified it on 28 July 1999, becoming a State Party on 1 January 2000 [10]. Domestic implementation legislation—the Law to Prohibit the Use of Anti-personnel Mines—took effect on 28 May 1999. Cambodia is also party to the Convention on Conventional Weapons (CCW) and its Amended Protocol II on landmines and Protocol V on explosive remnants. But it is not a party to the Convention on Cluster Munitions [10].

To committed with the Ottawa Treaty and the affected states parties to the convention, Cambodia developed a series of National Mine Action Strategy (NMAS), for instant, the National Mine Action Strategy 2018-2025 objectives is to support mine/ERW survivors and indirect victims to receive

adequate and gender sensitive medical and mental care, and physical rehabilitation and also to improve livelihood capacity of mine/ERW survivors and indirect victims to enhance their inclusion and full participation in the society.

The Ministry of Health (MoH) has prioritized rehabilitation as an essential health service and a key component of its health system strengthening agenda. Rehabilitation is now included in the Complementary Package of Activities (CPA), which outlines the clinical services and support systems required at referral hospitals, including kinetic therapy and mental health services [11]. It is also integrated into Clinical Practice Guidelines (CPGs), referral guidelines, and clinical care pathways to ensure standardized and quality care across the health system.

MoH's strategic health plans, including the Primary Health Care-Booster Implementation Framework (PHC-BIF), emphasize community engagement and flexible implementation strategies to improve access to essential services, including rehabilitation [12].

Despite notable progress in strengthening Cambodia's health system, significant challenges remain—particularly in the area of rehabilitation and assistive technology. According to the World Health Organization (WHO), approximately 1 in 4 people in Cambodia, or around 0.5 million individuals as of 2021, could benefit from rehabilitation services. A similar number of people are estimated to need assistive products, underscoring that these services are not exclusive to a small segment of the population but are essential for many. Rehabilitation supports individuals with a wide range of health conditions. The most common include hearing loss (6.6%), vision loss (6%), low back pain (6%), fractures (4.6%), and other injuries (3.2%). These figures highlight the widespread need for rehabilitation and assistive technologies as integral components of universal health coverage and inclusive health systems. These insights are drawn from the WHO's landmark study, Global estimates of the need for rehabilitation based on the Global Burden of Disease Study 2019, which emphasizes that rehabilitation is not a luxury but a necessity for millions worldwide. The study found that globally, the need for rehabilitation has increased by 63% since 1990, rising from 1.48 billion to 2.41 billion people, and calls for urgent scaling up of services, especially at the primary health care level [13]. People with functional difficulties face significant disadvantages across many aspects of life, including education, employment, health, living conditions, and safety. This report shows a clear disability gap in areas such as school enrollment, work participation, access to clean water and housing, health outcomes, technology use, and exposure to domestic violence. These gaps are even wider for those with severe disabilities and remain evident even after accounting for other differences.

Persons with disabilities face substantial health inequities in Cambodia. According to the World Health Organization (WHO), individuals with disabilities are 6.14 times more likely to experience poorer health outcomes than those without disabilities. For those with severe disabilities, this disparity can be as high as 16 times [14]. These inequities are not only avoidable but also unjust, driven by systemic barriers in the health sector and beyond. They underscore the urgent need for inclusive healthcare policies and practices that prioritize equity and accessibility for all.

The Landmines and ERW have caused over sixty-five thousand casualties since 1979. Today, the main causes are old age, disease, and accidents/injuries (including war-related). On the other hand, the

demographics of disability are more common among women, older persons, those with low education, poorer households, and rural communities.

1.4 Objective of the survey

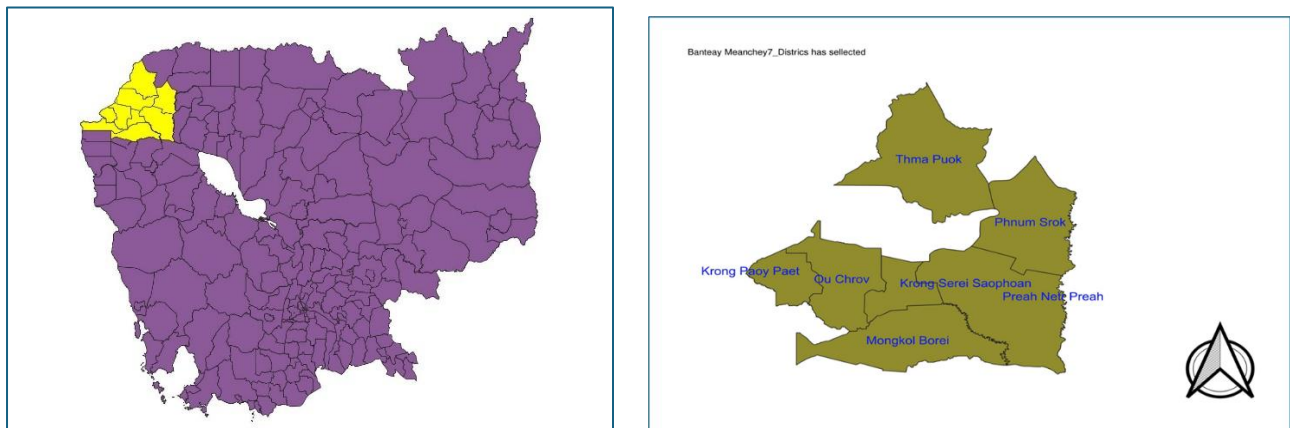
- To assess the availability of necessary services for Mine/ERW survivors and persons with disabilities in target districts to identify gaps and improve service delivery.
- To determine the level of social participation and the socioeconomic status of Mine/ERW survivors and persons with disabilities in target districts.
- To measure understanding of disability laws and rights for Mine/ERW survivors and persons with disabilities in the target districts.
- To gather reflections on the quality of life for Mine/ERW survivors and persons with disabilities.
- To assess local authorities' engagement and efforts in raising awareness of disability law and rights and properly taking action for Mine/ERW survivors and persons with disabilities.

2. METHODOLOGY

2.1 Survey Location

The survey was conducted in all villages and all communes of the 7 districts out of 9 in Banteay Meanchey province.

Figure 1: Target areas of the survey



2.2 Study Population Target

The study population included 4,260 (33.8% female) mine/ERW survivors and persons with disabilities recognized by local leaders. The study included all Sangkats/communes from Mongkol Borei, Phnum Srok, Preah Netr Preah, Ou Cheov, Krong Serei Saophoan, Thma Puok, and Krong Paoy Paet in Banteay Meanchey province. The lower number of female survivors and persons with disabilities could be attributed to factors such as increased male exposure to explosive ordnance, labor positions and risk exposure, and gender variations in reporting and identification. Men are more likely to engage in high-risk activities, whereas women may perform duties that involve less direct contact with potentially contaminated regions.

Table 1: Selected Districts of the survey

| BANTEAY MEANCHEY | # Mine/ERW survivors and persons with disability |
|---------------------------|---|
| 0102_Mongkol Borei | 720 |
| 0103_Phnum Srok | 468 |
| 0104_Preah Netr Preah | 835 |
| 0105_Ou Cheov | 456 |
| 0106_Krong Serei Saophoan | 499 |
| 0107_Thma Puok, | 673 |
| 0110_Krong Paoy Paet | 609 |
| Total | 4,260 |

2.3 Study Design

The QLS is a descriptive survey that gathers information from a target group. This survey collects respondents' characteristics, behaviors, opinions, or attitudes. Data on the quality of life of Mine/ERW survivors and persons with disabilities, including healthcare, rehabilitation, psychological support, social participation, economic inclusion, and disability laws and rights, were also collected through digitally completed questionnaires ([ArcGIS survey 123](#)).

Focus Group Discussions (FGDs) are an essential research method for gathering in-depth information about the living conditions and quality of life of specific populations, such as Mine/ERW survivors and persons with disabilities. These discussions provide valuable insights into the challenges and successes that quantitative surveys might miss. For example, FGDs can highlight the emotional effects of living with disabilities, assess the effectiveness of community support systems, and explore the aspirations of survivors beyond their immediate needs. This qualitative information is crucial for designing targeted interventions that can significantly enhance the quality of life for Mine/ERW survivors and persons with disabilities.

2.4 Sampling Method

2.4.1 Selection and Sample Size

The respondents were chosen by purposive sampling. The village leaders gave a list of participants to be interviewed. A total of 4260 participants, including 1,441 women of various ages, representing 5862 Mine/ERW survivors and Persons with Disabilities, were chosen for face-to-face interviews at home using digital questionnaires in seven districts of Banteay Meanchey. Children under the age of 15 are represented and assisted by their parents or guardians when answering interview questions to ensure accuracy and comfort. This pick was made with a 95% confidence level and a 0.001% margin of error.

2.4.2 Sampling Frame

The sampling frame was based on a comprehensive list of all persons with disabilities, prepared by the National Consultant using information collected from all villages in the seven districts of Banteay Meanchey Province in 2025. The list covers all 473 villages across the communes of these districts and includes a total of 5,862 Mine/ERW survivors and Persons with Disabilities.

Prior to the conduct of the list of all populations with disabilities, a cartographic map was prepared that identifies the boundaries of each district's area.

2.4.3 Estimation Method

The study sample was selected from the population of Persons with Disabilities, with a total of 4260 individuals chosen for interviews. Since there were no previous studies, the sample size was determined using the population proportion method, with a 95% confidence level, an assumed proportion of the target group $P = 0.5$, and a margin of error $e = 0.005\%$.

We first calculated the initial sample size using the formula $n_0 = P(1 - P)(Z/e)^2$, which represents the unadjusted sample size before correcting for the total study population $N = 5,862$.

Next, we computed the final sample size using the formula $n = n_0 / (1 + n_0/N)$.

Finally, the sample for each village (n_i) was calculated using the formula $n_i = (N_i * n) / N$, where N_i is the number of households in each respective village.

Selection and Sample Size for Respondent Focus Group Discussion

Six focus group discussions of mixed gender were held in various districts: Krong Serei Saophoan, Preah Netr Preah, and Thma Puok in Banteay Menchey province. Each group had seven to eight participants in the FGD. The responders were chosen by purposive sampling, with input from the Survivor Volunteer Network and the CMAA focal point for Persons with Disabilities.

2.5 Data Collection

2.5.1 Data Collection Tools for the Survey

Back to the 11th Meeting States Parties (11MSP) of APMBC in Cambodia in 2011, the President of the 11MSP declared “Mine/ERW survivors is the heart of Anti Personal Mine Ban Convention (APMBC)” and after the meeting, the Cambodian Campaign to Ban Landmine (CCBL) and Jesuit Refugee Service Cambodia (JRS), with strong collaboration from the CMAA developed the Quality of Life initiative. This team created a quality-of-life tool with input from Mine/ERW survivors and Persons with Disabilities, and it was implemented in 2012. This tool was managed by CMAA in 2014, and it was updated yearly to simplify words for users and modify some questions related to available services, such as Disability Identification Card for persons with disabilities in Cambodia and disability framework accordingly.

The tool has three questionnaires:

- A Village Profile that briefly describes the village history, the village leaders’ awareness of disability rights, and the number of Mine/ERW survivors and Persons with Disabilities living in the village.
- A Person with Disability Perception of Living Condition is a structured interview with each Mine/ERW survivor and Persons with Disabilities in each village at home to ascertain their situation by focus photo and GPS.
- A Life with Dignity Assessment is a Questionnaire for the quality of life of Mine/ERW survivors and Persons with Disabilities.

2.5.2 Data Collection Tools for the Focus Group Discussion

Sixes Focus Group Discussions (FGD) were conducted to explore participants' perceptions and experiences. The questions within the guide are typically open-ended to encourage discussion and provide qualitative data that complement the quantitative data from surveys. In quality of life research, an FGD can explore personal interpretations of living conditions and what it means to live with dignity, offering rich insights beyond numerical data.

2.5.3 Teams and Organization

- **Data collection period**

Survey data were collected in seven areas between July 2021 and October 2025. Furthermore, from November 8 to 12, 2025, qualitative data will be collected through Focus Group Discussions.

- **Team and training**

The district authorities appointed the 25 Survivors Volunteer Network (including 3 women and 3 Persons with Disabilities) as a survey data collector in consultation with CMAA. This survey data collector has experience in the community and is proficient in smartphones. In addition to the two days

of survey data collection, training and field testing were conducted. The refresher training on data collection methods and using digital questionnaires, as well as knowledge of disability laws and rights, was provided twice a year.

The recruited national consultation conducted FGDs and data analysis. These FGDs are a valuable qualitative method that can provide in-depth insights into the community's perceptions and experiences, enriching quantitative data.

- **Organization of data collection**

The survey was conducted using digital questionnaires via ArcGIS Survey123 at the participant's home and lasted approximately 30 minutes per respondent. In addition, FGDs, using the semi-structured interview questionnaire, was conducted in the commune council office and lasted approximately 80 minutes per group.

- **Data Management and Quality Control**

The chief of quality of life data conducts weekly and monthly quality checks on the database system, and the Quality Control team also conducts field visits to review data. This field visit includes verifying data with village leaders and focusing on disability types, family numbers, and demographics.

2.6 Data Encoding

In the data encoding and analysis phase, ArcGIS Survey 123 was utilized as a key tool for efficient mobile data collection. This platform enhanced the accuracy and efficiency of data gathering through mobile devices. The Database Unit (DBU) of CMAA was responsible for designing the system and providing continuous technical support, including necessary training sessions. Meanwhile, the Victim Assistance Department plays a vital role in overseeing and managing the data collection process, ensuring that the gathered data is analyzed and processed for inclusion in the monthly and quarterly statistical reports.

2.7 Data analysis

After verifying, cleaning, and coding the data, the data tables were produced based on the report table production plan prepared in advance. SPSS (statistical package for the social sciences) and Excel were used to generate data tables and figures, as well as to write explanations of the data presented in tables, figures, and maps.

Digital survey data was exported from ArcGIS Survey 123 to an Excel sheet. Responses are cleaned, and incomplete responses follow the questionnaire's skip logic. The consultant securely stores data, ensuring data protection and compliance with privacy regulations. The consultant regularly backs up data to prevent data loss. The consultant used Excel (pivotable) to analyze quantitative data collected through the digital survey and construct a do-file (code/command file) for transparent data cleaning and analysis replication.

FGD data was analyzed using deductive and inductive methods to analyze the transcripts, classifying quotes and qualitative insights according to specific quantitative data. While quotes were categorized by respondents, including type of disabilities, gender, age, and geography, all qualitative insights and quotes were anonymized to remove any identifying information about the interviewees.

2.8 Ethics

Data collectors were oriented and reminded of safeguarding policies, focusing on child protection and a code of conduct to ensure strict compliance. Informed consent was obtained (verbal), and respondents were assured confidentiality. Interviews were not conducted if consent was refused. Both female and

male enumerators were employed for sensitivity. CMAA guaranteed that survey data would remain confidential and not be shared with other organizations. Comprehensive training was provided to ensure the survey's professional and proper completion.

3. FINDINGS

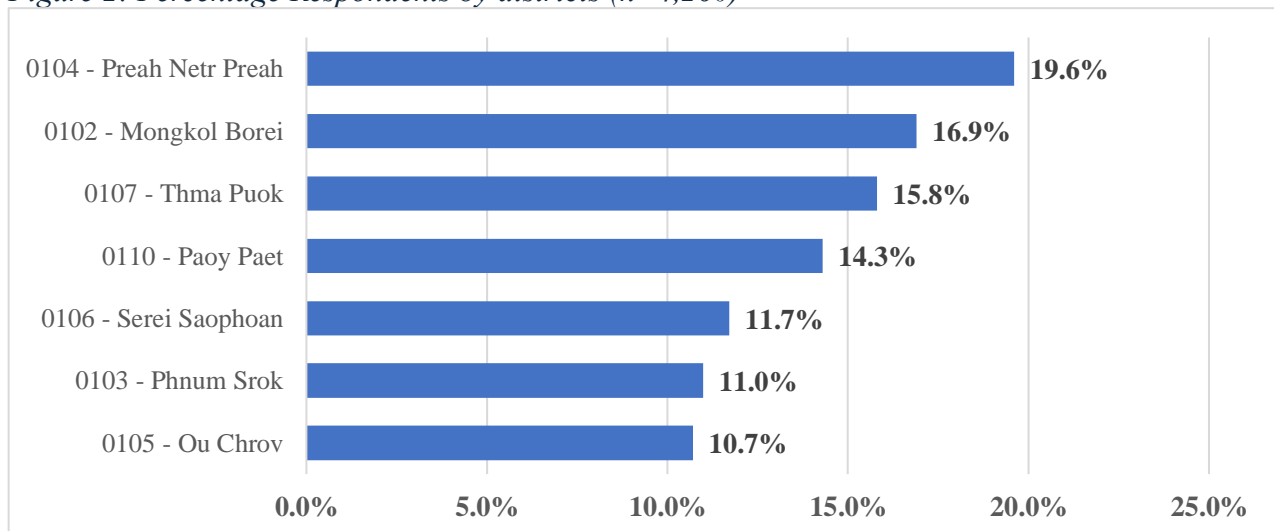
3.1 Demographic Profile

Banteay Meanchey Province has nine districts, 67 communes, and 664 villages. The province comprises a total of 201,381 households, with a population of 864,094 people, of whom 422,155 are female. The population density is approximately 124 persons per square kilometer.

Agriculture remains the dominant livelihood, with about 65% of residents engaged in farming and related agricultural activities such as rice cultivation, crop production, and livestock raising. The remaining 35% of the population is involved in business and non-agricultural sectors, including small trade, services, and various forms of commercial work. This combination of agricultural and business activities reflects the province's mixed rural and emerging urban economy, contributing to its overall socioeconomic development.

The study involved 4,260 Mine/ERW survivors and persons with disabilities across seven districts in Banteay Meanchey Province. The largest proportion of respondents came from Preah Netr Preah (19.6%), followed by Mongkol Borei (16.9%) and Thma Puok (15.8%), while Ou Chrov accounted for the smallest share at 10.7%. This distribution suggests that disability prevalence is concentrated in certain districts, likely due to historical mine contamination and socioeconomic factors.

Figure 2: Percentage Respondents by districts (n=4,260)



Gender and Age Profile

The report from the Cambodia Inter-censal Population Survey (CIPS) 2024 shows that about 27.7 percent of households were headed by females. The majority of the female heads of household were aged between 30-59 years (Table 10.2.4). This pattern has increased in each of the past three censuses (57.8 percent in 2019 and 58.0 percent in 2024). The CIPS 2024 found that 18.9 percent of household heads were widowed, divorced, or separated; 3.8 percent were never married; and 77.3 percent were currently married.

The majority of respondents were **male (66.2%)**, with females representing **33.8%**. This gender imbalance reflects the higher exposure of men to mine-related accidents, often linked to agricultural and labor activities in contaminated areas. In terms of age, the population is predominantly older: **39.6% are aged 60 years and above**, and **32.1% are between 45 and 59 years**. Combined, these two groups make up more than **70% of the sample**, indicating that most survivors and persons with disabilities are elderly, which may increase dependency and health care needs. And all so the female to join the focus group discussion has only 10% to discuss about benefits for the population with disabilities

Figure 3: Respondents, by gender (n=4,260)

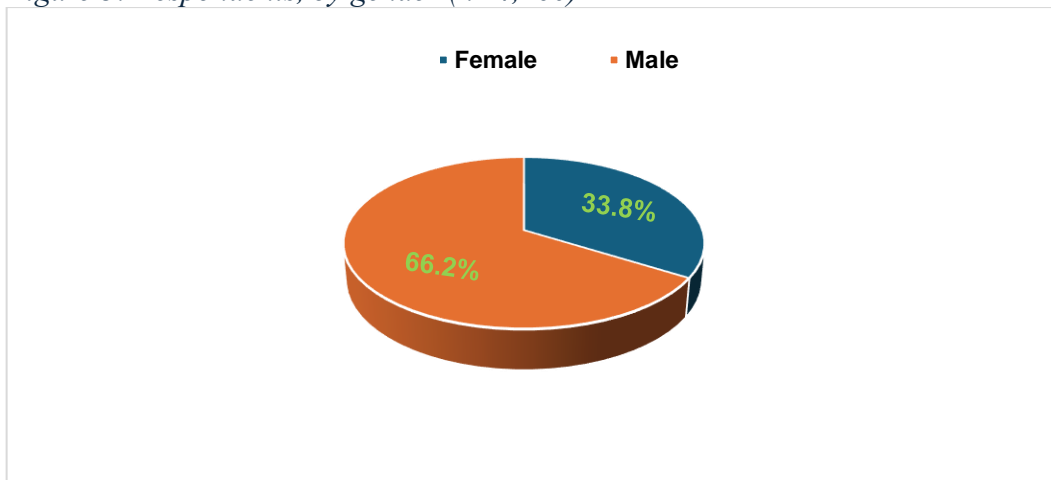
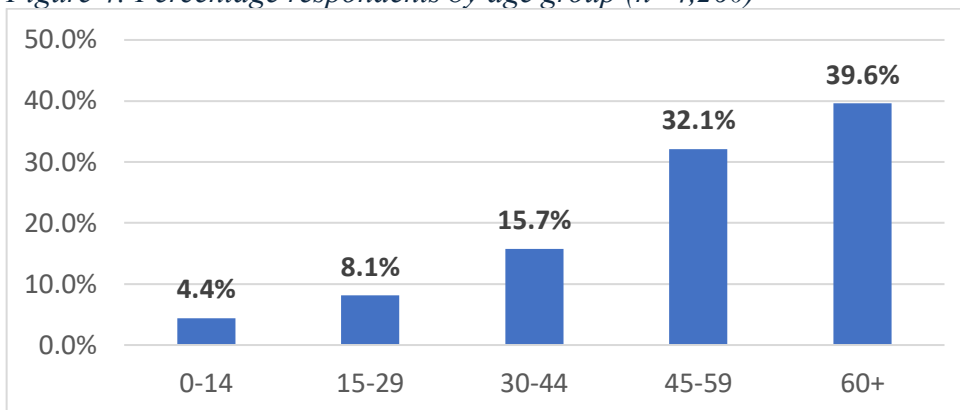


Figure 4: Percentage respondents by age group (n=4,260)



Family and Socioeconomic Status

The Cambodia Inter-censal Population Survey (CIPS) 2024 shows the percentage distribution of the population aged 5 and above with disabilities by their usual activity status. The percentage of persons with disabilities who were employed declined by **3.4% points overall—2.6 percentage points for men and 4.3 percentage points for women**. The employment rate of persons with disabilities in 2024 remained low, at **52.9%**.

The majority of responders (62.2%) are married, with 21% single and roughly 17% widows or widowers, indicating various levels of family support. Economic vulnerability is clear, with 34.2% classed as extremely poor, emphasizing the importance of targeted livelihood and social protection programs.

Figure 5: Respondents by marital status (n=4,084)

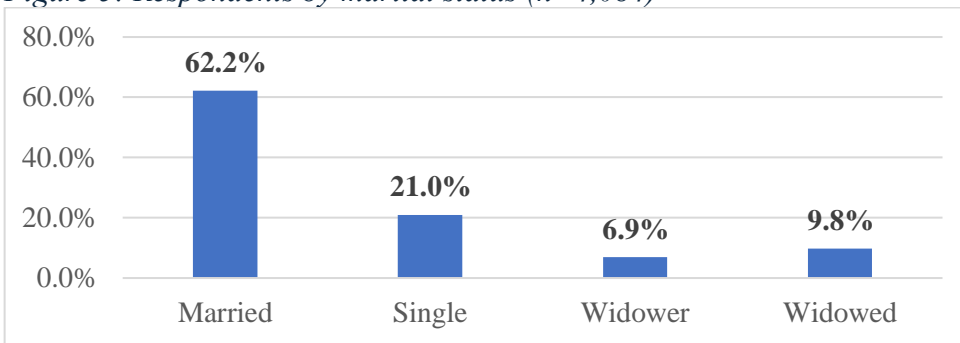
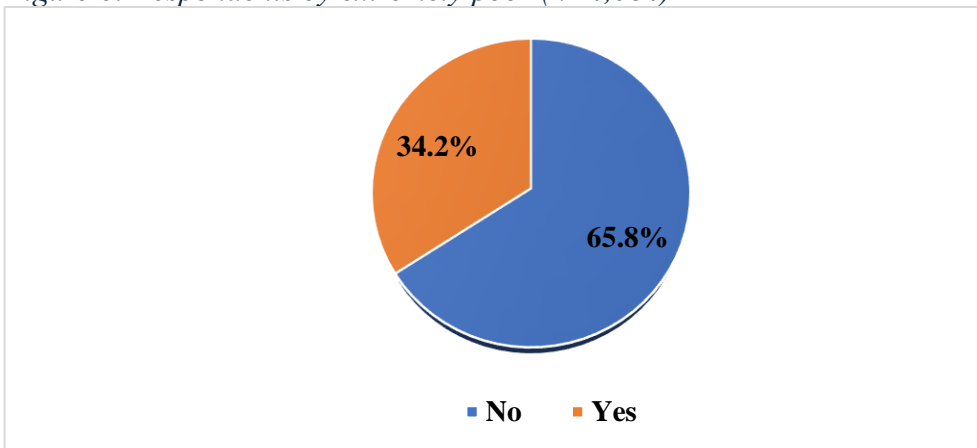


Figure 6: Respondents by extremely poor (n=4,084)



Causes and Types of Disability

Mine accidents remain the leading cause of disability, accounting for 27.4% of cases, followed by disease (23.4%), congenital conditions (17.3%), and explosive remnants of war (15.5%). Road accidents and other causes represent smaller shares. In terms of disability type, mobility impairment dominates (68%), followed by vision impairment (12.8%) and hearing and speech difficulties (6.2%). Mental and intellectual disabilities are less common but still significant, affecting over 8% combined.

Figure 7: Respondents by cause of accident (n=4,260)

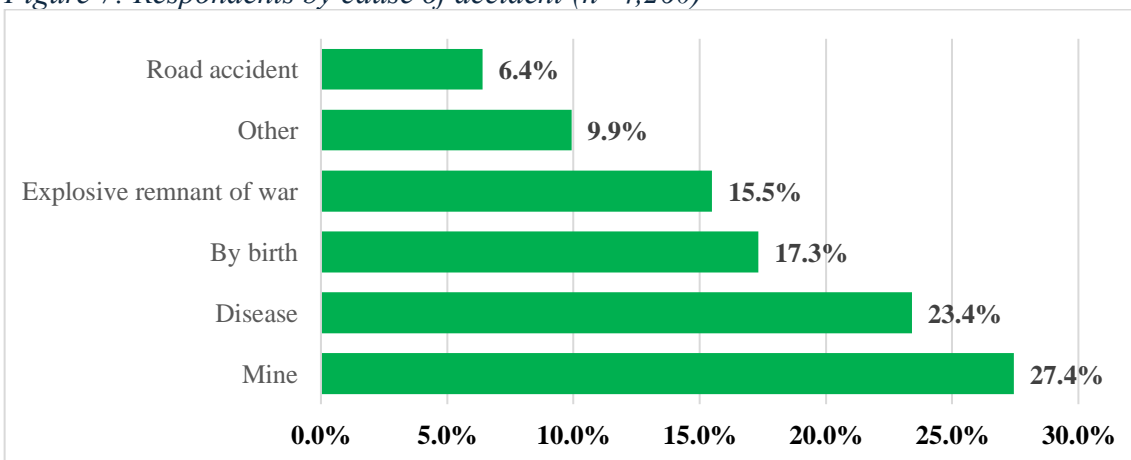
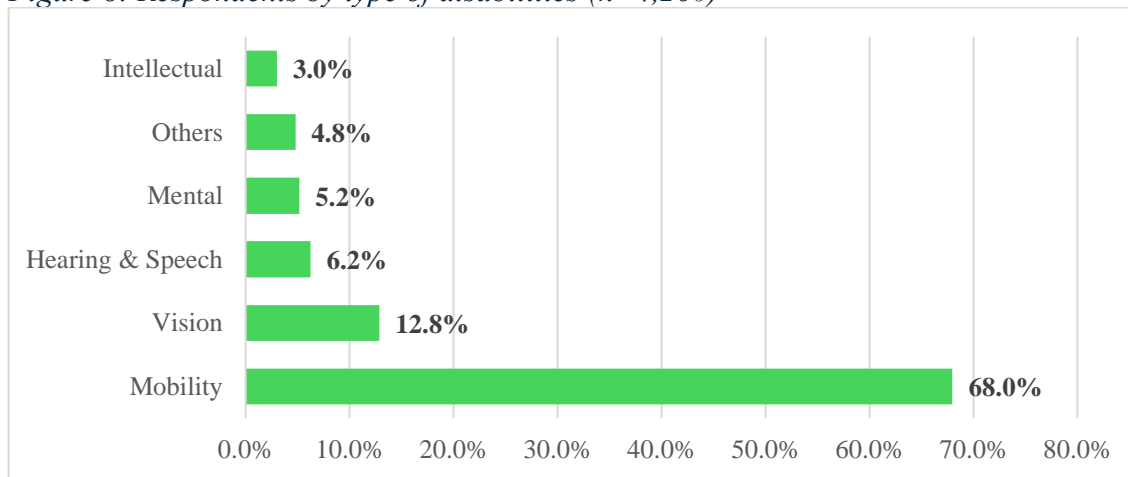


Figure 8: Respondents by type of disabilities (n=4,260)

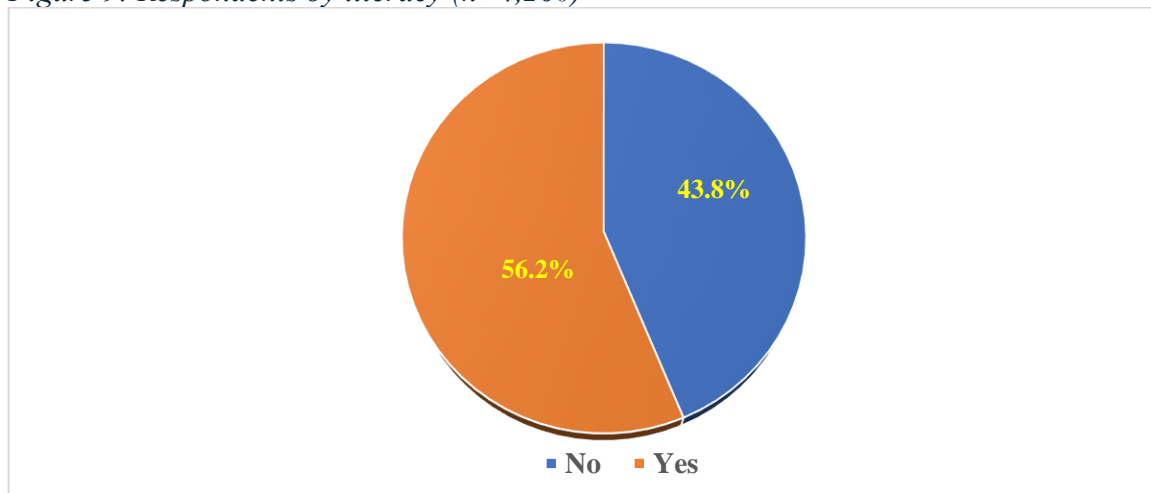


Literacy

This information is drawn from the national report based on data from the Cambodia Demographic and Health Survey (CDHS) 2021–22, which covers the entire country. The findings indicate that 21% of persons with mild or moderate disabilities and 26% of persons with severe disabilities have not completed primary school, compared with 16% of persons without disabilities. This reflects an education gap of 5–10 percentage points, equivalent to a relative gap of 33–65%, depending on the severity of the disability.

Literacy levels are relatively low, with **43.8% unable to read or write**. This poses challenges for accessing information, participating in community activities, and understanding rights and services available to them.

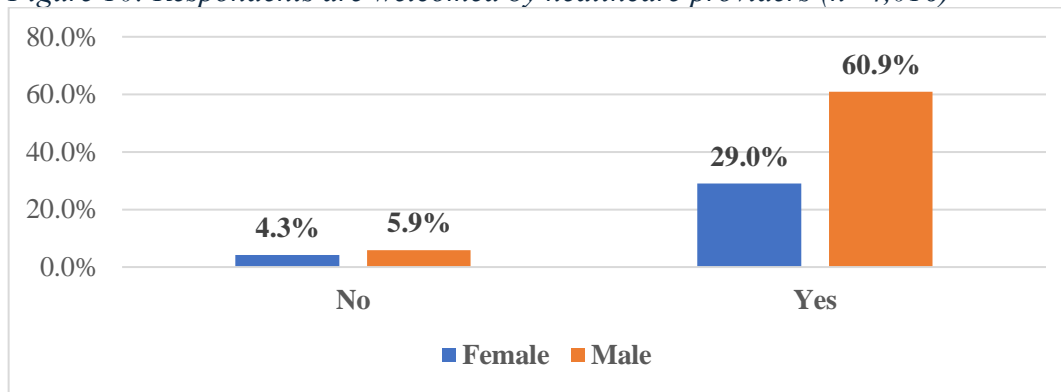
Figure 9: Respondents by literacy (n=4,260)



3.2 Healthcare

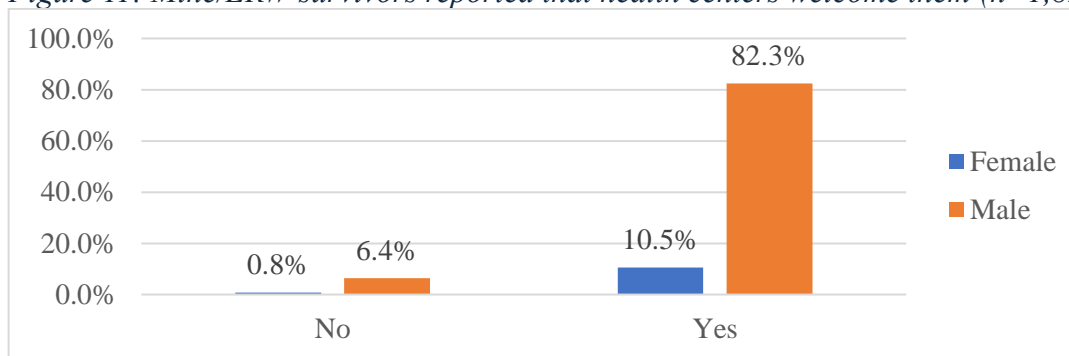
The majority of respondents reported positive experiences with local health facilities. **Nearly 90% (89.9%) indicated that health centers welcome Mine/ERW survivors and persons with disabilities**, with **29% being female and 60.9% male**, while only **10.1% felt otherwise** (4.3% female and 5.9% male). This suggests that health centers in Banteay Meanchey generally maintain an inclusive approach toward these vulnerable groups.

Figure 10: Respondents are welcomed by healthcare providers (n=4,016)



Among 1,829 Mine/ERW survivors, 92.8% reported that health centers welcome them, while only 7.2% said they do not. The graph shows a strong positive response overall, but women represent just 10.5% of those accessing services, indicating gender gaps in healthcare access.

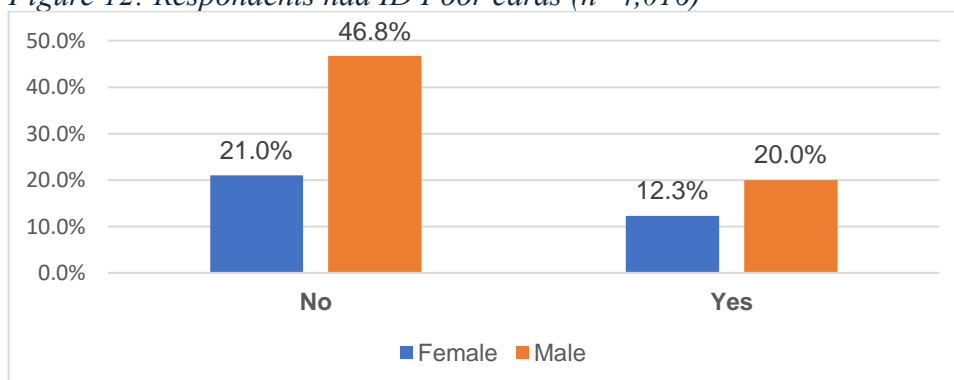
Figure 11: Mine/ERW survivors reported that health centers welcome them (n=1,829)



Access to social protection mechanisms, however, remains limited. Only 32.2% of respondents possess an ID Poor card, including 12.3% female and 20% male, leaving 67.8% without this critical support tool (21% female and 46.8% male). Among those who have the card, 96.1% have used it, with 36.4% female and 59.7% male, demonstrating that when available, the card is effectively utilized to access benefits.

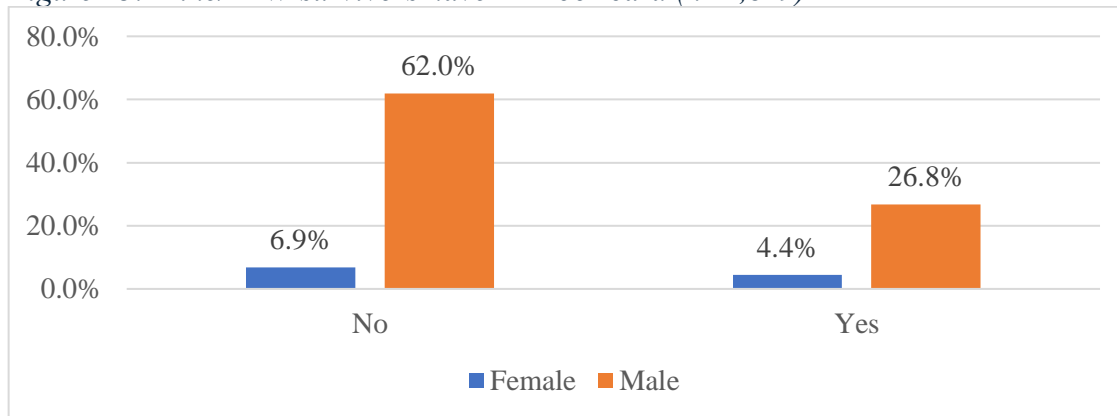
According to FGD, some participants explained that they did not receive an ID Poor card because they did not meet the government's criteria. This can include factors such as income level, family size, or lack of proper documentation. Additionally, some people did not know how to apply for the card or may not have had access to the application process.

Figure 12: Respondents had ID Poor cards (n=4,016)



Among 1,829 Mine/ERW survivors, only 31.2% reported having an IDPoor card, while the majority—68.8%—did not. The graph shows a clear gender disparity: 26.8% of men hold the card compared to just 4.4% of women, whereas 62% of men and 6.9% of women lack this critical social protection tool. This indicates that although access to ID Poor cards is limited overall, women are disproportionately excluded, which may hinder their ability to access health and welfare benefits.

Figure 13: Mine/ERW survivors have ID Poor card (n=1,829)



Similarly, coverage under the National Social Security Fund (NSSF) is low. Just **22.5% of respondents hold an NSSF card**, including **1.9% female and 20.6% male**, while **77.5% do not** (31.3% female and 46.1% male). Encouragingly, **94.9% of cardholders have used their NSSF benefits**, with **8% female and 87% male**, indicating strong uptake among those with access.

According to the focus group discussions (FGDs), a number of participants reported that they did not possess a National Social Security Fund (NSSF) card for several interrelated reasons.

First, many participants indicated that they had limited or no awareness of the NSSF program itself. They were not familiar with its purpose, benefits, or eligibility criteria, and lacked information on the procedures required to apply for an NSSF card. This lack of information was often linked to limited outreach or communication, particularly among individuals living in rural areas or those with lower levels of education.

Second, some participants explained that they were not eligible for NSSF membership because of the nature of their employment. Specifically, individuals working in informal sectors, such as self-employment, daily wage labor, agriculture, or small family businesses, are not required to register with the NSSF. Since NSSF coverage is primarily linked to formal employment in registered companies or institutions, these participants were excluded by default, even if they might benefit from social security protection.

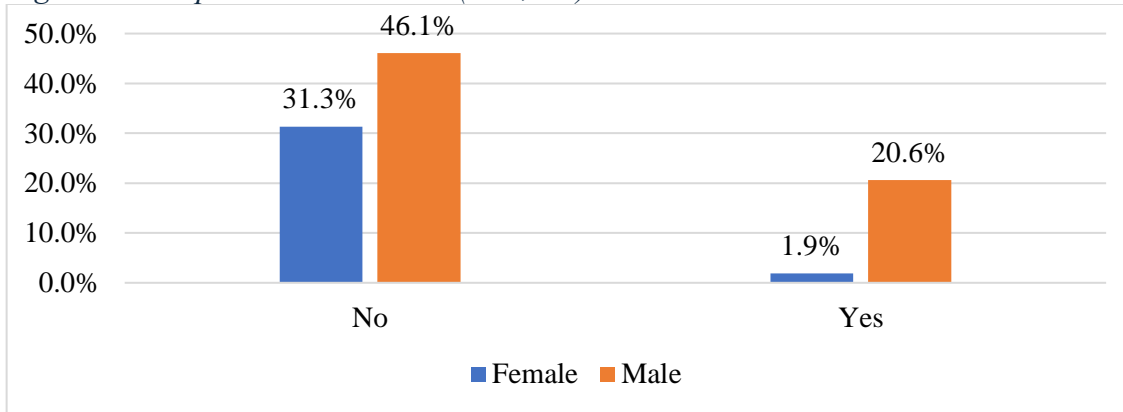
In addition, several participants expressed that they did not perceive a strong need to obtain an NSSF card. Some felt that the benefits were unclear or not relevant to their current situation, particularly if they were young, healthy, or had alternative coping mechanisms for health care and income support. Others were concerned about potential costs or contributions associated with the program, which discouraged them from seeking registration.

Finally, practical and administrative barriers also played a role. Some participants mentioned difficulties in accessing the application process, such as the distance to registration offices, lack of required documents, complex procedures, or limited assistance in completing the application. For persons with

disabilities or those with mobility constraints, these barriers were especially significant. Together, these factors help explain why a considerable proportion of FGD participants did not have an NSSF card.

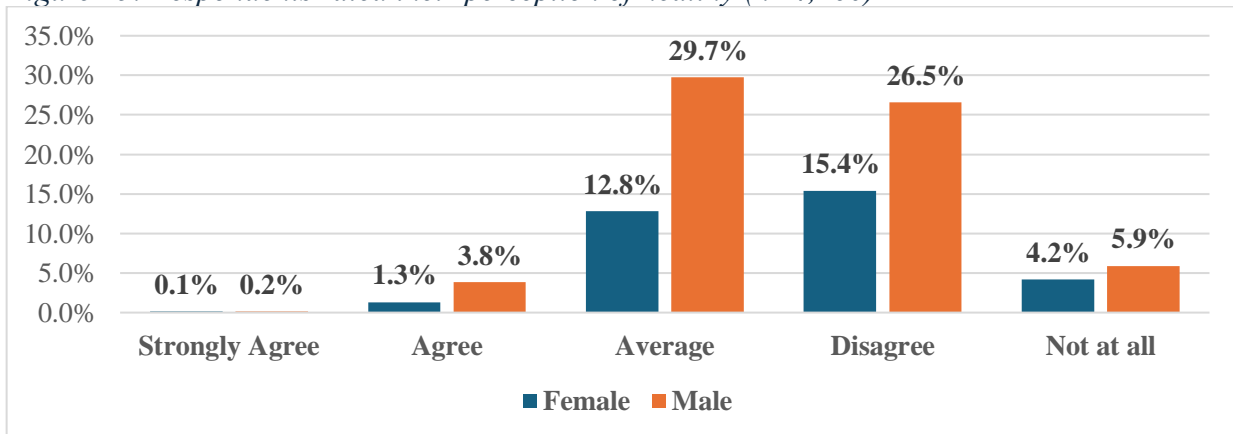
According to information from the Ministry of Social Affairs, Veterans and Youth, the total number of persons with disabilities who hold a disability identification card is 289,635, of whom 141,140 are female. In Banteay Meanchey Province, 16,187 persons with disabilities hold a disability identification card, including 7,839 females.

Figure 14: Respondents had NSSF (n=4,016)



When asked about their health status, responses revealed significant challenges. Only 5.4% of respondents agreed or strongly agreed that they feel healthy, including 1.4% female and 4% male, while 42.6% rated their health as average (12.8% female and 29.7% male) and 41.9% disagreed (15.4% female and 26.5% male), with 10.1% stating they do not feel healthy at all (4.2% female and 5.9% male). These findings highlight persistent health concerns among Mine/ERW survivors and Persons with Disabilities, despite the availability of some support mechanisms.

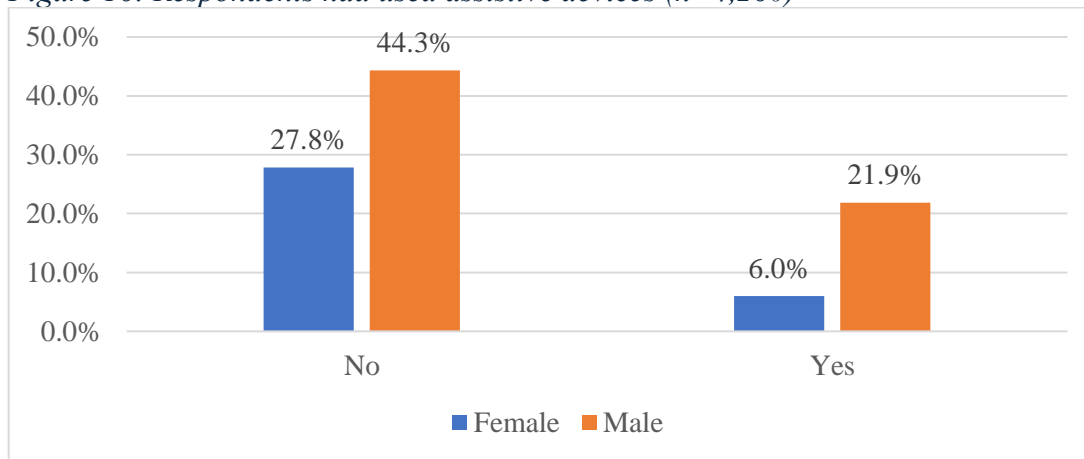
Figure 15: Respondents rated their perception of healthy (n=4,260)



3.3 Rehabilitation

Access to rehabilitation services and assistive devices among Mine/ERW survivors and Persons with Disabilities in Banteay Meanchey remains limited. **Only 27.9% of respondents reported having a prosthetic or assistive device**, while **72.1% do not have any**. Gender differences are evident: **6% of females and 21.9% of males have prosthetics**, showing that men are more likely to access such devices.

Figure 16: Respondents had used assistive devices (n=4,260)

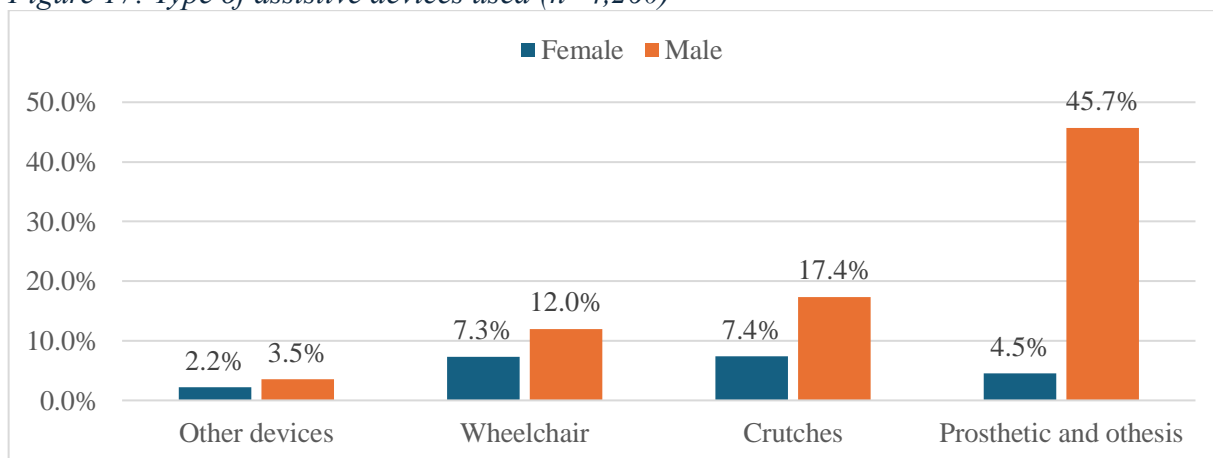


Types of Assistive Devices

Among respondents who use assistive devices, prosthetic and orthotic devices are by far the most common, accounting for 50.2% of all reported devices (4.5% women, 45.7% men). Crutches follow at 24.8% (7.4% women, 17.4% men), while wheelchairs represent 19.3% (7.3% women, 12% men). Other devices make up only 5.7% (2.2% women, 3.5% men).

This distribution highlights that prosthetic and orthotic devices dominate assistive technology use, particularly among men, whereas women show slightly higher representation in wheelchair use compared to other categories. These patterns may reflect differences in injury types, mobility needs, and access to rehabilitation services, suggesting the importance of gender-sensitive approaches in assistive device provision.

Figure 17: Type of assistive devices used (n=4,260)



Source of Assistive Devices

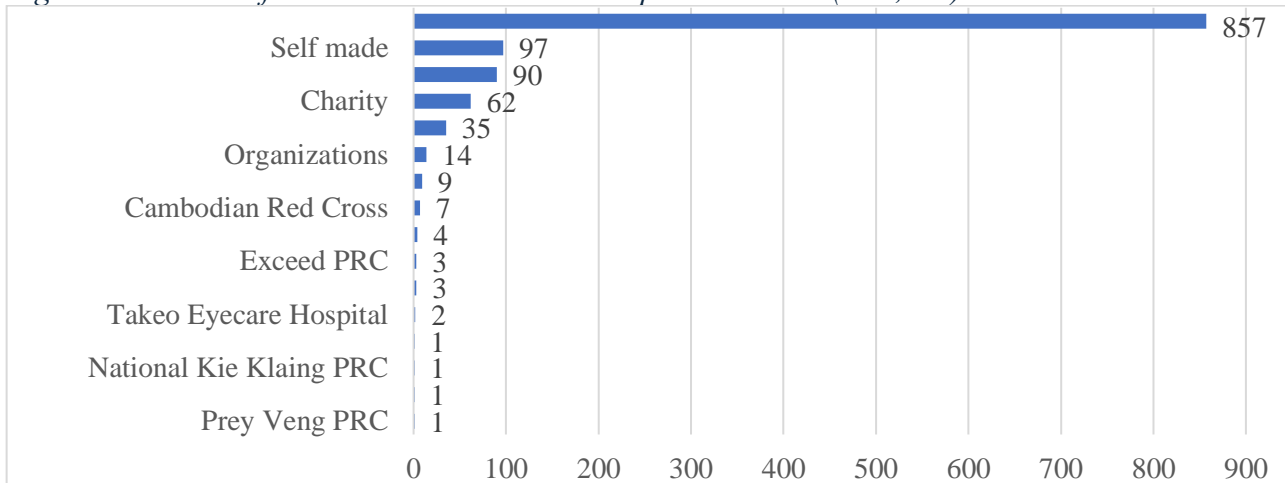
Among the 1,187 respondents who reported having assistive devices, the majority obtained them from Battambang Physical Rehabilitation Centers (PRC), which accounted for 857 cases, representing the primary source of prosthetic and rehabilitation support in the province. Other notable sources include self-made devices (97 cases) and purchases (90 cases), indicating that many individuals resort to personal solutions or buying equipment, likely due to limited institutional support.

With 62 cases receiving equipment from charity and 35 cases from other unidentified sources, charitable contributions also play a big part. Smaller numbers came from hospitals and rehabilitation facilities throughout Cambodia, including Siem Reap PRC (9 cases), Cambodian Red Cross (7 cases), and Battambang Hospital (4 cases), while organizations donated 14 cases. Only a few isolated cases were reported from facilities, including Prey Veng PRC, Kratie PRC, and National Kien Klaing PRC, while

specialized clinics like Exceed PRC (3 cases) and Kampong Cham PRC (3 cases) offered little assistance.

This distribution highlights a heavy reliance on Battambang PRC, supplemented by self-made solutions and charitable assistance, reflecting gaps in equitable access to rehabilitation services across the province.

Figure 18: Source of the assistive devices that respondents used (n=4,260)

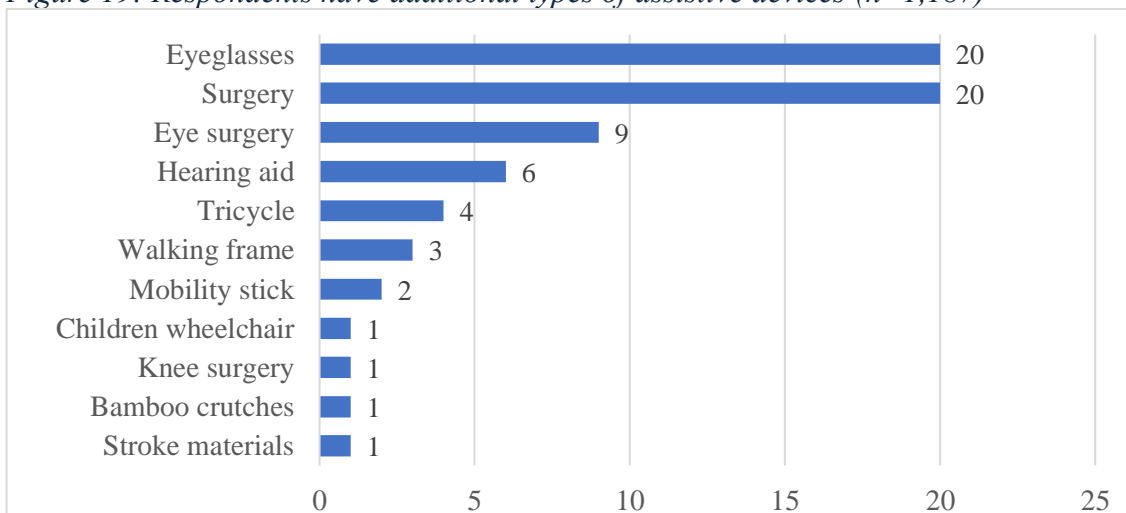


The survey identified a range of additional assistive devices reported by respondents, totaling 68 items across various categories, which represent specialized or alternative aids beyond standard prosthetics and orthoses. Eyeglasses and surgery were the most frequently mentioned, each appearing 20 times, together accounting for nearly 59% of all items. Eye surgery was noted 9 times, while hearing aids appeared 6 times, indicating some demand for vision and hearing support.

Mobility-related aids were also reported, including tricycles (4), walking frames (3), mobility sticks (2), and children’s wheelchairs (1). Other unique items, such as stroke rehabilitation materials, bamboo crutches, and knee surgery, were each mentioned once, reflecting diverse and individualized needs among respondents.

This distribution suggests that while prosthetic and orthotic devices remain dominant, there is a significant demand for vision correction and surgical interventions, as well as varied mobility solutions. These findings highlight the importance of tailoring assistive technology programs to address both common and specialized needs.

Figure 19: Respondents have additional types of assistive devices (n=1,187)

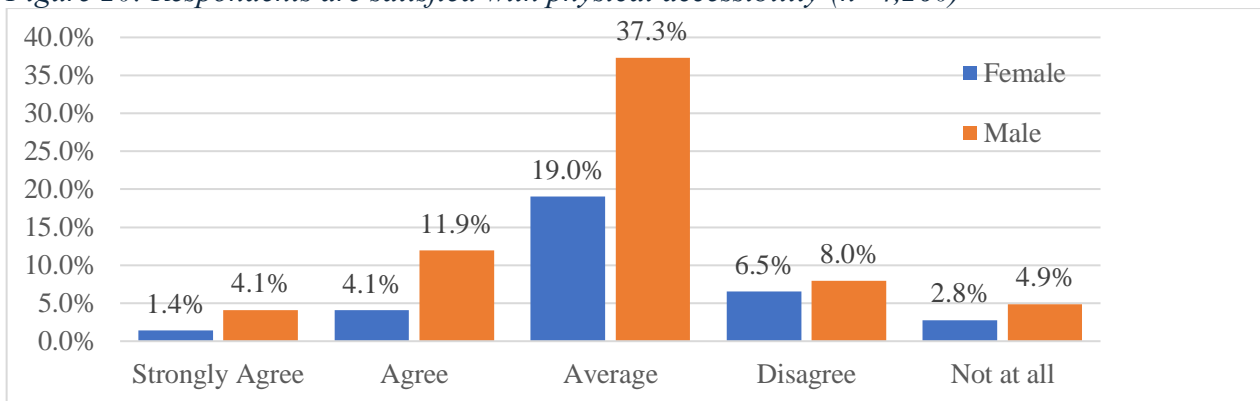


Satisfaction with Physical Accessibility

When asked about satisfaction with physical access around homes and public places, the majority of respondents (56.4%) rated access as Average, indicating that while basic accessibility exists, it is far from optimal. Positive responses were limited: only 5.5% strongly agreed and 16% agreed that they were satisfied. Conversely, 14.5% disagreed and 7.6% strongly disagreed, reflecting notable dissatisfaction among a significant minority.

Gender differences are evident. Men reported higher satisfaction overall, with 4.1% strongly agreeing and 11.9% agreeing, compared to women at 1.4% and 4.1%, respectively. Women were also more likely to express dissatisfaction, suggesting that accessibility challenges disproportionately affect them.

Figure 20: Respondents are satisfied with physical accessibility (n=4,260)



Satisfaction with Rehabilitation Services

The responses reflect mixed perceptions regarding the issue being assessed, indicating varying levels of satisfaction among respondents. Nearly 27% of respondents (27 out of those who received rehabilitation services ...) expressed overall satisfaction with the service or experience. Within this group, 14.5% reported being highly satisfied by strongly agreeing, while a further 12.3% indicated moderate satisfaction by agreeing. This suggests that slightly more than one quarter of respondents felt that the services met their expectations to some extent.

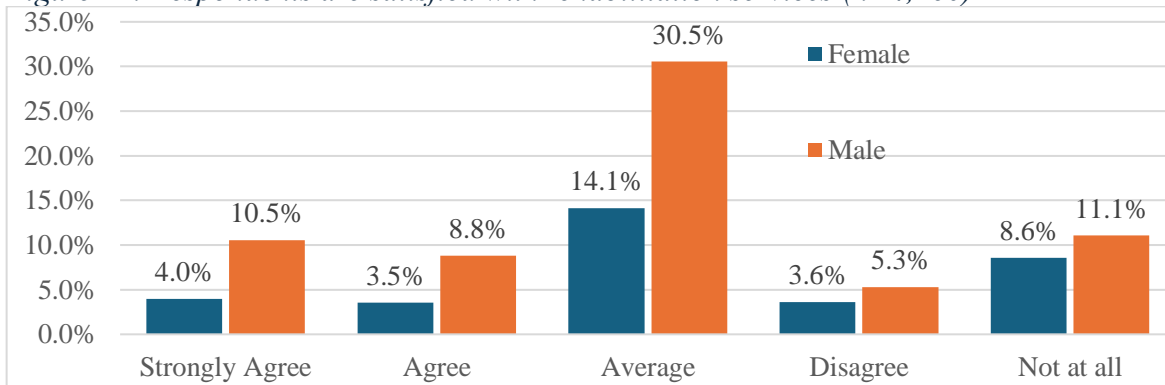
In contrast, a considerable proportion of respondents expressed dissatisfaction. Overall, 28.5% reported negative experiences, including 8.9% who disagreed and 19.6% who strongly disagreed with the positive statements about the service. The relatively high share of strong disagreement indicates that a notable segment of respondents experienced significant challenges or shortcomings, which may relate to issues such as service quality, accessibility, timeliness, or adequacy of support.

The largest group of respondents, accounting for 44.7%, rated their experience as “Average.” This suggests that for nearly half of the respondents, the services were neither clearly satisfactory nor entirely unsatisfactory. Instead, their experiences may have been acceptable at a basic level but lacking in key areas that would lead to higher satisfaction. Overall, the distribution of responses indicates that while some respondents had positive experiences, a substantial proportion perceived room for improvement, highlighting the need to address existing gaps in order to enhance overall service quality and user satisfaction.

Gender differences are notable. Men accounted for the majority of positive responses (10.5% strongly agree and 8.8% agree), whereas women reported lower satisfaction (4% strongly agree and 3.5% agree). Conversely, women were more likely to express dissatisfaction, with 8.6% selecting “Not at all”

compared to 11.1% of men. These findings point to persistent gender disparities, with women experiencing greater challenges and lower levels of satisfaction.

Figure 21: Respondents are satisfied with rehabilitation services (n=4,260)



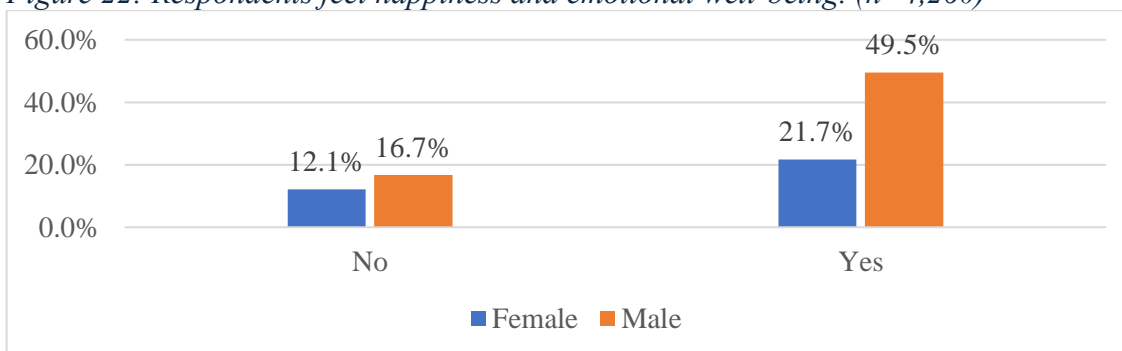
3.4 Psychosocial support

The psychosocial well-being of Mine/ERW survivors and persons with disabilities in Banteay Meanchey shows mixed results, with notable gender differences.

Happiness and Emotional Well-being

A majority of respondents reported feeling happy, with **71.2% saying “Yes”** and **28.8% saying “No”**. Among females, **21.7% reported being happy**, compared to **49.5% of males**, while **12.1% of females and 16.7% of males** said they were not happy. This suggests that men are more likely to report happiness than women.

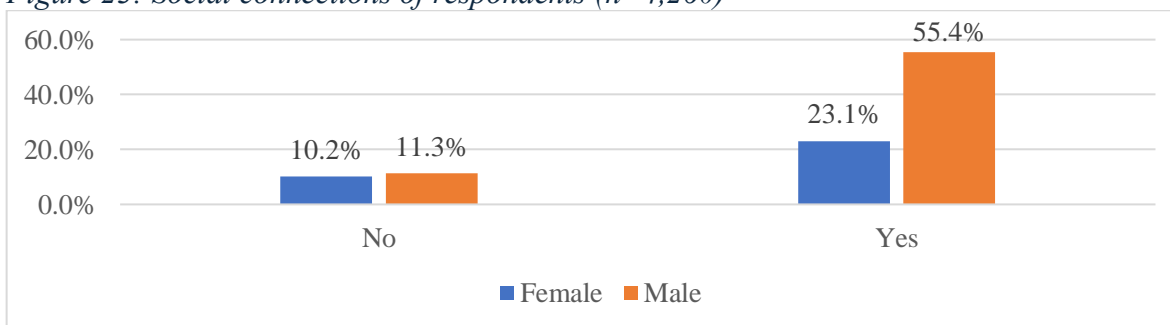
Figure 22: Respondents feel happiness and emotional well-being. (n=4,260)



Social Connections

Most respondents have friends in their village (**78.5% overall**), while **21.5% do not**. Gender analysis shows **23.1% of females and 55.4% of males** have friends, indicating stronger social networks among men.

Figure 23: Social connections of respondents (n=4,260)

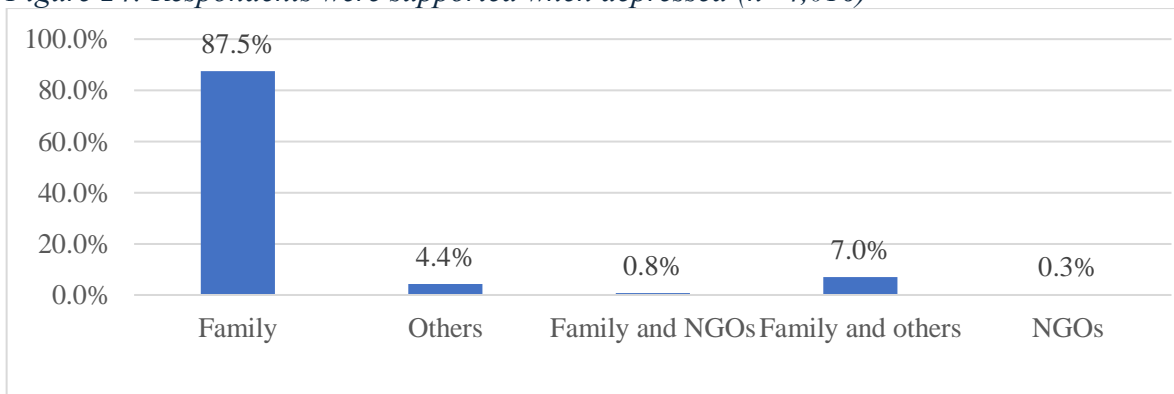


Support When Depressed

The survey reveals that family is overwhelmingly the primary source of emotional support, cited by 87.5% of respondents. A much smaller proportion—7%—reported relying on both family and others, while 4.4% depend solely on others. Support from NGOs is minimal, with only 0.8% mentioning family and NGOs together, and a mere 0.3% relying exclusively on NGOs.

This pattern underscores a heavy reliance on family networks for psychosocial support, highlighting the limited role of NGOs and other external actors in providing emotional assistance. Strengthening community-based and organizational support systems could help reduce this dependency and offer more diversified coping resources for Mine/ERW survivors and persons with disabilities.

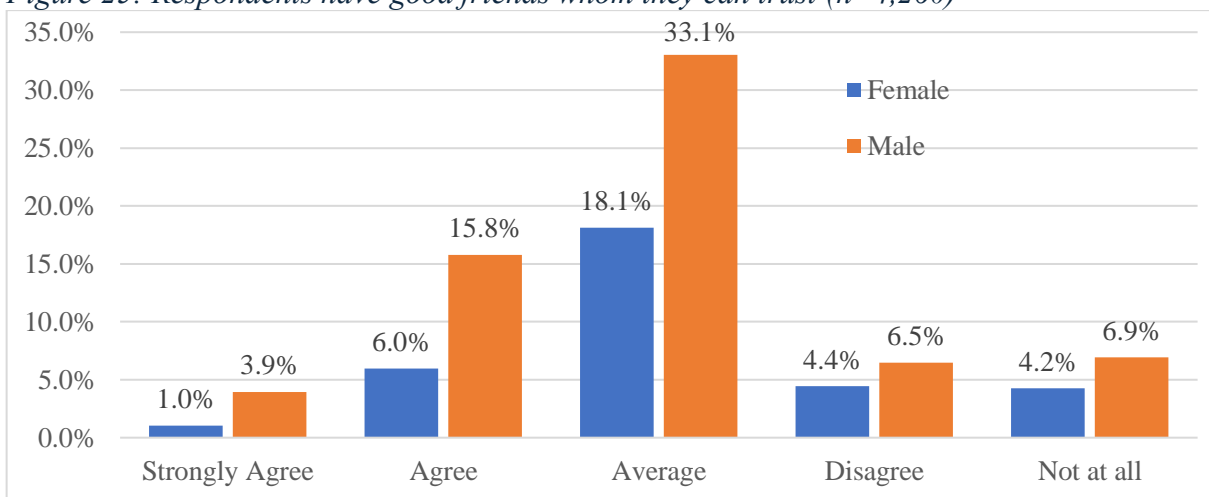
Figure 24: Respondents were supported when depressed (n=4,016)



Trust in Friends

When asked whether they have good friends they can trust, responses were mixed but leaned toward moderate confidence. Just 5% strongly agreed (with only 1% of women compared to 3.9% of men), and 21.8% agreed (6% women, 15.8% men). The majority—51.2%—rated their trust as average, indicating uncertainty or limited assurance in friendships (18.1% women, 33.1% men). Meanwhile, 10.9% disagreed and 11.2% said not at all, suggesting that over one-fifth of respondents lack strong trust in their social circles. Overall, men reported slightly higher levels of trust than women, pointing to a gender gap in perceived social support.

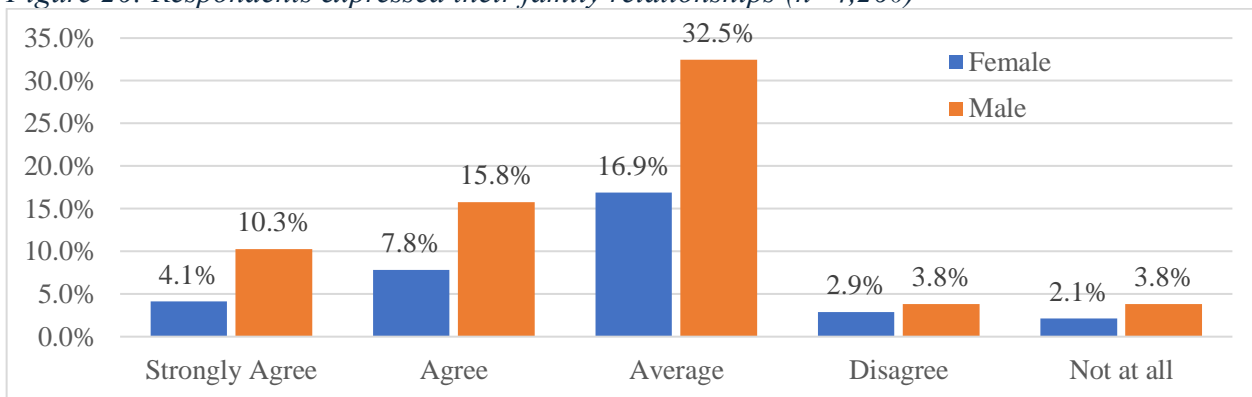
Figure 25: Respondents have good friends whom they can trust (n=4,260)



Family Relationships

When asked whether their family likes them, most respondents expressed positive feelings, though the strength of that sentiment varied. 14.4% strongly agreed (4.1% women, 10.3% men) and 23.6% agreed (7.8% women, 15.8% men), indicating that over one-third feel clearly accepted by their families. The majority—49.4%—rated their experience as average, suggesting a neutral or uncertain perception of family affection (16.9% women, 32.5% men). However, 6.7% disagreed and 5.9% said not at all, meaning nearly 12.6% expressed dissatisfaction with family acceptance. Women were slightly more likely than men to report feeling less accepted, pointing to a gendered dimension in perceived family support.

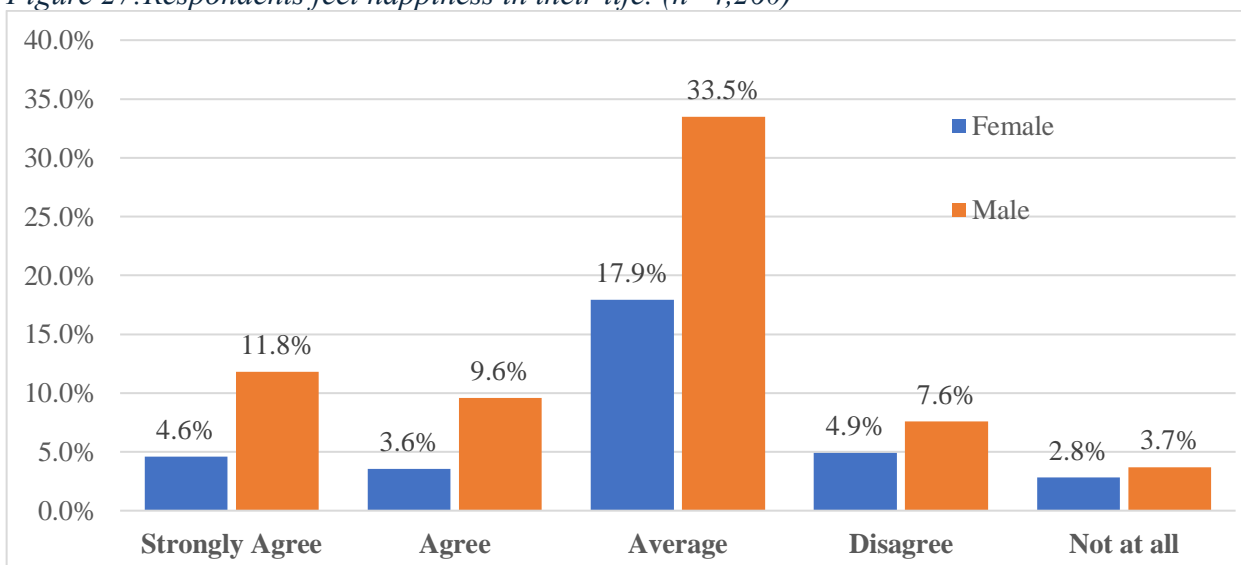
Figure 26: Respondents expressed their family relationships (n=4,260)



Life Satisfaction

When asked about their happiness in being alive, most respondents expressed moderate positivity rather than strong enthusiasm. 16.4% strongly agreed (4.6% women, 11.8% men) and 13.1% agreed (3.6% women, 9.6% men), meaning less than one-third reported clear happiness. The majority, 51.4%, rated their feelings as average, suggesting a neutral outlook on life (17.9% women, 33.5% men). However, 12.5% disagreed and 6.5% said not at all, indicating that nearly 19% expressed negative feelings about being alive. Women were slightly more likely than men to report dissatisfaction, pointing to a gendered difference in overall life satisfaction.

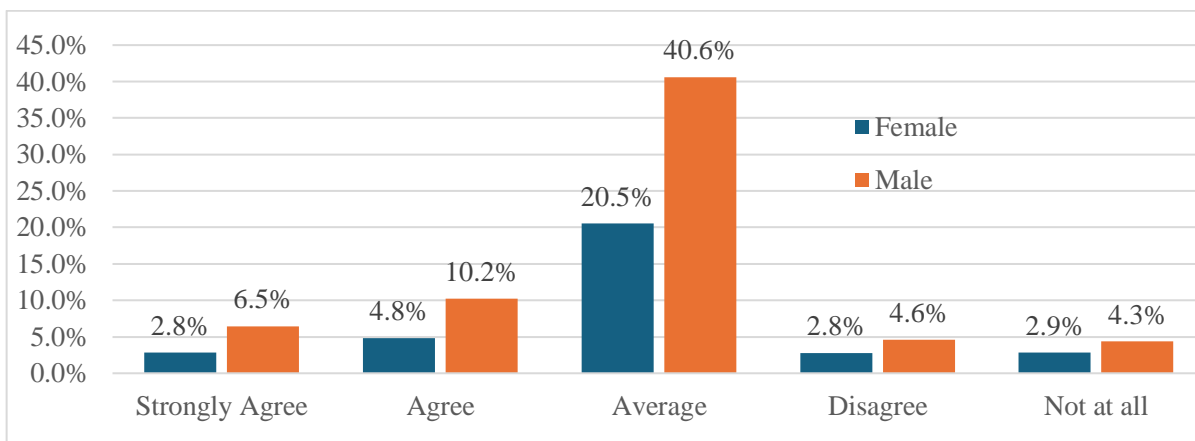
Figure 27: Respondents feel happiness in their life. (n=4,260)



Safety in Community

When asked about their sense of safety, most respondents reported feeling moderately secure rather than strongly confident. Only 9.3% strongly agreed that they feel safe (2.8% women, 6.5% men), and 15% agreed (4.8% women, 10.2% men). The majority—61.1%—rated their safety perception as average, suggesting a neutral stance (20.5% women, 40.6% men). However, 7.4% disagreed and 7.2% said not at all, meaning that 14.6% of respondents feel unsafe, with women slightly more likely to express concern. This indicates that while most respondents do not report feeling highly insecure, a significant minority experiences safety-related anxiety, warranting attention to protective measures and community reassurance.

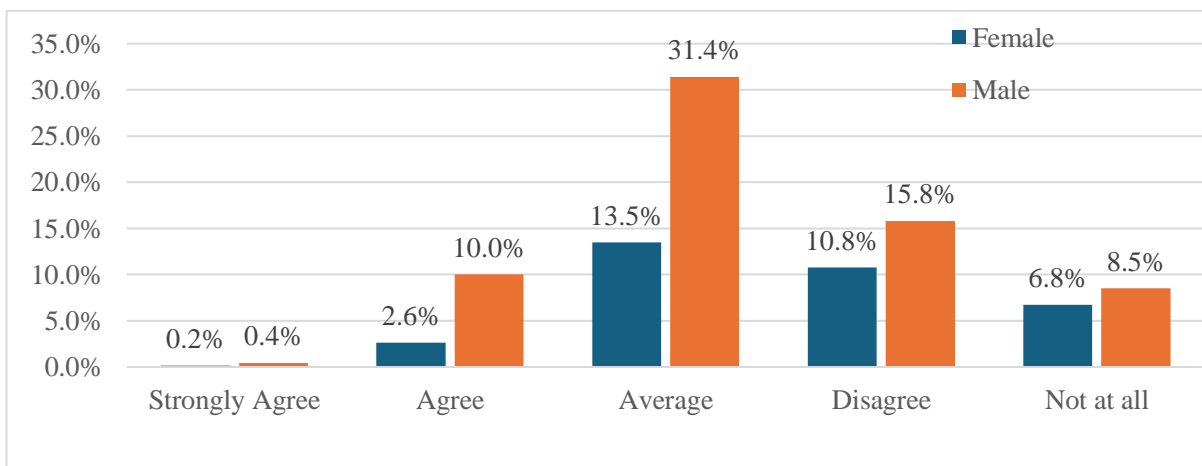
Figure 28: Respondents feel safe in my community (n=4,260)



Free Time Activities

When asked whether they have meaningful activities in their lives, responses suggest a considerable gap in engagement. Only 0.6% strongly agreed (0.2% women, 0.4% men) and 12.7% agreed (2.6% women, 10% men), meaning fewer than 14% feel clearly engaged in meaningful activities. The majority—44.9%—rated their experience as average, indicating uncertainty or limited fulfillment (13.5% women, 31.4% men). However, dissatisfaction is notable: 26.6% disagreed and 15.3% said not at all, totaling 41.9% who lack meaningful activities. Women appear slightly more affected than men, pointing to gender-related challenges in accessing purposeful opportunities. This highlights the need for programs that promote inclusive, meaningful engagement for Mine/ERW survivors and Persons with Disabilities.

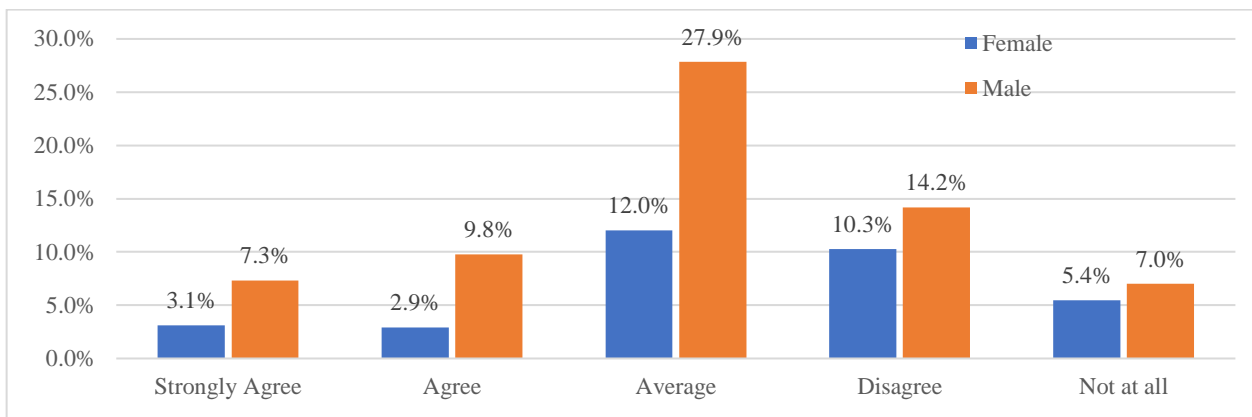
Figure 29: Respondents feel things to do in their free time (n=4,260)



Work Enjoyment

When asked about the enjoyment of work, responses indicate mixed feelings and notable challenges in occupational satisfaction. Only 10.4% strongly agreed that they enjoy their work (3.1% women, 7.3% men), and 12.7% agreed (2.9% women, 9.8% men), meaning just 23.1% expressed clear enjoyment. The largest share, 39.9% rated their experience as average, suggesting neutrality or ambivalence (12% women, 27.9% men). However, dissatisfaction is significant: 24.5% disagreed and 12.4% said not at all, totaling 36.9% who do not enjoy their work. Women appear slightly more dissatisfied than men, pointing to gender-related barriers or constraints in work conditions. These findings highlight the need for targeted interventions to improve job satisfaction and create more inclusive, supportive work environments.

Figure 30: Work enjoyment of respondents (n=4,260)



3.5 Social Participation

Availability of services (education/training) & access

Education access and participation remain limited among respondents. Only about one-third (34.6%) are currently attending school or training (n=243), indicating that ongoing education opportunities for adults are relatively scarce.

When asked about satisfaction with access to education and training, responses were mixed: just 22.0% agreed or strongly agreed that they are satisfied, while 38.0% expressed neutrality and 40.1% disagreed or said not at all (n=4,260). Gender differences are minimal, with 20.9% of women and 22.4% of men reporting satisfaction.

These findings point to significant gaps in educational service reach and quality, suggesting the need for targeted interventions to improve accessibility and relevance of training programs for Mine/ERW survivors and Persons with Disabilities.

Figure 31: Respondents have accessed education/training (n=4,260)

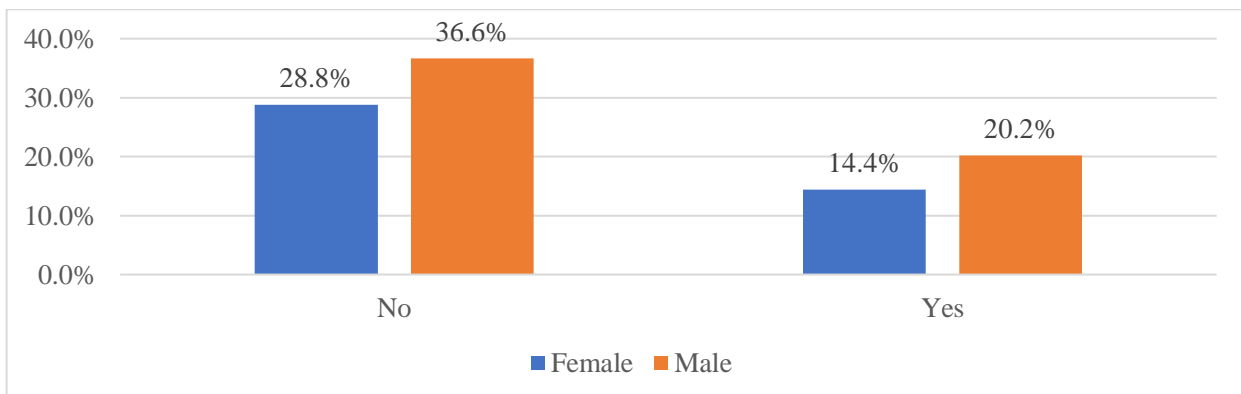
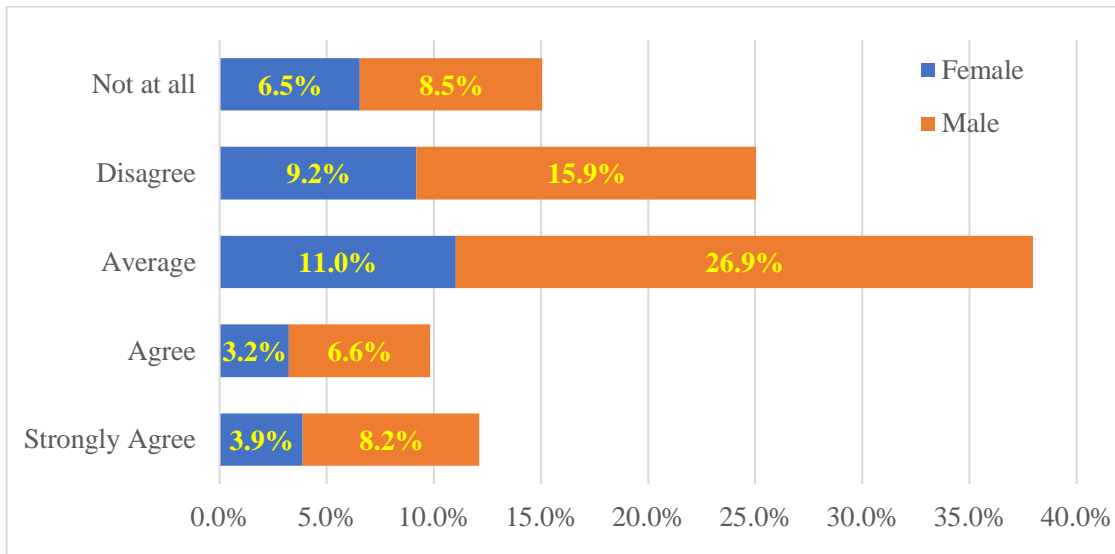


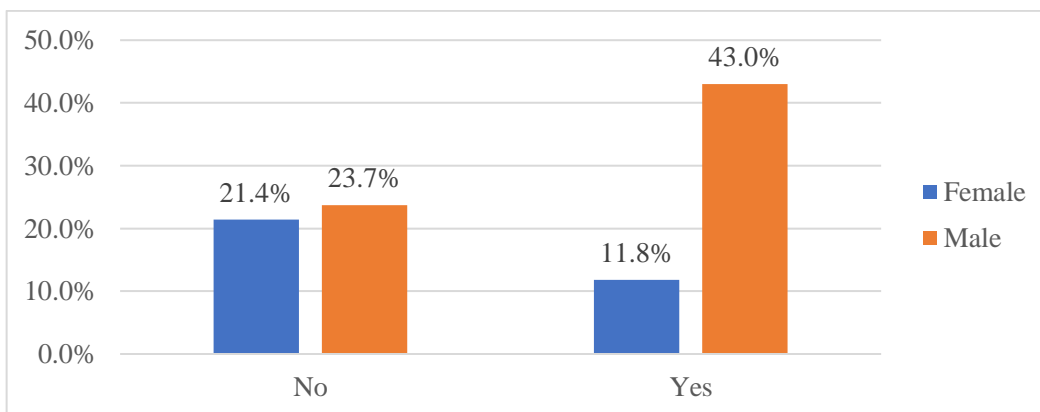
Figure 32: Participants are satisfied with access to education and training (n=4,260)



Community meeting

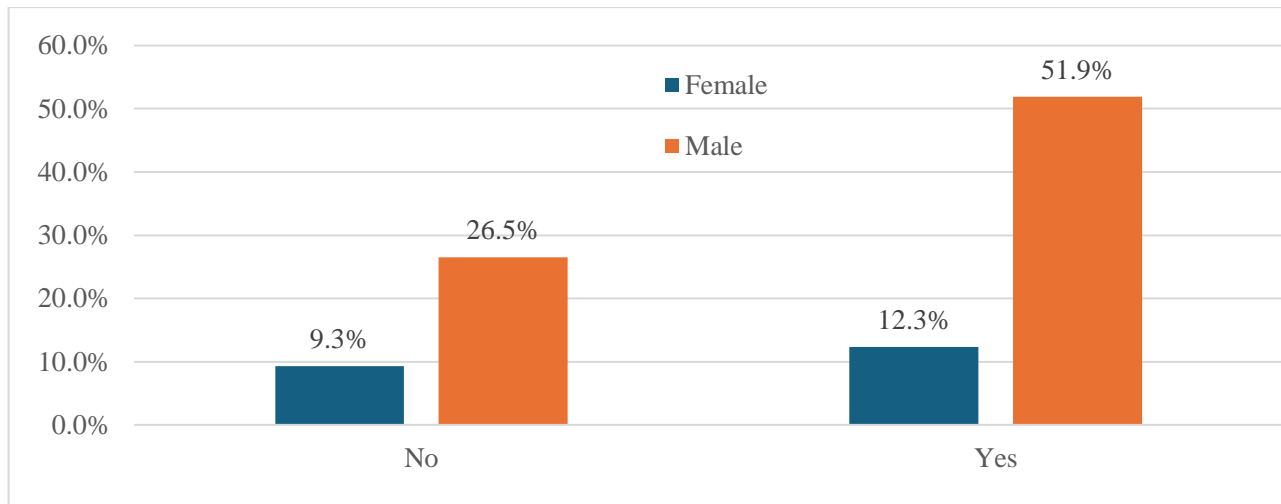
Participation in local governance activities shows a moderate level of engagement, but with a clear gender disparity. Just over half of respondents (54.8%) attend village meetings (n=4,016). However, men are far more likely to participate, with 64.4% reporting attendance compared to only 35.6% of women. This sizeable gap suggests that women face barriers, whether cultural, logistical, or structural, that limit their involvement in community decision-making processes. Addressing these barriers is essential to ensure inclusive participation and representation for Mine/ERW survivors and Persons with Disabilities.

Figure 33: Respondents attended village meetings (n=2,203)



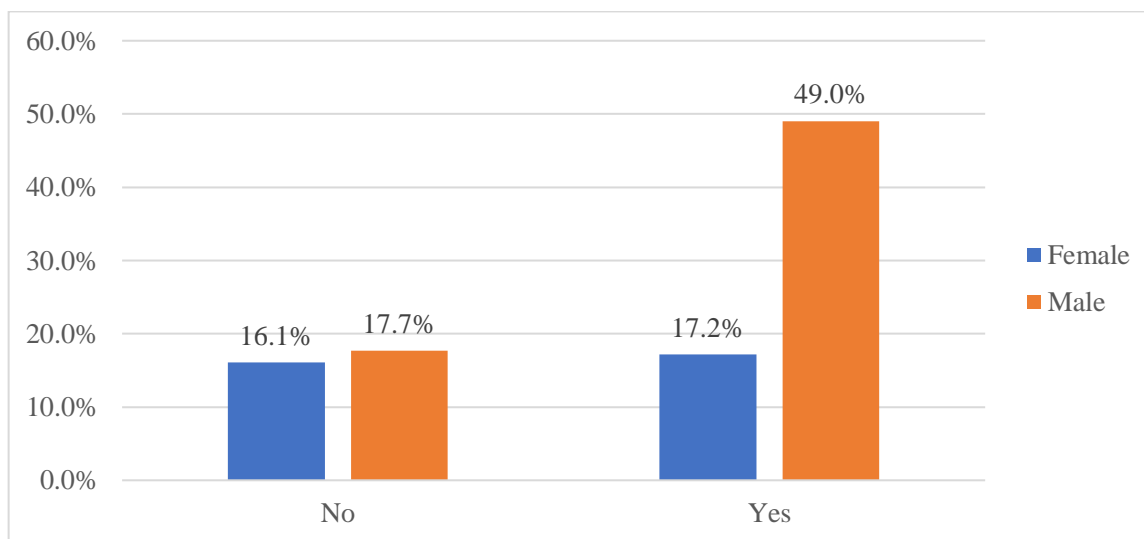
Among those who attend village meetings, 64.2% reported that they speak during these gatherings (n=2,203). Men are slightly more active in voicing their opinions, with 66.2% saying they speak, compared to 56.9% of women. This suggests that while both genders participate in discussions, men have a greater deliberative presence, indicating potential barriers for women in fully engaging in community decision-making processes.

Figure 34: Respondents spoke at the village meeting (n=2,203)



Attendance at community social events, such as weddings, is relatively high overall, with **66.2% of respondents reporting participation** (n=4,016). However, the data reveal a clear gender gap: **73.5% of men attend**, compared to only **51.7% of women**. While social network engagement appears strong, women’s lower participation suggests potential barriers—such as mobility challenges, cultural norms, or caregiving responsibilities—that may limit their involvement in community life. Addressing these constraints could help foster greater inclusion and strengthen social ties for women with disabilities and Mine/ERW survivors.

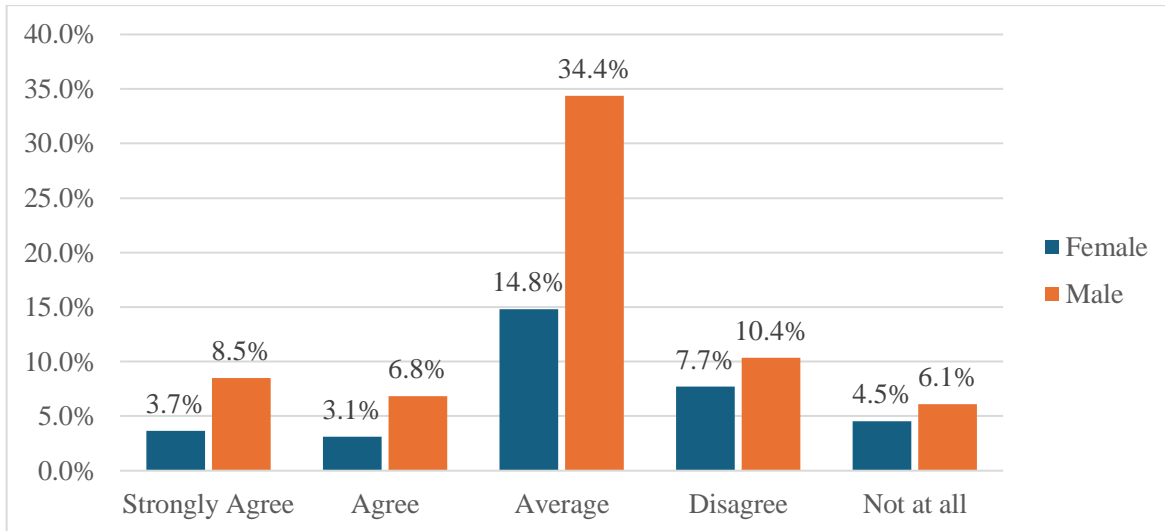
Figure 35: Respondents attended community social events (n=4,016)



Reflections on quality of life (community engagement & learning orientation)

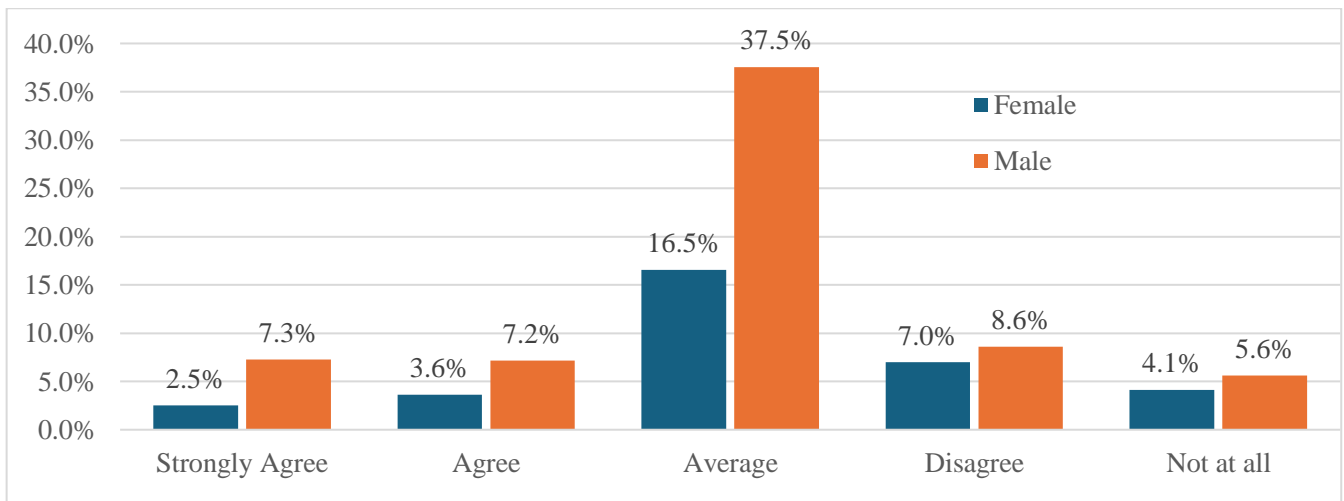
When asked whether they try to help others in their community, responses were mixed. Only 22.1% agreed or strongly agreed, indicating a modest level of proactive support, while 49.2% remained neutral, suggesting uncertainty or limited engagement. Meanwhile, 28.7% disagreed or said not at all (n=4,260), meaning nearly one-third do not actively help others. Men reported slightly higher agreement than women, pointing to a gender gap in perceived community contribution. These findings highlight the need for initiatives that encourage mutual assistance and strengthen social solidarity among Mine/ERW survivors and Persons with Disabilities.

Figure 36: Respondents actively help others in their community (n=4,260)



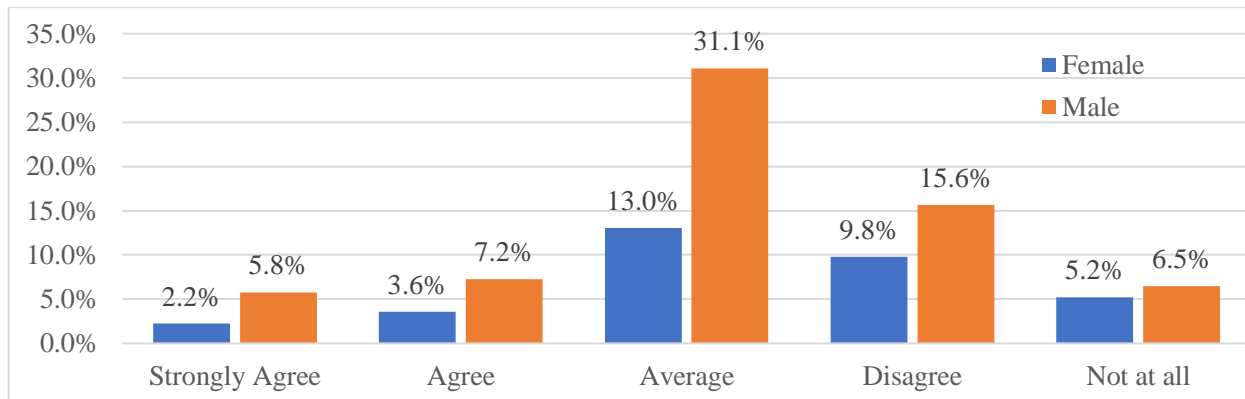
When asked whether they enjoy taking part in community activities, responses suggest moderate engagement. Only 20.6% agreed or strongly agreed, indicating clear enjoyment, while the majority, 54.1%, rated their experience as neutral, reflecting uncertainty or limited enthusiasm. Meanwhile, 25.3% disagreed or said not at all (n=4,260), meaning one in four respondents does not enjoy community participation. Overall, these findings point to moderate enjoyment levels, with many respondents undecided, highlighting an opportunity to strengthen inclusive and appealing community activities for Mine/ERW survivors and persons with disabilities.

Figure 37: Respondents enjoyed taking part in community activities (n=4,260)



When asked whether they like learning new things, responses indicate a relatively low level of enthusiasm. **Only 18.8% agreed or strongly agreed**, suggesting that fewer than one in five respondents actively enjoy learning. The majority, **44.1% rated their attitude as neutral**, while **37.1% disagreed or said not at all** (n=4,260). This limited agreement may reflect barriers such as lack of accessible learning opportunities, limited resources, or low confidence in acquiring new skills. Addressing these challenges through inclusive education and skill-building programs could help foster a stronger learning culture among Mine/ERW survivors and persons with disabilities.

Figure 38: Respondents like to learn new things (n=4,260)



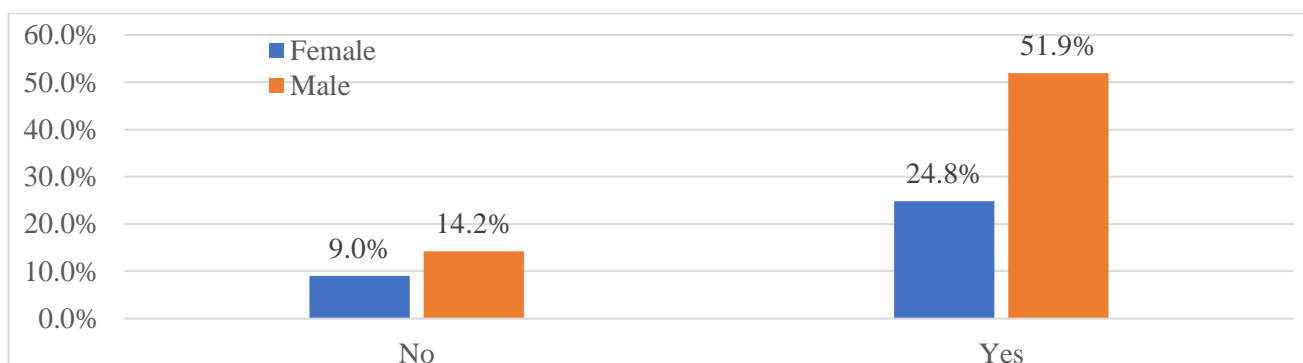
3.6 Economic inclusion

The survey reveals important insights into the economic conditions and quality of life of Mine/ERW survivors and Persons with Disabilities in the target districts.

Food Security:

A majority of respondents (76.7%) reported having enough food to eat, while 23.3% indicated they do not. Gender differences are evident: 51.9% of males and 24.8% of females reported food sufficiency. Despite this, a significant proportion still faces food insecurity, which impacts overall well-being.

Figure 39: Respondents have enough food to eat (n=4,260)



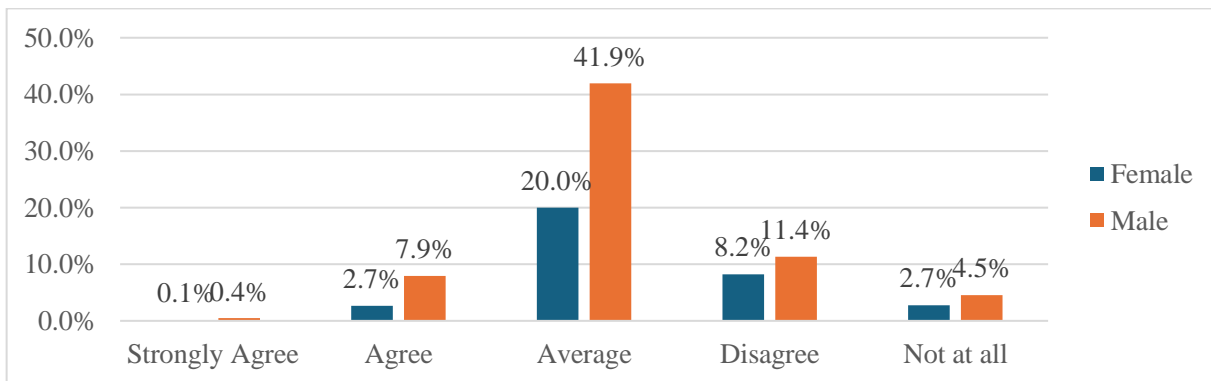
Most respondents rated their food sufficiency as *Average* (61.9%), suggesting that while basic needs are met, there is little margin for comfort. Only 10.6% agreed and 0.6% strongly agreed that they have enough food, whereas 19.6% disagreed and 7.3% strongly disagreed. Gender differences are notable: males (41.9%) were more likely than females (20%) to report an average level of food sufficiency, but dissatisfaction remains high across both groups.

According to the findings from the Focus Group Discussions (FGDs), a number of Mine/ERW survivors and persons with disabilities reported being unemployed due to multiple, interconnected barriers. Participants highlighted a general lack of job opportunities in their communities, particularly in rural areas where employment options are already limited. In addition, many survivors and persons with disabilities have low levels of formal education and limited access to vocational or technical skills training, which reduces their competitiveness in the labor market and restricts them to a narrow range of low-skilled jobs.

FGD participants also emphasized that negative perceptions and misunderstandings among employers further contribute to unemployment. Some employers were reported to have limited awareness of the abilities and potential contributions of persons with disabilities, often assuming they are unable to perform required tasks effectively. This lack of understanding discourages employers from hiring them, even when the individuals are capable of meeting job requirements with minimal or reasonable adjustments.

Moreover, structural and resource-related challenges were frequently mentioned. Several employers reportedly lack the financial resources, technical knowledge, or institutional support needed to make workplaces accessible, such as modifying physical infrastructure, providing adaptive equipment, or adjusting work processes. As a result, even willing employers may be unable to accommodate workers with disabilities. These combined factors—limited opportunities, insufficient education and skills, employer attitudes, and inadequate workplace accessibility—collectively hinder the employment prospects of Mine/ERW survivors and persons with disabilities.

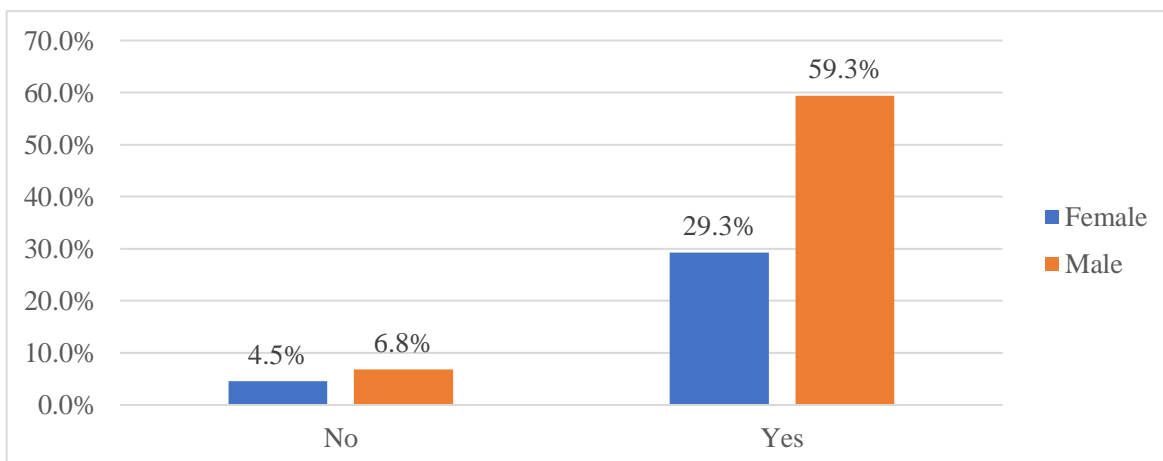
Figure 40: Respondents are satisfied with enough food (n=4,260)



Shelter:

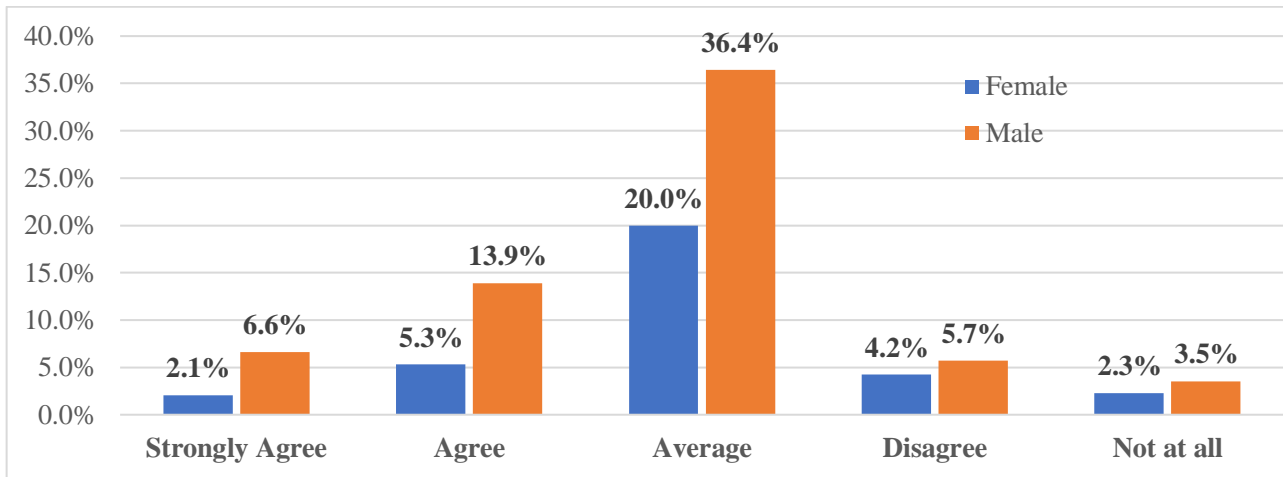
Access to housing is relatively high, with 88.6% of respondents having a place to live. However, 11.4% lack secure shelter, highlighting a critical area for intervention. Satisfaction levels with shelter are moderate, only 27.9% expressed happiness with their housing, while 15.8% were dissatisfied.

Figure 41: Respondents have a place to live (n=4,260)



Shelter conditions appear moderately satisfactory. Over half of respondents (56.4%) rated their shelter as Average, while 19.2% agreed and 8.7% strongly agreed they are happy with their housing. However, 10% disagreed and 5.8% strongly disagreed, indicating that a significant minority faces housing challenges. Gender analysis shows males reporting slightly higher satisfaction than females.

Figure 42: Respondents are satisfied with their shelter (n=4,260)

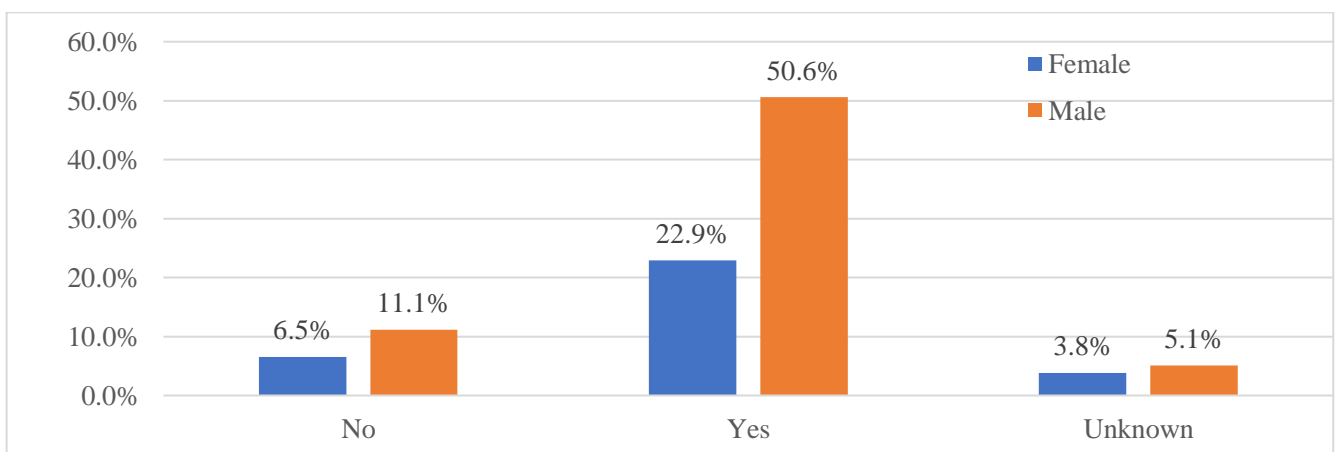


Land Ownership:

Land ownership is common among respondents, with 73.5% holding a land title. Yet, 17.6% do not own land, and 8.9% are unsure of their status. This uncertainty may limit economic stability and opportunities for agricultural development.

According to the Cambodia Demographic and Health Survey (CDHS) 2021, based on data from the National Institute of Statistics (NIS), a small but notable proportion of persons with disabilities live in households deprived of assets. Specifically, 2% of persons with mild or moderate disabilities and 4% of persons with severe disabilities were found to reside in households lacking essential assets, compared to only 1% of persons without disabilities. This indicates a disparity of 1 to 3 percentage points, depending on the severity of the disability, highlighting that persons with disabilities are slightly more likely to experience material deprivation at the household level.

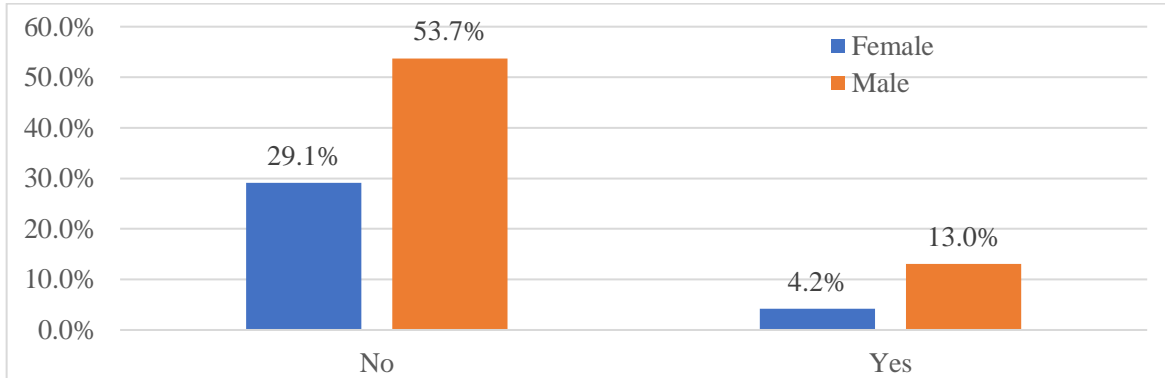
Figure 43: Respondents have land ownership (n=4,018)



Access to Micro-Credit:

Only 17.2% of respondents have access to micro-credit loans, while 82.8% do not. Among those with loans, 63.8% reported that the loan helps improve their situation. Expanding access to micro-credit could support small business development and income generation.

Figure 44: Respondents have access to micro-credit loans (n=4,017)



Employment:

Employment opportunities remain limited. Just 37.8% of respondents have a job, while 62.2% are unemployed. Among those employed, most work in agriculture (36.5%), followed by self-employment (19.8%) and casual labor (19.6%). Formal employment in government, NGOs, or private companies accounts for less than 10%, indicating a reliance on informal and subsistence activities.

Figure 45: Respondents have a job (n=4,016)

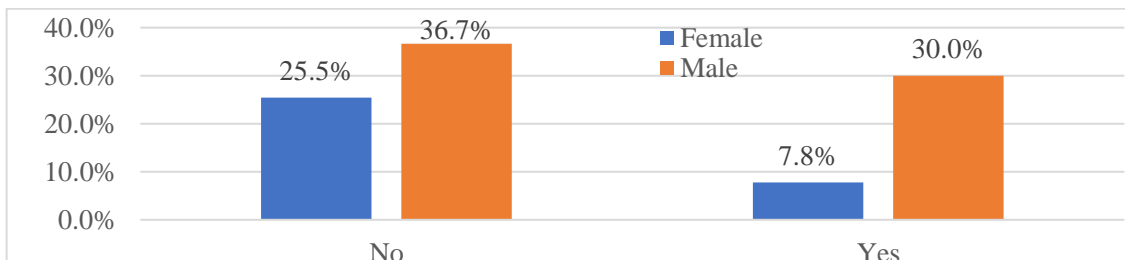
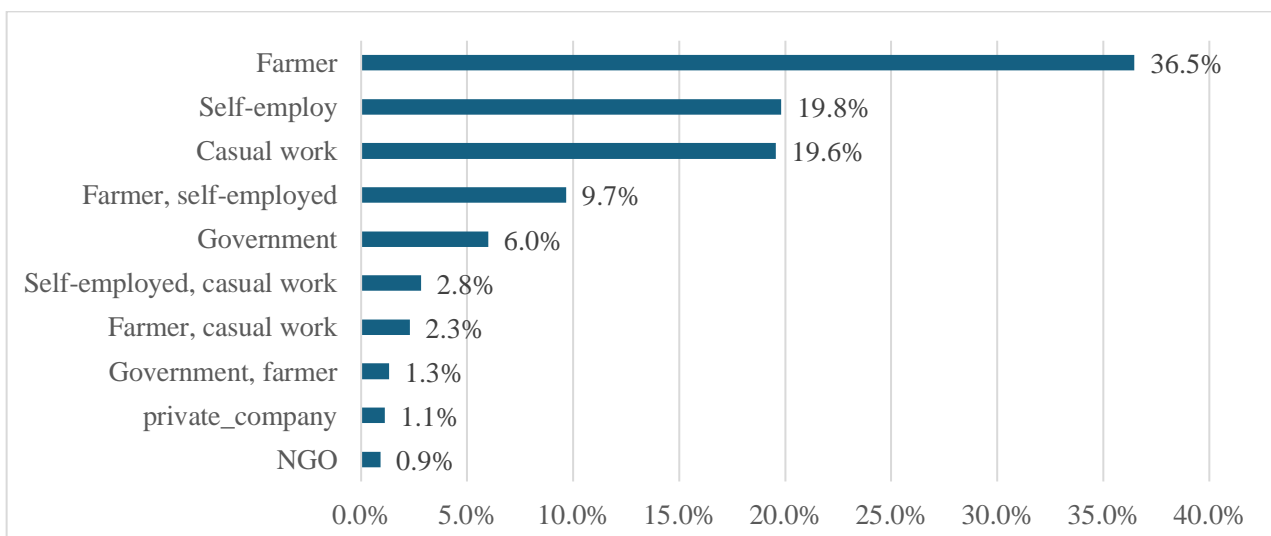


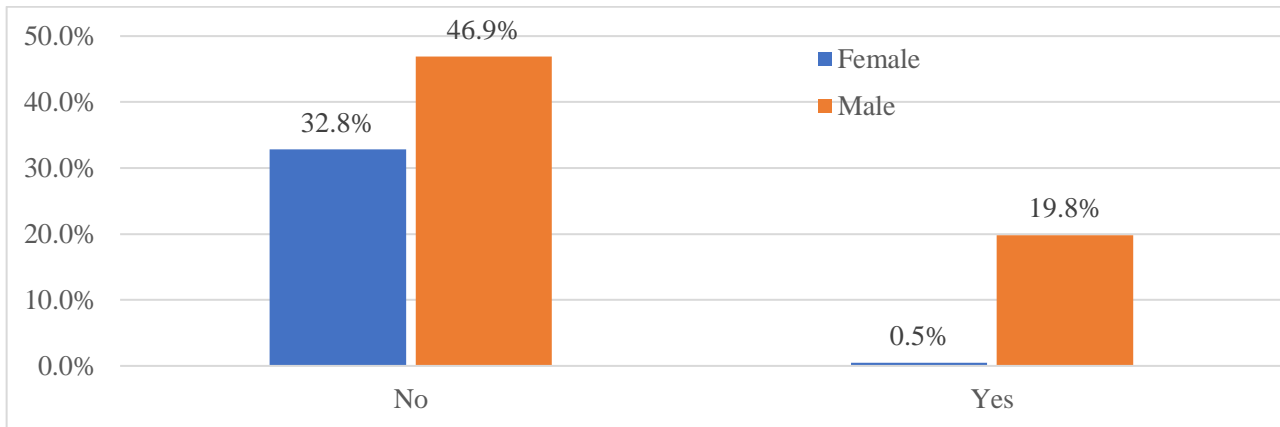
Figure 46: Type of job of respondents (n=4,016)



Pension Coverage:

Only 20.3% of respondents receive a pension, while 79.7% do not. Gender disparities are stark, males are far more likely to receive pensions (19.8%) compared to females (0.5%). This gap underscores the need for inclusive social protection measures.

Figure 47: Respondents receive a pension (n=4,016)



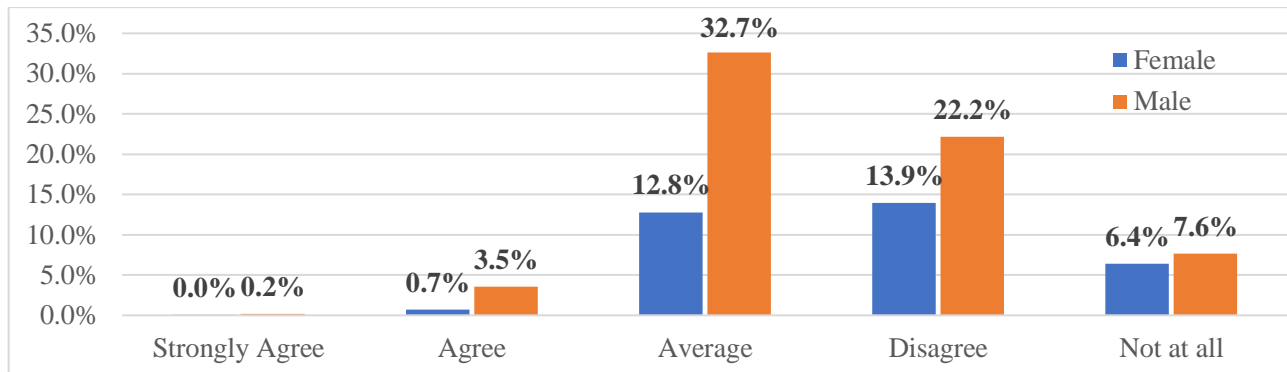
Perceived Quality of Life:

According to the Cambodia Demographic and Health Survey (CDHS) 2021, using data from the National Institute of Statistics (NIS), a significant proportion of persons with disabilities live in poor-quality housing, which reflects broader challenges related to living conditions and socio-economic vulnerability. The survey found that 63% of persons with mild or moderate disabilities and 66% of persons with severe disabilities resided in housing considered to be of poor quality. In comparison, 57% of persons without disabilities lived in similar conditions. This indicates a gap of 6 to 9 percentage points, or 11 to 16% depending on the severity of the disability, showing that persons with disabilities are more likely to face inadequate housing conditions.

Poor-quality housing can include factors such as structurally weak dwellings, inadequate access to clean water and sanitation, unsafe or deteriorating building materials, and limited space or ventilation. These conditions not only affect physical health and safety but also contribute to social and economic disadvantages, as individuals may struggle with accessibility, privacy, and opportunities for study or work within the home. The data highlights that housing challenges are particularly pronounced for persons with severe disabilities, emphasizing the need for targeted interventions, such as inclusive housing programs, financial support, and policies that improve the safety, accessibility, and overall quality of homes for vulnerable populations.

Subjective well-being indicators show widespread dissatisfaction. Only 4.2% agree they have enough income to live with dignity, while 36.1% disagree and 14% strongly disagree. Similarly, perceptions of food sufficiency and shelter satisfaction are low, reflecting economic vulnerability.

Figure 48: Respondents are satisfied with well-being (n=4,260)



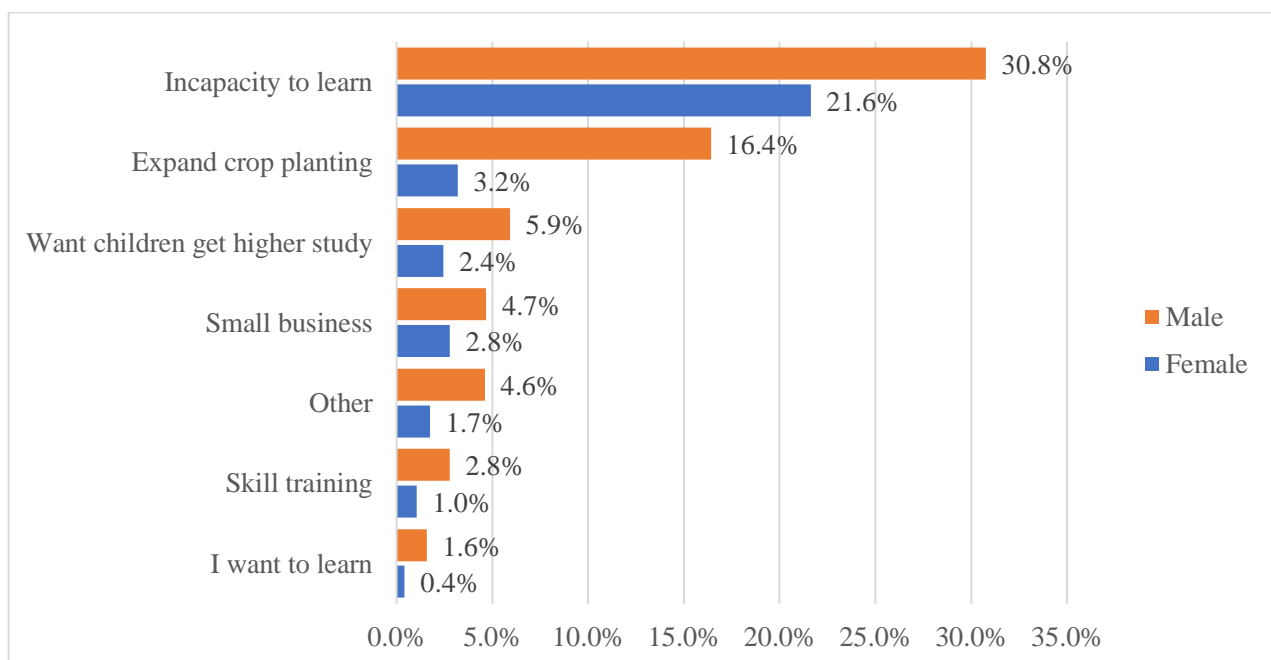
Suggestions for Improvement:

When asked how they could improve their quality of life, 52.4% cited incapacity to learn as a barrier, while 19.6% suggested expanding crop planting. Other priorities include starting small businesses (7.5%) and supporting children’s education (8.4%). These responses highlight the need for skills training, livelihood support, and educational opportunities.

According to the findings from the FGDs, persons with disabilities expressed that all individuals with disabilities should receive a regular salary or financial support, particularly because many face significant challenges in finding employment or accessing other sources of income. Participants highlighted that due to physical limitations, lack of skills training, and limited job opportunities, many are unable to secure stable work and, as a result, cannot sustain themselves or their families.

They emphasized that providing a guaranteed salary or social benefit would help reduce economic vulnerability and improve their overall quality of life. Such financial support would not only assist with meeting basic needs like food, healthcare, and education but also enable greater participation in community activities and access to services. The discussions underscored the importance of government and NGOs recognizing the economic challenges faced by persons with disabilities and implementing measures to ensure they have a secure and dignified livelihood.

Figure 49: Respondents are planning to improve their quality of life (n=4,016)



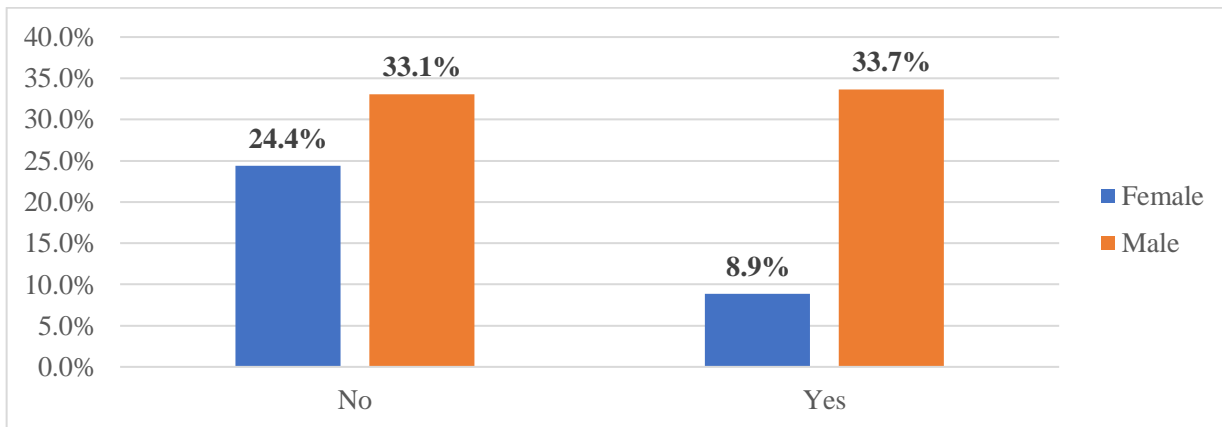
3.7 Law and policy framework

The survey findings reveal significant gaps in awareness and understanding of human rights and disability-related laws among Mine/ERW survivors and persons with disabilities.

Awareness of Human Rights:

Overall, only 42.6% of respondents reported knowing about human rights, particularly the rights of persons with disabilities, while 57.4% indicated they were unaware. Gender differences are notable: 33.7% of men reported awareness compared to just 8.9% of women. This disparity suggests that women are disproportionately excluded from information channels related to rights and advocacy.

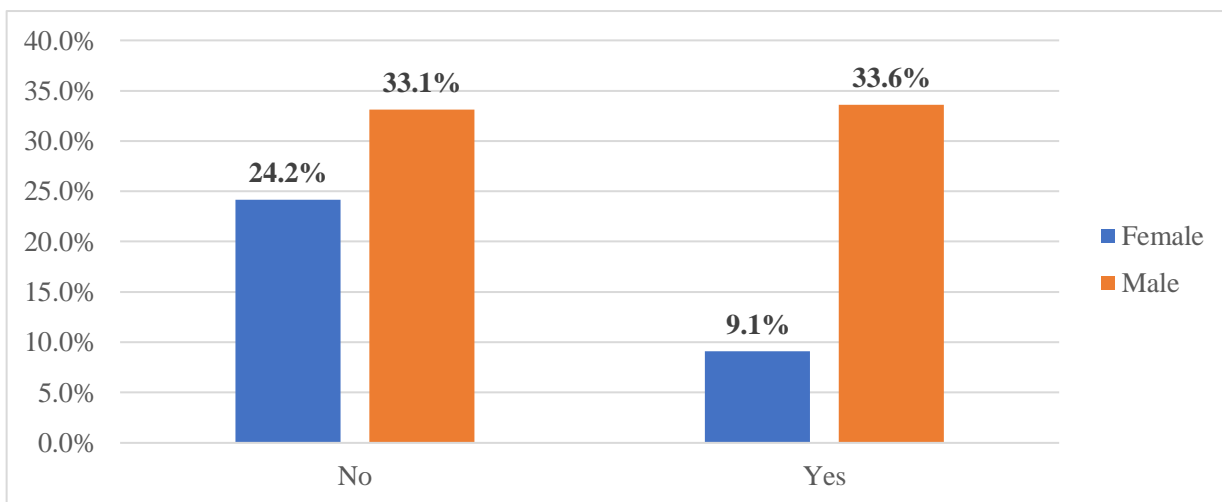
Figure 50: Respondents are aware of and understand human rights and disability law (n=4,016)



Knowledge of Disability Law:

Similarly, awareness of the law on the rights of persons with disabilities is limited. Just 40.3% of respondents had heard of the law, while 54% had not, and 5.7% did not provide an answer. Men again demonstrated higher awareness (31.7%) compared to women (8.6%). These findings highlight a critical need for targeted outreach and education, particularly for women and marginalized groups.

Figure 51: Respondents had heard of the disability law (n=4,016)



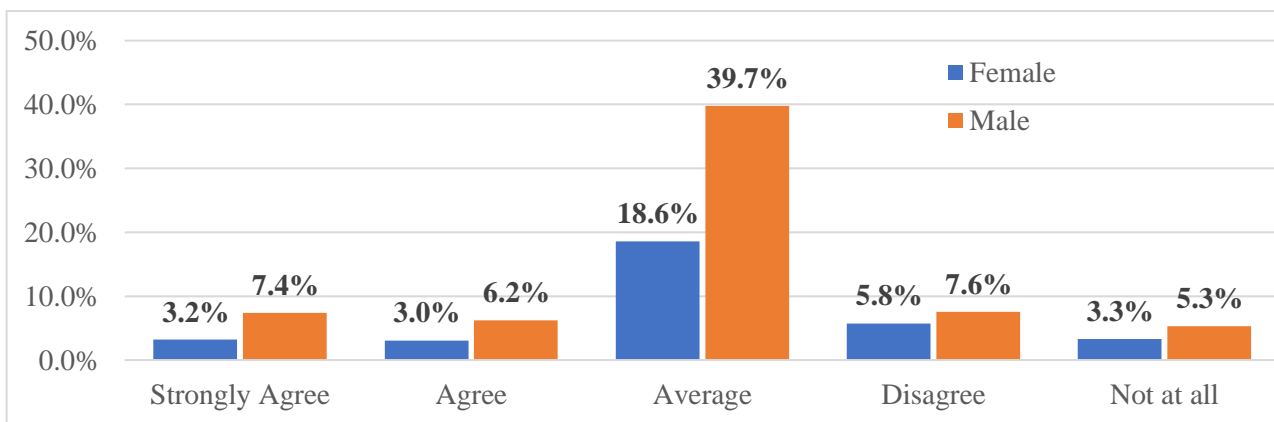
Perception of Inclusion in Community Decisions:

When asked about their sense of inclusion in community decision-making, most respondents (58.3%) rated their participation as *Average*. Only 10.5% strongly agreed and 9.2% agreed that they feel included, while 13.3% disagreed and 8.6% strongly disagreed. Gender analysis shows that men feel slightly more included than women, but overall, the data indicate limited participation and influence in local governance processes.

Findings from the Focus Group Discussions reveal that persons with disabilities strongly desire active inclusion in local meetings and community gatherings. They emphasized that participation is essential for receiving timely and accurate information from government agencies and non-governmental organizations (NGOs). Many participants noted that exclusion often results in missing critical updates, programs, and services that could improve their lives—such as information on health, education, livelihood opportunities, and social support.

Participants further highlighted that inclusion would not only enhance access to information but also provide a platform to voice their concerns, needs, and suggestions. They stressed that meaningful participation requires organizers to ensure accessibility measures, including sign language interpretation, accessible venues, and clear communication materials, so individuals with diverse disabilities can fully engage. Overall, the discussions underscored the importance of creating inclusive spaces that empower persons with disabilities to participate equally in community life.

Figure 52: Respondents rated their inclusion in community decision-making (n=4,260)



4. DATA ANALYSIS AND INTERPRETATION

The survey data present a **multifaceted picture of vulnerability** among Mine/ERW survivors and persons with disabilities in Banteay Meanchey Province. The findings highlight interconnected challenges across health, rehabilitation, education, economic security, social inclusion, and rights awareness, with gender disparities evident throughout.

Demographics

The population is predominantly **male (66.2%)**, reflecting historical exposure to mine-related risks in agricultural and labor activities. Age distribution shows that **71.7% are aged 45 years and above**, indicating an aging survivor population with increased dependency and heightened health care needs. This demographic profile underscores the urgency of long-term care strategies, including geriatric health and social support.

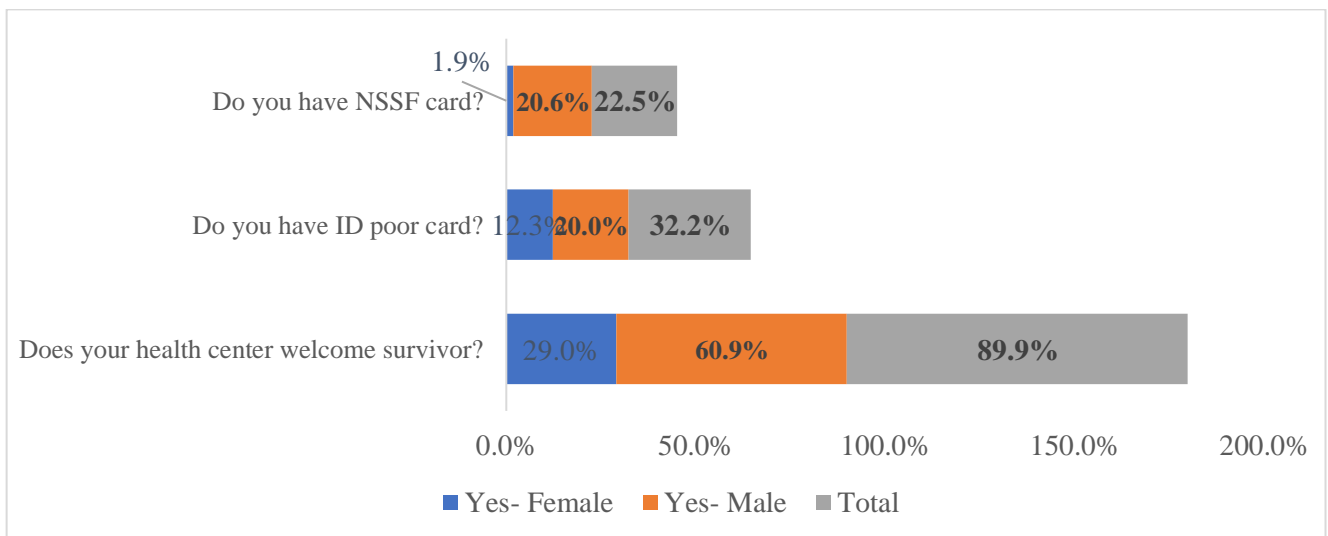
Healthcare and Social Protection

The graph illustrates three key indicators of healthcare access and social protection among Mine/ERW survivors and persons with disabilities. First, an overwhelming majority—89.9%—reported that health centers welcome them, suggesting strong inclusivity overall. However, the gender breakdown reveals that men account for 60.9% of these positive responses, while women represent only 29.0%, indicating a notable gender imbalance.

In contrast, access to social protection mechanisms is far more limited. Only 32.2% of respondents possess an ID Poor card, leaving 67.8% without this essential support. Among cardholders, men make up 20.0% and women just 12.3%, highlighting a significant gender gap. The situation is even more pronounced for the National Social Security Fund (NSSF) card, with only 22.5% of respondents holding one. Of these, 20.6% are men and a mere 1.9% are women, underscoring severe disparities and minimal coverage.

Overall, while health centers appear welcoming, the lack of access to ID Poor and NSSF cards—especially among women—limits financial security and benefits for survivors. These findings emphasize the urgent need for targeted outreach and inclusive registration processes to bridge this gap.

Figure 53: Respondents experienced with healthcare services



Rehabilitation

Assistive technology access is uneven. **27.9% of respondents use assistive devices**, with prosthetic and orthotic devices dominating (50.2%). However, distribution is heavily centralized at Battambang PRC, forcing many to rely on self-made solutions or charitable donations. Additional needs for **eyeglasses, hearing aids, and mobility aids** indicate that rehabilitation services are not comprehensive, limiting functional independence and social participation.

Psychosocial Well-being

Emotional support networks are fragile. **Family is the primary source of support (87.5%)**, while NGO involvement is negligible. Trust in friends and family acceptance is moderate, and **19% of respondents express negative feelings about being alive**, signaling mental health vulnerabilities. Women report

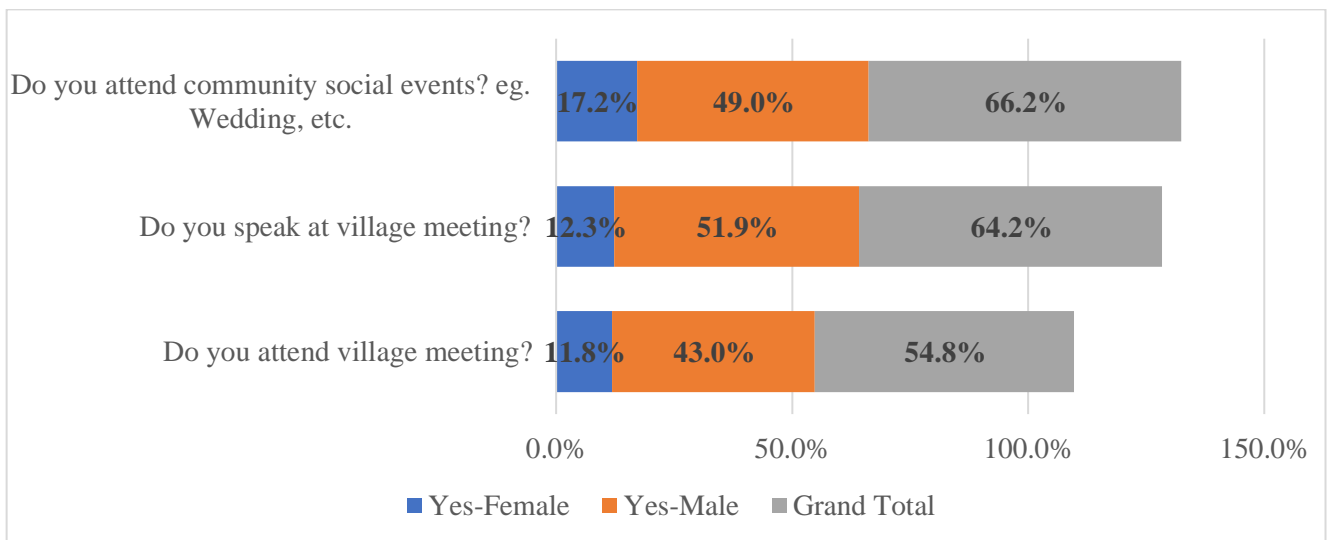
slightly lower levels of trust and acceptance, suggesting gendered barriers to social connectedness. The lack of structured psychosocial services exacerbates isolation and stress among survivors.

Social Participation

The graph highlights patterns of community engagement among Mine/ERW survivors and persons with disabilities, revealing both participation and gender disparities. Overall, engagement is moderate: 54.8% of respondents attend village meetings, and 66.2% participate in social events such as weddings. However, women’s involvement is significantly lower compared to men. For social events, 49.0% of men participate versus only 17.2% of women. Similarly, attendance at village meetings shows a gap—43.0% for men compared to 11.8% for women. Speaking during meetings follows the same trend, with 51.9% of men voicing opinions compared to just 12.3% of women.

These figures suggest that while opportunities for engagement exist, cultural norms, mobility limitations, and caregiving responsibilities likely restrict women’s participation. This imbalance reduces women’s influence in local governance and decision-making processes, reinforcing structural barriers to gender equality. Addressing these gaps requires targeted strategies, such as creating safe spaces for women’s voices, flexible meeting arrangements, and community sensitization to promote inclusive participation.

Figure 54: Respondents reported their social participation



Economic Inclusion

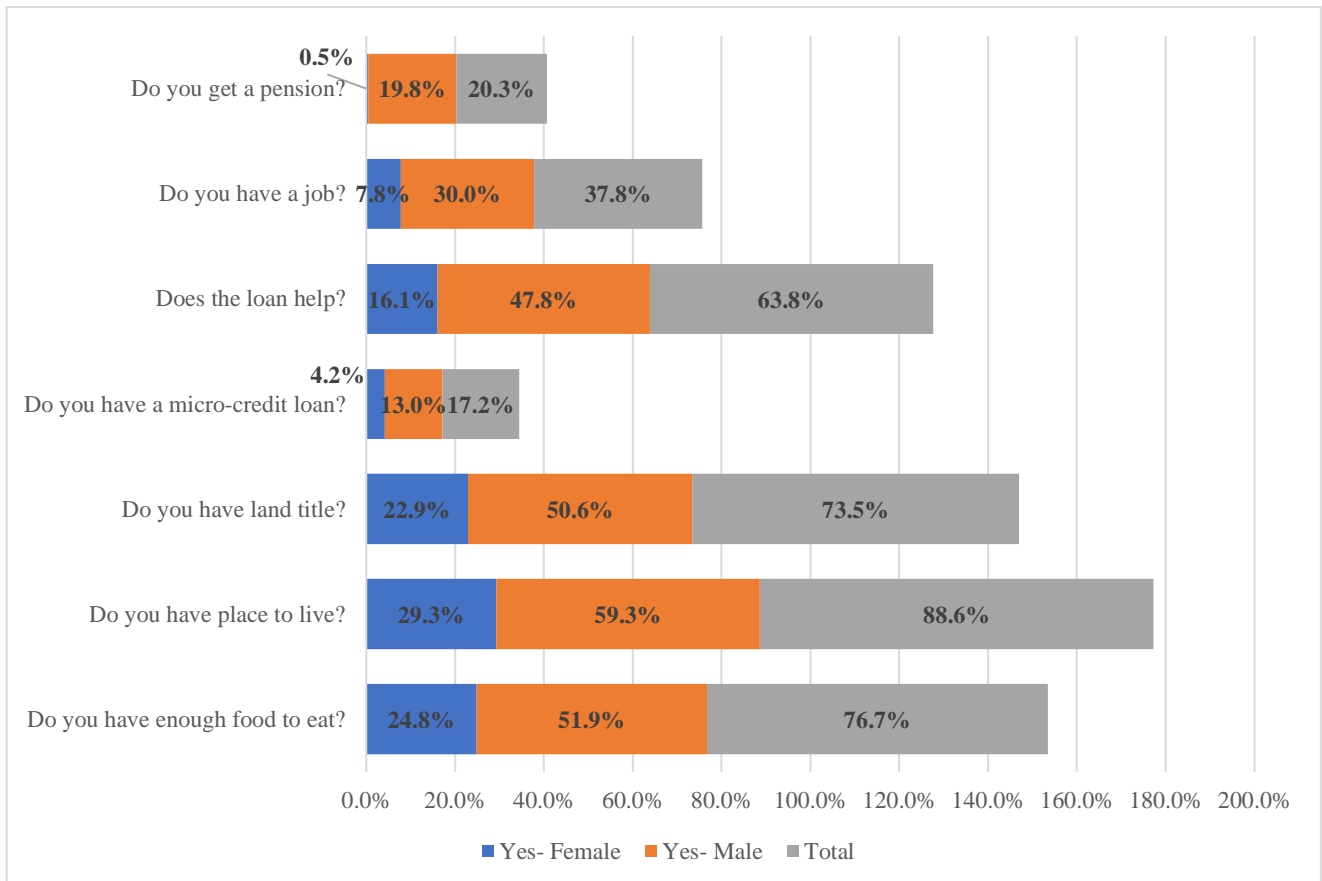
The graph underscores severe economic vulnerability among Mine/ERW survivors and persons with disabilities. Unemployment is alarmingly high at 62.2%, and those employed primarily depend on informal work such as agriculture and casual labor, leaving them with unstable incomes. Access to financial support mechanisms is minimal: only 17.2% of respondents have micro-credit loans, and while 63.8% of those who borrow find loans helpful, this benefit reaches a very limited group. Pension coverage is equally low at 20.3%, with a stark gender gap—men (19.8%) are far more likely to receive pensions than women (0.5%), reflecting systemic inequality in social protection.

Basic needs remain precarious. Nearly one-quarter (23.4%) of respondents report food insecurity, and housing satisfaction, though relatively higher at 88.6%, does not offset broader livelihood challenges.

Land ownership is somewhat better, with 73.5% holding land titles, yet this does not translate into economic resilience due to limited access to credit and markets.

Overall, the data reveal structural poverty and entrenched gender disparities, restricting survivors' ability to achieve financial security. These findings highlight the urgent need for targeted interventions—such as expanding formal employment opportunities, improving access to micro-credit, and ensuring gender-inclusive pension schemes—to reduce vulnerability and promote sustainable livelihoods.

Figure 55: Respondents experienced in economic inclusion



Rights Awareness

Knowledge of disability law and human rights is alarmingly low. Only **42.6% are aware of human rights**, and **40.3% have heard of the disability law**, with women disproportionately uninformed. This lack of awareness undermines the ability of survivors to claim entitlements and advocate for inclusion, perpetuating systemic exclusion.

5. CONCLUSION

The survey findings reveal that Mine/ERW survivors and persons with disabilities in Banteay Meanchey Province face multidimensional and persistent challenges that affect their overall quality of life. While basic health services and community engagement mechanisms are present, these alone are insufficient to ensure dignity, independence, and full inclusion.

Healthcare and Rehabilitation: Access to health facilities is generally positive, yet self-reported health status remains poor, and rehabilitation services are limited and centralized. Many respondents lack

assistive devices, and those who have them rely heavily on a single provincial center, indicating systemic gaps in equitable service delivery.

Education and Skills Development: Opportunities for education and vocational training are scarce, with only one-third of respondents currently enrolled in any form of schooling or training. Satisfaction with access to education is low, reflecting barriers such as cost, distance, and lack of inclusive programs.

Economic Security: Economic vulnerability is pronounced. A majority of respondents report insufficient income, limited employment opportunities, and restricted access to micro-credit and pensions. Food insecurity and inadequate housing further compound these challenges, leaving many families in precarious living conditions.

Social Inclusion and Participation: Although community engagement exists—over half attend village meetings and two-thirds participate in social events—gender disparities are stark. Women consistently report lower participation in decision-making, limited voice in public forums, and reduced access to social protection mechanisms such as IDPoor cards.

Psychosocial Well-being: Emotional support relies almost entirely on family networks, with minimal involvement from NGOs or community-based services. While most respondents express moderate happiness, a significant proportion report feelings of isolation and lack of meaningful activities, underscoring unmet psychosocial needs.

Rights Awareness: Awareness of disability law and human rights remains low, particularly among women, limiting their ability to claim entitlements and advocate for inclusion. This gap reflects systemic weaknesses in outreach and education.

In summary, while progress has been made in some areas, structural barriers, gender inequality, and limited-service integration continue to hinder the realization of a dignified and inclusive life for Mine/ERW survivors and persons with disabilities. Addressing these challenges requires a comprehensive, rights-based, and gender-sensitive approach that combines health, rehabilitation, economic empowerment, education, and advocacy.

6. RECOMMENDATIONS

■ Health and Rehabilitation

- Expand decentralized rehabilitation services and ensure equitable distribution of assistive devices.
- Integrate mental health and psychosocial support into primary health care.

■ Economic Inclusion

- Promote vocational training and inclusive employment programs.
- Increase access to micro-credit and social protection schemes, including pensions.

■ Education and Skills Development

- Improve access to adult education and training tailored to persons with disabilities.
- Provide gender-sensitive learning opportunities to address barriers for women.

- The need for strengthened inclusive education policies and targeted interventions to ensure that children and adults with disabilities are able to complete at least primary education on an equal basis with others.
- Addressing these gaps is essential for promoting social inclusion, reducing inequality, and supporting national human capital development
- Increase the school enrollment ratio and primary school completion rate of children and young persons with disabilities.

■ Social Participation

- Facilitate inclusive community meetings and decision-making processes.
- Support initiatives that encourage women’s participation in social and governance activities.

■ Rights Awareness

- Strengthen outreach campaigns on disability law and human rights.
- Engage local authorities and community leaders in promoting rights-based inclusion.

■ Monitoring and Advocacy

- Establish regular quality-of-life assessments to track progress.
- Advocate for increased funding and technical support from development partners.

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8. ANNEXES

8.1 Village Profile Form



Village Profile Form

| | |
|-----------|--------------|
| | Report Code: |
| Surveyor: | Date: / / |

| | | | | |
|--|---------------------------|-----------|-------------|---|
| ❶ Village: | commune: | District: | Province: | |
| ❷ Short history of village:(Describe about village situation, including landmine/ERW accidents and demining efforts) | | | | |
| | | | | |
| | | | | |
| ❸ Population in village: | | | | |
| | No. of family: | | | |
| | Male include children: | | | |
| | Females include children: | | | |
| | Total population: | | | |
| 4 How do people earn a living in this village? | 1. Farmer | % | 4. Migrants | % |
| | 2. Civil Servants | % | 5. Business | % |

| | | | | |
|---|------------|---|--|--|
| | 3. Workers | % | 6. Others | % |
| 5 No. of persons with disability living in the villagepersons (estimated): | | | | |
| 6 Informer: | Name | Sex | Tel no. | Persons with disabilities by |
| Village chief: | | <input type="radio"/> Male <input type="radio"/> Female | | <input type="radio"/> Mine <input type="radio"/> Other |
| Village vice: | | <input type="radio"/> Male <input type="radio"/> Female | | <input type="radio"/> Mine <input type="radio"/> Other |
| Other: | | <input type="radio"/> Male <input type="radio"/> Female | | <input type="radio"/> Mine <input type="radio"/> Other |
| 7 Did the village leader know or heard about disability law? | | | <input type="radio"/> Yes <input type="radio"/> No | |
| 8 If he/she doesn't know about the law, did you talk with them (village leader) about it? | | | <input type="radio"/> Yes <input type="radio"/> No | |
| 9 How does a village community try to uphold the rights of persons with disabilities and meet the needs of the most vulnerable?..... | | | | |

8.2 Person with Disability Perception of Living Condition Form



Person with Disability Perception of Living Condition Form

| | | | |
|-----------------|------------------|---|--|
| | | Village code: | |
| CMAA-VAQLS Code | CMAA/VAQLS/..... | Survey date: | / / |
| | | ID card: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | Interviewee: (for Deaf, Intellectual or child below 10 years) | |

| | | | | |
|--|------------------|--|--|---------------|
| Village: | Survivor name: | Sex: <input type="checkbox"/> M <input type="checkbox"/> F | Year of Birth | Y of accident |
| Disability type: | Accident cause: | No. of child | Family Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow/Widower <input type="checkbox"/> Children | |
| Extremely poor <input type="checkbox"/> Yes <input type="checkbox"/> No | Telephone number | <input type="checkbox"/> Personal <input type="checkbox"/> Other (List name)→ | | |

| | |
|--|---|
| 1) Are you happy? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2) Do you have enough food to eat? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3) Do you have a place to live? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, please fill) It belongs to | <input type="radio"/> You <input type="radio"/> Parent <input type="radio"/> Children <input type="radio"/> Relative |
| 4) Do you have a land title? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 5) a. Do you have children go to school? | <input type="checkbox"/> Yes <input type="checkbox"/> No (if child, chose C) |
| b. Does your children go to school? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. if you are a child, do you go to school? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6) Does your health center welcome survivors? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7) Do you have any card? | <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, skip to 9) |
| Do you have a Health Equity Card? | |
| Do you have a National Social Security Fund Card? | |
| Do you have an ID Card for Persons with Disabilities? | |

| | |
|---|--|
| 8) Have you used it? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9) What prosthetic do you have? | <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, please choose below) <input type="checkbox"/> Wheelchair <input type="checkbox"/> Prosthetic / Orthotics <input type="checkbox"/> Other devices |
| 10) Where did you get it?.....(List of centers name).....and who gave it to you? | <input type="checkbox"/> made it by yourself <input type="checkbox"/> bought <input type="checkbox"/> generous |
| 11) Do you have a friend in your village? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12) Who helps you if you are depressed? | <input type="checkbox"/> Family <input type="checkbox"/> Other Persons with disabilities in the village <input type="checkbox"/> NGOs <input type="checkbox"/> other..... |
| 13) Do you have a micro-credit loan? | <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, skip to 16) |
| 14) Do you have difficulty with loans? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15) Does a loan help you live better? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16) Do you have a job? | <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, skip to 18) |
| 17) What types of jobs do you have? | <input type="checkbox"/> Government <input type="checkbox"/> NGOs <input type="checkbox"/> Farmer <input type="checkbox"/> Self-employ <input type="checkbox"/> Private company <input type="checkbox"/> Casual work |
| 18) Do you get a pension? | <input type="checkbox"/> Yes <input type="checkbox"/> No (if no, please indicate) Are you military? <input type="radio"/> Yes <input type="radio"/> No |
| 19) Do you attend village meetings? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20) Do you speak at the village meeting? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21) Have you spoken at provincial, national and international levels? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22) Do you know about human rights, particularly the rights of persons with disability? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23) Have you heard about the law on the rights of persons with a disability? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 24) Do you attend community social events? eg. wedding...etc. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25) Can you read and write? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other comments or descriptions (if any) | |

| | |
|---|--|
| 1) What has made your life happier and easier in the last five years? | <input type="checkbox"/> Children got a job, <input type="checkbox"/> bought tools to support their daily job <input type="checkbox"/> Got appropriate shelter <input type="checkbox"/> Other..... |
| 2) How can you improve your quality of life? | <input type="checkbox"/> Skill training, Small business, <input type="checkbox"/> Expand crop planting, Want children to get higher study <input type="checkbox"/> I want to learn the capabilities to learn <input type="checkbox"/> Other |

8.3 Life with Dignity Assessment



Life with Dignity Assessment (Quality of life measure)

Please tick (✓) the value that you think is right for you

| Descriptions | Strongly Agree:5 | Agree:4 | Average:3 | Disagree:2 | Not at all:1 |
|---|------------------|---------|-----------|------------|--------------|
| 1. I feel I have good friends that I can trust | | | | | |
| 2. I feel I have enough food to eat | | | | | |
| 3. My family likes me | | | | | |
| 4. I am happy with my shelter | | | | | |
| 5. I am satisfied with the physical access around my home and public places | | | | | |
| 6. I have enough income to live with dignity | | | | | |

| | | | | | |
|---|--|--|--|--|--|
| 7. I feel my rights are respected | | | | | |
| 8. I am satisfied with my access to rehabilitation services | | | | | |
| 9. I feel healthy | | | | | |
| 10. I am satisfied with my access to education /training | | | | | |
| 11. I am happy I am alive | | | | | |
| 12. I feel included in my community's decisions | | | | | |
| 13. I feel my opinion is respected in public | | | | | |
| 14. I respect the rights of others | | | | | |
| 15. I try to help others in my community | | | | | |
| 16. I enjoy taking part in community activities | | | | | |
| 17. I like to learn new things | | | | | |
| 18. I feel safe in my community | | | | | |
| 19. I have things to do in my free time | | | | | |
| 20. When I work I enjoy the work | | | | | |

Data Gathering and Quality Control

| | Surveyor | Checker | Approval |
|-----------------|-------------------|-------------------|-------------------|
| Name: | | | |
| Title: | | | |
| Date: |/...../..... |/...../..... |/...../..... |
| Contact Number: | | | |

8.4 Guide Questions for Focus Group Discussion to confirm data collection

Objective

To gather information on living conditions and experiences that influence the quality of life of persons with disabilities.

Questions

Living condition of Persons with Disabilities

1) To what extent have existing services, support mechanisms, projects, programs, policies, or legislation addressed your specific needs?

- 1) Health Care Services
- 2) Rehabilitation services
- 3) Psychosocial support
- 4) Social Participation
- 5) Economic Inclusion
- 6) Disability Law and Rights

Yes, specify
If no, why?

2) Which services, support mechanisms, projects, programs, policies, or disability laws are most important for your life? Select 3 and specify why

- 1) Health Care Services
- 2) Rehabilitation services
- 3) Psychosocial support
- 4) Social Participation
- 5) Economic Inclusion
- 6) Disability Law and Rights

Persons with Disabilities

3) Services, support mechanisms, projects, programs, policies, or legislation following are you still a challenge and impacting their quality of life?

Let each participant give a score: from 1 (very weak) to 5 (very good) and give a reason.

- 1) Health Care Services
- 2) Rehabilitation services
- 3) Psychosocial support
- 4) Social Participation
- 5) Economic Inclusion
- 6) Disability Law and Rights

4) What are your suggestions and recommendations for addressing the obstacles mentioned above?

KII with the local authority

1. As you know, persons with disabilities always face challenges in accessing health care services, rehabilitation, psychological support, social participation, economic inclusion, and legal protections related to disability rights. What measures have you taken in the past to enhance and improve their living conditions?
2. What are your comments and recommendations to promote and enhance the living conditions of Persons with Disabilities?