In recent years, CARITAS Takeo Eye Hospital (CTEH) in Cambodia has worked hard to be more inclusive of people with disabilities. While there have been some challenges along the way, the overall results of the new practices appear to be very positive.

The first change came in 2008, when the old, run-down eye hospital was replaced with a brand new facility. The major donor, CBM, encouraged the local partner CARITAS Cambodia to grasp the opportunity to design the new building so that it would meet high standards of accessibility. CBM emphasised that a ‘universal design’ approach, reducing the (physical) barriers for everybody, regardless of age and ability, could lead to a win–win situation for all patients, not only those with disabilities. Guidance from CBM (based on the document Promoting universal access to the built environment) was invaluable for local architects, and the result was the construction of an eye hospital with significantly improved physical accessibility.

The second important change in strengthening practices related to people with disabilities, beyond just physical accessibility, was triggered by the Avoidable Blindness Initiative funded by the Australian Agency for International Development (AusAID). This programme emphasised wider issues including disability inclusion, gender, and child protection. Eye care projects had to report specifically against these issues, for example, physical accessibility for people with disabilities and the number of eye health services with documented referral pathways to disability services and disabled people’s organisations. In collaboration with CBM Australia, a number of activities on different levels were implemented between 2009 and 2012:

- A ‘knowledge, attitude and practices’ (KAP) survey was conducted on people with and without self-reported impairment. This provided a ‘baseline’ or starting point from which to measure the hoped-for improvement.
- Training of local staff on inclusion – facilitated by a partnership between CBM Australia and the Nossal Institute for Global Health, University of Melbourne.
- In order to build and share knowledge, and to foster collaboration and partnership, workshops on disability inclusive practices were also conducted with local hospital staff, local provincial health authorities, community-based rehabilitation (CBR) organisations, partner eye care organisations, government officials and the National Program for Eye Health.
- A manual, called Disability-inclusive practices in eye health, was written in collaboration with the CBM Australia-Nossal partnership and distributed to those involved in the work. A condensed, translated version was also distributed to all local health authorities in Takeo province.
- CTEH advocated for consideration of disability inclusive eye care practices into national eye health guidelines. As a result, Cambodia’s National Programme for Eye Health – run by the ministry of health – made disability inclusion part of the national primary eye care curriculum from 2011.
- A key recommendation for improved disability inclusive practice in eye health relates to access to low vision services. CTEH has developed a low vision department, employing refractionist nurses trained to provide low vision services.
- Collaborations with both mainstream schools and specialist schools for blind

### BARRIERS FACED BY PEOPLE WITH DISABILITIES

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<th>Diane Mulligan</th>
<th>Deputy Director, Advocacy and Alliances for Inclusive Development, CBM.</th>
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<tr>
<td>The specific identification and removal of barriers is the essence of accessibility. Barriers can be grouped into four categories:</td>
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<td>1 Physical or environmental barriers. Access to buildings, schools, clinics, water pumps, transport, roads, paths, etc.</td>
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<tr>
<td>2 Communication barriers. Written and spoken information including media, flyers, internet, community meetings, etc.</td>
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<tr>
<td>3 Policy barriers. Including legislation that discriminates against people with disabilities, and/or an absence of legislation that might otherwise provide an enabling framework. Departmental and organisational policies can also be addressed here.</td>
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<tr>
<td>4 Attitudinal barriers. Including negative stereotyping of people with disabilities, social stigma and other forms of overt discrimination. It is not uncommon that disability is associated with cultural beliefs about sin, evil and witchcraft. People with disabilities often report that attitudes are the most disabling barriers of all.</td>
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Better physical accessibility and greater awareness of disability by hospital staff have improved the inclusion of people with impairments. CAMBODIA

For Global Health, University of Melbourne.
Disability: recommendations for eye programmes

In 2012, CBM’s Medical Eye Care Advisory Working Group met in Hyderabad, India to discuss the inclusion of people with disabilities in eye care.

As a result of these discussions, the following recommendations were made:

• Involve local disabled people’s organisations (DPOs) in planning (page 12).
• Appoint a member of staff as the coordinator for disability inclusion in all eye units (this may be a part time role).
• Identify barriers to access, both internal and external, noting which are easy and which are difficult to fix. Put in place an action plan to address these.
• Consider any additional needs based on gender and age.
• Ensure that eye care services are comprehensive and include health promotion, disease prevention, curative medical and surgical services, and rehabilitation services.
• Ensure counselling, links and referrals to rehabilitation and education services are available to people who cannot be helped clinically. Ensure these services also refer patients to eye units.
• Staff with the heaviest loads – such as ophthalmologists – need to know that they can (in a caring manner) refer patients to other skilled staff in the unit.
• Employ people with disabilities to work in eye clinics.
• Only 83% of people with self-reported impairments said that they would look for treatment in case of an eye problem, compared with 95% of people with no impairment.

The implementation of the new low vision department at CTEH has been especially successful. The refractionist nurses who were trained in low vision care received ongoing monitoring. They have been able to integrate the new service into outpatient department activities. In addition, rehabilitation of visually impaired patients in the hospital and through growing collaboration with mainstream and specialist schools is leading to improved outcomes for these patients.

The inclusion of a disability component in the new health information system raised several problems. These included the need for a simple definition of disability in this context (e.g. a definition of ‘hearing impairment’ in an environment where hearing tests are not available) and staff members’ concerns about the additional workload required. Asking patients to self-report any disabilities – for example by including the Washington Group’s self-reporting questions in patient registration forms – is highly recommended, as it is both simple and efficient. CTEH is now able to provide evidence that a significant number of patients have other impairments in addition to visual impairment.

Overall, our efforts to strengthen disability-inclusive practices appear very worthwhile, but more research is certainly needed.

References
5. www.cdc.gov/ncih/washington_group/wg_questions.htm

Improving access for women and girls with disabilities

Nearly all eye health programmes strive to reach the most marginalised people. They also seek to be gender sensitive, ensuring equal access for all people. Women and girls with disabilities (including those with impaired vision) are some of the most marginalised people, as they face the triple discrimination of being female, having an impairment, and being among the poorest.

It is important that eye health programmes consider how they can support women with a disability. Here are some practical tips:

• Consult with women with disabilities to identify what is blocking their access to eye care, and to talk about how best to overcome these barriers.
• Raise awareness among staff and collaborators about the impact of disability on women and girls and work together to address barriers.

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