CARE-GIVING AND CARE-SEEKING BEHAVIOUR FOR PEOPLE WITH COMMUNICATION DISABILITY WITHIN CAMBODIAN COMMUNITIES

January 2023

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Abstract

Currently, in Cambodia there are very few services and supports available for individuals with communication disabilities, with most services located in the capital city Phnom Penh. Cambodians with communication disabilities, including children without typically developing speech and language skills, and adults with lifelong and/or acquired disabilities, not only face limited services but experience multiple barriers to accessing education, employment and health services. The project aimed to build an understanding of caregiving and care-seeking behaviours for supporting these individuals within provincial and rural Cambodian communities. An oral survey was conducted across rural and provincial urban locations in Kompong Speu and Kompot provinces (N=161).

The survey data included demographic data and responses to two case studies presented by the data collectors. Data were analysed to identify categories or responses regarding the understanding of causes of communication disabilities and caregiving and care-seeking behaviours to support those with communication disability. Further, patterns between rurality and province were explored in relation to categories of responses provided.

The data demonstrated that many participants engaged in caregiving for a family member, and many knew someone with communication difficulties, thus establishing the relevance of the research for the participants. While participants were able to identify a range of ways they would care for and seek support for a family member with communication disability, there was also evidence of misinformation, information gaps and bias regarding the causes of communication disability. Further a lack of accessible health and rehabilitation services in rural areas and Kompot resulted in these participants being more likely to seek alternate supports.

This project has sought to build a culturally and contextually responsive foundation for a speech therapy profession in Cambodia. This understanding is central to the development of sustainable services that build on existing local practices and are relevant to the community. Recommendations from the Stakeholder Advisory Group and from dissemination workshops reflect the current needs and priorities for Cambodian service providers, people with communication disabilities and their families, and therefore should be central to our response.

Background

A 2013 situational analysis estimated that 600,000 people have communication or swallowing difficulties in Cambodia, implying at least 1 in 25 Cambodians would benefit from speech therapy, 4% of the total population (Salter & Yeoh, 2017). Unlike physical disability, communication difficulties are rarely highlighted in Cambodian government documents or policies. Cambodia is widely acknowledged to be proactively developing its health, education and rehabilitation sectors, however, services for People with Communication Disabilities (PWCD) remain extremely limited. In High-Income Countries (HIC), PWCD seek professional support from speech therapists, special education specialists, rehabilitation workers and disability advocates. In addition to professional health, education and disability services, widespread inclusive practices enable PWCD access to mainstream services and utilities. In contrast, the vast majority of Cambodian's who live with communication difficulties are solely reliant on informal community and family support with public services rarely considering inclusive practices. Informal community-level supports are often overlooked and undervalued by formalized health care systems ignoring their potential role in contributing significant social capital and influencing community attitudes and behaviour (MacKian, 2002).

Community caregiving and care-seeking behaviours for communication disability

People with communication disabilities exist across all countries and all cultural contexts. However, caregiving and care seeking behaviours vary significantly due to beliefs and attitudes regarding the cause of communication disability, the availability of services, and structural support for those experiencing communication disability and their families (Wylie et al., 2017). Consequently, to develop services and systems to support PWCD, an understanding of community caregiving and care-seeking behaviours and the beliefs and attitudes that underpin these are required (Hopf et al., 2018). This is particularly important in majority world countries where the cultural context differs significantly from the White-Anglo dominant origins of the speech therapy profession and subsequent medicalised models of care are unable to provide appropriate and/or acceptable services (Khosa-Shangase & Mophosho, 2018). Emerging studies in this field from the contexts of Ghana (Wylie et al., 2017) and Fiji (Hopf et al., 2018) identify a range of physical, behavioural, emotional, and spiritual supports provided by community members to PWCD as well as identifying a range of traditional, spiritual, educational and medical practitioners who would be approached for support. The relationships between these types of support and care-practitioners vary between cultural groups within and between these countries (Hopf et al., 2018) and it can be expected that within Cambodian caregiving and care-seeking behaviours will differ from other countries, and also differ between communities in Cambodia based on factors such as rurality, level of education, and personal experience (c.f. Chu et al., 2019; Tang & Chu, 2021).

Thus, this research focussed on a community-level investigation to gather evidence about existing beliefs, behaviours and supports for an underserviced and unrecognised group of people. This data can be used in policy and system development increasing the potential of the emerging system to be integrated and building upon current practice. It also allows the identification of any potentially harmful trends or teaching which can be addressed strategically in future initiatives and service development.

Project aims

This project aimed to build an understanding about existing strategies used by rural Cambodians to support children and adults with communication difficulties. To ensure that the research was culturally and contextually responsive, the project team also sought to evaluate and adapt the research tool for the Cambodian context. To achieve these aims, the following research questions were addressed:

1. How do rural Cambodians describe the existing community strategies, resources, and people for supporting people with communication disabilities?
2. Can Wylie et al. (2017)'s self-help and help-seeking for communication disability survey be adapted to create a tool that is appropriate and acceptable for use within a rural Cambodian context? And if so, what is required?

Ethical considerations

Ethical approval was sought and gained from the Cambodian National Ethics Committee for Health Research (protocol no. 180 NECHR), and Charles Sturt University Human Research Ethics Committee (protocol no. H22375).

Methodology

The study design drew on the values of social justice, inclusion, and cultural responsiveness. It is important to the research team that the project is led by Cambodians, guided by Cambodian stakeholders, and privileges the perspectives of Cambodians, particularly those from provincial areas. To ensure that these values remained central, the study design was scaffolded by a series of stakeholder meetings at key stages. A mixed methods approach was utilised to ensure that data collection and analysis focussed on the perspectives and beliefs of the research participants.

Establishment of a Stakeholder Advisory Group

Key to the methodological approach of this project was stakeholder engagement. A stakeholder advisory group representing key perspectives regarding support for rural Cambodians with communication disabilities was established following Cambodian Ethics Approval, with the first meeting held on Friday 8th July 2022.

This group included 10 members plus 6 members of the research team. Team members included:

- Cambodians experiencing communication disabilities,
- Family members/ carers of those with communication disability
- Community leaders/service providers from target rural research locations
- Representatives from relevant NGOs
- Individuals currently working with people experiencing communication disability
- Representatives from relevant government departments

A list of members is included in Appendix A.

As part of the establishment of this group, the terms of reference were developed (see Appendix B: Stakeholder Advisory Group Terms of Reference). The role of the stakeholder advisory group was to provide cultural and contextual review and feedback of the project to the research team during key

stages (see Appendix C: Project Timeline). The Stakeholder Advisory Group supported the research team to:

- review and adapt the survey tool and research methodology
- review feedback on the use of the survey tool and further adaptation for future research
- review survey outcomes to identify and explore key themes
- disseminate research findings
- discuss project outcomes in relation to ongoing research

Development of a survey tool

An oral survey was developed based on Wylie et al. (2017) for use in Ghana and adapted by Hopf et al. (2018) for the Fijian context. The survey was designed around three sections. The first collected participant demographic data, including age, gender, level of education, occupation household demographics and personal experience of people with communication difficulties. This was followed by presenting two scenarios: a child (5-year-old) who is not yet talking, and an adult who has acquired speech and language difficulties. Participants were asked a series of questions about each scenario:

តើអ្នកគិតថាមូលហេតុអ្វីបណ្តាលអោយគាត់ ពិបាកនិយាយ?

តើអ្នកនឹងធ្វើអ្វី ឬផ្លាស់ប្តូរអ្វីនៅផ្ទះសម្រាប់ជួយអោយគាត់ចេះនិយាយបាន?

តើអ្នកនឹងទៅរកជំនួយឬដំបូន្មានពីអ្នកណា? ហេតុអ្វីបានជាអ្នកទៅទីនោះ?

What do you think caused this person's communication difficulties?
What would you do or change at home to help with the talking?
Who would you go to for help or advice? Why would you go there?

The inclusion of questions such as "what might others do?" was designed to provide respondents with a means of "saving-face" if there was an action that maybe widespread, however rarely spoken about in direct terms outside the family. This component was retained for the Cambodian tool.
The case studies are provided below in Khmer with an English translation.
To support appropriate cultural and contextual responsivity of the methodology, the research team made a number of changes to the survey used by Wylie et al (2017) and Hopf et al (2018) to create a draft tool for the current project. A Khmer translation of the draft tool was then shared with Cambodian-based members of the research team who reviewed the survey in relation to the research questions. The research group sought consensus on changes to be made. Key adaptions to the survey during the process included:

- Reordering of questions: demographics as part 1 followed by case studies
- Additional of questions to demographics including rurality, income status, marital status, gender (other),
- Modification question types regarding location, occupation, age, experiences as a carer
- Change of key terminology from community 'self-help and help-seeking support' to 'caregiving and care-seeking'.

- Removed questions regarding attitudes towards inclusive education and communication disability, community attitudes towards communication disability and workforce participation.

The survey was then developed for and uploaded into an electronic version and trialled for ease of accessibility and useability by the research team.

Case study 1: Child Communication Difficulty

ខ្ញុំចង់អោយអ្នកគិតមើលថា ប្រសិនបើនៅក្នុងក្រុមគ្រួសាររបស់អ្នកមានក្មេងម្នាក់អាយុ៥ឆ្នាំ ដែលមិនទាន់ចេះនិយាយ អ្វីទាល់តែសោះ។

I would like you to think about your family. Imagine there is a 5yo child in your family who is not yet talking at all

Case study 2: Adult Communication Difficulty

ស្រមៃមើលថាមានមនុស្សពេញវ័យម្នាក់នៅក្នុងគ្រួសាររបស់អ្នក នៅពេលពួកគេភ្ញាក់ពីដំណេក។ ហើយអ្នកសង្កេតឃើញថាការនិយាយរបស់ពួកគេមិនច្បាស់ហើយពិបាកយល់ណាស់។ ពួកគេមានជំងឺដាច់សរសៃឈាមខួរក្បាល មុខមួយចំហៀងរបស់ពួកគេមិន សូវមានចលនាល្អទេ ហើយការនិយាយរបស់ពួកគេក៏មិនបានប្រសើរឡើងដែរ។

Imagine that there was an adult in your family. When they woke up, you noticed that their speech was not clear and they were very difficult to understand. They had a stroke. One side of their face was not moving well and their speech did not get better.

Recruitment

Question 1: How do rural Cambodians describe the existing community strategies, resources, and people for supporting people with communication disabilities?

The project originally aimed to collect data from 100-150 participants across two provinces: Kompong Speu, & Kompot. A final number of 162 (81 for each province) was calculated based on 2019 Census population data of the two provinces ((p)of 5%+/-5, confidence limits as % of 100(absolute +/-%) (d) of 5% and DEFF of 1, and 10% non-response rate) (National Institute of Statistics, 2019).

Participants were recruited by two teams of trained research assistants. These research assistants approached members of the public and invited them to participate in the survey. Potential participants were told about the aims and procedures of the research and provided with oral and/or written project information based on participant preference before providing consent. Consent was recorded by the research assistants as the answer to the first question on the electronic survey tool. In order to gather data that reflected everyday attitudes and beliefs, members of the public were approached in public spaces such as markets, bus stations, river-front, and playgrounds. To ensure that people from urban and rural locations were included, the research teams travelled to both the provincial capitals and rural locations outside of these major provincial centres.

The inclusion criteria were:

- both males and females, 18 years or over
- able and willing to give informed consent to participate
- Khmer national or has lived in Cambodia for more than 10 years

Question 2: Can Wylie et al. (2017)'s self-help and help-seeking for communication disability survey be adapted to create a tool that is appropriate and acceptable for use within a rural Cambodian context? And if so, what is required?

All research assistants (*n=6*) and research leaders (*n=2*) were informed of the opportunity to participate in research regarding question 2. During data collection, research assistants and leaders participated in daily reflections. These were recorded by the research leads who shared these reflections for the research project. All involved in data collection were invited to participate in a focus group to explore the daily reflection data. Four research assistants and one research lead participated.

Data collection

Question 1: How do rural Cambodians describe the existing community strategies, resources, and people for supporting people with communication disabilities?

Data was collected by trained research assistants via an oral survey in Khmer language. Responses were recorded (text only) during the survey using a tablet with the survey pre-uploaded. The focus was on collecting data from individuals, however on occasion a group of people wished to participate together, and this was recorded on a separate response form for each individual. Research assistants spent three days in each province. Two key data collectors worked with teams of two research assistants. Author 1 participated in data collection in Kompong Speu alongside the research assistants to ensure that research support could be provided. A trained research leader was also present during the Kompot data collection. At the end of each day of data collection, the research leader met briefly with the research assistants (in person or via zoom) to debrief logistical issues and review processes. To ensure that data was not lost, the Kobotoolbox data was uploaded to a cloud and downloaded into a computer at the end of each day.
Participants were recruited across eight locations across the two provinces with an equal number of provincial urban and rural locations. A summary of participant numbers by location, rurality, age, and gender is provided in table 1.

Table 1: Participant numbers by location, rurality, age and gender.

Town	**Rurality**	**Age**		**Gender**		**Total**
		Md	Range	Male	Female	
Kompot Province		43.0	18-72	29	50	**79**
Chhuok District	Urban	44.5	24-66	6	8	**14**
Commune in Chhuok District	Rural	48.0	28-70	8	9	**17**
Kampong Bay	Urban	45.0	19-70	12	21	**33**
Commune in Kampong Bay	Rural	31.0	18-72	3	12	**15**
Kompong Speu Province		42.0	19-75	40	42	**82**
Chbar Morn	Urban	45.0	19-68	14	13	**27**
Commune in Chbar Morn	Rural	32.0	32	1		**1**
Somroeung Torng district	Urban	42.5	19-75	11	9	**20**
Commune in Somroeung Torng	Rural	40.5	20-65	14	20	**34**
Total		**42.64**	**18-75**	**69**	**92**	**161**

Question 2: Can Wylie et al. (2017)'s self-help and help-seeking for communication disability survey be adapted to create a tool that is appropriate and acceptable for use within a rural Cambodian context? And if so, what is required?

Two sources of data were used to answer question 2. At the end of each day of data collection, data collection team leaders documented their reflections and experiences of data collection in a reflection sheet provided. After data collection was completed, Author 3 conducted a participatory focus group with the researchers and research assistants involved in data collection.

Data analysis

Question 1: How do rural Cambodians describe the existing community strategies, resources, and people for supporting people with communication disabilities?

Once data collection was completed, the survey data were translated into English for analysis. To ensure that meanings were not lost or changed, the original Khmer text was kept next to the English translation.

Demographic data included both quantitative and qualitative responses. Descriptive statistics techniques were applied to analyse quantitative data, while content analysis was applied to identify codes and categories in qualitative responses. Statistical analysis was conducted in SPSS (IBM Corp., 2019), while content analysis, including calculations, was undertaken with support from NVivo (QSR International, 2018).

The research team then conducted a question-by-question latent semantic content analysis (Hsieh & Shannon, 2005) of the responses to the case study data. To ensure both methodological and cultural validity of analysis, the research team collaboratively analysed the first 40 responses for the first three questions of the child case study (120 responses in total). Initial semantic codes were discussed by the research team to inductively identify emerging themes within the data. Feedback on data analysis was sought from the Stakeholder Advisory Group at two key points: following initial coding of a child case study responses and following complete analysis. Coding for was reported to the Stakeholder Advisory Group together with examples of original quotes for each category. The Group were asked for feedback about the codes in relation to their own experiences. This feedback helped shape later stages of analysis.

The analysis of 'other: please specify' responses to categorical questions provided a platform for initial content analysis training for the research team, and culturally/contextually responsive research practices for expat researchers. A team of five research assistants who participated in the data analysis training coded the remaining data. Two further research team meetings were held to check data coding and problem solve translation and cultural context questions.
Finally, data was analysed to identify patterns within and across data from each location based on the research questions and input from the Stakeholder Advisory Group. In particular, patterns based on location and rurality were explored to answer the research question.

Question 2: Can Wylie et al. (2017)'s self-help and help-seeking for communication disability survey be adapted to create a tool that is appropriate and acceptable for use within a rural Cambodian context? And if so, what is required?

Prior to the focus group, Author 3 analysed the reflective diary responses to identify key themes. These were presented back to the participants visually during the focus group. Participants were asked to identify their connection to each theme by placing 'thumbs up' sticky notes next to the relevant themes (Figure 1 &2 below). Following this, participants shared their stories and experiences in relation to each theme, as well as their recommendations for future research. The discussion was audio recorded and transcribed. As the discussion moved between English and Khmer, the transcription included English translation where required.

Figure 1 Data collector focus group

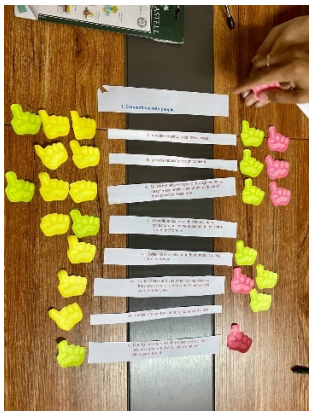

Figure 2 Interacting with key quotes from reflection journal

Results

Question 1: How do rural Cambodians describe the existing community strategies, resources, and people for supporting people with communication disabilities?

161 people participated in the research from Kompot (*n*=80, 49.7%) and Kompong Speu (*n=81, 50.3%*). This included participants from rural areas (*n=67, 41.6%)* and urban areas (*n=94, 58.4%*). Data collectors reflected that this was approximately a 50% response rate from those approached.

A total of 123 participants (79.73%) reported being a caregiver. Of these, 100 (81.3%) were carers for a child (n=100, 62.13%), 37 (30.1%) for an older person, 8 (6.5%) for a person with a disability, and 13 (10.6%) for *another.* Table XXX provides frequency and percentage in relation to province and rurality. Based on Pearson's Chi Square test, an association between province and caregiver was observed ($X^2(1) = 6.981$, $p = 0.008$) with participants from Kompong Speu significantly more likely to be a carer than those from Kompot. Also observed were relationships that approached statistical significance between the province and being a caregiver for a child ($X^2(1) = 3.307$, $p = 0.069$) with those from Kompong Speu more likely to be caring for a child, as well as *rurality* and *caregiver older person* ($X^2(1) = 3.623$, $p = 0.057$), with those from urban areas more likely to be caring for an older person.

Table 2: Relationships between province, rurality and caregiving

	Child		Older person		Disability		Other		Caregiver total	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Kompong Speu	60	86.6	21	30.4	6	8.7	6	8.7	69	100
Kompot	40	74.1	16	29.6	2	3.7	7	13.0	54	100
Rural	40	81.6	10	20.4	2	4.1	7	14.3	49	100
Urban	60	81.1	27	36.5	6	8.1	6	8.1	74	100
Total	**100**	**81.3**	**37**	**30.1**	**8**	**6.5**	**13**	**10.6**	**123**	**100**

In addition, 115 participants (71.4%) reported knowing someone who had difficulty talking and/or communicating: including community members (n=46, 40.0%), family members (n=42, 36.5%), neighbours or friends (n=33, 28.70%), self (n=4, 3.48%), and/or someone else (n=3, 2.6%). Table XXX outlines these relationships by province and rurality. Based on Pearson's Chi Square test, an association between *rurality* and *family members* was observed ($X^2(1) = 3.996$, $p = .046$) with those from rural areas more likely to know a family member with a communication difficulty. A relationship between *rurality* and community member was also observed ($X^2(1) = 6.454$, $p = .011$), with those from urban areas more likely to know a community member with a communication difficulty.

Table 3: Relationships between the province, rurality and knowing someone with communication difficulty

	Community member		Family member		Neighbour/ Friend		Self		Other		Know someone	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Kompong Speu	29	47.5	21	34.4	16	26.2	2	3.3	2	3.3	61	75.3
Kompot	17	31.5	21	38.9	17	31.5	2	3.8	1	1.9	54	67.6
Rural	13	26.5	23	46.9	14	28.6	1	2.0	1	2.0	49	73.1
Urban	33	50.0	19	28.8	19	28.8	3	4.5	2	3.0	66	70.2
	46	**40.0**	**42**	**36.5**	**33**	**28.7**	**4**		**3**	**2.6**	**115**	**71.4**

Child case study

Causes of a child's communication difficulties

132 responses provided responses to the question: *What do you think causes this child's difficulties?* Responses were semantically coded, applying more than one code to a single response as necessary. In response to *What do you think causes this child's difficulties?* approximately half the participants (*n=65, 50.4%*) explained the cause as being 'from birth'. A range of codes relating to the child's health/wellbeing were identified, including: mouth anatomy, genetics, illness (n=11, 8.33%), head injury or accident, and epilepsy or seizures (n=2, 1/52%), disabilities including deafness, autism and physical disabilities, and child's emotions/personality. Overall, these relate to 38.8% of total responses.

Three codes related to the child's social and language environment: child's phone use parental neglect and parental style. Codes relating to the prenatal context of the mother included negative effects of prenatal medication use, prenatal nutrition, and spiritual impacts of maternal or family

behaviours during pregnancy. Fourteen participants (10.9%) responded that they 'don't know' what might have caused the child's difficulties.

Table 4: Categories for *What do you think causes this child's difficulties?*

Category	***n***	***%***	***Example***	
From birth	*65*	*50.4%*	*កើតពីកំណើត*	*comes from birth*
Child health & wellbeing	*50*	*38.8%*	*អណ្តាតធំ*	*big tongue*
Child's social & language environment	*19*	*14.7%*	*មើលទូរសព្ទច្រើនពេក*	*using phone lots*
Don't know	*14*	*10.9*	*អត់ដឹងទេ*	*don't know*
Maternal pre-natal behaviour	*6*	*4.7%*	*ម្តាយហូបអាហារអត់មានវិតាមីន*	*mother did not eat healthy food*
Nothing	*5*	*3.9%*	*ទេ*	*No*
Inappropriate treatment	*1*	*0.8%*	*មកពីការព្យាបាលមិនត្រឹមត្រូវ*	*from inappropriate treatment*

Rurality did not have a notable impact on reported causes of the child's communication difficulties. However, those from Kompong Speu were more likely to identify that the difficulties were 'from birth' (Kompot, *n*= 20, 40.0%, Kompong Speu, *n*= 45, 57.0%), while those from Kompot were more likely to state that they 'don't know' (Kompong, *n*= 7, 14.0%, Kompong Speu *n*=7, 8.9%).

Table 5: Relationship between rurality, province and identified causes of child's communication difficulties

	Urban		**Rural**		**Kompot**		**Kompong Speu**	
	n	%	*n*	%	*n*	%	*n*	%
From birth	38	48.7	27	52.9	20	40.0	45	57.0
Child health &wellbeing	31	39.7	19	37.3	19	38.0	31	39.2
Child's social & language environment	11	14.1	8	15.7	8	16.0	11	13.9
Don't know	9	11.5	5	9.8	7	14.0	7	8.9
Maternal prenatal behaviour	5	6.4	1	2.0	2	4.0	4	5.1
Nothing	2	2.6	3	5.9	3	6.0	2	2.5
Inappropriate treatment	0	0.0	1	2.0	0	0.0	1	1.3
Total	**78**	**100.0**	**51**	**100.0**	**50**	**100.0**	**79**	**100.0**

However, when the codes within each category were explored, strong patterns between rurality, province and identified aspects of child health and wellbeing emerged. Participants from urban areas were more likely to identify features of mouth anatomy, genetics, and head or neurological issues. Meanwhile, those from rural areas were more likely to identify aspects of the child's emotional behaviour or a child's inability to make themself understood. Participants from Kompot were more likely to identify the impact of illness or neurological issue, while those from Kompong Speu identified features of mouth anatomy, disability, head injury or a child's inability to make

themself understood. Percentages for these are provided in Table XXX. Patterns did not emerge within other categories.

Table 6: Relationship between rurality, province and child's health & wellbeing

	Urban		Rural		Kompot		Kompong Speu		Total	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
mouth anatomy	10	32.3	4	21.1	3	15.8	11	35.5	14	28.0
Illness	7	22.6	5	26.3	10	52.6	2	6.5	12	24.0
Disability	7	22.6	4	21.1	2	10.5	9	29.0	11	22.0
Child emotions & personality	1	3.2	6	31.6	3	15.8	4	12.9	7	14.0
Genetic	6	19.4	1	5.3	3	15.8	4	12.9	7	14.0
Lack intelligibility	1	3.2	4	21.1	0	0.0	5	16.1	5	10.0
Head injury	2	6.5	0	0.0	0	0.0	2	6.5	2	4.0
Neurological issue	2	6.5	0	0.0	2	10.5	0	0.0	2	4.0
Total	**31**		**19**		**19**		**31**	**100.0**	**50**	**100.0**

What people do or change at home

Participants were asked to consider how they might support a child with communication difficulties at home. 127 participants responded to these questions. Six categories were identified in the analysis: Adapt language environment, adapt caregiving, seek support, treat at home, don't know, and nothing special. 23.62% of participants stated they did not know what they would do in this situation. Strategies identified to adapt the home language environment included: use gesture (*n*=32, 25.5%), talk with the child more (*n*=16, 12.6%), reduce phone time (*n*=8, 6.3%), and other communication strategies (n=11, 8.7%). Strategies for adapting their own caregiving included providing opportunities for play and socialisation (*n*=5, 3.9%), education strategies (*n*=4, 3.2%), and other caregiving behaviours (*n*=13, 10.2%). Home treatments included providing medicine, traditional treatments and other home treatments.

Table 7: Categories for *What would you do or change at home?*

Category	***N***	**%**	**Example**	
Adapt language environment	57	44.9	សួរអោយច្រើន ប្រើកាយវិការ ចង្អុល	talk with them [the child] more, use gesture
Don't know	30	23.6	អត់ដឹងធ្វើម៉េចទេ	don't know how to do
Adapt caregiving	22	17.3	នាំកូនដើរលេងខាងក្រៅ និងលេងជាមួយកូន	take the child out, and play with them
Seek support	18	14.2	នាំកុមារទៅពេទ្យ	take to paediatric hospital
Treat at home	7	5.5	យកដង្ហៀនមាសកោសអណ្តាត	use gold ring to scratch the tongue
Nothing special	7	5.5	អត់មាន	Nothing
Total	**127**			

Exploration of the codes in relation to rurality and province identified notable differences between rurality and adapt language environment (urban n=32, 41.0%; rural n=25, 51.0%), rurality and seek support (urban n=14, 18.0%; rural n=4, 8.2%), and province and treat at home.

Table 8: Relationship between rurality, province and categories *What would you do or change at home?*

	Urban		Rural		Kompot		Kompong Speu		Total	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Adapt language environment	32	41.0	25	51.0	20	42.6	37	46.3	57	44.9
Don't know	20	25.6	10	20.4	11	23.4	19	23.8	30	23.6
Caregiving strategies	15	19.2	7	14.3	10	21.3	12	15.0	22	17.3
Seek support	14	18.0	4	8.2	5	10.6	13	16.3	18	14.2
Nothing special	3	3.9	4	8.2	4	8.5	3	3.8	7	5.5
Treat at home	5	6.4	2	4.1	5	10.6	2	2.5	7	5.5
Total	**78**	**100.0**	**49**	**100.0**	**47**	**100.0**	**80**	**100.0**	**127**	**100.0**

Further exploration of the relationship between rurality, province and adapt language environment uncovered further patterns. Rural participants were more likely to adapt how (communication strategies: urban *n*=5, 6.4%; rural *n*=6, 12.2%) and how much (talk with child: urban *n*=8, 10.3%; rural *n*=8, 16.3%) they talk with the child. Meanwhile province impacted on how the language environment was adapted with those from Kompot more likely to increase the amount they talk with the child (Kompot *n*=9, 19.2%; Kompong Speu *n*=7, 8.8%), while those from Kompong Speu were more likely to use gesture (Kompot *n*=10, 21.3%; Kompong Speu *n*=22, 27.5%) and reduce phone time (Kompot *n*=1, 2.1%; Kompong Speu *n*=7, 8.8%).

Table 9: Relationship between rurality, province and Adapting language responses *What would you do or change at home?*

	Urban		Rural		Kompot		Kompong Speu		Total	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Use gesture	19	24.4	13	26.5	10	21.3	22	27.5	32	25.2
Talk with child	8	10.3	8	16.3	9	19.2	7	8.8	16	12.6
Communication strategies	5	6.4	6	12.2	4	8.5	7	8.8	11	8.7
Reduce phone time	4	5.1	4	8.2	1	2.1	7	8.8	8	6.3
Total	**32**	**41.0**	**25**	**51.0**	**20**	**42.6**	**37**	**46.3**	**57**	**44.9**

Rurality also impacted the types of caregiving strategies identified with those from urban areas more likely increase opportunity for play and socialisation (urban *n*=5, 6.4%; rural *n*=0, 0.0%), and those from rural areas more likely to provide education strategies (urban *n*=1, 1.3%; rural *n*=3, 6.1%). Province did not have the same impact in relation to caregiving strategies.

Table 10: Relationship between rurality, province and Caregiver strategies responses *What would you do or change at home?*

	Urban		Rural		Kompot		Kompong Speu		Total	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Caregiving	9	11.5	4	8.2	5	10.6	8	10.0	13	10.2
Play and socialisation	5	6.4	0	0.0	3	6.4	2	2.5	5	3.9
Education strategies	1	1.3	3	6.1	2	4.3	2	2.5	4	3.2
Total	**14**	**18.0**	**7**	**14.3**	**9**	**19.2**	**12**	**15.0**	**21**	**16.5**

Where people go to seek advice or help

131 participants responded to the question regarding where or from whom they would seek advice or help. Six categories were identified in the analysis: Government health and rehab services, authority figures, NGOs, education sector, don't know and no one. Twenty (15.3%) participants stated they did not where to seek advice or help, while an additional 17 (13.0%) responded that they would not seek support. Government health and rehabilitation services (n=58, 44.3%) included health centres, hospitals, and rehabilitation centres. Local authorities (n=24, 18.3%) included doctors (*n*=12, 9.2%), teachers (*n*=7, 5.34%), Khmer healer (n=1, 0.8%) and other village or local leaders (n=5, 3.8%). Education services included both specialist services and local schools.

Table 11: Categories for *Where and to who people go to seek advice or help*

Category	*n*	%	Example	
Government health/rehab services	58	44.3%	ទៅពេទ្យ ពិនិត្យ និងជួយណែនាំ	go to hospital, check and get advice
Authority figures	24	18.3%	រកជំនួយពីខាងមេភូមិ និង អង្គការផ្សេងៗ	find support from village leader
Don't know	20	15.3%	អត់ដឹងយកទៅណាទេ	don't know where to go
No one	17	13.0%	មិនមាន	don't have
NGOs	15	11.5%	រកជំនួយពីអង្គការ ប្រហែលគេអាចជួយបាន	find support from NGOs, maybe they can help
Education services	8	6.1%	ដាក់ឱ្យចូលរៀន ប្រហែលអាចជួយបានខ្លះ	put them at school that might be able to help some
Total	**131**			

Both rurality and province were influential in participants' responses. Those from urban areas were more likely to seek support from authority figures (urban *n*=17, 21.3%; rural *n*=7, 13.7%) and NGOs (urban *n*=12, 15.0%; rural *n*=3, 5.9%), while those from rural areas were more likely to report that they did not know who to seek support from (urban *n*=10, 12.5%; rural *n*=10, 19.6%). Participants from Kompot were more likely to seek support from the education sector (Kompot *n*=5, 10.0%;

Kompong Speu *n*=3, 3.7%), and those from Kompong Speu more likely to seek out government health and/or rehabilitation services (Kompot *n*=18, 36.0%; Kompong Speu *n*=40, 49.4%).

Table 12: Relationship between rurality, province and *Where and to who people go to seek advice or help?*

	Urban		Rural		Kompot		Kompong Speu		Total	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Government health/rehab services	34	42.5	24	47.1	18	36.0	40	49.4	58	44.3
Authority figures	17	21.3	7	13.7	10	20.0	14	17.3	24	18.3
Don't know	10	12.5	10	19.6	8	16.0	12	14.8	20	15.3
No one	9	11.3	8	15.7	8	16.0	9	11.1	17	13.0
NGOs	12	15.0	3	5.9	5	10.0	10	12.4	15	11.5
Education sector	4	5.0	4	7.8	5	10.0	3	3.7	8	6.1
Total	**80**	**100.0**	**51**	**100.0**	**50**	**100.0**	**81**	**100.0**	**131**	**100.0**

Further exploration of patterns regarding rurality, province and Authority Figures found that despite those from urban areas being more likely to seek advice and help from Authority Figures overall, this pattern was reversed in relation to teachers (urban *n*=2, 2.5%; rural *n*=7, 9.8%). In additional, those from Kompot were more likely to seek support from doctors (Kompot *n*=8, 16.0%; Kompong Speu *n*=4, 4.9%), while those from Kompong Speu were more likely to seek support from teachers (Kompot *n*=2, 4.0%; Kompong Speu *n*=5, 6.2%) and local authorities (Kompot *n*=1, 2.0%; Kompong Speu *n*=4, 4.9%).

Table 13: Relationship between rurality, province and Specific authority figures *Where and to who people go to seek advice or help?*

	Urban		Rural		Kompot		Kompong Speu		Total	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Doctor	10	12.5	2	3.9	8	16.0	4	4.9	12	9.2
Teacher	2	2.5	5	9.8	2	4.0	5	6.2	7	5.3
Local authority	4	5.0	1	2.0	1	2.0	4	4.9	5	3.8
Khmer healer	1	1.3	0	0.0	0	0.0	1	1.2	1	0.8
Total	**17**	**21.3**	**7**	**13.7**	**10**	**20.0**	**14**	**17.3**	**24**	**18.3**

Adult case study

Causes of an adult's communication difficulties

157 participants provided responses the question: *What do you think causes this person's difficulties?* Once again, responses were semantically coded, applying more than one code to a single response as necessary.

In response to this question, two thirds of the participants (*n=107,* 66.5%) provided an explanation related to the person's health and/or wellbeing. In addition, one third (*n*=58, 36.0%) identified a

specific health event, such as a stroke. Other causes included lifestyle factors, spiritual causes, and aging. 13.7% (*n*=22) stated that they did not know what caused the communication difficulties.

Table 14: Categories for *What do you think causes this person's difficulties?*

Category	***n***	***%***	***Example***	
Health & wellbeing	*107*	*66.5*	*លើសឈាម*	*High blood pressure*
Health event	*58*	*36.0*	*ដាច់សរសៃឈាមខួរក្បាល*	*bleeding in brain*
Don't know	*22*	*13.7*	*អត់ដឹងទេ*	*don't know*
Lifestyle	*14*	*8.7*	*ខំធ្វើការពេក*	*working too hard*
Unclear speech	*6*	*3.7*	*លើសឈាម និយាយមិនច្បាស់*	*Speech not clear*
Nothing	*4*	*2.5*	*ទេ*	*No*
Spiritual cause	*4*	*2.5*	*ផ្លូវងងិត ព្រោះគាត់ទៅរុះរើកន្លែងគេ រស់នៅ*	*Evil spirit. Because he moved their living place.*
Aging	*3*	*1.9*	*មកពីអាយុចាស់ 50ទៅ60ឆ្នាំ*	*Aging. 50-60 years*

Rurality did not have a notable impact on responses. However, province did impact on participants identifying the adult's overall health and/or well-being as causing the communication difficulty with those from Kompong Speu more likely to identify this factor (Kompot *n*=47, 58.8%; Kompong Speu *n*=60, 74.1%). While the numbers were small, both rurality and province were related to identifying a spiritual cause for the communication difficulties, with those from rural areas (urban *n*=1, 1.1%; rural *n*=3, 4.6%) and Kompot (Kompot *n*=4, 5.0%; Kompong Speu *n*=0, 0.0%) more often identifying this cause.

Table 15: Relationship between rurality, province and *What do you think causes this person's difficulties?*

	Urban		**Rural**		**Kompot**		**Kompong Speu**		**Total**	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Health & wellbeing	64	67.4	43	65.2	47	58.8	60	74.1	107	66.5
Health event	32	33.7	26	39.4	28	35.0	30	37.0	58	36.0
Don't know	14	14.7	8	12.1	10	12.5	12	14.8	22	13.7
Lifestyle	8	8.4	6	9.1	13	16.3	1	1.2	14	8.7
Unclear speech	4	4.2	2	3.0	5	6.3	1	1.2	6	3.7
Nothing particular	4	4.2	2	3.0	2	2.5	4	4.9	6	3.7
Spiritual cause	1	1.1	3	4.6	4	5.0	0	0.0	4	2.5
Aging	3	3.2	0	0.0	2	2.5	1	1.2	3	1.9
Total	**95**	**100.0**	**66**	**100.0**	**80**	**100.0**	**81**	**100.0**	**161**	**100.0**

What people do or change at home to help with the talking

Participants were asked to consider how they might support an adult family member with communication difficulties at home. 157 participants responded to these questions. Seven categories were identified in the analysis: Seek support, don't know, adapt communication

environment, adapt caregiving, treat at home, nothing in particular, and adapt to physical environment. Frequency of these categories is provided in Table XXX. Notably, one quarter of participants (*n=40, 25.5%)* stated they did not know what they would do in this situation.

Table 16: Categories for *What would you do or change at home?*

Category	***n***	***%***	***Example***	
Seek support	*45*	*28.7%*	*យកទៅពេទ្យ*	*take to hospital*
Don't know	*40*	*25.5%*	*មិនដឹងទេ មិនចេះផង*	*don't know, no skill*
Adapt communication environment	*30*	*19.1%*	*កាយវិការ និយាយលុលជ្វើសញ្ញា*	*gesture, slur speech, sign language*
Adapt caregiving	*30*	*19.1%*	*មើលថែរ*	*look after*
Treat at home	*21*	*13.4%*	*បង្រៀននិយាយ*	*teach them to speak/talk*
Nothing in particular	*12*	*7.6%*	*ទេ*	*no*
Adapt physical environment	*8*	*5.1%*	*យកក្រូចឆ្មារ ដេកនៅកំរាលតាំដ*	*use lamp and sleep on the floor*
Unclear	*1*	*0.6%*	*ប្រះដេក*	*sleep*
Total	***157***	***100%***		

Strategies identified to adapt the home communication environment included: use gesture (*n*=17, 10.8%), language strategies (*n*=7, 4.5%), observe communication attempts (*n*= 5, 3.2%), talk with the person more (*n*=3, 1.9%), and use communication devices (*n*=1, 0.6%). Participants from rural areas were more likely to use communication strategies (urban, *n=16, 17.0%; rural n*= 14, 22.2%) however rurality appeared to have little impact on type of communication strategies used. Overall, participants from Kompong Speu were more likely to use communication strategies (Kompot *n*=12, 15.79%, Kompong Speu *n*=18, 22.2%), with greater likelihood of reporting using gesture (Kompot *n*=6, 7.9%, Kompong Speu *n*=11, 13.6%), or observe the person's communication attempts (Kompot *n*=0, 0.0%, Kompong Speu *n*=5, 6.2%).

Table 17: Relationship between rurality, province and *What would you do or change at home?*

	Urban		**Rural**		**Kompot**		**Kompong Speu**		**Total**	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Seek support	26	27.7	19	30.2	23	30.3	22	27.2	45	28.7
Don't know	26	27.7	14	22.2	23	30.3	17	21.0	40	25.5
Adapt communication environment	16	17.0	14	22.2	12	15.8	18	22.2	30	19.1
Adapt caregiving	15	16.0	15	23.8	11	14.5	19	23.5	30	19.1
Treat at home	10	10.6	11	17.5	13	17.1	8	9.9	21	13.4
Nothing in particular	6	6.4	6	9.5	5	6.6	7	8.6	12	7.6
Adapt physical environment	6	6.4	2	3.2	3	4.0	5	6.2	8	5.1
Unclear	1	1.1	0	0.0	0	0.0	1	1.2%	1	0.6
Total (unique)	**94**		**63**		**76**		**81**		**157**	

Home treatments included providing massage (*n*=8, 5.0%), traditional treatments (*n*=8, 5.0%), exercise (n=5, 3.1%), teach to speak (*n*=3, 1.9%), buy medicine (*n*=2, 1.2%), prayer (*n*=1, 0.6%), and other home treatments (*n*=1, 0.6%). While the numbers are small, participants from rural areas were more likely to report using massage (urban, *n*=3, 3.2%; rural *n*= 5, 7.6%), traditional therapies (urban, *n*=4, 4.2%; rural *n*= 4, 6.1%), and/or exercise (urban, *n*=1, 1.1%; rural *n*= 4, 6.1%).

Where and to who people go to seek advice or help

156 participants responded to the question regarding where or from whom they would seek advice or help. Six categories were identified in the analysis: Medical or health facility, Doctor, Khmer healer, Family member, no one specific and don't know. 119 participants (76.3%) identified that they would seek support from a medical or health facility (*n*= 95, 60.9%) and/or doctor (*n*=26, 16.7%). 21 participants (13.5%) stated they did not know where to seek advice or help, while an additional 11 (7.1%) responded that they would not seek support.

Table 18: Categories for *Where and to who people go to seek advice or help*

Category	***n***	***%***	***Example***	
Medical/health facility	*95*	*60.90%*	*ទៅពេទ្យ ទៅវៀតណាម*	*go to hospital, go to Vietnam*
Doctor	*26*	*16.67%*	*ពេទ្យ មានពាក់ព័ន្ធប្រសើយប្រាសាទ*	*neurology doctor*
Don't know	*21*	*13.46%*	*អត់ដឹង ថាយកទៅកន្លែងណាអោយជួយទេ*	*Don't know where to get help*
No one specific	*11*	*7.05%*	*អត់*	*No*
Khmer healer	*7*	*4.49%*	*គ្រូខ្មែរ*	*Khmer healer*
Family member	*2*	*1.28%*	*ទៅពេទ្យរុស្សី ហៅប្អូនមកជួយមើលថែរ*	*go to Khmer soviet hospital, ask brother to help taking care*
Total	***156***			

As for the child case study, both rurality and province were influential in participants' responses. Those from urban areas were more likely to seek support from a medical or health facility (urban *n*=58, 63.7%; rural *n*=37, 56.9%), while those from rural areas were more likely to report that they would not seek specific support (urban *n*=4, 10.8%; rural *n*=10, 19.6%). Participants from Kompot were more likely to seek support from a doctor (Kompot *n*=19, 24.7%; Kompong Speu *n*=7, 8.9%), and those from Kompong Speu more likely to seek out a medical or health facility (Kompot *n*=44, 57.1%; Kompong Speu *n*=51, 64.6%) or no one specific (Kompot *n*=1, 1.3%; Kompong Speu *n*=10, 12.7%). Those from Kompot were more likely to report not knowing where to go for help or advice (Kompot *n*=13, 16.9%; Kompong Speu *n*=8, 10.1%). Seeking support from Khmer healer was consistent across rurality (urban *n*=4, 4.4%; rural *n*=3, 4.3%), and province (Kompot *n*=3, 3.9%; Kompong Speu *n*=4, 5.1%).

Table 19: Relationship between Rurality, Province and *Where and to who people go to seek advice or help*

	Urban		***Rural***		***Kompot***		***Kompong Speu***		***Total***	
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Medical or health facility	58	63.7	37	56.9	44	57.1	51	64.6	95	60.9
Doctor	17	18.9	9	13.9	19	24.7	7	8.9	26	16.7
Don't know	11	12.1	10	15.4	13	16.9	8	10.1	21	13.5
No one specific	4	4.4	7	10.8	1	1.3	10	12.7	11	7.1
Khmer healer	4	4.4	3	4.6	3	3.9	4	5.1	7	4.5
Family member	2	2.2	0	0.0	1	1.3	1	1.3	2	1.3
Total	**91**		**65**		**77**		**79**		**156**	

Research question 2

Can Wylie et al. (2017)'s self-help and help-seeking for communication disability survey be adapted to create a tool that is appropriate and acceptable for use within a rural Cambodian context? And if so, what is required?

During data collection, team leaders recorded notes based on daily team reflections. Overall, these notes identified key challenges encountered by the teams as well as actions to respond to these changes. Key Challenges reported by enumerator team were participant engagement, tensions regarding ethics principles, participant availability and issues with the survey tool itself.

The data collection team estimated a refusal rate of at least 50% for people being willing to be interviewed. The most common reason provided was the busyness of the person "I'm too busy". In addition, the enumerators sensed a hesitancy to discuss the topic of communication disability, with people voicing a lack of familiarity in the topic. In a few specific cases there was an explicit unwillingness to discuss the topic of disability with participants appearing afraid or angry and stating that they did not see the topic as suitable for discussion.

The data collectors identified tension between the principles of privacy and consent, with creating transparency and interviewee comfort during the interviews. A combination of written and verbal consent was required with some refusing to be recorded while others gave verbal recorded consent but did not want to sign. Others declined to be interviewed but listened in to other being interviewed and gave answers to questions, wanting to join in on others' interviews.
There was large variation between participant availability across locations and times of the day. Public places like markets, riverfront, playgrounds, train stations were positive, but each place had its own availability time and rhythm across the day. Likewise, specific groups of people - market sellers, tuktuk drivers, and families also had their own rhythm of availability.

Finally, issues with technology and wording of questions were identified. These are discussed further below.

Focus group data was transcribed and analysed, identifying key six key themes. These themes expanded on some of the challenges and facilitators identified above. In addition, they provide concrete strategies for adapting the tool and survey format for future use.

Table 20: Themes and quotes regarding data collection process

Theme	Recommendation	Enumerator statements
Training and technology literacy	Ensure technology fluency and literacy with the tablet device including typing in Khmer font on the device	"*Some junior enumerators were not used to tablet. it worked ok for the paper backup… hire people who have more experience with technology. and more training and practice using it.*"
	Ensure fluency of survey question and KOBO data entry requirements	*"Understand and remember the questionnaires well. Know your role well and don't change roles within the data collection"*
Training and expectations	Hold realistic expectations of survey participant rate	*"Don't take refusals personally - be ready to be refused"*
Participant engagement	Establish rapport well before beginning documentation and recording	*"The formality of our procedure does not help here. They refuse when we bring out our forms, [the people] maybe don't trust when they have to sign. Other people see the paper and feel lazy. They say "I'm too lazy to sign"" "In my experience. when I introduced myself first as coming from the organization, many people don't want to talk."*
	Provide personalized connection to the topic of communication development and difficulty to encourage engagement and confidence in participating in the survey	*"I tried a different strategy. When I meet someone, I just start the conversation by asking them about themselves. "Come from where? How many children and grandchildren? What experience they have with small children?" One man said he looked after his 2-year-old grandchild… I asked him about his grandchild's speaking, "a lot already or just a few words?" After he tells more about his grandchild I said, "you know a lot about your grandchild and help them well. Actually, this is what I'd like to talk with you about. Can I interview you about this topic please?" After this he said yes, I can interview"*
Data collection set up and resourcing	Have transport available for flexible locations	*"Need to go around a lot to find location for interview, be flexible, have moto to go to new location"*
	Send research team to collection site earlier to scope out locations and make clear	*"Because each town and area is a little bit different, we need to understand the location more clearly before the data collection.*

	plan for the day based on business and availability of participants	*Perhaps we could go and observe the area beforehand - to understand the best time and locations - then the team can have a very clear plan."*
Interview questions and format	Flexibility in format of interviewing to enable group interviewing or explanation as well as individual answers	*"When we call people to the side and have them sit in quite place they can become scared and nervous about what we say together. It can give people confidence and reassurance to sit with their friends [when they answer] so they can understand together and the person doesn't have to understand the question on their own. For people who know each other well they are not worried about privacy, they can help each other and feel more confident together."*
Small changes to question wording and format	Review the inclusion of the "what would others do?" question for each of the scenarios	*"When we asked the question about "what would other people do?" - often they didnt have different answer. They felt many that we didn't believe their answer and follow up, or they answered I don't know what others would do, like they don't care about others. When I made it more specific to "What would other people in the village or in your family do? …Then they could answer."*

Discussion and Recommendations

This project built our understanding of existing strategies used by rural and urban Cambodians to support children and adults with communication difficulties. To ensure that the research was culturally and contextually responsive, the project team also adapted and evaluated the research tool for the Cambodian context. An exploration of the participant demographic data identified the relevance of this research to the lives of Cambodians both as caregivers and as members of families and communities of those with communication disabilities. The findings are discussed in relation to our two research questions.

How do rural Cambodians describe the existing community strategies, resources, and people for supporting people with communication disabilities?

Child Case study

In response to the child case study, participants provided a range of explanations for communication difficulties among children. These explanations reflected local beliefs about child development including the role of birth, maternal behaviours, and connections with disability more generally. While a surface exploration of categories did not reveal any relationship between rurality, province and beliefs/practices regarding causes of communication difficulty, a deeper exploration of codes relating to the category 'child health & wellbeing' revealed patterns in these areas. Those from urban areas were more likely to provide medical explanations for communication difficulties such as

genetics or specific illness, while those from rural areas were more likely to centre the cause on the child themselves identifying the child's social-emotional status and/or difficulty being understood as core factors. Further exploration is needed to understand these relationships.

Participants identified a range of home-based strategies and external services for supporting a child with communication disability. Rurality and Province impacted on home-based caregiving including the use of language strategies, and approaches to providing care and enrichment for the child. Rural participants were more likely to adopt the language environment, including how & how much they talk with the child, and less likely to seek external support. Rural participants were also more likely to use education strategies to teach the child but did not identify the role of play in supporting development. These factors potentially reflect different understandings of child development and/or parenting alongside the limited availability of external support outside of urban centres. Province also impacted how the language environment was adapted with participants from Kompot, where there are fewer rehabilitation services, and more likely to be 'treat' at home.

Participants identified a range of services & people to support the family with communication disability, including hospitals, NGOs, authority figures, and education services. Urban participants were more likely to seek care from Authority figures and NGOs reflecting the availability of these services in urban areas. Province also impacted sector/services accessed reflecting the availability of government health and rehabilitation services in Kompong Speu. Also reflecting accessibility, Rurality and Province impacted which local authorities people go to.

Data collected reveals both perceived resources (people and strategies) and the places where families identified as a starting place to seek services. Within both anticipated care-seeking and caregiving behaviours, there was noticeable proactivity in seeking our support for the child to improve their communication difficulties. Both the identification of authority figures of health, education, local authority and spiritual leaders as well as the proactivity in looking for support is consistent with Morgan et al (2011) in their study interviewing parents of children with Cerebral palsy in rural Cambodia. Despite the intention to seek support, data revealed misinformation, information gaps and bias in relation to communication disabilities were prevalent within both rural and provincial urban communities.

Adult case study

Based on the case study provided, participants provided a range of explanations for communication disability in adults. Many of these responses reflected public messaging regarding the impact of diet, lifestyle, high blood pressure and diabetes on increasing likelihood of a stroke and consequent physical difficulties including speech difficulties. Several participants based their response on their own experience of knowing a family or community member who had a stroke.

The connection between speech and other physical impacts of a stroke was also reflected in caregiving strategies identified by participants to support the person with a communication disability at home. Participants identified only a limited range of home-based strategies and external services for supporting an adult with a communication disability. Many of the home-based caregiving strategies focused on providing general care and physical support rather than communication-specific support. However, rural participants were more likely to adopt the communication

environment and caregiving and to treat at home. Participants identified a limited range of services and people to support families with communication disabilities. Doctors and hospitals were key in providing support for patients with stroke. Rural participants and those from Kompong Speu were less likely to seek specific care potentially reflecting the lack of nearby medical and hospital services. However, this largely focussed on medical care, not support for communication. This is unsurprising given the absence of communication-related speech therapy services for adults in rural areas (Bryce et al., 2022) and where existing hospitals and rehabilitation services do not currently have trained staff to provide communication rehabilitation or speech therapy.

While the connection between health/wellbeing and stroke along with the focus on seeking medical support reflects current scientific understandings and best practice guidelines, misinformation, information gaps and bias in relation to stroke related communication disability were also evident. The second most common response in relation to the causes of the communication difficulty and ways to respond at home was 'don't know'. This was also the third most common response regarding where or from whom they would seek support. Together with the lack of focus on support for communication identified in relation to care giving and care seeking strategies, this suggests a significant lack in understanding regarding supporting those with communication disability following stroke, especially beyond the acute phase of the stroke.

Communication disability and spirituality

While the numbers were relatively small, cultural beliefs and practices regarding spiritual causes and treatments for communication disability were evident in survey responses for both case studies. Feedback from the stakeholder advisory group and dissemination workshop suggests that the numbers presented are not representative of practice, with Rehabilitation centre staff sharing their experience that "almost all" adults seeking their services had previously engaged Khmer traditional healers. This pattern of underreporting was also identified in previous studies in Ghana (Wylie et al., 2017) and Fiji (Hopf et al., 2018). Thus, it is important to consider the role that Khmer healers play in supporting those with communication difficulties and their families.

Can Wylie et al. (2017)'s self-help and help-seeking for communication disability survey be adapted to create a tool that is appropriate and acceptable for use within a rural Cambodian context? And if so, what is required?

The data collection tool modified from Wylie et al (2017) was successfully used to create a foundation of evidence about perceived resources and attitudes about communication disabilities within the two Cambodian provinces. The analysis of data based on rurality and province enabled the discovery of patterns which can be investigated further to clarify and address strengths and weaknesses regarding the understanding of and caregiving/care-seeking for communication disabilities.

Further consideration and analysis are required of the usefulness of the question "what would others do?" within the Cambodian context. This question was retained from the original survey due to the existence of a similar face-saving culture, providing an opportunity to provide an answer they were not directly admitting to. Initial data revealed that for those who provided responses regarding seeking support from Khmer healers, their did not appear to be shame associated with spiritual or non-medical responses unlike the Ghanaian context of the original survey tool. Rather, the data

collection team reflected that in many cases this question felt awkward as there was not a sense of being comfortable assuming what others would do, or bewilderment at what they perceived as a repetition of question.

Both the advisory group and stakeholder feedback group were able to accept the data results as new research, complementing the existing knowledge and experience of the group. For the specific area of engaging traditional or spiritual leaders, it was suggested the data may be more accurate if the questions were closed options (*Would you go to Khmer healers?*) rather than open ended, *Who might you go to?* The range of categories and themes identified in this study could be used to design a more focused quantitative study in the future.

The data collection focus group revealed strong learning and suggestions for logistical and social factors for data collection in the Cambodian context (Table 20). The building of a Cambodian research team was essential to gather these insights. It is strongly recommended these practical suggestions and learnings are considered for future research in this area.

Recommendations for building Cambodian research capacity and evidence-base

1. **Involve a stakeholder advisory group.** The stakeholder advisory group was key in supporting the development of key relationships required to complete the project. This group shaped the research to ensure it was responsive to the needs of Cambodia including health and rehabilitee services, those with communication disability and their carers and families
2. **Build relationships through research.** Through the ethics application process and the subsequent data collection phase of the project, relationships with provincial rehabilitation services and national health bodies were strengthened. These processes provided an opportunity to work collaboratively and explore ongoing opportunities to build on the research findings through practical outcomes. They also provided an opportunity to bring the field of communication disability to the attention of new stakeholders within the health research community.
3. **Train Khmer researchers for data collection and analysis.** The Khmer data collection and analysis team were vital to producing culturally responsive and relevant research. Providing specific opportunities for feedback and reflection on research processes supported the development of this team. As demonstrated in our findings regarding research question 2, the cultural and linguistic knowledge of the Khmer researchers was vital in collecting data appropriate for the research questions and providing cultural expertise to guide expatriate researchers.
4. **Train Khmer/English translators for communication disability research.** As research in communication disability is still an emerging field in Cambodia, there is a lack of translation resources to support the work. However, this is vital to release other researchers to complete their components of the research and build overall capacity.
5. **Continue to initiate discussions around communication disability and Khmer language.** For example, an advisory group member suggested changing the using term “disability” to “difficulties” to be more inclusive of children with milder delays or language difficulties who would not be considered within the Cambodian category of disability.

Recommendation for future research topics and interventions

Recommendations from this research come from two main sources: the research team and the participants in the dissemination workshops.

Based on analysis of the data, the research team presented the following recommendations (edited based on feedback from workshop participants:

- Upskill community leaders, health professionals, educators, healers and others who currently provide support in the identification of and support for child and adult communication disabilities
- Invest in the training and infrastructure required for a collaborative, holistic response across the health, education and rehabilitation sectors.
- Need for community-based accessible support within urban **AND** rural areas and across provinces
- Develop a public health response to educate the community about child and adult communication disabilities in Cambodia
- Continue building on this research and the establishment of a Cambodian evidence base for support those with communication disabilities through ongoing research, including:

    - Keep analysing existing data
    - Further explore differences in rural and provincial responses
    - Explore the impact of additional factors (e.g. age, education level, occupation) on caregiving and care-seeking for those with communication disability

In presenting this research to the stakeholder group and the broader dissemination workshop, there was widespread engagement and discussion. During the dissemination workshops, participants were encouraged to consider the findings of this research in relation to the following two questions:

How do these results reflect your own experience?

What opportunities are there to respond to these findings?

In addition to the discussion of the method and results mentioned above, there was also many ideas of priorities and needs to support people with communication disabilities. These included:

1. Need to understand better the link between “screen time” and early childhood communication development in Cambodia
2. Need clearer data on prevalence of communication disability in Cambodia
3. Need to use current survey tools in broader sizes and locations in Cambodia
4. Need to have greater understanding of the perspective of communities on the cause of communication disabilities by a belief
5. Need to look at the relationship of nurturing care to child communication development in Cambodia
6. Investigate how social media/online sources affected to care seeking behaviour and decision of the family in seeking service support with the skilled professional team for children with Autism in Cambodia
7. Need to produce community-level resources to support and include people with communication disabilities in this time with little to no services available

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Appendices

Appendix 1: Stakeholder advisory group members

Name (English)	Name (Khmer)	Gender	Disability	Affiliation	Role*
Srey Ya	ស្រីយ៉ា	F	Y	Saravorn Organisation	1
Ly Hang	លី ហេង	M	Y	individual	1
Kol Duch SOFIYA	កុល ឌុច សុហ្វីយ៉ា	F	N	Professor at PUC	2
H.E Yeap Malyno	ឯកឧត្តម យៀប ម៉ាលីណូ	M	N	Director of Policy Department/MoSVY	4
Suy Sarith	ស៊ុយ សារិទ្ធ	M	N	Deputy Chief Office of Public Service Management and Pension Support Scheme/People with Disability Foundation	5
Hak Nget	ហាក់ ង៉ែត	M	N	Deputy department of health promotion at Provincial health department, Kompot	4
Chea Phearom	ជា ភារម្យ	F	N	ST practitioners/CIF	3
Sok Dearozet	សុខ ឌៀរ៉ូហ្សែត	F	N	Community Program Manager/CCAMH org.	3
H.E Prak Thaveak Pheary	លោកជំទាវ ប្រាក់ ថាវរៈភារី	F	N	Deputy director of Disability Action Council	5
Chhoy Sarom	ឆយ សារុំ	F	N	PT/PRC Kompong Speu	4

** Code for SAG roles*

Code	Role	F	M	Total
1	Adult with Communication disability	1	1	2
2	Parent of child with communication disability	1		1
3	Direct service provider to children/adult with disabilities in target provinces	1	1	2
4	Rep. from a NGOs working on Adult/Children with Disability program	2		2
5	Rep. from government -Disability & rehabilitation sector	1	2	3
Total		**6**	**4**	**10**

Appendix 2: Stakeholder Advisory Group Consent and Terms of Reference

ទម្រង់យល់ព្រមសម្រាប់អ្នកចូលរួមប្រឹក្សាយោបល់
គម្រោងសិក្សាស្រាវជ្រាវ ស្តីពី
"ឥរិយាបថនៃការយកចិត្តទុកដាក់និងការថែទាំជនមានពិការភាពក្នុងការប្រាស្រ័យទាក់ទងនៅក្នុងសហគមន៍នៃប្រទេសកម្ពុជា"

ព័ត៌មានសង្ខេប និង គោលបំណងគម្រោងស្រាវជ្រាវ៖

បច្ចុប្បន្ននៅក្នុងប្រទេសកម្ពុជា សេវាជួយគាំទ្រដល់អ្នកដែលមានដែលមានពិការភាពក្នុងការប្រាស្រ័យទាក់ទងនិង លេងអាហារមានចំនួនតិចតួចណាស់ ហើយសេវាភាគច្រើនមាននៅតែនៅទីក្រុងភ្នំពេញ។ អាស្រ័យហេតុនេះ កុមារនិងមនុស្សពេញវ័យដែលមានពិការភាពក្នុងការទំនាក់ទំនងនិងលេងអាហារត្រូវពឹងផ្អែកលើការគាំទ្រនិងការថែទាំនៅត្រឹមសហគមន៍ប៉ុណ្ណោះ។ ក្រុមស្រាវជ្រាវរបស់យើងចង់ស្វែងយល់អំពីការគាំទ្រកម្រិតសហគមន៍ទាំងនេះឱ្យកាន់តែច្បាស់។

គម្រោងស្រាវជ្រាវនេះមានគោលបំណង ស្វែងយល់ពីមធ្យោបាយដែលប្រជាពលរដ្ឋដែលរស់នៅក្នុងខេត្តកំពង់ស្ពឺ និង ខេត្តកំពត អំពីការថែទាំនិងការស្វែងរកជំនួយជួយគាំទ្រដល់កុមារនិងមនុស្សពេញវ័យដែលមានពិការភាពក្នុងការប្រាស្រ័យទាក់ទងនិងលេងអាហារ។ដោយធ្វើការបង្ហាញប្រាប់ពីធនធានសមត្ថភាពដែលមានស្រាប់ នឹងសង្ឃឹមថាបង្កើតបាននូវមូលដ្ឋានគ្រឹះដ៏រឹងមាំមួយសម្រាប់ការអភិវឌ្ឍន៍ក្រុមអ្នកជំនាញវិជ្ជាជីវៈផ្នែកព្យាបាលការប្រាស្រ័យទាក់ទងនៅ ប្រទេសកម្ពុជា។

តើខ្ញុំអាចចូលរួមតាមរបៀបណា?

ចូលរួមប្រឹក្សាយោបល់លើគម្រោងស្រាវជ្រាវនេះ ក្នុងគោលបំណងផ្តល់យោបល់ និងពត៌មានត្រលប់ទាក់ទងនឹង ដំណើរការនិងផែនការសកម្មភាពស្រាវជ្រាវនៃគម្រោងគ្រប់ដំណាក់កាល។ ប្រសិនបើអ្នកមិនចង់អ្នកអាចជ្រើសរើសបញ្ឈប់ការចូលរួមរបស់អ្នកនៅពេលណាក៏បាន។ ជំហានគន្លឹះនៃការត្រួតពិនិត្យសម្រាប់ក្រុមប្រឹក្សាស្រាវជ្រាវ រួមមាន៖ ពិនិត្យ និង ផ្តល់យោបល់លើកម្រងសំនួរស្រាវជ្រាវ ពិនិត្យមើលលទ្ធផលស្រាវជ្រាវ និង ស្វែងរកការកំណត់ប្រភេទនៃចំលើយពី អ្នកចូលរួម ផ្តល់យោបល់លើការរៀបចំផែនការក្នុងការឃ្លាញលទ្ធផលគម្រោងស្រាវជ្រាវ ផ្តល់យោបល់លទ្ធផលចុងក្រោយនៃគម្រោង ស្រាវជ្រាវសម្រាប់ការស្រាវជ្រាវពេលអនាគត។

រយៈពេលក្រុមប្រឹក្សាយោបល់ស្រាវជ្រាវ៖ ចាប់ពីខែមិថុនា ឆ្នាំ២០២២ ដល់ ខែកុម្ភៈ ឆ្នាំ២០២៣

ពេលវេលាក្នុងការចូលរួម៖ ជួបប្រជុំជាមួយក្រុមអ្នកស្រាវជ្រាវគម្រោង ចំនួន៥ទៅ៦ដង នៅក្នុងអំឡុងពេលនៃការស្រាវជ្រាវ (៩ខែ)។

ចំនួនក្រុមប្រឹក្សាស្រាវជ្រាវ៖ ពី ៨ ដល់ ១២នាក់

សមាសភាពរួមមាន៖

១. ជនមានពិការភាពក្នុងការប្រាស្រ័យទាក់ទង ឬការនិយាយ

២. ឪពុកម្តាយ ឬអាណាព្យាបាលកុមារដែលមានផលវិបាកក្នុងការប្រាស្រ័យទាក់ទង

៣. ប្រធានភូមិ ឬក្រុមអ្នកផ្តល់សេវាគាំទ្រនៅក្នុងតំបន់គោលដៅ ខេត្តកំពង់ស្ពឺ និង ខេត្តកំពត

៤. មន្ត្រីឬបុគ្គលិក បច្ចេកទេសធ្វើការផ្ទាល់ជាមួយជនឬកុមារដែលមានពិការភាពក្នុងការប្រាស្រ័យទាក់ទង

៥. មន្ត្រី ឬ បុគ្គលិក តំណាងពីអង្គការ ឬស្ថាប័នរដ្ឋាភិបាល

តើនឹងមានអ្វីកើតឡើងចំពោះព័ត៌មានរបស់ខ្ញុំ?

ក្រុមស្រាវជ្រាវនឹងកំណត់ពីគំរូនៃការថែទាំនិងការស្វែងរកការថែទាំនៅក្នុងនិងរវាងខេត្តគោលដៅទាំងពីរ។ ព័ត៌មាននេះនឹងត្រូវបានប្រើប្រាស់ដើម្បីជួយកំណត់មធ្យោបាយបន្ថែមទៀតក្នុងការជួយ ដល់ជនមានពិការក្នុងការប្រាស្រ័យទាក់ទង និងលេបអាហារ និងគ្រួសាររបស់ពួកគេនៅក្នុងសហគមន៍កម្ពុជា។ ព័ត៌មានរបស់អ្នកនឹងត្រូវបានកត់ត្រាទុកជាអនាមិកហើយនិងរក្សាទុកជាការសម្ងាត់។ ចំពោះលទ្ធផលដែលបានរកឃើញអាចត្រូវបានបោះពុម្ពផ្សាយ ហើយទិន្នន័យ ឬការរកឃើញដែលប្រមូលបានក្នុងការស្រាវជ្រាវនេះ អាចត្រូវបានប្រើប្រាស់ក្នុងគម្រោងស្រាវជ្រាវបន្ថែមទៀតនាពេលអនាគត។

តើអ្នកណាកំពុងធ្វើការស្រាវជ្រាវ?

ដំណើរការគម្រោងស្រាវជ្រាវនេះបានសហការណ៍ជាមួយអង្គការអូរអាយស៊ីកម្ពុជា (OIC Cambodia) ដែលដឹកនាំដោយលោកស្រី នេត ចិន្តា (នាយកប្រតិបត្តិអង្គការអូរអាយស៊ីកម្ពុជា) ព្រមទាំងក្រុមការងារស្រាវជ្រាវចំនួន៥រូប (ជនជាតិអូស្ត្រាលី ០២រូប ខ្មែរ០៣រូប) ដែលទទួលខុសត្រូវក្នុងការប្រមូលទិន្នន័យស្ទង់មតិ។

គម្រោងស្រាវជ្រាវនេះ ត្រូវបានគាំទ្រដោយគម្រោងជំនួយខ្នាតតូចមួយ តាមរយៈ កម្មវិធីអាហាររូបករណ៍អូស្ត្រាលីនៅកម្ពុជា Australia Awards Cambodia)។ មតិដែលឃ្លាញក្នុងការស្រាវជ្រាវនេះគឺជាគំនិតរបស់ក្រុមស្រាវជ្រាវ (និង លោកស្រី នេត ចិន្តា ដែលជាប្រធានដឹកនាំគម្រោងស្រាវជ្រាវ) ដែលមិនឆ្លុះបញ្ចាំងពីទស្សនៈរបស់កម្មវិធីអាហាររូបករណ៍អូស្ត្រាលីនៅកម្ពុជាឡើយ។

គណៈកម្មាធិការត្រួតពិនិត្យក្រមសីលធម៌ របស់ក្រសួងសុខាភិបាលនៅប្រទេសកម្ពុជា បានអនុញ្ញាតិលើការអនុវត្តគម្រោងស្រាវជ្រាវនេះ នៅថ្ងៃទី១១ ខែកក្កដា ឆ្នាំ២០២២។ ប្រសិនបើអ្នកមានការមិនពេញចិត្ត ឬមានក្តីបារម្ភណាមួយចំពោះក្រមសីលធម៌នៃគម្រោងនេះ លោកអ្នកអាចទាក់ទងទៅ គណៈកម្មាធិការ ក្រមសីលធម៌ស្រាវជ្រាវកម្ពុជា តាមរយៈលេខទូរសព្ទ៖ ០១២ ៥២៨ ៧៨៩, ០៨៦ ៧៦២ ១១៣, ០១២ ២០៣ ៣៨២ ឬអ៊ីមែល nouthsarida@gmail.com, cheatasoft27@gmail.com ។ បញ្ហាទាំងឡាយដែលអ្នកលើកឡើងនឹងត្រូវបានដោះស្រាយដោយទំនុកចិត្ត និងសើ៊ីអេរង្គេតយ៉ាង ពេញលេញ ហើយអ្នកនឹងត្រូវបានជូនដំណឹងអំពីលទ្ធផល។

ដើម្បីយល់ព្រមចូលរួមក្នុងក្រុមទីប្រឹក្សាយោបល់គម្រោងស្រាវជ្រាវនេះ សូមគូសលើចម្លើយខាងក្រោម៖

- ☐ ខ្ញុំយល់ព្រមចូលរួមនៅក្នុងគម្រោងស្រាវជ្រាវនេះ
- ☐ ខ្ញុំយល់ពីព័ត៌មានស្រាវជ្រាវដែលបានផ្តល់មកឱ្យខ្ញុំ ហើយខ្ញុំមានឱកាសសាកសួរសំណួរនិងពេញចិត្តចំពោះការឆ្លើយតបសំនួរបស់ខ្ញុំពីក្រុមស្រាវជ្រាវ។ ខ្ញុំបានទទួលការពន្យល់អំពីគោលបំណងនៃការស្រាវជ្រាវនេះ តួនាទី និងការទទួលខុសត្រូវរបស់ក្រុមទីប្រឹក្សាយោលបល់នៃគម្រោងស្រាវជ្រាវនេះ។
- ☐ ខ្ញុំយល់ច្បាស់ថា ការចូលរួមរបស់ខ្ញុំក្នុងការស្ទង់មតិនេះគឺជាស្ម័គ្រចិត្ត ហើយថាខ្ញុំមានសិទ្ធិបញ្ឈប់ការចូលរួមរបស់ខ្ញុំគ្រប់ពេលវេលាដោយគ្មានហេតុផល ដោយមិនមានផលប៉ះពាល់អវិជ្ជមានតាមមធ្យោបាយណាមួយឡើយដល់ខ្ញុំឡើយ។
- ☐ ខ្ញុំយល់ថាព័ត៌មានលម្អិតផ្ទាល់ខ្លួនដែលខ្ញុំផ្តល់ឱ្យនឹងត្រូវបានរក្សាទុកជាសម្ងាត់ ហើយគ្មានព័ត៌មាន កំណត់អត្តសញ្ញាណណាមួយនឹងត្រូវបានផ្សព្វផ្សាយ ឬប្រើប្រាស់ឡើយ។
- ☐ ខ្ញុំយល់ព្រមចំពោះការរក្សាទុកនូវការឆ្លើយតបរបស់ខ្ញុំ ដើម្បីរក្សានូវពត៌មានដែល ត្រឹមត្រូវពិតប្រាកដ
- ☐ ខ្ញុំយល់ថាការរកឃើញនៃការស្រាវជ្រាវអាចនឹងត្រូវបានបោះពុម្ពផ្សាយហើយទិន្នន័យឬការរកឃើញ ដែលប្រមូលបាននៅក្នុងការស្រាវជ្រាវនេះអាចនឹងត្រូវបានប្រើប្រាស់ក្នុងការស្រាវជ្រាវនាពេលអនាគត។

ឈ្មោះទីប្រឹក្សាយោបល់ ៖ _____

មកពី (តួនាទី និងស្តាបនំ) ៖ _____

ហត្ថលេខា៖_____ **កាលបរិច្ឆេទ៖** _____

CONSENT FORM FOR RESEARCH ADVISORY GROUP
"Care-giving and care-seeking behaviour for people with communication disability within Cambodian communities"

Project summary and aims

Currently in Cambodia there are very few services and supports available for individuals with communication disabilities, and the majority of services exist in Phnom Penh. Consequently, children and adults with communication disabilities rely on community-level support and care. Our research team is keen to understand these community-level supports better.
So this project aims to: develop understanding of the ways people in Kampong Speu province and Kompot province care for and seek support for children and adults with communication disability. By highlighting existing capacities we hope to build a strength-based foundation for development of a Cambodian speech therapy workforce.

How can I participate?
A Research Advisory participation involves through this research process to advise & give feedback on process and plans during all stages. If you don't want to continue, you can choose to discontinue participating at any time. Key stages for advisory group review include:

- Review and advise on questionnaire
- Review of findings and explore key themes
- Advise dissemination and sharing of research findings
- Advise project outcomes in relation to ongoing research

Advisory group time period: June 2022 – Feb 2023
Advisory group involvement: 4-5 meetings across the time of research.
Number of People in advisory group: 08 to 12 people
Can include:

- People with communication disability,
- Caregivers of children/adult with communication disabilities
- Service providers from target rural research locations
- People working with people with communication disabilities
- Representatives from government departments; disability, rehabilitation, health

What will happen to my information?
The research team will identify patterns of caregiving and care-seeking within and between the two provinces. This information will be used to help identify additional ways to support people with communication disability and their families in Cambodia communities.

Your information will be recorded anonymously and your confidentiality maintained. The findings may be published and the data or findings collected in this research may be used in future projects.

Who is conducting the research?
The research project is being co-conducted by OIC Cambodia, led by Chenda Net (Executive Director OIC Cambodia) and research team of 5 people (2 expats and 3 Cambodians), are responsible for collecting the survey data.

This research is supported with a small grant through Australia Awards Cambodia. The opinions expressed in this research are those of research team (and Ms. Chenda NET as the team leader) and do not necessarily reflect the views of Australia Awards Cambodia.

The Ethics Committee in Cambodia has approved this project on 11 July 2022. If you have any complaints or reservations about the ethical conduct of this project, you may contact the Committee on phone number: **012 528 789, 086 762 113, 012 203 382** or EMAIL: **nouthsarida@gmail.com, cheatasoft27@gmail.com**. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

To consent to participate in this survey, please answer the following questions.

- ☐ I consent to participate in this research
- ☐ I understand the research information provided to me and I have had the opportunity to ask questions and any questions have been answered to my satisfaction. The purpose of this research and the role of advisory has been explained to me clearly.
- ☐ I understand that my participation in the survey is voluntary and that I have the right to stop participating at any time without reason, and that if I do, I will not be adversely affected in any way.
- ☐ I understand that any personal details I give will be kept confidential and no identifying information will be published or used.
- ☐ I consent to my responses being recorded so that accuracy is maintained.
- ☐ I understand that the research findings may be published and that the data or findings collected in this research may be used in future research.

Name (print): _____

Affiliation From (position & institute): _____

Signature: _____ Date: _____

Appendix 3: Project Timeline

No.	Activities	May					Jun				Jul				Aug					Sep				Oct					Nov				Dec	Jan -23
		2	9	16	23	30	6	13	20	27	4	11	18	25	1	8	15	22	29	5	12	19	26	3	10	17	24	31	7	14	21	30	1-30	1-31
1	Research ethics approval																																	
2	Establish Stakeholder Advisory Group																																	
3	Stakeholder Advisory Group Meeting																																	
4	Establish survey tool																																	
5	Research assistant recruitment																																	
6	Research assistant training																																	
7	RQ1: Data collection																																	
8	RQ1: Data analysis																																	
9	Q2: Data collection																																	
10	Q2: Data analysis																																	
11	Finalise Revised tool																																	
12	Draft project findings																																	
13	Dissemination workshop																																	
14	Next steps workshop																																	
15	Research team meeting																																	
16	Submit completion final report																																	
17	Submit final project report																																	
18	Publication of the final report																																	

Acknowledgement

- Charles Sturt University, Australia
- OIC Cambodia
- Stakeholder Advisory Team
- Research team
- Research participants
- Provincial health department in Kompong Speu and Kompot province
- Australia Awards Cambodia

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Co-conducted by

OIC Cambodia

Charles Sturt University

Supported by Small Research Grant through:

Australia Awards