

Community participation in externally funded health projects: lessons from Cambodia

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This article provides lessons learned on establishing effective community participation in two externally funded, NGO-implemented health projects working at district level in Cambodia. The first project was implemented in accordance with the Cambodian national guidelines on community participation. The second – using lessons and experiences gained as a result of the first project – worked with Buddhist pagoda volunteers. Primary research was conducted in both settings to assess the effectiveness of the two participation strategies. The article concludes that the success of community participation in externally funded health projects with relatively short implementation timeframes requires engagement with *existing* community-based organizations and agencies. In Cambodia, where Theravada Buddhism is the dominant religion, pagodas and associated volunteers appear to represent such an organization. Community participation structured around pagoda volunteers – who are held in high esteem within their local communities – is more effective and sustainable than newly (and externally) established community structures with formally elected representatives. Pagodas and associated volunteers in rural Cambodia offer the advantages of effective leadership, local organization, resource mobilization and management. It is recommended that programmes and agencies wishing to adopt community participation strategies in health utilize participatory research to identify the most appropriate local organization to lead such initiatives.

Key words: community participation, lesson learning, NGOs, community-based organizations, participatory research strategies

Introduction

Community participation is portrayed as a cornerstone of primary health care as articulated in the Alma Ata declaration of 1978 (Rifkin 1986; Tarimo and Webster 1994), and is defined as a process whereby community members collectively assess their health needs and problems and organize to develop strategies for implementing, maintaining and monitoring solutions to those problems (Zakus and Lysack 1998). The rationale for pursuing community participation includes promoting positive health behavioural change; improving service delivery; mobilizing human, financial and other material (including in-kind) resources for health services; and as a means of empowering the community (Woelk 1992). In recognizing that achieving community participation is time-consuming, advocates argue for a gradual approach, whereby realistic, easily achievable and visible successes are identified and achieved (Laverack and Labonte 1998). While health promotion can play a valuable role during the initial community participation process (*ibid*), a range of interventions and initiatives need to follow, with a focus on meeting identified needs (Rifkin 1986; Woelk 1992). Establishing and sustaining community participation is facilitated when the community has a history of common struggle, a tradition of voluntarism and a politically supportive environment (Walt et al. 1989; Woelk 1992).

A key institutional prerequisite for the successful implementation of community participation is a local community-based organization to lead the process, which has effective relations

with local politicians and government, and which excels in collaboration and coordination (Zakus and Lysack 1998). Morgan (2001) argues that such an organization is most effective if it is established with considerable inputs from the community, either through direct consultation or by election of its members. Community participation initiated by outside actors is only likely to be effective and lasting if the local community achieves a sense of ownership (Zakus and Lysack 1998; Morgan 2001).

Community participation is well embedded in the international development discourse (Stone 1992), but the short timeframes of externally funded projects and the emphasis on visible outcomes are major impediments to its realization (Morgan 2001). There is increasing recognition that, even within project cycle and donor-funding constraints, all projects should at least initiate a process of community participation as a fundamental component of broader community development (Laverack and Labonte 1998).

This article provides lessons learned on establishing effective community participation in two externally funded, NGO-implemented health projects in Cambodia. Both projects were undertaken at the Operational Health District level. The first was implemented in accordance with the Cambodian national guidelines pertaining to community participation. The second, implemented using lessons and experiences gained from the first project, worked with pagoda volunteers to facilitate community participation in health. The aim of the article is to illustrate the importance

of identifying the most appropriate actors and strategy for initiating community participation in time-bound externally funded health projects.

Study setting

The research was undertaken in two Operational Health Districts in Cambodia. Table 1 provides a comparison of these two districts in terms of population and health facilities. Maung Russay Operational District, located to the north-west of the country, has a population of 134 378 (1998 census) living in 103 villages spread over 12 communes. It has 10 functional health centres and an 85-bed hospital providing major surgery. Kirivong Operational District is located to the south-east of the country, and has four administrative districts with a population of 201 870 residing in 290 villages divided over 31 communes. It has 20 functional health centres and an 82-bed hospital that also provides major surgery. In both operational districts, the majority of the population are subsistence farmers who complement their income by gathering and fishing. Due to their proximity with neighbouring countries petty trading (and smuggling) is common.

Community in Cambodia¹

Some commentators have argued that even before the Khmer Rouge regime of Pol Pot, Cambodian rural society was not characterized by strong social cohesion and that mutual assistance did not reach much beyond the family nucleus (see for instance Van de Put 1997). Such lack of social solidarity is variously ascribed to Khmer individualism, to the absence of communal land and to the absence of effective political decision-making structures at village level (Ministry of Planning 1999). Others have, however, described mutual assistance practices beyond close kinship ties, highlighting the common practice of borrowing interest-free rice or cash from neighbours, and labour exchange in rice cultivation (McAndrew 1998). Perhaps the strongest expression of community solidarity can be seen in the Buddhist pagodas, around which social, religious and welfare activities in the village are organized (Charya et al. 1998; Collins 1998). Most pagodas were destroyed during the country's 30 years of civil conflict, but have been rigorously rebuilt, relying on voluntary community financial, material and labour donations.

One of the Buddhist monks' 227 precepts states that they should not possess material belongings. Therefore the Pagoda Committee deals with the physical needs of the pagoda and is responsible for bookkeeping of voluntary donations. The Committee has between five and seven members, including the pagoda abbot, elected *achaar* and *chas tom*. The abbot, who chairs the Pagoda Committee, tends to be the most educated monk and is responsible for pagoda discipline. *Achaar* are monks who have returned to laypersons' life and are often teachers of young monks. They adhere to nine precepts. *Achaar* are the abbot's counterpart and are responsible for raising funds from the community. *Chas tom* are respected elders, who have never been monks, are often illiterate and adhere to five precepts. *Chas tom* of the pagoda committee are proposed for election by the abbot on the basis of their respect by others. They, together with the *chas tom* and *achaar* who are not elected for the committee, represent the pagoda at village and neighbourhood level and are often consulted for solving conflicts. *Chas tom* are mostly women. A further distinction is made between *chas tom* (respected elder) and *pritticaar* (elder teacher). The latter are literate and educated lay-people who actively participate during pagoda activities and are known for their piety. Needs of the pagoda are determined during plenary sessions attended by the abbot and all the monks, nuns, *achaar* and *chas tom* in the parish. Pagodas often provide free shelter for students and poor people, have a history of constructing local schools and roads, and are recommended by the local government as key partners in community development (Ministry of Planning 1999, p. 47). The line management of pagodas follows closely that of the official authority administration whereby each administrative district has a District Chief Monk.

The Cambodian Ministry of Health approach to community participation

The Cambodian Ministry of Health's *Guidelines for developing operational districts* (Ministry of Health 1997a) and the *Charter on health financing* (Ministry of Health 1997b) endorse the importance of community participation in the management of health facilities. The two main vehicles for community representation and participation in the planning, implementation and use of health services are Health Centre Co-Management Committees (HCCMCs) and Feedback Committees (FBCs).

Table 1. Overview of the operational districts

	Maung Russay	Kirivong
Population ^a	134 378	201 870
No. of administrative districts	1	4
No. of communes	12	31
No. of villages	103	290
No. of health centres	10	20
No. of hospital beds	85	85
No. of pagodas	56	91
Study period	May 2000–January 2001	October 2001–July 2002

^a 1998 census.

The recommended membership of the HCCMC is three health centre staff, plus an elected community representative from each of the (on average of two) communes covered by the health centre (Ministry of Health 1997c; Overtoom 1999). The main roles and responsibilities of the HCCMC are to ensure provision of preventive and curative care; to improve quality of care and its utilization; and to create a transparent accountability system for efficient use of health centre resources, including user fees. Membership of FBCs is larger, with the 'ideal' being the entire HCCMC plus a male and female elected representative from each village served by the health centre. The Ministry of Health considers the FBC to be too large for decision-making, and advises that its role be primarily the exchange of information between the health centre and the community, as well as health promotion. Recently the Inter-Ministerial Committee on Primary Health Care (2002) renamed Feedback Committees as Village Health Support Groups. Members on both committees should be elected by the community they represent, with a mandatory 50% of village households required to turn out for such elections. Members should act for the interests of the community rather than those of the health centre.

Co-managing of the health centre has to be endorsed by the signing of a contract between representatives of the HCCMC, the Health Centre Chief, the Commune Chief, District Chief, District Director of Health and Provincial Director of Health. The presence of an HCCMC and FBC is a prerequisite to instigating user fees.

Research methods

Study design

The research was undertaken in Maung Russay and Kirivong Operational Health Districts during, respectively, May 2000 – January 2001 and October 2001 – July 2002. Both operational districts were receiving technical assistance from externally funded international NGOs at the time of the research. In both settings community participation had been introduced by the NGOs following an initial 2 years of project activities.

The following research methods were used.

Personal observation

Personal observation constitutes an important component of the study. The first author was the coordinator of both the NGO health projects during the respective study periods and a key actor in introducing community participation. Detailed notes were made of all observations.

Structured interviews with committee members

Structured open-ended interviews were conducted with randomly selected members of the HCCMC and FBC. They were questioned regarding their perceived ability to communicate with the community, perceived roles and responsibilities, difficulties encountered in performing their

expected tasks, and suggestions to improve their role as committee members.

Cross-sectional surveys

A cross-sectional survey was conducted at Maung Russay 6 months after establishment of the HCCMC and FBC. Two villages were randomly selected per health centre and in each village women with children under 5 years of age were interviewed using a structured, pre-coded questionnaire. Four trained local women conducted the interviews. Starting from the centre of the village, the four interviewers would each walk in a different direction and select the fifth household on their walk. If an appropriate interviewee was not present, the adjacent household was selected. The process was repeated until each interviewer conducted three or four interviews per village. Questions concerned the interviewees' socio-economic background, whether they knew the HCCMC or FBC members, if so whether they knew about their activities, if they considered HCCMC/FBC members good representatives at village or commune level for women's affairs, and whether they would disclose their physical and personal problems to them. A similar approach was applied at Kirivong where interviews were conducted in 18 villages: nine with and nine without a pagoda.

Outcome measures

The main outcome measures are the acceptability by committee members of their assigned duties and acceptance by women of committee members for stimulating participation in health related issues. For the former, specific outcome measures constitute perceived roles, perceived ability to influence health-seeking behaviour, level of activities related to health, and suggestions to improve their roles. Acceptability of committee members by women was determined by the views regarding gender appropriateness (ability to represent women's issues at village or commune level), and whether women felt able and comfortable to discuss physical and personal problems with the committee members.

Statistical analysis

Data from the cross-sectional surveys were analysed using the statistical package Epi-Info 6.04b. Proportions were compared using the χ^2 test and significance determined at the 5% level ($p < 0.05$).

Results

Establishing HCCMCs and FBCs

Maung Russay

Only two of the 10 health centres in Maung Russay had established HCCMCs and FBCs – with financial and technical support from UNICEF – before the international NGO embarked on community participation for the operational district. At one of these health centres, the HCCMC was comprised of the Commune Chief, respective village chiefs

and the pagoda abbot. A similar composition was reported at the other health centre, although staff members differed in their opinions regarding the committees' existence, suggesting that the level of activities were minimal. FBCs in both health centres had been established through an electoral process.

For the remaining eight health centres the FBCs were established through elections in their 74 villages to select two village members – one male and one female. Initially the Commune Chief was informed regarding the intention of the elections, thereafter similar discussions occurred with the village chiefs. The village chief appointed candidates, many of whom were inactive male Village Health Volunteers (VHV). During the Vietnamese occupation of 1979–89, men had to choose between working as a VHV or military conscript. The NGO provided financial support of US\$200 per health centre to organize elections. Additionally, each staff member of the respective health centres received a stipend of US\$25 for stimulating their participation for this exercise. Votes were supposedly cast anonymously, although illiterate individuals had to request a third person to write down the name of their choice. Following the elections and establishment of the FBC, the HCCMCs were created from five to seven members of the FBC, including the Commune Chief. Health centre staff and members of both committees subsequently received 2-day training regarding their roles and responsibilities. There were a total of 156 FBC members for the eight health centres.

Kirivong

In Kirivong Operational District the NGO opted to institute committees with pagoda-associated volunteers to enable an effective and efficient dissemination of information using their social networks. A Community Participation Advisory Committee, comprising monks, *achaar*, *chas tom*, village chiefs, and a Commune and District Chief, was established at a centrally located pagoda. Its role was to guide the operational district and NGO on cultural and political appropriateness during the process of establishing the committees and to ensure the active participation of pagoda volunteers in health related issues.

The advisory committee suggested a meeting with the District Chiefs and District Chief Monks of the four administrative districts to clarify the objectives of using pagoda volunteers to make up the committees. During this meeting a workplan was developed. In those health centres with only one pagoda in their catchment area, the Chief Monk of the parish appointed two pagoda volunteers, one male and female, per village to comprise a joint HCCMC-FBC. In those health centres with between two and five pagodas in their catchment area, the Pagoda Chief Monk appointed one male and one female volunteer from each pagoda to the joint HCCMC-FBC. Health centres with more than five pagodas followed a similar approach but established two separate committees, the HCCMC being formed by seven members of the FBC. The Cham Muslim minority was not overlooked by the Buddhist authorities and were invited to send two representatives per mosque (five in total for the

operational district) to join the respective HCCMC and/or FBC.

A half-day training on roles and responsibilities was provided to all members, including health centre staff. Communication regarding establishing committees with pagoda volunteers occurred via the District Chief Monks. District Governors were concurrently informed regarding all endeavours. No financial support – apart from a *per diem* for training and reimbursement of transport fees – was provided during the creation of the committees. Commune Chiefs joined the committees at a later stage, bringing the number of committee members to a total of 254 for 20 health centres.

Introducing user fees

In tandem with the establishment of HCCMCs and FBCs, user fees were introduced at all facilities in both operational districts. The main aim was to increase the income for the staff of the health centres and as such to motivate them to improve accessibility and provide higher quality services. The initial task of the committee members was therefore the setting of user fee price schedules at health centres (prices being set following cross-sectional surveys that assessed mothers' willingness and ability to pay). Concern was expressed by committee members regarding access to care for the poorest at Kirivong but not Maung Russay. Contracts to formalize the introduction of user fees were signed between the chiefs of the health centre, operational district, commune, district, and Director of the Provincial Health Department (to secure approval of the fee scheme from the national level).

Activities following introduction of user fees

At Maung Russay the FBC met monthly and the HCCMC bimonthly. In some health centres committee members assisted with outreach services by informing fellow villagers regarding the event. Monitoring and follow-up evaluation of the FBC and HCCMC meetings were minimal. Health centres provided remuneration to the committee members for transportation to attend the meetings. This money was derived from the user fees.

In Kirivong, both committees met monthly. Members were stimulated to actively participate in health promotion. For this activity the NGO would select monthly messages to be disseminated to caretakers of children. Messages were derived from Murray et al. (1997) regarding stimulating behaviour change of caretakers for developing maternal and child health programmes. Members were further stimulated to encourage pregnant women to attend antenatal care sessions and to assist during vaccination campaigns. Committee meetings were monitored every 2 months.

Five months after establishing the HCCMC and FBC, Health Action Groups were established at each pagoda and mosque. At pagoda level the Health Action Groups comprised three volunteers, of whom two were members of the FBC, and one a monk. The monk was in charge of coordinating the activities of the volunteers. A nutrition campaign was initiated

during July 2002. Two Health Action Group members of the pagoda were requested to actively assemble children aged less than 60 months for measurement of nutritional status during monthly outreach activities at the respective parish villages. Also at these outreach sessions they would provide education on hygiene and appropriate nutrition practices. At each pagoda and mosque sealed boxes were installed in which people could anonymously insert written concerns or suggestions regarding health centre activities. The boxes were emptied prior to the monthly committee meeting for discussion. At the time of the cross-sectional survey among women, Health Action Groups had assisted during one outreach campaign.

HCCMC and FBC members' views

Roles and responsibilities

Five months following the establishment of the HCCMCs and FBCs in Maung Russay, 34 committee members were interviewed. Males – aged a median of 35 years (range 21–50) – accounted for 62% of the 34 interviewees. The median age of the female interviewees was similar to that of the male (range 19–61). Two interviewees were not keen on being elected, expressed their desire to resign and were subsequently dropped from the study. The tasks reported by the other 32 interviewees are displayed in Table 2. The most mentioned task was to assist health centre staff during vaccination campaigns (65%), followed by referring sick villagers to the health centre (62%), health education (56%) and providing information from the community to the health centre (47%).

Prior to the creation of Health Action Groups and instigation of the nutrition project, 46 committee members were interviewed at Kirivong. Women accounted for 28% and had a median age of 51 years (range 46–63), compared with 60 years for men (range 44–74). Seven women were *chas tom* without specified tasks at the pagoda, four were pagoda committee members, one a cook at the pagoda and one a *pritticaar*. Of the male interviewees, 26 (79%) were pagoda committee members, five were *achaar* and one was the Imam of a mosque. The most reported activity of the committee members was health education (96%), followed by informing the community about health services (65%), assisting

during vaccination campaigns (57%) and informing pregnant women to attend antenatal care (41%).

Ability to influence health-seeking behaviour

At Maung Russay, 15 respondents (47%) reported difficulties in influencing community members' actions, especially those of youths and elders. One interviewee of 20 years of age reported that none of the women would listen to her.

At Kirivong, 30% reported problems in influencing behaviour change, related primarily to factors other than personality. For example, 11% mentioned that some children develop fever following vaccination, impeding attempts to persuade parents to have their children vaccinated. Nine percent reported that adherence to traditional beliefs at the expense of allopathic medicine was deemed a hindrance. Other impediments were preference for injections over tablets, and poor people being unable to pay for transport for consultations at the health centre.

Level of activity

At Maung Russay, five (16%) interviewees reported that they were inactive due to the absence of any financial remuneration. Additionally, two interviewees were not acquainted with the health centre staff or their expected activities as they had recently replaced absent relatives, two reported that the health centre staff failed to inform them of their tasks, and one said he was too busy with his own practice as a *Kru Khmer* (traditional healer). The remaining 69% reported that they attended meetings and assisted during vaccination campaigns at their village by informing the population of the date on which the health centre teams were to visit.

At Kirivong, all interviewees reported to be active, mainly disseminating information on health services and promoting health messages. Seventy-six percent of the committee members reported that they spread such information during pagoda ceremonies. The second most reported means of disseminating information (39%) was during the Sabbath, closely followed by conducting home visits (37%). The Sabbath is a weekly meeting, during which people gather at

Table 2. Reported tasks of the HCCMC and FBC members

Tasks	Maung Russay n = 32 (%)	Kirivong n = 46 (%)
Assist in vaccination campaign	21 (65)	26 (57)
Refer sick people to the health centre	20 (62)	7 (15)
Health education	18 (56)	44 (96)
Give information from community to health centre	15 (47)	15 (33)
Be a member of the feedback committee	15 (47)	0
Inform community about health centre services	8 (25)	30 (65)
Inform pregnant women to attend antenatal care	7 (22)	19 (41)
Inform community about user fees	2 (6)	1 (2)
No idea	2 (6)	1 (2)

the pagoda to offer food to the monks and to receive spiritual cleansing. Fifty-seven percent reported that they assisted during monthly vaccination campaigns by actively assembling target groups.

Suggestions for improvement

At Maung Russay, 28% of interviewed committee members had no suggestions for improving their performances (Table 3). A third of interviewees would welcome training on selected topics and 6% would value educational materials to assist them in their expected tasks. Most would value some financial remuneration for their health related activities: 22% referred to *per diem* allowances, 19% reimbursement of transport expenses, and 9% free treatment for themselves and family members. Only 16% mentioned improvements in health centre performance.

At Kirivong, 54% were satisfied with their roles and functions. Provision of a financial remuneration was mentioned by 16% only: 2% a *per diem*, 7% reimbursement of transport costs, and 7% a financial reward for best performing committee. Twenty-two percent of interviewees would value an improvement of health centre staff's interpersonal skills.

Women's views

Maung Russay

At Maung Russay Operational District 290 women with a child aged less than 5 years were interviewed. The median age of the women was 31 years (range 18–47) and 36% were illiterate, 32% literate and 32% could read but not write. The vast majority (77%) were farmers, followed by petty traders (13%) and housewives (10%). The women had a median of three children (range 2–11), of whom a median of two (range 1–3) were aged less than 5 years. Nine percent had no husband. All interviewees reported visiting the pagoda regularly: 3% weekly, 6% monthly and 91% during ceremonies.

Of the 290 interviewees, 180 or 62% knew a committee member. Of those, 87% reported that the committee members they knew were active in disseminating information regarding the vaccination campaign.

Eighty-six percent of the interviewees who knew a committee member were of the opinion that s/he was a good representative at village or commune level for women's affairs. All of these respondents reported having a good relationship with the committee member. Seventy-eight percent of these women would disclose a physical problem (e.g. illness) to them, but only 29% a personal problem (e.g. poverty). The reasons for being unwilling to disclose a personal problem were: 19% because of embarrassment/privacy and 81% because HCCMC/FBC members were considered to be inactive or to lack authority.

The likelihood, therefore, that committee members in Maung Russay would be able to convince a village woman to attend antenatal care, for example, is 48% (0.62×0.78). The likelihood that such a village woman will admit to the HCCMC/FBC member that she is too poor to pay the expenses incurred with such a consultation is only 18% (0.62×0.29).

Kirivong

The median age of the 288 women interviewed at Kirivong Operational District was 30 years (range 19–49) and 37% were literate. Ninety-one percent were farmers, 7% housewives and 2% traders. Interviewees had a median of 3 children (range 1–9) of whom a median of 1 was aged less than 5 years. Four percent had no husband. All but two interviewees reported regularly visiting the pagoda: 1% daily, 5% weekly, 10% monthly and 83% during ceremonies.

Of the interviewees, 63% knew a HCCMC/FBC member. Significantly more interviewees who visited the pagoda at least once a month knew a committee member than those only attending ceremonies or not visiting the pagoda at all: 79% (38/48) versus 60%, respectively ($p = 0.01$). Knowledge regarding the existence of committee members was also significantly higher at villages with pagodas than those without: 70% (102/146) versus 56%, respectively ($p = 0.01$). Of those knowing a committee member, 87% reported that the committee member actively gathered people together during outreach activities, 42% that they assisted during nutrition sessions, 21% that they conducted health education sessions and 17% that they provided information on health

Table 3. Suggestions by committee members to improve their roles

Suggestions	Maung Russay n = 32 (%)	Kirivong n = 46 (%)
Training	11 (34)	12 (26)
Provision of per diem	7 (22)	1 (2)
Provision of transport/fuel expenses	6 (19)	3 (7)
Health centre to be more proactive at village level	5 (16)	1 (2)
Free treatment for family	3 (9)	0
Provision of information, education and communication (IEC) materials	2 (6)	0
Provision of financial remuneration for best performing committee	0	3 (7)
Health centre staff to improve their interpersonal skills	0	10 (22)
Situation is satisfactory	9 (26)	25 (54)

services. Two respondents reported that the committee members were not active.

All respondents (100%) knowing the committee members deemed them good representatives for women's affairs. Ninety-two percent would disclose a physical problem to them and 67% a personal problem. The reasons for disclosing a personal problem were: they are trustworthy (74%), they are intelligent (23%), they have a good relation with them (12%) and they are empathic (6%). Reasons for not disclosing a personal problem were: they have little authority or are inactive (60%), privacy (33%), and 'don't know them well enough' (20%). Interviewees residing in a village with a pagoda were significantly more likely (75%) to disclose a personal problem than respondents from villages without a pagoda (58%; $p = 0.02$).

In Kirivong, the likelihood that pagoda volunteers of the HCCMC/FBC would be able to convince a pregnant woman to attend antenatal care is estimated at 58% (63% of interviewees knew the HCCMC or Health Action Group member and 92% of these reported they would disclose a physical problem to a volunteer, i.e. $0.63 \times 0.92 = 0.58$). The likelihood that pagoda volunteers of the HCCMC/FBC would discuss personal problems is 42% (0.63×0.67).

Figure 1 provides a comparison between the levels of acceptability of the committee members by women of Maung Russay and Kirivong and their likely ability to address physical and personal problems.

Discussion

We are not aware of other studies comparing the ability of different community representatives to instigate and sustain community participation in health. Several authors, however, indicate the importance of selecting the appropriate persons for this task, especially their acceptance by the community and their ability to mobilize others (Marchione 1984; Philips 1986; Berman et al. 1987; Walt et al. 1989). Lalamen and Annys (1989) recommend using existing organizations that have their own information networks as this facilitates the incorporation of the health programme into other activities, and may allow for sustainability by overcoming problems with leadership, organization, resource mobilization and management. The network of volunteers that supports pagodas in Cambodian rural society constitutes such an 'existing' organization. A tradition of voluntarism was identified by Walt et al. (1989) as a condition enhancing sustainability of large-scale volunteer programmes. Their study took place in Sri Lanka where the majority of the population is also Theravada Buddhist, similar to Cambodia, Thailand, Myanmar and Laos.

In the Cambodia case reported here, the establishment of committees with pagoda volunteers was considerably easier than selecting members through elections. Expenses for establishing the HCCMC/FBC were considerably lower at Kirivong than at Maung Russay. The establishment of and advice given by the Advisory Committee proved indispensable for ensuring a smooth process. The consultative meeting

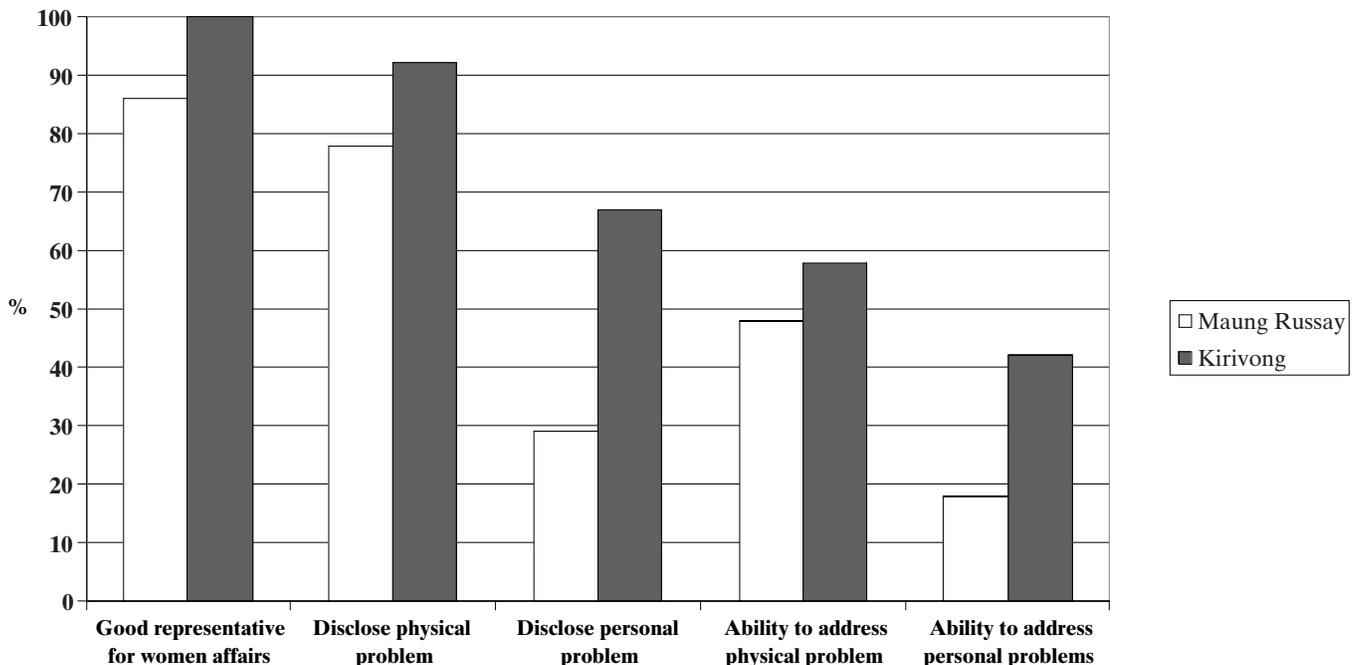


Figure 1. Women's perceptions of the acceptability of committee members and their effectiveness in addressing physical and personal problems

with District Chief Monks and Governors ensured that the Cham Muslim minority was not overlooked.

Almost half the elected volunteers (47%) in Maung Russay reported difficulties influencing health-seeking behaviour, compared with 30% of the pagoda volunteers. Factors impeding ability to persuade people to utilize health services related to traditional beliefs and other key influences (such as children developing fever following vaccination, preference for injections over tablets, and poor people being unable to pay for transport to the health centre).

Women were questioned regarding their willingness to disclose a physical problem to the committee members as the role of these members focuses on health. Similarly, we elicited the women's willingness to inform the volunteers on personal problems, as health – in line with the WHO definition – concerns mental, physical and social well-being and not merely the absence of disease. Only 78% of those women in Maung Russay who knew a committee member were willing to disclose a physical difficulty and 29% a personal problem, despite reporting that they had good relations with the committee member. Notwithstanding the non-election of committee members, women in Kirivong were significantly more willing to disclose a physical and personal problem to the concerned persons – 92% and 67% respectively – than in Maung Russay ($p < 0.001$ for both indicators).

Data on women's views regarding volunteers' suitability for representing women's affairs² revealed that considerably less of the women in Maung Russay who knew a HCCMC/FBC member (86%) were of the opinion that the elected member would be suitable for this task in comparison with unanimous agreement (100%) for pagoda volunteers.

These results suggest that elections may not be essential for introducing community participation in health in Cambodia, a country that has a long history of authoritarian politics. Nuscheler (1995, p. 231), for example, points out that 'participation . . . is not simply voting but a way of life'. Morgan (2001) suggests that selection of volunteers through the electoral process does not necessarily stimulate support for participation. Nichter (1984) reports from India that poorer people preferred that selection of community health workers be performed by a small committee to avoid political infighting.

At Maung Russay, elected members displayed little enthusiasm for their roles, with one in six reporting to be inactive. Considerably less reported being satisfied with their assignment (28%) compared with Kirivong (54%), and far more demanded financial remuneration: 50% versus 16%, respectively.

However, it is important to recognize the influence of village chiefs in the selection of committee members. At Maung Russay, the village chiefs appointed most candidates for elections and the electoral process was not confidential, at least for illiterate people. Walt et al. (1989) suggest that this is not necessarily a negative influence. The effect of the village chiefs' involvement on acceptability of the elected members

by women in Maung Russay could not be ascertained. Pagoda volunteers were also appointed by the pagoda abbot. However, the elections held every 2 to 3 years for pagoda committee membership invite the whole population to cast their votes anonymously (79% of male HCCMC/FBC members were also Pagoda Committee members). Pagoda volunteers' participation in the nutrition activities during outreach sessions may bias the results. Since they participated only during one outreach session, however, the extent of such bias will be small, as indicated by the fact that only 26% of interviewees (0.63×0.42) were aware of this activity.

The effectiveness of elected volunteers in addressing the physical and personal problems of women was 48% and 18%, respectively, at Maung Russay, compared with 58% and 42%, respectively, in Kirivong. The relative low results are mainly due to the fact that only 62% of interviewees at both study sites knew the HCCMC/FBC member. This figure, however, is in line with the 62% found during an evaluation of community health workers in Thailand (Berman et al. 1997). Sepheri and Pettigrew (1996) report from Nepal that only 30–44% of villagers knew the health volunteer despite having elected these individuals.

Effectiveness in addressing physical and personal difficulties by HCCMC/FBC members increases concurrently with the proportion of women who know them, especially when they are pagoda volunteers (as the analysis of women's views above illustrates). Elected members, on the other hand, will require a considerably longer time period to establish trust among the population; Berman et al. (1987) argue that it might require a decade to realise. Given the 3–5 year time period of most externally funded projects, elections may not be the most appropriate means of identifying and selecting health committee members.

At Kirivong, Buddhist monks were not identified to work as committee members, as for instance reported in Thailand by Hathirat (1983). Khmer traditions suggest that monks play a more spiritual than secular role in the lives of Cambodians. Monks, for example, have to be addressed with pronouns and verbs that are different from the commonly used language. Further, in Khmer rural society *chas tom* and *achaar*, who reside among the population, constitute the link between community and monks. Additionally, monkhood, especially for the youth, is mostly a transitional period. Monks were involved in the projects only through the Health Action Groups in order to motivate the volunteers.

The contrasting level of community participation in Maung Russay and Kirivong

Rifkin et al. (1988) provide an analytical framework for measuring the level of community participation. The framework employs qualitative indicators for five factors that influence the process and degree of participation: needs assessment, leadership, organization, resource mobilization and management. For each factor a five-point ranking scale that measures the degree of participation is provided, ranging from 'narrow' participation at one extreme (ranked 1) to

'wide' participation at the other (ranked 5), with three levels in between of 'restricted' (which we term as 'limited' in our analysis), 'fair' and 'good' (ranked 2, 3 and 4 respectively). Using the Rifkin et al. framework, we were able to map the contrasting levels of community participation in Maung Russay (which utilized elected representatives) and Kirivong (where pagoda volunteers were engaged); see Figures 2 and 3.

Needs assessment

In both locations, needs assessments were conducted by the NGO, which in turn used the data for planning interventions. The community did not participate in the analysis of the data nor did either NGO provide any feedback of the findings. At Maung Russay monthly and bimonthly meetings of the HCCMC and FBC were dominated by the health staff, who were mainly concerned about spreading information from the health facility to the population. The needs assessment ranking for Maung Russay is thus classified as 'narrow'.

In Kirivong an approach emphasizing health education was applied, although the medical view dominated as the education sessions aimed at changing health behaviour. The NGO staff conducted needs assessments in a similar way to

Maung Russay, with no feedback to the community. The views and concerns of the community were considered (in contrast to Maung Russay), albeit in a limited way by use of the suggestion boxes installed at all pagodas. The needs assessment ranking for Kirivong was therefore considered to be 'limited'.

Leadership

The elected members in Maung Russay displayed limited enthusiasm for their expected roles. Little cohesion was observed regarding the way they perceived their roles and self-interest tended to dominate. Their ability to convince people of the need for better and more appropriate health-seeking behaviour was minimal. Two-thirds of members reported that one of their roles was to refer sick people to the health centre, suggesting health centre staff's domination in defining their roles. Members' low level of effectiveness for addressing personal problems suggests that they do not necessarily represent the population who elected them. The elected members' leadership ranking is considered 'narrow'.

Two-thirds of women knowing the pagoda volunteers in Kirivong would disclose a personal problem to them, the majority because they perceived them trustworthy,

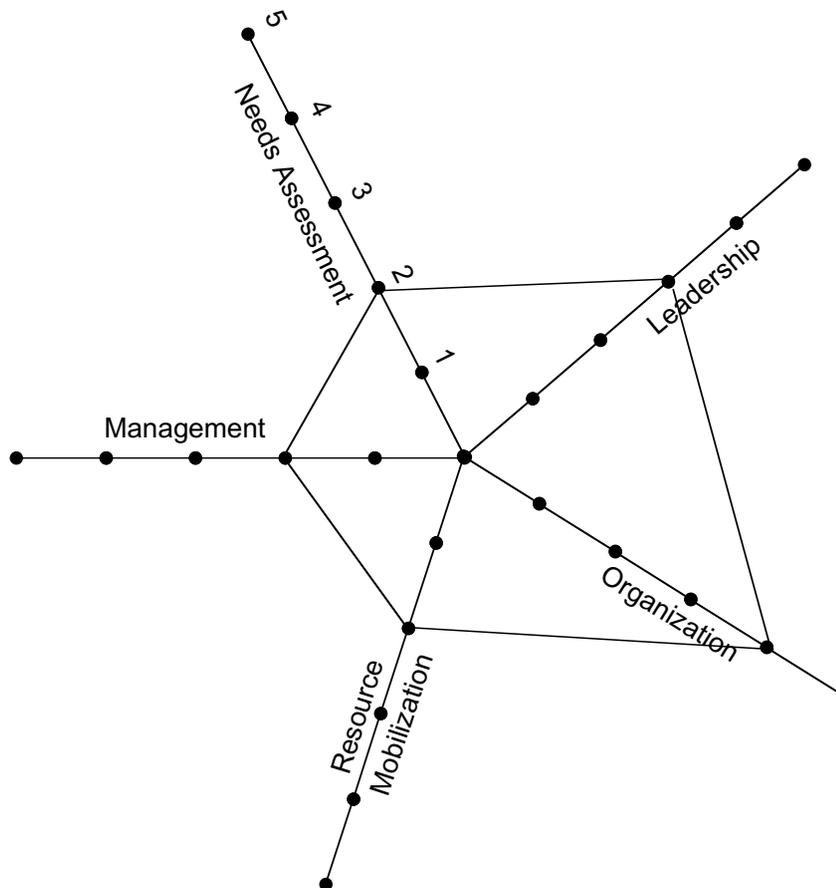


Figure 2. Community participation in Kirivong (using the Rifkin et al. 1988 framework)

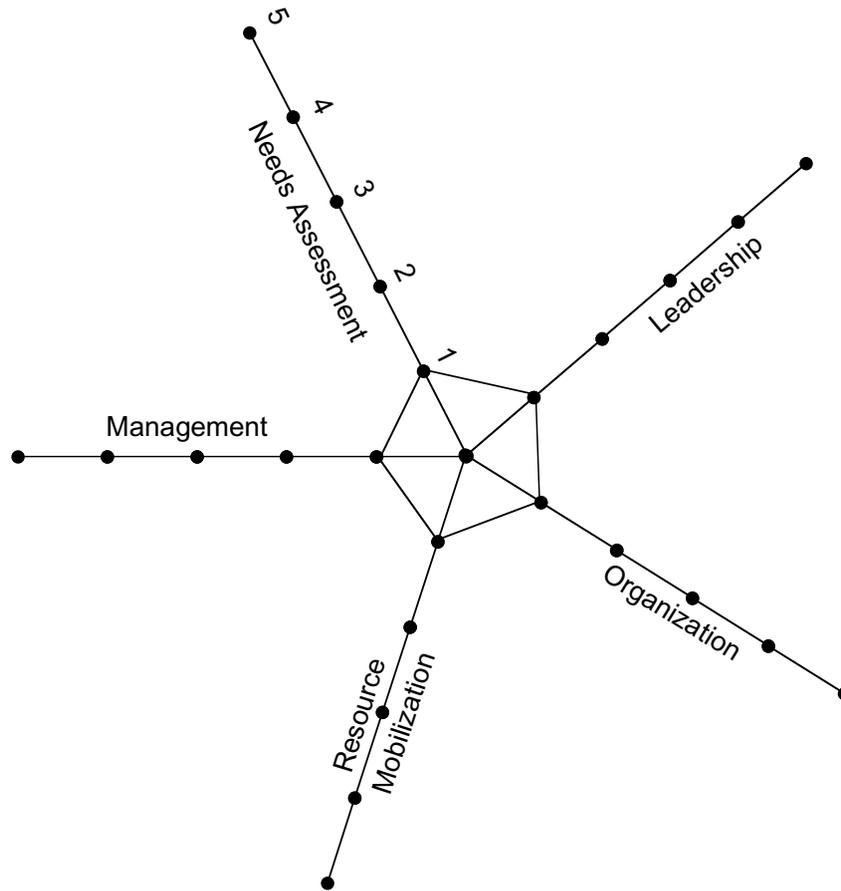


Figure 3. Community participation in Maung Russay (using the Rifkin et al. 1988 framework)

suggesting that they are appropriate representatives for other community members. Pagoda volunteers tended to be more motivational in their roles as providers of information than elected members at Maung Russay. The minutes of HCCMC/FBC meetings indicated that concerns were often raised about poorer people’s access to care. Their leadership is therefore graded as ‘fair’.

Organization

In both operational districts community participation was instigated by the NGO running the Operational Health District. In Maung Russay, however, activities were limited to disseminating information regarding vaccination campaigns. Committee members displayed little enthusiasm. Committees had no links with any organization other than the health sector and the members did not undertake efforts to integrate their activities with those of other organizations or sectors. Concerted efforts with other elected members appeared absent. The elected members’ organization is considered ‘narrow’.

Members of the committees in Kirivong were already part of a wider organization with well-established community networks for dissemination of information and raising food and funds for the pagodas and their members. Pagoda volunteers employed a variety of communal platforms such as

Sabbath days and ceremonies to disseminate information related to health. The degree of organization is therefore assessed as ‘good’.

Resource mobilization

Elected members in Maung Russay clearly indicated that they had little interest in raising funds or in contributing financial resources to the health sector (indeed, they refused to work in the absence of remuneration and their transport costs for attending meetings at the health centre were met from user fees levied at the health centres). Their capacity for resource mobilization is consequently ranked ‘narrow’.

Although pagoda volunteers demonstrated an impressive ability to raise funds and to mobilize human resources for collecting these – as reflected by the pagodas built with funds raised from local populations and managed by the pagoda committee – this capacity was not fully realised in relation to mobilizing resources for health, at least during the period of this study. They were, however, actively involved in a range of health promotion activities (other than just the monthly vaccination campaigns), but their activities tended to be biased towards the pagoda itself or villages with a pagoda. Pagoda volunteers at Kirivong were also considerably less inclined to demand financial compensation, and their transport costs for monthly meetings at the health centre were

paid by government funds. Resource mobilization is categorized as 'limited' but with potential to develop to 'wide'.

Management

Committee members in Maung Russay tended to operate independently from other structures or organizations other than the health centre. Their functions appeared to be limited to attending meetings and disseminating information. Health centre staff conducted no evaluation of members' performances and the community was not stimulated to participate in any activity. Their management degree is therefore considered 'narrow'.

Committee members at Kirivong, on the other hand, were actively involved in planning the outreach sessions of the health centres. The majority were passive recipients of health education training, although HCCMC/FBC chiefs attended workshops on elaborating the information campaigns. They took the initiative with regard to choosing methods to disseminate information, independent of health centre staff, by spreading information to the Sabbath attendees who in turn spread the news at village level, allowing a considerable number of people to be reached. The initiative for health education was, however, taken by the NGO at the Operational Health District, albeit implemented by the volunteers who were supervised by health centre staff. Evaluation and planning was undertaken by the health professionals. The management level is thus ranked as 'limited'.

Conclusion

This case study from Cambodia indicates that establishing effective community participation in externally funded health projects with relatively short implementation time-frames requires engagement with *existing* community-based organizations and agencies. In Cambodia, where Theravada Buddhism is the dominant religion, pagodas and associated volunteers appear to represent such an organization. Pagoda volunteers are highly esteemed among the community, making their involvement in health initiatives more effective; and their commitment makes the initiatives more sustainable than newly (and externally) established community structures with formally elected representatives. Pagodas and associated volunteers in rural Cambodia offer the advantages of established (and apparently trusted) leadership, local organization, resource mobilization and management.

A major programmatic recommendation emerging from this study is that participatory research (as suggested by Nichter 1984) should be utilized at the outset of community-based health interventions to identify (and subsequently develop the capacity of) an appropriate local organization to lead community participation initiatives. While it is accepted that the pagoda volunteer structure associated with Theravada Buddhism might enjoy a higher level of trust and respect than some indigenous community organizations found in other rural communities, this should not detract from the main conclusion and recommendation which emerges from this study, namely that community participation is more likely to

succeed if it is rooted in established community structures, rather than externally created institutions.

Endnotes

¹ An overview of Cambodia's history and the role of foreign aid are provided by Lanjouw et al. (1999).

² We sought to explore the extent to which women were willing to have their future interests presented, discussed and consequently decided by volunteers, especially with regards to rights, domestic violence, access to education by girls, etc.

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