Health centers with higher community participation scores had relatively higher utilization of services, as expressed by the number of outpatient consultations per inhabitant per year (Pearson's correlation coefficient=0.659, p=0.075). Most of the interview participants, except those of HC-H, mentioned that feedback from the community was discussed at their committee meetings and that health center services had improved and more people came to health centers. The mode of meetings of two committees, i.e. whether HCMC and VHSG were held separately or jointly, had no significant influence on the community participation score.

Characteristics of the selected NGOs

Profiles, roles and approaches of the eight NGOs are summarized in Table 4. Code names of the NGOs correspond to the code names of their respective partner health centers, shown in Table 3. The eight NGOs were consciously shifting their roles from direct intervention and direct provision of services to facilitation of links between patients and health facilities (health centers and hospitals). They participated in the NGO network meetings and sent their staff members to training sessions to update their knowledge of the health system and of health policy changes.

Another common characteristic was each of the eight NGOs' strong commitment to the specific geographical area in which it was working. Seven out of the eight NGOs were

founded either by local residents, who were local teachers and social workers in the area, to act upon urgent needs and to improve the living condition of the people, or by returnees from refugee camps who wanted to apply their skills and experiences back in their home villages. Their long term commitment to the specific locality was symbolized by their staff members' living in the area served or in the neighboring district. Since they were local residents, they were familiar with the local situation and had effective local human networks, and they said that they had no intention of moving away from the area. NGO directors felt that they had decision-making autonomy and could flexibly adjust their work according to the changing local situation.

Staff and budget size of the organization and having health professionals were not critical factors associated with community participation. In fact, partner health centers of NGOs without any health professionals, such as HC-A, B, D had even higher scores. However, most NGOs were very much concerned that their small budgets and their lack of technical expertise in health might be obstacles in relating to health centers.

Roles and approaches by the selected NGOs

All eight NGOs were involved in some form of community organizing and capacity building at the village level, although their objectives and approaches varied. Six NGOs (a, b, d, e, f, h) were employing a general organizing approach such as self-help group

formation, starting from the development of savings and credit arrangements and expanding their activities according to the problems and needs that emerged, including health. NGO-b and NGO-f were each forming groups to deal with a specific infectious disease problem in addition to general groups.

Four NGOs (a, b, d, h) were consciously tying to utilize community development experiences in the health sector. They encouraged their community group leaders to run for election as community representatives of HCMC and VHSG. Many of them were in fact elected and joined the committees. In the case of NGO-b, the majority of HCMC members were community group leaders nurtured by the NGO, and one of them was chairing the HCMC.

The NGO's influence on community representatives regarding the perception of "participation" was indicated in the responses to the question regarding key indicators for participation. Commonly mentioned by various stakeholders were: attendance at meetings; following the instructions of health staff or of health education sessions; and using health center services. Those practices were cited most by health center workers and NGO workers who focused on specific infectious disease problems. Community representatives who had many years of community work experiences listed more qualitative indicators, such as raising questions, spending time and labor in spite of the lack of incentives, having more people express opinions, and solidarity among people in attempting to solve problems. Indicators suggested by NGOs and by their partner

community representatives were similar.

In spite of the similar profiles and community approaches of the NGOs, the scores of their partner health centers were different. For example, Figure 1-a shows the difference between HC-A and HC-H. NGO-a had regular contact with the health center, observed the election process of the community representatives, and had assisted by facilitating the initial committee meetings. They occasionally joined the meetings as observers, and they followed up with the community representatives from the more distant villages by encouraging them to share obtained information and to discuss issues to bring to the future meetings. On the contrary, NGO-h did not have regular contact with the health center and did not monitor the committees. In the area of HC-H, an international NGO with health expertise had been active in recent years, and HC-H paid attention to the international NGO but essentially ignored the local NGO-h, leading NGO-h to keep at a distance from the HC-H.

The significance of incorporating management interventions beyond specific health technical aspects was underscored by the differences observed between HC-C and HC-G, shown in Figure 1-b. Their partner NGOs (c and g) had similar approaches, utilizing their health expertise and focusing on specific infectious disease problems. NGO-c assisted HC-C to strengthen HCMC/VHSG management such as in writing job descriptions of members, election of members, and training of community representatives. Members of the HCMC at HC-C were taking turns in moderating meetings and to taking

minutes. In contrast, NGO-g was concentrating its role in providing basic care and patient referrals, and only health professionals of HC-G were doing those tasks in the meetings.

Regarding relationships with other local actors, NGO-a, NGO-b, and NGO-d were particularly active in working with village chiefs, village development committees and commune councils by providing training on health issues and those stakeholders' roles and responsibilities in health and by advocating the inclusion of health in village and commune plans and budgets. NGO-c and NGO-g, focusing on specific infectious disease problems, had very limited contact with commune councils, limited mainly to sending them their NGO activity reports.

NGO-a and NGO-b were organizing periodic meetings (in addition to the HCMC/VHSG meetings) for other local actors, including community group leaders and village health volunteers who were not members of the two official committees. NGO-d had organized a first "annual" community health forum, inviting various local key actors, and had encouraged community members to raise questions and raise their voices concerning health. That forum was appreciated by the partner health center for having increased understanding and support for health among community members and local authorities.

Discussion

Based on our study of eight cases, we identified three critical roles of NGOs in facilitating higher levels of community participation in health center management through Cambodia's HCMC/VHSG committees: the NGOs needed to work with communities, with health centers, and with other key local actors. Long-term commitment to certain locality and small financial inputs were identified as advantageous characteristics of the NGOs for taking those roles.

Community organizing and capacity building and application of experiences in health

The NGOs' principal approach was to nurture a base for community participation in health center management through community-organizing and capacity-building work, and through helping communities to see the relevance to health and health services of their own human resources and their own experiences in fields other than health. In their community organization work, NGOs started with what the communities considered to be their most urgent needs and then moved on to other priority issues. The confidence and leadership that communities developed through experiences with practical problem-solving established a base for focusing their skills and motivation in various sectors when needs and opportunities arose, including the incorporation of community participation mechanisms in the management and activities of health centers.

NGOs specifically sought to assist communities to apply their non-health experiences and acquired capacities in health. Communities were encouraged to send some of their members to run for election as community representatives on the health committees. Such elected representatives had wider concepts of "participation", and they were known to people and could utilize their established relationships both to collect and present the views of their fellow community members and to provide feedback from the health center to the community. NGOs made positive differences in the level and quality of community participation by nurturing quality candidates and through providing further support and training for elected community representatives.

Studies of community participation in health in the Philippines, Colombia and various other countries also found that preparedness and capacity on the side of the community are critically important (Kahssay & Baum, 1996; Zakus & Lysack, 1998; Laverack &Labonte, 2000; Mosquera et al., 2001; Ramiro et al., 2001; Gibbon, Labonte, & Laverack, 2002). In Cambodia, Jacob and Price (2003), based on their comparative study of community participation in two health districts supported by international NGOs, suggested that existing community-based organizations, such as pagoda committee, need to be actively involved. Our study indicates that mature community groups which have learned from their accumulated experiences may be well-prepared to serve as such "existing community-based organizations".

Regular communication, monitoring, and management support to health centers

The second role of NGOs is communicating with and monitoring health centers regularly and providing management support for them. We found that interventions to help health center officials improve their management and use of community participation, beyond specific technical collaboration, were necessary to increase effective community participation. Previous pilot projects in Cambodia (Feenstra, 2001; Wilkinson, Holloway, & Fallavier, 2001), as well as experiences from other developing countries (Kahssay & Baum, 1996, Kahssay & Oakley, 1999), also emphasized the importance of monitoring of and management support for health centers.

In the eight cases we studied, we found that even small NGOs without health professionals could provide some basic management support to help health centers incorporate community participation, based upon the NGOs' general community development experiences. Such NGO involvement was especially important at the initial stage of setting up the health center committees, when NGO support could help health center officials assure the proper selection of community representatives and lead or facilitate the committees' in ways that encourage true community participation. The NGOs' interventions helped health center staff to improve their own skills and behaviors so that they could provide better services and manage activities including those of the committees.

Linking local actors for health

The third major NGO role is to link key local actors for health, as a basis for local resource mobilization and for local promotion of community participation. Beyond the health center staff and community representatives, other actors involved as members of health committees include for example representatives of the commune councils, village chiefs, and often also school teachers and monks.

Among the various actors involved, there is wide variation in their expectations of the health committees and their consciousness of their own and others' roles and responsibilities, so that gaps are often left unfilled. Actors outside of the health sector often consider that the committees are to deal with technical issues in health and therefore concern only the health ministry. Moreover, some health center catchment areas cover more than one commune or regular governmental administrative unit in Cambodia, a fact which may dilute the commune councils' feeling of responsibility (Ministry of Interior, UNDP, & GTZ, 2003). The development funds allocated by the government to the commune councils are still very limited, and the resources are often used for infrastructure development as a priority by the councils (Rusten et al., 2004).

By joining the planning meetings and providing training, NGOs tried to orient local authorities and advocate their becoming more concerned with health and taking greater

responsibility for health. Such efforts can help develop the supportive environment that is necessary for effective community participation. Similar issues were identified, and the need for active coordination across sectors was observed, in other developing countries where decentralization was taking place, including the Philippines, Uganda and others, (Kahssay & Baum, 1996; Turner & Hulme, 1997; Ramiro et al., 2001; Saito, 2003).

NGO effectiveness with long-term commitment, even with small inputs

Certain characteristics of local NGOs in Cambodia's provinces can enhance their effectiveness in the three critical roles discussed above. The process of building the capacity and confidence of a community takes a long time, and a local NGO with a long-term commitment to a certain geographical area can continue its work for as long as necessary. Mediating among and coordinating various actors is very delicate and time consuming work, and community-focused NGOs are often very familiar with local power dynamics and can effectively play such roles.

Local NGOs often describe their very limited financial and material inputs as "weaknesses". However, such limitations could be strengths in the long run, because they can help to minimize attitudes of dependency upon NGOs and external agencies, both in communities and in government agencies. The absence of large scale project

inputs and of large incentives for government counterparts and villagers could help local NGOs in their efforts to increase community and government ownership and thereby also the sustainability of health services and of community participation in them.

However, low recognition of local NGOs and their potential contributions hinders their collaboration with health centers for the promotion of community participation. Given chronic limitations of public budgets and resources, government agencies have long relied upon NGOs to supplement insufficient public services (Kao 1999). At least in part because financial inputs from local NGOs are quite small (NGO Forum on Cambodia, 2006), government counterparts have been much more interested and active in communicating and collaborating with international NGOs and UN agencies, who bring both major financial resources and high levels of health expertise.

Conclusion

This study found that local NGOs can play effective facilitating roles in promoting community participation in the health sector, even without health expertise and without major financial resources. Local NGOs with long-term commitments to specific communities and geographical areas, working to build capacities and link local actors for health, can prepare communities, health center staff and other local actors for effective community participation in the management and activities of health centers. In

Cambodia, such roles of local NGOs are critically important for sustainable heath development and therefore should be further recognized, encouraged and supported.

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Tables

Table 1

Indicators for measuring the level of community participation through HCMC/VHSG at the health centers associated with the eight local NGOs selected for the study

Ranks / Indicators	Very low 1	Low 2	Medium 3	High 4	Very high 5
REPRESENTATION					
Selection of community representative (CR)	Appointment by local authority or HC with no consultation.	Selection by local authority or HC with consultation.	Local authority or HC select candidates for election.	Candidates from voluntary will, and election by community.	Election by community with their own set criteria.
Representation of CR	All from local authority or elites.	Mostly from local authority or local elites.	Villagers with health experience.	One from vulnerable group.	More than one from vulnerable group.
Concern for the poor by CR	No issues raised for the poor.	Sometimes raise exemption issue for the poor.	Always raise exemption issue for the poor.	Always raise exemption issue and sometimes other concerns for the poor.	Always raise exemption issue and other concerns for the poor.
COMMITMENT AND RESOURCE MOBILIZATION					
CR attendance in meeting	Always absent.	About 25 % attend.	About 50% attend.	About 75% attend.	Almost 100% attend.
Responsibilities and tasks of CR	CR not know about own responsibilities and tasks.	Minimum reporting on health data to HC.	Minimum reporting and assistance asked by HC.	Regular reporting and assistance asked by HC	Self initiated activities beyond requests by HC.
Resource mobilization by community for health activities	Only with incentives in money or kind, community offer time and labor.	Community contributes time and labor asked by HC.	Community contributes time labor, fees or other kinds asked by HC.	Some amount of resources raised by community initiatives.	Considerable amount of resources raised community initiatives.
DECISION MAKING					
Expressing opinions by CR	Almost none	Some CR express but agreement only.	Most of CR express but agreement only.	Express disagreement also, but feel uncomfortable.	Open expression even different opinions and disagreement.
Decision making power of CR for problem solving	All decided by HW without consulting CR.	Ideas informed by HW, and CR listen, and accept.	Ideas presented by HW, CR can raise question/ ideas but basically agree.	Ideas presented by HW, and CR has power to disagree.	Jointly make decisions by all, CR also propose ideas and make decisions.
Needs assessment	Totally by higher health offices or project funders.	Totally by HW of HC.	Dominated by HW but consult CR.	CR raise needs and assess with HW.	Community in general is involved.
MANAGEMENT					
Management and supervision of health activities in community	Totally by higher health offices or project funders.	Totally by HW of HC.	Mostly by HW assisted by CR.	CR assisted by HW.	Mostly CR and other community members.
Work information shared HC-CR	Almost none, both not know each other's work and schedule.	HC tells CR about HC work schedule, but HC not know CR activities.	Both HC and CR share information related to work/ tasks of CR.	Both HC and CR share information about their work fully.	Both HC and CR share wider information beyond their work.
Financial transparency of HC	Almost none without relevant reason.	Income partly, but not spending.	Income fully, but spending partly.	Income and spending shared fully.	Decide together with CR on how to spend income.
CR-COMMUNITY ACCOUNTABILITY					
Information sharing by CR with community	Almost none CR keep individually.	Share only with neighbors and relatives.	Share with community but occasionally and informally.	Share through formal community meetings.	Share through regular formal and informal mechanism.
CR's feeling of accountability	Self interest	Local authority	HC chief/staff	HCMC/VHSG	Community
Recognition of CR and roles by community	Almost no one knows who is CR.	50% of people know but not know roles of CR.	50% of people know and some know roles of CR.	Almost everyone knows and some can explain roles of CR clearly	Almost everyone knows and can explain roles of CR clearly.

HCMC = health center management committee, VHSG = village health support group, HC=health center, HW = professional health workers at health center.

Tables

Table 2
Understanding of health systems and collaboration with health centers among local NGOs ($n = 50$)

Selected questionnaire topics	Positive response %
Knowledge of health systems and policies	
National health strategic plan	40
Operational district health coverage plan	38
Community participation systems at HC	36
Collaboration with HC	
More than 3 years	30
3 years or less	48
No collaboration at all	20
Enough knowledge of HC to assess its services	42
Involvement in HCMC and VHSG	
Awareness of existence of HCMC at HC	26
Awareness of existence of VHSG at HC	46
Observation in HCMC meetings	10
Observation in VHSG meetings	22
Activities related to HC	
Health education to communities	70
Training health volunteers	60
Specific disease-focused national programs	42
Incentives to health volunteers	28
Support for exemption/reduced user fees for the poor	26
Health rights education and policy advocacy	18
Income generating projects for health volunteers	6
Budgetary support to HC	6
Provision of own free clinical services to community	6
Management advice and training to HC	4
Regular supplementary salary to HC staff	4
Material support to HC	2

HC = health center, HCMC = health center management committee, VHSG = village health support group.