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 the two policy-mandated health committees: the NGOs needed to work with communities, health centers, and other key local actors. We further found that long-term commitments to certain localities and small financial inputs were advantageous characteristics of the NGOs for taking those roles.

The NGOs' principal approach was to nurture a base for community participation 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 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 *et al.*, 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 *et al.*, 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 better 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 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 religious leaders.

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, and 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 (Ministry of Health, 1997), a fact which may dilute the commune councils' feelings 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 also 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 prepare the ground and facilitated the process. 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.

On the other hand, 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; Lanjouw *et al.*, 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.

By examining roles of NGOs influencing the level of community participation through health committees, we confirmed the importance of a long-term community-based and comprehensive approach, which leads to increased participation with sustainable motivation of stakeholders. Maximizing their unique characteristics, local NGOs can consider and enhance the quality of participation in such committees, looking beyond the common indicators such as the existence of the committee structure, the regularity of the meetings, and the attendance rate of members. Further investigations are needed to demonstrate concrete impacts on the health status of the people, especially of the poor, of sustained active community participation with NGO engagements.

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 and then facilitate such participation. In Cambodia, such roles of local NGOs are critically important for sustainable health development and therefore should be further recognized, encouraged and supported.

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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.

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.

Table 3.

Levels of community participation at the health centers associated with the eight local NGOs selected for the study

Health center	#OPC/ inhabitant/ year (2003)	Mode of committee meetings *	Community participation scores					
			Represen- tation	Commit- ment	Decision making	Manage- ment	Account- ability	Total
A	0.52	joint	12	12	11	10	13	58
B	0.75	separate	12	10	11	9	13	55
C	0.55	joint	10	10	10	10	12	52
D	0.68	separate	11	12	8	9	10	50
E	0.38	separate	9	8	11	9	12	49
F	0.37	separate	9	10	9	7	11	46
G	0.36	joint	9	8	9	7	10	43
H	0.37	joint	7	7	7	6	10	37

Maximum possible score for each major aspect is 15. Maximum possible total score is 75.
OPC = outpatient consultations.
* "Joint" means that HCMC and VHSG meetings were held together, essentially as one committee. "Separate" means that, as mandated in the national health policy, the meetings of HCMC and VHSG were held separately.

Table 4.

Profiles, roles and approaches of the eight local NGOs selected for the study

NGO	Years of operation	Size	Health professional staff	Health approach	CO and CB in communities	Collaboration with partner HC	Collaboration with commune councils	Score of partner HC
a	Medium	Small	None	General	General CO and CB as core activities	Regular contact Monitor Management advice on health committees	Reporting of project Meeting Training Planning Link for health	58
b	Long	Medium	None	General + Specific infectious disease	General CO and CB as core activities	Regular contact Monitor Disease specific referral	Reporting of project Meeting Training Planning Link for health	55
c	Long	Big	20 %	Specific infectious disease	Group formation for specific issue/project	Regular contact Monitor Overall management training Disease specific project support	Reporting of project	52
d	Long	Small	None	General	General CO and CB as core activities	Regular contact Monitor	Reporting of project Meeting Training Planning Link for health	50
e	Long	Medium	10 %	General	Group formation for specific issue/project	Project/issue specific contact and referral	Reporting of project	49
f	Medium	Small	None	General + Specific infectious disease	Group formation for specific issue/project	Regular contact Monitor Disease specific referral	Reporting of project Training	46
g	Long	Small	80 %	Specific Infectious disease	Group formation for specific issue/project	Disease specific referral	Reporting of project	43
h	Medium	Small	None	General	General CO and CB as core activities	Very irregular contact	Reporting of project Meeting Training Planning	37

Years of operation: short = 1-4 years, medium = 5-8 years, long = 9 years or more. Size of organization by number of staff members: small = 1-10, medium = 11-25, big = 26 or more. CO = community organizing, CB = capacity building, HC = health center. Score: Total score on level of community participation through health committees.

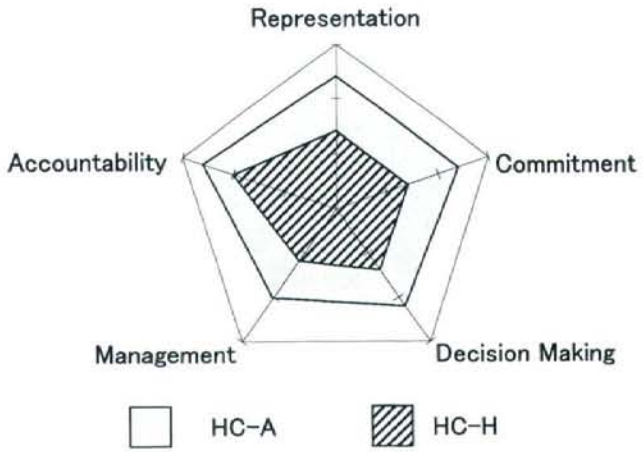
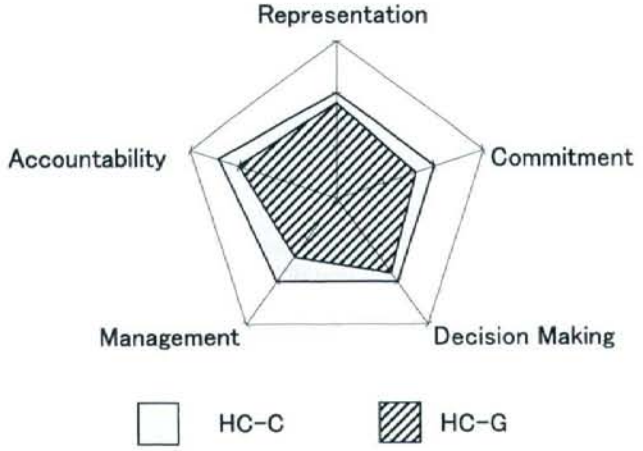


Figure 1-a. Differences between Health Center-A and Health Center-H in scores on community participation



1-b. Differences between Health Center-C and Health Center-G in scores on community participation

Captions (titles and notes) for Tables:

Table 1

Title:

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

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Table 2

Title:

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Table 3

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Note:

Maximum possible score for each major aspect is 15. Maximum possible total score is 75. OPC = outpatient consultations.

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Score: Total score on level of community participation through health committees.