were conducted with 35 stakeholders of the eight health centers, using the assessment tool as a question guide. Other questions were asked regarding their community activities, their ideas of active participation, and changes they observed in the health center services in the past few years, especially after the health committees were created. Interviewees were selected from various positions and roles, four to five persons per health center, including health center chiefs and staff members, health volunteers, local authorities (village chiefs and commune councilors) who were members of HCMC or VHSG, and NGO workers in charge of the relations with health centers. Each interview lasted approximately one hour.

After each interview, researchers entered scores on each indicator in the assessment tool, using pre-established 1-5 scales, based on the responses and information from each interviewee. For some qualitative indicators, for which observations and judgments differed among stakeholders of the same health center, the mean was taken. In case of a large disparity in scores among the stakeholders, the most deviant score was excluded from calculating the mean, after cross checking the validity of the responses with another information source.

Each interviewee was informed before the interview that he or she had the right not to answer any questions and that their names, individual or organizational, would be kept anonymous. This study was not required to undergo ethical reviews, because it was not an epidemiological, clinical or genetic study, and did not collect data which disclose

the personal identity and privacy.

Results

Limited knowledge of local NGOs regarding health systems and policies

Most of the 50 local NGOs that responded to the initial questionnaire survey did not understand the new health systems and policies well enough to take active roles in promoting community participation. The respondents had insufficient understanding of the new national health systems and policies, of potential collaboration with health centers, and of policy-mandated community participation mechanisms at health centers, regardless of the length of their organizational history or the size of the organization, as shown in Table 2. Key health policies and guidelines were not widely understood, which limited their collaboration with health centers in their working areas. Although some knew that health committees, HCMC and VHSG, had been created in the local health center, few NGOs had been involved with those committees. Many NGOs hesitated to become involved in the committees, especially the HCMC. NGOs without technical expertise in health considered that there was no space for NGOs without health professionals to get involved.

The NGOs responding to the questionnaire survey were active in providing health

education to communities and in training health volunteers. Their volunteers, however, were not necessarily linked to health centers, because many NGOs did not know the newly created mechanisms for community participation. Many NGOs had practical contact with health centers for implementation of specific national programs such as HIV/AIDS and tuberculosis control, because of the availability of donor funds. The NGOs' budgetary and material supports to health centers and their provision of clinical services were very minimal.

Levels of community participation at the selected health centers

All eight of the selected health centers were in agrarian rural areas, and seven of them were located along internal roads away from the major national roads. Differences in the levels of community participation in health center management through HCMC/VHSG were observed among the eight health centers, as shown in Table 3. Scores for three indicators were summed up under each major aspect and totaled, and the eight health centers were code-named HC-A to HC-H, in order of descending total scores.

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 such information and discussion had improved health center services and staff attitudes towards users. They observed that health center working hours also had become more regular and longer, and that more people came to the health centers for services. 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. A common characteristic was each of the eight NGOs' strong commitment to the specific geographical area. 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 staff members were living in the serving area as residents, and they were familiar with the local situation and had close local human networks. 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 NGO and having health professionals on staff were not critical factors associated with community participation. In fact, partner health centers of NGOs without health professionals, such as HC-A, B, and D had even higher scores. Even so, most of the 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 of 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-related ones. 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 trying 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 NGOs' influence on community representatives regarding the perception of "participation" was indicated in the responses to the question regarding key indicators of 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 facilitated the initial committee meetings. They occasionally joined the meetings as observers, and they followed up with the community representatives from distant villages by encouraging them to share obtained information and to discuss issues to bring to 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 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, by providing assistance 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 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 moderating meetings and taking minutes.

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 on 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 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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