DECLARATION

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university. To the best of the author's knowledge and belief, it contains no material previously published or written by another person, except where due reference is made in the text.

Beth Rushton
ABSTRACT

Participatory decision making practices were introduced into the Cambodian health sector in the late 1990s by the international development community. These practices were consolidated into a government policy in 2003. The participation policy requires lay citizens and other community representatives to be involved in management committees for health centres. In this thesis I report my research to ascertain if a participation policy results in strong participation.

I did an ethnographic study of seven health centres in regional Cambodia. I found that participation levels of all lay citizens and other community representatives in health centre management were very low – the committees were only established where an international NGO supported them. Where the committees were operational, they were not decision making bodies. Community representatives including lay citizens had low levels of participation partly because of poor process design and lack of policy institutionalisation. This context enabled international NGOs to dominate and manipulate the committees. They used committees as a forum to educate community leaders about health, mobilise leaders to promote health centres, and lobby the government for changes in health centre management.

By drawing together and extending the work of others, I show how in Cambodia both the participation process used in the study area and the national participation policy became commodities that were consumed in the game of international development. International development actors produced, marketed, and “sold” participation policies and processes and, in return, offered an implicit promise of resources to the government. As a result, lay citizens and other community representatives in Cambodia were short-changed by the consumption of participation policies and processes, being left without meaningful involvement in government decision making.
PUBLICATIONS BY THE AUTHOR IN SUPPORT OF THIS THESIS

REFEREEED PUBLICATIONS


NON-REFEREED PAPERS AND REPORTS


CONFERENCE PAPERS


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The biggest contribution my parents made to this work was not the words of encouragement along the way or the interest they showed in my work, although this was appreciated. Their biggest contribution was my upbringing. They set me on the path of international development from a young age. It was definitely the best childhood possible, and I am eternally grateful to them for it. That trajectory – started all those years ago – has resulted in this thesis. I dedicate it to them: Andy Nuss and Annie Rushton.
EXPLANATORY NOTE

In Cambodian names, the family name comes first, and the individual’s name is second. So for example, Mr Mem Pheap is Mr Mem. For foreigners, I have used the Western convention: Mr Sam White is Mr White.
# Acronyms and Terms Used in This Thesis

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<tr>
<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>Ajar wat</td>
<td>The religious lay person who is the head of a temple</td>
</tr>
<tr>
<td>BONGKIA</td>
<td>Pseudonym for an international NGO assisting one health centre in the study area</td>
</tr>
<tr>
<td>Commune Chief</td>
<td>Leader of the commune council; they are also a commune councillor</td>
</tr>
<tr>
<td>Commune Council</td>
<td>Elected local government body</td>
</tr>
<tr>
<td>Commune Councillor</td>
<td>Member elected to the commune council</td>
</tr>
<tr>
<td>Community Representative</td>
<td>Member of the Management Committee: informal leaders and lay citizens</td>
</tr>
<tr>
<td>CPP</td>
<td>A Cambodian political party; Cambodian People’s Party</td>
</tr>
<tr>
<td>DRAY</td>
<td>Pseudonym for an international NGO supporting HCMCs in the study area</td>
</tr>
<tr>
<td>FUNCINPEC</td>
<td>A Cambodian political party; National United Front for an Independent, Neutral, Peaceful, and Cooperative Cambodia</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>HCMC</td>
<td>Health Centre Management Committee</td>
</tr>
<tr>
<td>Health centre</td>
<td>Primary health care facility in public health system</td>
</tr>
<tr>
<td>International NGO</td>
<td>NGO with headquarters in a foreign country</td>
</tr>
<tr>
<td>KADARM</td>
<td>Pseudonym for an international NGO previously supporting HCMCs in the study area</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
</tr>
<tr>
<td>Operational District</td>
<td>Unit in the health administration that serves approximately 10,000 people and supervises health centres</td>
</tr>
<tr>
<td>Per diem</td>
<td>An allowance paid to participants to attend training and meetings</td>
</tr>
<tr>
<td>Riel</td>
<td>Cambodian currency; the exchange rate is relatively stable: 4000 riel to one US dollar is used in this thesis</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>UNC</td>
<td>Pseudonym for a United Nations Agency that assisted with policy development</td>
</tr>
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<td>UNDP</td>
<td>United Nations Development Program</td>
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<td>United Nations Children’s Fund</td>
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<td>VHSG</td>
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<td>WHO</td>
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CHAPTER ONE. INTRODUCTION TO THE 
RESEARCH AND THESIS

Participation policies and programs have been introduced in various countries and sectors around the world, furthering the participatory democracy and development agenda. Increased participation has officially been pursued either to make services more responsive or to include the voices of those usually left out of decision making processes (Barnes et al 2004; Rowe and Shepherd 2002: 279; see also Gideon 2005: 169; Morgan 2001: 221; Rifkin and Kangere 2002; Pitkin and Shumer 1982: 43). Participation programs are usually introduced accompanied by the rhetoric of giving the public involvement in decisions that directly affect them. Although there is literature critical of participation (see for example White 1996; Cooke and Kothari 2001a; Cornwall and Brock 2005), participation within international development is still largely viewed as desirable and “good” (Stiefel 1994; Bainbridge et al 2000; Blackburn et al 2000; Seymour 2001; Pimbert 2004).

In 2003, a national policy was introduced in Cambodia requiring community participation in the management of health facilities in the public health system (Ministry of Health 2003). This policy requires Health Centre Management Committees (HMCs) to be established in all 970 public health centres across the country. These committees are mandated to make management decisions and are a mechanism to enable public involvement in decision making about the management of primary health care facilities. They are to consist of health centre staff, local authorities, and community representatives.

Despite a national policy requiring their existence, my preliminary investigations showed HMCs existed in some health centres but not in others (Ministry of Health 2001a; Jacobs and Price 2003). Additionally, health sector staff reported that some committees were weak and some were strong (Lek 2005). Clearly there were factors that facilitated or impeded the existence or robustness of HMCs, and when I began I sought to identify and examine these factors.
1.1 THE RESEARCH QUESTION

I adopted a grounded theory approach to the study of the Health Centre Management Committees. The overarching research problem was to understand the factors affecting the implementation of a participation policy. The two research questions that I sought to answer in the study were:

1. Does the adoption of a national participation policy result in strong lay citizen and community participation in government decision making?
2. What other factors shape the levels of lay citizen and community participation in government decision making, when the participation policy has been adopted in an aid dependent country?

I originally set out to understand the enabling factors for participation by analysing how and why the levels of public participation in government decision making varied. All the cases included in this study were overseen by the same operational district and provincial health department and were located within the same culture. This study therefore sought to determine what factors affected the levels of participation at a local level; i.e. how and why participation varied between different health centres within the same broad context.

I used a qualitative research design. The fieldwork was conducted in public health centres in a province in central Cambodia and I examined the experience of HCMCs in 2006, when the fieldwork was completed. Based on a review of the literature, an empirical framework was developed for analysing the levels of participation in different Health Centre Management Committees. Drawing on 60 interviews and observations of 17 management committee meetings, training sessions and other activities across seven different health centres, the levels of participation in each case were examined and then explored in order to establish why they were low.

My research evolved as data was collected and analysis began, in line with a grounded theory approach. My focus began to shift from looking at enabling factors generally to understanding how the policy and international aid contexts affected the participation
policy adoption, and its implementation. This included examining the role of international Non-Government Organisations (NGOs) in supporting and shaping participation in the health sector.

1.2 RATIONALE AND IMPORTANCE OF THE STUDY

The initial rationale for the study was to understand the enabling factors for participation in a non-Western context and to examine the impact of a participation policy on citizen involvement in government decision making. As discussed, the grounded theory approach meant that the key research questions changed as the study progressed. Examining the role of international NGOs implementing a government participation policy became increasingly important as their significant role became clear.

There are few studies of the implementation of national participation policies (for some examples see Wilson 1997; Miraftab 2003; Clisby 2005; Gideon 2005; Stich and Eagle 2005). To my knowledge, only in Bolivia and Vietnam has the role of NGOs in the implementation of participation policies been examined (Kohl 2003a; Mattner 2004). However, the research in Bolivia did not include international NGOs; and although mentioned, international NGOs are given little attention in Mattner’s (2004) work in Vietnam. There are implications of foreign agencies mediating state-citizen relations, and as international NGOs play a key role in implementing the participation policy in Cambodia, their interests and involvement in mediating the relationship between citizens and state deserve examination.

This study makes contributions in three areas. The first is to area studies. A participation process in Cambodia is subjected to an in-depth empirical examination, furthering understandings about Cambodian participation practices and state/society relations, and the importance of international NGOs and donors in the Cambodian political landscape. Second, the implementation of participation policies is studied. The focus on international NGOs implementing a government participation policy in the present study fills a research gap, as this phenomenon is hardly examined in political science and development studies.
Third, the study is also important because it extends the work of others to better understand the ways that participation policies are consumed in the international development game.

1.3 ORIENTATION TO THE THESIS

In Chapter Two I review relevant literature, drawing together analyses of participation in the democracy, development and health fields with a focus on the role of power in participatory processes. I review studies of participation policies and develop an empirical framework for examining the levels of participation within the different cases that I examine. I conclude the chapter by assessing the literature on NGOs implementing government participation policies and research that addresses similar concerns.

An introduction to Cambodia, its political and development context, historical and contemporary experiences with participatory processes and the detail of the participation policy are all examined in Chapter Three. In Chapter Four I outline in detail the methodology and methods used in this study. In Chapter Five, the analysis of the levels of citizen participation in each of the health centres included in the study area is presented. In Chapter Six I examine the importance of process design and the degree of policy institutionalisation. The role of international NGOs in shaping and supporting implementation of the government’s participation policy is examined in Chapter Seven. In Chapter Eight I bring together and extend scholarship on the consumption of social policies and commodification of participation to examine how the participation policy became a product that was consumed and resisted by the aid dependent Cambodian government. I conclude the thesis in Chapter Nine by drawing together the key findings of this study and identifying directions for future research.
CHAPTER TWO. PARTICIPATION IN DEMOCRACY AND DEVELOPMENT

In this chapter, the literature on four topics is reviewed. There is an extensive literature published in the field of participation and I begin by briefly examining how participation has been considered in development, democracy and health before examining types of and reasons for participation, and participation’s relationship to power. The implementation of participatory processes and policies are then examined. Different approaches to measuring participation are considered as I develop the empirical framework used to assess the levels of participation in this research. I conclude the chapter by reviewing the literature about the role of national and international NGOs in democracy and development, and particularly focus on research that is relevant to the involvement of international NGOs in implementing government participation policies.

2.1 PARTICIPATION AND THE QUESTION OF POWER

Participation has various meanings. Participation can be defined by demarcating it from other activities such as elite governance (Powell and Geoghegan 2005: 133) and communication from agencies to communities (Rowe et al 2004: 89). This thesis is primarily concerned with active participation, that is, participation in decision making. This means that people are able to have a say in decisions that affect them (Blair 2000: 22). Active participation requires institutions to engage in:

the practice of consulting and involving [people] in the agenda-setting, decision making, and policy-forming activities of the organizations or institutions responsible for such functions (Rowe et al 2004: 88-9).
This definition is sufficient for now, but after considering how participation has been understood in development, democracy and health I will examine in more detail the difference between active and passive participation.

There are multiple sites where active participation happens: in policy development (Caddy 2001; Poteete 2002; Mayer et al 2005), policy implementation (Wilson 1997; Pasteur 2002), defining research agendas (O’Donnell and Entwistle 2004), within research projects (Busza 2004) or within specific projects of other kinds (Ramiro et al 2001; Jacobs and Price 2003). Various groups and types of people are considered as participants including the community (Morgan 2001), the public (Tang et al 2005; Williams 2005), women (Clisby 2005), the poor (Parnwell 2003), the marginalised (Smith and Stephenson 2005), the indigenous population (Quantz and Thurston 2006), citizens (Caddy 2001; Stich and Eagle 2005), lay citizens (Hendriks 2004), stakeholders (Edelenbos and Klijn 2005; Poolman and van de Giesen 2006), service users (Titter and McCallum 2006), patients (Thompson 2007), consumers (O’Donnell and Entwistle 2004), civil society (Lavalle et al 2005) and NGOs (Gideon 2005).

Several scholars of public participation have focused on the inclusion of lay citizens as representatives of the broader public (Hogg and Williamson 2001; Adams 2004; Hendriks 2004). Lay citizens are people with no association with or specialist knowledge of the issue being considered in a participatory process (Hendriks 2004: 4). They are not office-bearers, and do not work in the field that they are asked to consider (Hogg and Williamson 2001). Lay citizens are considered representative because they are “ordinary” or typical citizens who share the experiences and values of the general population. The views of lay citizens are therefore considered to be representative or typical of those of the broader population (Hendriks 2004: 7).

Pitkin and Shumer (1982: 52) identify the characteristic that participants, as non-experts in the field being considered, bring to the decision making table:
knowledge alone is never enough... knowledge can only tell us how things are, how they work, while a political resolution always depends on what we, as a community, want and think right.

‘Right’ here refers to morally good and fair outcomes. Participants are brought into decision making processes to provide public judgment, to make decisions based on social values. Involving lay citizens can improve the quality and type of information considered in decision making and can be part of a much broader movement towards shifting power away from the government toward the lay public (Rivera-Guieb et al 2004).

The participation literature includes instructive (advice-giving), empirical and theoretical approaches. The instructive literature consists of guides on “how to do” participation (see for example Sarkissian et al 1997; Burns 2004). A number of tools have been created that can be used to facilitate participation. These tools are shared through books as well as practitioner web-sites and associations (see for example Coastal CRC n.d.). There are a number of web-sites that provide case-studies of participatory processes and link practitioners to each other (see for example Coastal CRC n.d.; International Association of Public Participation n.d. a; LogoLink n.d.; NSW Government n.d.). In the empirical literature, there is a tension between positivist and critical realist approaches in studies on participation. Positivists seek to discover relationships between different phenomena. Critical realists, by contrast, seek change in the way the world operates. Empirical studies of participation are generally descriptive and focus on the experience of participation in one case (see for example Busza and Schunter 2001; Marschke and Nong 2002). There are also some action research projects completed by practitioners (see for example Ritchie et al 2003; Busza 2004). Both academics and practitioners write about participation. Although they are usually separate, at times academic and practitioner writings converge (see for example Gastil and Levine 2005). The theoretical literature tends to be normative and promote participation (see for example Rifkin and Kangere 2002). As noted by Gueye (1999), participation is often seen as the panacea for all ills. There is increasingly more scholarly work that considers the role of power in participation, which is a direct critique of these more value-laden analyses and studies (see for example Cooke and Kothari 2001a). These critiques will be studied later in section 2.1.
In the remainder of section 2.1 I draw together scholarship on participation in three key sub-fields: participatory democracy (political science), participatory development (development studies) and participation in health (health studies). Unless otherwise stated, within this thesis development refers to international development, i.e. that development funded by and happening within the context of international aid. In section 2.1.1 I provide only a brief introduction to participation in development, democracy and health as I consider detailed debates from each of these literatures in other parts of this thesis. I use the writing in these three fields to identify different types of participation, particularly making a distinction between active and passive participation (section 2.1.2), before examining how power has been considered in the literature on participation (section 2.1.3).

2.1.1 Brief Introduction to Participation in Development, Democracy and Health

Participation in Development

After World War II, international development interventions by multinational organisations were focused on achieving economic growth (O’Leary 2006: 67). As such, large infrastructure projects were often the focus of international development assistance. Development at that time meant becoming more ‘modern, rational, industrial and westernized’ and ‘the power, money and expertise remained in the hands of the rich countries’ (Christens and Speer 2006: 1). Development was driven by the knowledge and decisions of experts, largely white Western men (Christens and Speer 2006: 2), as development was conceived of as something brought by the “developed world” to assist those in “less developed countries” (O’Leary 2006: 67).

Despite this early emphasis on economic approaches to development, community participation has been a theme in development discourse since the 1950s (Rifkin and Kangere 2002). In the 1960s and 1970s, participation became central within many development projects and was seen as ‘a means to seek sustainability and equity, particularly for the poor’ (Rifkin and Kangere 2002: 38). In the 1980s participation was reinvented by people like Chambers (1983) as a way to bring development closer to people after
There is an increasing emphasis by academics, donors and international NGOs on participation as a means to understand and implement programs that address poverty and therefore contribute towards development (Porter 2003: 139). Participation is usually considered in terms of project beneficiaries becoming involved in decisions within development agencies (Cooke and Kothari 2001b: 5), and sometimes society's broader political participation is also considered (Clarke 1998: 41). The key approaches in participatory development are Participatory Rural Appraisal, Rapid Rural Appraisal, Appropriate Technology and Participatory Action Research (Keogh 1998: 188). According to some, participatory development is now a ‘veritable industry of participatory methodologies’ (de Vries 2007: 33).

**Participation in Democracy**

Although not all residents had citizenship, Ancient Greek city states are held up as the earliest and best examples of participatory democracy (Abelson et al 2003: 242; Marinetto 2003). The size of cities and towns today precludes such participatory structures (Abelson et al 2003: 242), and systems have been adopted in many countries to ensure that people have an opportunity to choose, through elections, their representatives. Participatory processes have been re-introduced as a way to address the democratic deficit inherent within the representative democracy system (Drydyk 2005; Mohan 2007: 790). Dewey (1927) called for increased democratic participation rather than an extension or refinement of aggregative models of decision making (see also Knight and Johnson 1994). Croft and Beresford (1992) note three concurrent fields in which participation became increasingly prominent since the late 1950s: public participation in land use planning, community development, and the involvement of public service users in decisions about public services. Recently this focus on direct or participatory democracy has at least been maintained, if not increased (Heller et al 2007: 627).
Abelson et al (2003: 239) argue that ‘policy makers, regulators, experts and public advocacy groups agree on the importance of involving the citizenry in the decisions that affect them’. Participation can be considered to be a democratic right (see for example Young 1990). Participatory democracy is concerned with citizens and citizenship, and people playing active roles in the decision making processes of authorities (Goven 2006). In contrast, in participatory development the focus is on the involvement of project beneficiaries, usually “the poor”.

Various definitions of participation and different perspectives on how citizens can be involved in governing have been adopted within political science scholarship. Voting is sometimes considered to be (political) participation (Steelman 2001: 74), but this should be distinguished from more substantive involvement in decision making. Adopting a participatory decision making process has been praised for helping democracy through contributing to the ‘education of citizens to [create] better and informed citizens’ (Edelenbos 1999: 571). Yet, a focus on education outcomes has been criticised for detracting from citizen involvement in making decisions (Campbell 2005a). Participation has also been conceived of as conveying public opinion to bureaucrats (Adams 2004: 46; Rowe et al 2004). This is a weak form of participation as again citizens are not involved in making decisions. Active participation, as already discussed, means that participants contribute their judgment rather than just providing information or labour, and are to be involved in making decisions rather than just being consulted on the decisions being made by administrators (Simrell King 1998). Participation studies have taken a deliberative turn in recent years, as the focus has shifted from symbolic democratic control towards the substantive involvement of citizens in governance (Dryzek 2000). In deliberation, participants need to be judgmental, that is, provide and justify their views on different options (Pettit 2001: 270) and collectively come to a decision. Deliberation is active participation.

The key concerns in the literature relevant to this study have been to ensure that participatory processes include participants who are representative of the general public or minorities and that they deliberate to ensure decisions are made well. Consequently, researchers have particularly focused on who is involved in participation (Rowe and Frewer 2000; Campbell 2005a) and how participatory processes are structured (see for example
Deliberation and representativeness are not discussed in detail here as they are considered in section 2.3. There has been some focus on determining enabling conditions for participation (see for example Posner 2003; Solitare 2005), and these are examined in section 2.2.

Much research attention has been directed at developing innovative techniques that enable citizens to participate in government decision making, for example citizens’ juries, citizens’ panels, consensus conferences and other deliberative inclusive processes (see Carson 2001; Fung and Wright 2003; Carson and Hart 2005; and Hendriks 2004 for a description of some of these processes). Some methods have been taken up as part of a participatory governance agenda; participatory budgeting has become widespread (Cabannes 2004), and Venezuela’s communal councils are an example of how participatory governance approaches have become mainstream in some places (Learner 2007). Both political scientists and development scholars have examined the links between the rise of participation with broader democratic changes and social movements (Ulvila and Hossain 2002: 149). Unlike some in development studies, those concerned with participation in political science view participation as inherently and primarily a political activity.

Participation in Health

In 1978, member states of both the United Nations Children’s Fund (UNICEF) and the World Health Organisation (WHO) made the Alma-Ata Declaration, focusing on Primary Health Care (Banerji 2003). One of the Declaration’s key principles was that the community should participate in health, through being involved in the creation of healthy environments and the development and management of health services (Hall and Taylor 2003). Following the Alma-Ata Declaration, many governments around the world introduced participation policies into their health systems (Zakus 1998). In a study five years after the Alma-Ata Declaration 53 health participation studies were reviewed (International Health Programs 1983), showing that participation became pervasive in the delivery of health programs.
Participation was not sustained as the preferred approach in global health discourse. Economic reform approaches to health services delivery instead resulted in “Health Sector Reform” (Hall and Taylor 2003: 20), where user fees were introduced and the focus was on running health services more like an economically viable business than a public service. Within this approach, paying user fees is considered to be a form of participation. In an attempt to reinvigorate interest in more substantive participation, the WHO changed the term it used and began promoting “Community Involvement in Health” (CIH) in the late 1980s (Olico-Okui n.d.: 2; see Oakley 1989 for WHO’s first substantive study on CIH). Although the market-orientated approach is now dominant in the discourse in the health sector (Segall 2003), the primary health care approach is still evident in many countries.

Participation approaches taken in health are diverse, and the broad range of definitions of participation in the context of health reflects this. Definitions range from people taking an active role in looking after their individual health, to paying fees for health services, to contributing to the development of policies and participating in the administration of health services through membership on advisory or management boards (Smith 1998: 199; Ramiro et al 2001; Gideon 2005: 175). Some recent approaches to participation in health care have returned to participation’s more radical roots, with scholars and practitioners using the language of community building and community organising as a way to distinguish the active participation that they encourage from the paying of user fees as a form of participation (see examples in Minkler 1997).

Like participatory democracy, there has been an argument that people have a right to participate in health (Potts 2005). Approaches to active participation in health are not based on citizenship, but on the involvement of service users, service consumers, or patients (Thompson 2007; O’Donnell and Entwistle 2004).

Many techniques have been used to involve the public in decision making in the health sector. Maxwell et al (2003) used dialogue sessions to examine options for improvements within the health sector in Canada, citizens’ juries have been popular in the United Kingdom and New Zealand (Abelson et al 2003: 243), and citizens’ boards and committees have been instituted in many countries including the Philippines, Brazil and Canada.
(Ramiro et al 2001; Coehlo 2006; Quantz and Thurston 2006). I consider boards and committees in greater detail in section 2.2.

2.1.2 Types of and Reasons for Participation

There are a number of typologies that have been developed to help further define participation and differentiate distinct levels of involvement. Arnstein’s (1969: 216) ladder of participation is a seminal article in this field. She classified seven types of participation, based on the ‘extent of citizens’ power in determining the plan and/or program’. The involvement ranges from non-participation (including manipulation and therapy) at the bottom of the ladder, to degrees of tokenism to degrees of citizen power; citizen control is at the top of the ladder (Arnstein 1969: 217). Some academics and practitioners have extended Arnstein’s model or developed new typologies (see for example Rifkin et al 1988; Gaventa cited in Drydyk 2005), or focussed on a particular type of participation and sought to define this further (see for example Seymour 2001). Professional associations have also developed their own typologies of participation (see for example International Association of Public Participation n.d. a).

Different types of participation have been considered within debates about participation across and within the fields of development, democracy, and health. There is a spectrum of participation, ranging from passive to active participation. This is different from Arnstein’s (1969) typology, in which she focused on the degree of manipulation, rather than the type of citizen involvement in government activities. As already outlined, active participation is input into an institution’s decision making; citizens contribute public judgment. There are different types of passive participation that are considered in the literature. This includes looking after one’s own health and utilising government health services (Royal Government of Cambodia n.d.; Smith 1998). Contributions of labour or financial resources to a project or public service are also forms of passive participation. These contributions include building health facilities, having health volunteers who perform public functions for a government service, or paying fees for services (Smith 1998: 199 - 200). Such forms of passive participation have been considered tokenistic or weak (Smith 1998; Prokopy 2005:...
1802). Here I consider them passive, defined as such because of the lack of citizen involvement in decision making. The contribution of information to a government body fails to be active decision making as participants’ labour (in sharing information) is required, not their judgment in decision making. It is incorrect to say that defining the provision of labour as participation is evidence of governments manipulating the public as Arnstein might suggest, unless the rhetoric surrounding the participation process suggested that public involvement in decisions was to be achieved. However, the provision of labour can be considered a lower level of participation than actively participating in decision making, as the latter provides citizens with greater influence over their government or over the convenors of participatory processes. In this thesis I am concerned with active participation because it has been suggested that people need to be involved in decision making rather than more passive forms of participation in order to achieve sustainable outcomes (Schouten and Moriarty 2003, cited in Prokopy 2005).

There are many reasons for the inclusion of different types of participants in decision making processes, with significant similarities emerging from the three fields of scholarship introduced above. Although some argue that participation contributes to both efficiency and empowerment (Prokopy 2005: 1801), most often proponents argue for participation on the basis of one or the other of these outcomes: greater efficiency in the decision making process (Cleaver 1999: 602), or empowerment of participants (White 1996: 7).

It is argued that active participation can make government decision making processes more efficient because it results in better decisions as local knowledge is used, the support of stakeholders is gained, and the community and citizens are educated and informed (Edelenbos 1999: 571; Gideon 2005: 169). Such participation is expected to result in improved public services, as through gaining the views of users, services are able to be more responsive to them and obtain a financial advantage because of this (Rowe and Shepherd 2002: 279; see also Barnes et al 2004). Passive participation has also been portrayed as a way to make projects efficient through using it to obtain resources from within a community (Zakus 1998: 492; Morgan 2001: 221; Rifkin and Kangere 2002). Participation conceived of as paying fees for health services is seen to increase the levels of health centre utilisation (Smith 1998: 199). In the efficiency argument, both active and
passive participation are portrayed as instrumental, as a means to an end (Cleaver 2001: 37). Miraftab (2003: 227) notes that participation as a means rarely lives beyond the life of a project and does not result in any greater community influence in government decision making.

Proponents who argue for participation on the basis that it empowers participants claim that ‘people can and should govern themselves’ (Pitkin and Shumer 1982: 43). Participation conceptualised in this way must by definition be active participation. People cannot become empowered if they are to be passive recipients of projects and their outcomes; they must instead become active citizens playing decision making roles (Miraftab 2003: 227). There are arguments for participation based on justice. Young (1990) argues, for example, that society will continue to be organised around groups of differing status and therefore the interests of elite groups will dominate the public sphere. To achieve social justice there is therefore a need to ensure the representation of minority and marginalised groups in decision making (Young 1990: 184; Catt and Murphy 2003: 411). Young (1990: 191) argues that people need to be involved in ‘collective discussion and decision making in all settings that depend on their commitment, action and obedience to rules’, for example neighbourhoods, schools, and workplaces. In the empowerment approach participation is seen as an end in itself (Cleaver 2001: 37; Miraftab 2003: 227).

2.1.3 Power and Participation

The key critiques of participation relate to its relationship with power. Within my thesis I particularly draw on the work of Lukes (1974) in relation to power. He identified three dimensions in which power exists and can be exercised. Lukes’ (1974) first dimension is the ability to win a game according to the rules, or to exercise influence and have one’s needs met when following the rules of a particular interaction. Lukes’ second dimension of power is the ability to set the rules of a process or interaction. Lukes’ first and second dimensions will be considered in relation to the present study in section 2.3. The creation of the social environment in which rules for interactions are set is Lukes’ (1974) third, and deepest, dimension of power.
There are two conceptions of power that critics have called on. The first is of power as a zero sum game where government needs to lose power in order for citizens to gain it (Miraftab 2003: 228). People are seen as being either powerful or powerless. The second view is of power as something that circulates (Kothari 2001: 141). It can be a positive sum game where the power of one person complements the power of others and is transformative (Miraftab 2003: 228). This latter conception relates particularly closely to views of participation as empowerment. However, this circulation of power is not always seen as a transformative and positive process. It also hints at Foucault’s (1977) conception of power, in which power is everywhere and is something that circulates and controls behaviour. In Foucault’s work, knowledge and norms are socially and politically produced and power is embedded in particular forms of knowledge (this view has been applied to development studies in Kothari 2001: 141; and Rossi 2004: 3). The ability to produce these norms correlates with Lukes’ (1974) third dimension of power.

There are three inter-related critiques of participation with which I am concerned. First, participation processes have been criticised for being tokenistic (Arnstein 1969; Miraftab 2003: 228). The conflation of active and passive participation has resulted in participation processes often being considered tokenistic because weak forms of participation such as monetary contributions to projects (Prokopy 2005: 1802) or unpaid labour (Smith 1998: 198) are considered as participation. Even in ostensible attempts at active participation – where the public has been given a ‘voice’ in decision making – participation processes can still result in low levels of influence when participants are not able to exercise their judgment in decision making (see for example Prokopy 2005). Cupps (1977: 484) – not an advocate of participation – called for citizen participation to be ‘within well-defined and manageable limits’. Bachelor and Jones (1981: 518) found that government officials promoted and confined participation at the same time; one measure for doing this was allowing participation only in ‘policy areas considered “safe” by administrators and elected officials’. Steckler and Herzog (1979) have parodied the actions that convenors of participatory boards take to reduce the influence of participatory decision making structures on the convening institutions, to ensure that participation remains tokenistic.
Second, despite participation being by definition a political process concerned with power, it is often depoliticised and treated as a technical intervention; consequently limited attention has been paid by scholars to the political functions and uses of participatory processes (White 1996: 7; Cooke and Kothari 2001b). The tokenistic approaches to “active” participation outlined above are often possible because participation is treated as non-political and therefore critique of the level of participation or the type of involvement is limited. Depoliticisation also happens when agencies implementing participation programs fail to engage with the politics of community, not challenging existing power structures and so deliver ‘depoliticized and demeaning versions of empowerment’ (Shaw 2008: 34). It also happens because participation is usually implemented within the confines of projects and is used to achieve pre-defined goals; as such it is particularly evident when participation is pursued as a means of improving program efficiency. Cornwall and Brock (2005: 1055) demonstrate how the meaning of participation in international development policy has shifted from being about power to being a one-size-fits-all “development blueprint” rather than enabling poor people to have a voice and choices. This denotes a shift from participation as empowerment to the depoliticisation of participatory processes.

Third, even attempts at active participation can result in low levels of participant involvement in an institution’s decision making because of the manipulation of the participatory process by government or elites. Such manipulation can be used to decrease influence but at the same time legitimate decision making (Arnstein, 1969; White 1996: 7; de Vries 2007: 33). Participation processes have been criticised for being used as a ‘technology of legitimation’, a way to gain legitimacy for decisions made by managers and staff (Harrison and Mort 1998: 60). The use of participatory processes can create the appearance of consulting the public, or gain access to resources within the community, without having to permit the community to exercise any genuine influence (see for example Harrison and Mort 1998). Manipulation of participatory processes also occurs to ensure that the interests of the convening agency or elites prevail. Kothari (2001) has extended Foucault’s (1991) work on governmentality to show how participation processes have been used to extend a government’s power rather than reduce it. Consultation has been criticised for being a ‘means of indoctrinating the public in the values and priorities of the planners’ to ensure that the decisions of planners obtain public endorsement (Smith 1998: 198).
Manipulation has been reported in many countries. In the United States, researchers have uncovered techniques used by government staff members convening participation processes to manipulate the outcomes of participation (Bachelor and Jones 1981). Arnstein’s (1972) early study *Maximum Feasible Participation* demonstrated how a community in the United States was manipulated by government officials implementing a participation policy. Staff members of NGOs, who were participants, felt manipulated by the government’s participation processes in Chile (Gideon: 2005: 176). In China, participation was regulated and ideologically shaped by the government (Yan and Gao 2007: 232). Participation processes can be manipulated by elites, by being subject to elite capture, where the more powerful within communities dominate the participation processes and their interests are represented (Cooke and Kothari 2001a; Miraftab 2003). Francis and James’ (2003: 336) research in Uganda shows that ‘those with vested interests are capable of turning the institutions and opportunities of decentralization to their own advantage’. Poor people in Cambodia believe that state institutions are only accountable to the rich and powerful (Trasmonte Jr 2005: 1).

There has been significant debate about the impact of participation on existing power relationships (see for example Phillips 1991; White 1996; Newman 2001; Eversole 2003; van Stokkom 2005; Tam 2006). It has been argued both that participation can transform them and that it can reinforce them (Narayan et al 2000; Pacheo 2004; Carson 2005). Although public participation is often promoted as a means for transforming existing power relationships in decision making it has been criticised because it rarely results in a redistribution of power. One of the main ways that power is reinforced is through who participates. Although May (2007: 71) argues that the “usual suspects” of participation should be encouraged to participate because they have the ‘capacity for engagement’, others more convincingly argue for random selection. The work of those advocating random selection in politics arises from a critique on participatory mechanisms that attract the “incensed and articulate” (Carson and Martin 1999: 130), but exclude others who may be affected by policies but are disenfranchised from the political process. Random selection is rarely used in structures such as committees. Selection from minority groups is another approach to transforming power relations in government decision making. The approach to
selection and the specific mechanisms chosen have a significant impact on the ability of participatory processes to challenge existing power relationships.

2.2 IMPLEMENTING PARTICIPATION MECHANISMS AND POLICIES

As I examine participation in the context of a policy requiring it, my research is at the same time a study of participation and of policy implementation. I examine here the literature relevant to participation policy implementation, considering in particular the enabling factors for participation policies, committees, and instances where entities other than the government implement government participation policies.

2.2.1 Factors Affecting Participation Policy Implementation

There is a difference between participation in policy development and participation policies. In the former, participation is used to gain input into the content of policies, for example obtaining citizen views on what a government transport policy should be regarding a new trucking licensing program. Citizen involvement in policy development has been extensively researched (see for example Edelenbos 1999: 570; Caddy 2001; Mayer et al 2005). In participation policies, on the other hand, participation itself is the content of the policy; the policy requires participation in other decision making processes, for example ongoing citizen involvement in the management of a trucking license program through membership of an oversight committee. Participation policies – where participation is the content of the policy – are the focus of this review.

The adoption of a national participation policy is not an activity isolated to Cambodia. Research on participation in Cambodia is reviewed in Chapter Three, along with a detailed outline of the participation policy. The implementation of participation policies has been studied in various countries including the United States (Arnstein 1972; Stich and Eagle 2005); United Kingdom (Titter 1994); New Zealand (Wilson 1997); South Africa (Miraftab
Having a relevant policy has enabled participation in particular cases (Fung and Wright 2003; Pimbert 2001: 81). However, Miraftab (2003: 236) cautions that ‘participation will not simply “happen” as a result of a government decree’. Participation policies are not always successful in achieving participation, and adopting a participation policy is not the only factor required for participation to be realised. For example, political support for the policy is another enabling factor (Fung and Wright 2003). In New Zealand, Wilson (1997) found that a participation policy was not enough to ensure strong community participation, and the key barriers faced were the lack of time, expertise and money for people to write submissions on resource management. As a result, industry organisations were among the few who could afford to participate and therefore rarely were other voices heard (Wilson 1997).

Even when the rhetoric of participation is embedded within the policy discourse, the policy does not always achieve a participatory agenda (see for example Miraftab 2003: 226). Bolivia’s participation policy has received mixed reviews (compare for example Kohl 2003b; Clisby 2005). Although Kohl (2003b) agrees that the policy did not achieve all that it set out to, it did increase levels of participation. Conversely, Clisby (2005) found that women’s participation was eroded as the policy opened up spaces usually reserved for women to all people, and men then dominated that participatory space to the exclusion of women. In a South African example, private sector interests ‘hijacked the participatory discourse, and communities’ interests have been marginalised’ (Miraftab 2003: 226). Government officials have manipulated communities through supposedly participatory processes, by limiting the scope and shaping the outcomes of such processes (Arnstein 1972; Gideon 2005).

Research has demonstrated that the implementation of participation policies is not necessarily uniform (Bachelor and Jones 1981: 519; Mattner 2004). Bachelor and Jones (1981: 521) suggested that the shape and focus of citizen participation programs that were implemented under the auspices of vague national mandates would be ‘substantially shaped
by the political, economic, and social characteristics' of the different locations where they are implemented.

As well as specific studies on participation policies, the literature on policy implementation more generally is relevant to the present study. Policy studies are traditionally in three areas: formation and design, implementation, and evaluation (Younis and Davidson 1990). The majority of policy studies focus on policy formulation; implementation suffered from a ‘black box’ approach for a long time, where it was assumed that ‘policy decisions were automatically carried through the implementation system as intended and with the desired end results’ (Younis and Davidson 1990: 3).

Pressman and Wildavsky’s (1973) book on policy implementation, is widely cited as the original work that examined the complexities of implementation. Since its publication, a number of other scholars have examined issues that affect the implementation of policy. Hill (2003) notes that scholars have identified over 300 variables that might affect implementation that can be classified into four general classes of influence: the policy and its process; organisations and their milieu; agents, i.e. bureaucrats; and conditions in the implementation environment. Hill (2003) argues that in addition to variables mentioned by others, learning about policy, what it means and how to implement it is a fundamental factor affecting implementation. Differences in training can therefore lead to variation in the implementation of a policy. In light of Hill’s work, I examine the policy development process and its content, the organisations that adopted and implemented the policy, the broader conditions in the implementation environment, and the role of training in the study area.

Researchers have previously sought to understand why policies have not been implemented in some locations. Lipsky’s (1979) book on street-level bureaucrats examines the influence that bureaucrats who interact directly with the public have on what and how policy is implemented. A recent study in Cambodia examined the strategies health sector staff adopted to affect how health reform policies were implemented on the ground (Grove et al 2002). In examining the Tasmanian education system, Pusey (1976) analysed the role of those responsible for policy implementation. His study emphasised the importance of
understanding bureaucracies as organisations. He drew on three sets of organisational theory to come up with a systems model that could explain organisational behaviour (Pusey 1976). Organisations have three dimensions according to Pusey. The distribution of formal authority in decision making is important in the bureaucratic dimension. The distribution of resources and their orientation towards achieving organisational goals is important in the technical dimension. Pusey’s third dimension involves seeing organisation as social systems; personalities and group dynamics become very important in the analysis of organisational behaviour and dysfunction here. Pusey (1976) argued that how these dimensions interact with each other is as important as the dimensions themselves. Pusey’s work serves as a reminder to analyse what is happening with power and where it resides in each of these three dimensions within my study of Cambodian committees: formal authority, the mobilisation of resources towards organisational goals, and the social dynamics of the individuals involved in the committees.

As well as the policy implementation literature, research on the factors that enable participation is relevant to the present study. There is no accepted typology that identifies the enabling conditions for participation (Rowe and Frewer 2004: 549). At the macro-level, enabling conditions for participation have most visibly been examined by scholars of democratisation (Lipset 1959; Lipset 1994; Przeworski and Limongi 1997; Pimbert 2001; Lee 2002; Boix and Stokes 2003; Posner 2003). Studies have particularly focussed on the relationship between economic development and democratisation (Przeworski and Limongi 1997; Boix and Stokes 2003). Lee (2002) examines various macro-level causes of democracy in the Asian context, finding traditional ideas of causal factors inaccurate (such as economic development, a British colonial heritage, etc.) and determining that political protests are the causal factor in Asia. The studies mentioned here all compare cases across different countries rather than examining micro-level participation structures.

Overall there is little theoretical or empirical research into factors that enable participation at the micro-scale. Within the literature, the factors tend not to be determined through empirical evidence but rather can be implied from the steps given in the advice-giving literature regarding what conditions they are advising practitioners to create. Most often factors that hindered or helped participation are mentioned to explain the outcomes of
participatory approaches within singular case studies. For example, in two cases in Fung and Wright’s (2003) book, it is noted that the participatory processes adopted were only brought about because a political party with a strong participatory agenda came into power. Kombe (2001) also found that the enabling factors for participation were on a macro or national level, such as the policy of the political party in power. There is an empirical literature at the micro-scale. For example, Carson (1996) examined the barriers that decision makers face when adopting or considering adopting community participation practices. She examined this within an Australian context, focusing on the experimentation and use of innovative and more traditional forms of participation in a local government body. In a different study, Carson (2005) found that enabling leaders and process champions were fundamental to an institution adopting participatory approaches. Developing an agency culture that supports participation has been identified as a key factor that enables community participation (Curtis and Lockwood 2000: 70).

2.2.2 Committees: A Widely-Implemented Participatory Structure

Committees are the participation structures used in the Cambodian policy under examination in this thesis. A committee is a ‘group of citizens who gather regularly to discuss and address a specific public issue or domain’ (Williamson and Fung 2004: 9), and they can also be known as boards or councils. A committee can be decision making or advisory in nature, and can meet for a set period of time or continue indefinitely. Although most committees that include members of the public consider local-level issues, these committees can also deal with issues at state, regional, national, or international levels. It has been argued that committees can increase public access to the decision making process by including them within it, that media coverage can be increased if a citizen committee is considering an issue, that they can be vehicles for increasing minority involvement in leadership training, and where legitimate differences in opinion about an issue can be resolved (Rodgers 1977 cited in Callahan 1999: 10).

Committees have been criticised on the basis that their contribution to democracy is weak and questionable (see for example Carson 2001; Williamson and Fung 2004). Arguments
against them are that they are not representative and they exclude or under-represent marginalised and disadvantaged groups (Lynn and Busenberg 1995; Zakus 1998; Williamson and Fung 2004). It is possible that citizen committees can become little more than a forum for citizens to vent their frustrations or to uncritically legitimate government decisions (Lynn and Busenberg 1995: 148). Although Horton (1980) was discussing specialist rather than citizen committees, his comment that decision making processes in committees are ‘frequently time-consuming, inefficient and frustrating’ holds true for citizen committees as well. Hannah and Lewis (1982) examined the level of citizen control in committees through calculating the proportion of interactions that were initiated by citizen members of the committees. They found varying levels of control across the different committees included in their study. In another older study on committees, committees were able to influence government decision making to a greater degree when committee members were able to undertake activities independent of the government administrators of the committee (Houghton 1988).

Numerous alternative processes to committees have been developed to encourage greater deliberation and participation, including citizens’ juries, deliberative polls and consensus conferences (Pimbert 2001). However, committees are still one of the most widely-used structures for involving lay citizens in government decision making in areas as diverse as local governance, health and natural resource management (see for example Callahan 1999; Bossert and Beauvais 2002; Marschke 2004). Understanding better whether and how committees can achieve participation will inform practitioners, scholars and agencies wanting to convene committees. Much of the research on citizen committees is old and there is a need for more contemporary research on such a widely instituted form of public participation.

Committees, councils and boards have been set up for the management of health facilities in many countries including Uganda, the Philippines, Zambia (Bossert and Beauvais 2002), Brazil (Coelho 2006), the United States (Morone and Kilbreth 2003: 271), Colombia (Mosquera et al 2001) and Bangladesh (Mahmud 2004). These structures have mostly been introduced under national policies, and studies in the countries listed above have shown that a policy has not always been enough to ensure lay citizen and other community
representative involvement in the management of health facilities. Their findings include that in some cases adopted participation policies have not been fully implemented (see for example Bossert and Beauvais 2002 on Uganda; Morgan 1990 on Costa Rica) and that the impact of status and power structures negatively affects the levels of participation (Mahmud 2004). These studies have also found that participation is constrained by a political culture that is traditionally authoritarian in nature and where democracy is fragile (Ramiro et al 2001), and that participation policies have been implemented for only a short period of time (Morone and Kilbreth 2003). Coelho (2006) found that only a combination of a mobilised civil society, a committed public manager and the design of the selection mechanism for committee members resulted in high levels of diversity of members. This diversity is related to the pluralised voices and representation as called for by Young (2000).

2.2.3 Government Participation Policies Implemented by Other Entities

A systematic review of the literature uncovered only two examples of government participation policies being implemented by other agencies (Kohl 2003a; Mattner 2004). Leading participation scholars confirmed that they were unaware of any additional studies of international NGOs implementing a government participation policy (Cooke 2007; Kothari 2007).

The first study in which a non-government agency implemented a national participation policy is Kohl’s (2003a) research on national NGOs implementing a participation policy in Bolivia. National NGOs were important in implementing a participation policy that required local municipalities to prepare participatory plans for local development (Kohl 2003a). The authors of Bolivia’s Law of Popular Participation assumed that NGOs ‘would play a key role in implementing the law by providing technical and planning assistance’ (Kohl 2003a: 318). The role of the NGOs was providing technical support in developing annual operating plans and five-year municipal development plans (Kohl 2003a: 319). The municipalities or the NGOs contracted to develop the plans were to consult with civil society in the form of community-based Grassroots Territorial Organisations. This contrasts with the involvement of unaffiliated community representatives in the present
study. In Bolivia, the response of NGOs to the role expected of them to implement the law varied from suspicion that the government was trying to shirk its responsibilities to address poverty, to cautiously embracing the law, ‘appreciating the new possibilities for increasing the scope of their organizations’ activities and funding’ (Kohl 2003a: 319).

Kohl’s sample was five municipal governments, and NGOs played a major role in implementing the Law of Popular Participation in four of these (Kohl 2003a: 320). The ‘short-term success in participatory planning was directly dependent on whether an NGO worked on the [Municipal Development Plan]’ (Kohl 2003a: 323). The policy was still implemented without the support of NGOs in the fifth municipality where it was instead implemented by a consulting firm, but with much lower levels of citizen participation (Kohl 2003a: 324). This firm flouted some of the policy requirements; for example, it met with only 60% of the Grassroots Territorial Organisations in the municipality, rather than with all of them. Kohl (2003a: 317) offers lessons ‘both on the opportunities and on the limitations of NGOs as partners’. The effects on the planning depended on the NGO itself, particularly its approach to planning and beliefs about development. This affected how extensive the consultation process was, and whether it included a capacity building component for municipal planning officials or an educative element for the population (Kohl 2003a: 324-5).

Like the present study, Kohl’s (2003a; 2003b) research focuses on the early implementation of the participation policy; later work is far less optimistic about the effects of the policy (see especially McNeish 2006). Although Kohl focused on NGOs, international NGOs were not included in this research, and their involvement in implementing the Bolivian participation policy was not mentioned in the paper or elsewhere in the literature (see other writing on the Bolivian participation policy including Clisby 2005; McNeish 2006; Medeiros 2007).

The second study of a non-government entity implementing a national participation policy is Mattner’s (2004) research into the implementation of a national participation policy in Vietnam. This included examining the role of international NGOs in the implementation of the policy. Decree 29 introduced participation in decision making at the commune level, the
lowest level of government administration. The policy was adopted as a means to quell internal civil dissatisfaction with local level governance (Mattner 2004: 123). There was also significant financial and technical support from donors and international agencies for the public administration reform agenda. Mattner (2004: 124) found that there was an uneven pattern of policy implementation. One of the challenges identified was that it appeared that local administrators were not clear on the policy’s requirements, often informing residents only after major decisions had been taken (Mattner 2004: 125).

Mattner (2004) does not provide his methodology, and he considers the general problem of why the policy was introduced and some issues with its implementation. It is not possible to conclude from Mattner’s study how important international agencies are to the implementation of the policy. He does not claim that the policy is implemented only where international donor or NGO support is provided, but he does suggest that good implementation occurred when donors and development agencies such as international NGOs assisted to implement the policy. In addition, international agencies played a key role in all the examples of policy implementation that he includes in his study. It may be that he considered the role of international development actors because there are a significant number of instances where they support the implementation of the policy, and information about them would no doubt have been more accessible to a foreign researcher than examples where the government implements its own policy, because of strict controls on access to government information in Vietnam. However, it is also possible that the policy is only, or largely, implemented where an international agency supports it.

Rather than provide an in-depth empirical examination of the policy implementation, Mattner briefly lists three examples where international donors and/or international NGOs have been key to the implementation of the policy in a particular area and sector. He notes that international development actors provided this kind of support where it complemented and fitted into their development interventions (Mattner 2004). Given his focus on general issues of implementation, Mattner does not focus on the unique issues and dilemmas posed by having international development actors implementing a government participation policy bar a passing remark about potential issues with the sustainability of the participation processes. This is the only work to my knowledge that includes any consideration of the
role of international agencies and more specifically international NGOs in implementing government participation policies. Although it provides some brief empirical examples, not enough information is provided in Mattner’s seven pages to understand the nature and implications of international NGOs taking on such a role. In this thesis I seek to add to this research gap.

2.3 Measuring Participation

The Cambodian health sector participation policy, even when implemented to the letter, may not create the necessary conditions for strong public involvement in health centre management. Therefore it is necessary to examine the experience of health centres not only with regard to the policy implementation literature, but more broadly within the context of participation. For this study, I developed an empirical framework to assess the levels of participation in each health centre. This framework is based on democratic and social justice theory, and it provides a means of conducting a rigorous analysis. To create the framework I reviewed the literature for understandings of both what good participation is and how to measure levels of participation.

2.3.1 Criteria and Techniques Used in the Literature

Although evaluative frameworks for measuring the levels of public participation have been developed, they have predominantly been for innovative forms of participation such as consensus conferences rather than for committees (Rowe et al 2004; Carson and Hart 2005). As long as committees continue to be established as a site of governance, it is necessary to know how effective they are at involving the public in government decision making, so in this study I build on these existing frameworks to develop one appropriate for studying committees.

In 1950 Bales developed a technique to determine the levels of participation of the public (cited in Hannah and Lewis 1982). The method compares how many interactions within a
group setting were initiated by members of the public and how many by government staff (Hannah and Lewis 1982). This method is quantitative only, with four variables ranked on a scale of -3 to +3 for each of a range of stakeholders, and these are aggregated to establish the level of influence of a particular stakeholder (Hannah and Lewis 1982). The method is problematic, as a range of assumptions need to be made about the influence of other stakeholders in the participatory process.

Rifkin et al (1988) developed a framework for measuring community participation in health care programs. In order to make a judgment of the overall level of participation in a particular health program, they identified that the level of public involvement in the needs assessment, leadership, organisation, resource mobilisation and management should be determined (Rifkin et al 1988). They do not provide specific questions to determine what level of involvement has been achieved for each of the five key areas in each case (Rifkin et al 1988). Rifkin et al’s (1998) framework was the tool used by Jacob and Price to assess the effectiveness of Health Centre Management Committees in two operational districts in Cambodia (Jacobs and Price 2003). They examined how readily the representatives were able to do their work depending on whether they were elected or selected (Jacobs and Price 2003).

Some of the most interesting recent research that attempts to measure and evaluate success has been within the field of deliberative democracy. Rowe et al (2004) have developed an evaluative framework for measuring the effectiveness of deliberative processes, and have demonstrated its applicability through using it to evaluate a consensus conference. Their evaluation framework measures effectiveness against nine criteria: task definition, representativeness, resource accessibility, structured decision making, independence, transparency, influence, early involvement and cost-effectiveness (Rowe et al 2004). Their framework informs my own but I have also drawn on the contributions of other scholars. I have compacted their framework, combining several of their criteria into one, and discarded some of their measures of participation. For example, a factor such as the early involvement of participants in the design and practice of the participation process is not relevant to ongoing committees. Renn et al’s (1995) book on measuring participation focuses on the two meta-criteria of fairness and competence, and these authors have
worked with others to further expand their evaluative framework. Their framework builds on Habermasian theory regarding the ideal speech situation (Habermas 1990). Fairness refers to ‘the opportunity for all interested or affected parties’ to have a legitimate role as participants in the process (Webler and Tuler 2000: 568). Competence is the ability of the process to result in ‘the best decision possible given what was reasonably knowable under present conditions’ (Webler and Tuler 2000: 568). It has been predominantly applied in the environmental sector, and although it has value, it is not the most relevant framework for the current study.

Carson and Hart (2005) considered the three key principles that are essential to deliberative inclusive processes: representativeness, deliberativeness and influence. Although representativeness in the use of deliberative processes is usually meant as descriptive representativeness (i.e. to what extent the demographic characteristics of the participants represent those of the broader population), it would be useful to see how the members of the committees in Cambodia are not only descriptively representative, but also to what extent disadvantaged groups are represented, and the broader population’s issues of concern are considered by the committees. Singleton (2000) outlines the issue of capture, and my study will attempt to identify whether broad community interests – or only particular interests – are being considered within the committees.

Grant and Curtis (2004) completed a review of evaluation criteria for participatory approaches and worked with participants to define criteria that were meaningful to them. In their study they identify a number of factors that can be used to measure participation, including that input is representative of interested publics, the community has input into the development of alternatives, the agency is clear on objectives of participation, participants know what level of power/degree of involvement they are being offered, decisions are implemented, and public concerns are identified (Grant and Curtis 2004).

Table 2.1 summarises some of the key criteria used by scholars and practitioners to evaluate levels of lay citizen and other community representative participation.
Table 2.1 Criteria from the Literature for Measuring Participation

- Representativeness, deliberativeness and influence (Carson and Hart 2005)
- Level of public involvement in needs assessment, leadership, organisation, resource mobilisation and management (Rifkin et al. 1988)
- Fairness and competence (Renn et al. 1995)
- Task definition, representativeness, resource accessibility, structured decision making, independence, transparency, influence, early involvement and cost-effectiveness (Rowe et al. 2004)
- Input representative of interested publics, community has input into the development of alternatives, agency to be clear on objectives of participation, participants know what level of power/degree of involvement they are being offered, decisions are implemented, and public concerns are identified (Grant and Curtis 2004)
- Those affected by decisions are involved, a promise of influence is made, the needs and interests of all participants are communicated, participants have input into the process, informed participation, report back of how participant input affected the decision (International Association of Public Participation n.d. b)

Although not a framework for measuring participation per se, the International Association of Public Participation’s Core Values provide guidance on practitioners’ views of best practice. These values are that people affected by decisions are involved in making them, a promise is made that people’s input will influence the decision, the needs and interests of all participants are communicated, participants have input into how they will participate, they are provided with adequate information that is presented meaningfully, and there is a feedback loop telling participants how their input affected the decision (International Association of Public Participation, n.d. b).

2.3.2 The Empirical Framework Used in this Study

Drydyk (2005: 249) argues that democracy must be conceptualised not as a category – i.e. a country or process is democratic or it is not – but according to a scale – i.e. the process is more or less democratic. Drydyk (2005: 254) and I both define participation according to the empowerment model, whereby if a process is more democratic, citizens have control
over aspects of their lives that are important to them, and citizens have a substantive freedom to achieve outcomes for themselves.

The development of criteria is vital to examining specific committees, but the criteria must be carefully chosen in order that they provide a useful measure of the level of participation. Having criteria ensures a standardised process. This enables the comparison of different committees with each other and with a theoretical framework. This is useful as it allows judgments to be made about the quality of participation and for comparisons to be made between structures and between different time periods. It also makes it easier to monitor whether convenors are using the process to manipulate the public through tokenistic performances of participation.

Steenbergen et al (2003) note that a tool to examine the levels of participation must be grounded in theory and be based on observable behaviour. The framework used in this study builds on the contributions of a range of scholars who have sought to empirically examine participation practices (Rifkin et al 1988; Rowe and Frewer 2000; Carson and Hart 2005; South et al 2005; Butterfoss 2006). Four criteria are used in this study for examining the level of participation of lay citizens and other community representatives in health centre management:

1. Operation – whether or not a committee is operating, including procedural matters such as the frequency of meetings and recording of minutes.
2. Representativeness – the extent that the membership reflects and represents the broader population, including disadvantaged groups.
3. Deliberativeness – the quality of the debate when making decisions.
4. Influence – how much influence the public has on health centre management.

These criteria were used to determine the level of public participation in the management of health centres. The four criteria are briefly outlined below.
Operation of Committee

Drydyk’s (2005: 264) democratic functioning approach articulates the question of whether an attempt at participatory development achieves a forum for stakeholders. Interpreted at its simplest, this means analysing whether or not a structure has actually been established. In the case where a policy exists that requires management committees, as is the case in the Cambodian public health sector, it is important to first establish that a committee exists in each location where it is meant to exist, i.e. each health centre. Then additional information needs to be determined regarding its operation to ensure that the committee is actually functioning in each health centre. Indicators include the frequency of meetings and performance and procedural functions required in the policy such as the taking of minutes. These indicators will demonstrate whether the committee is functioning.

Representativeness

Representation is seen as a key measure of participation (Carson and Hart 2005; Rockloff and Moore 2006). Ideas of representativeness in participatory democracy are very different from those that prevail in representative democracy (Barnes et al 2007: 68). In representative democracy, the claim to represent others comes through elections. Legitimacy for participatory processes depends on the ability of participants to represent those not included (Parkinson 2003: 180; Parkinson 2004: 370). In deliberative and participatory democracy it comes from participants being similar to the community or public that they are representing (Parkinson 2004: 373), or participants representing the interests of different groups, or having minority or disadvantaged groups in the membership. “The community” and “the public” are social constructions (Barnes et al 2007: 63). Shaw (2008) has identified many (often conflicting) meanings of the term community, and highlights the ambiguous and contested nature of the term. The term “community” ‘is fraught with complications and can hide internal... hierarchies’ (Busza 2004: 195). Communities are not homogenous, and cultural practices that reinforce power and their interactions with formal institutions need to be examined (Bebbington et al 2004). There are many “publics”, and it is important that their interests are represented.
Lay citizens and other community representatives can be chosen to reflect proportions of different types of people in the broader community, and are then seen as being descriptively representative. Descriptive representativeness is relatively easy to assess, as long as a demographic profile is available for the broader population and the lay citizen and other community representative committee members. It may not be the most appropriate measure of representativeness for committees though, as they typically have a small membership (often under ten people), and ensuring that this membership reflects the demographics of the broader population may be difficult. The term “minipublic” was coined by Fung (2003; drawing on Robert Dahl’s minipopulus), to mean a small selection of citizens who were meant to represent the larger population. Descriptive representativeness has been criticised because the traits that are to be replicated in a “minipublic” are subjectively chosen (Baum et al 1997), and when such a small sample is chosen it can be difficult to get representation of a range of characteristics. The policy itself gave some guidance on representation, calling for equal male and female lay citizen and other community representatives, and for the committees to include poorer citizens. How committee members are selected will affect the level of representation. Both appointment through traditional mechanisms and elections of lay citizens and other community representatives are problematic as it is usually only those who are relatively well-off and politically engaged who become involved in the committees (Mok 1988: 167). By contrast, if people can be randomly selected it makes the sample of lay citizens and other community representatives a “minipublic” that is more likely to represent broader public opinion (Fung 2003). An alternative way to consider the level of representation is to determine whether marginalised and disadvantaged groups have membership on the committee.

**Deliberativeness**

The level of deliberation is also a useful criterion for examining the level of participation (Carson and Hart 2005). Deliberation does not automatically happen when people are put in a room and invited to talk together (Barnes et al 2004), so what exactly is deliberation? Habermas is one of the key deliberative democratic theorists and his principles of deliberative democracy identify the ideal speech situation. This situation provides a
benchmark of ideal practice for deliberative exchanges, even though it is acknowledged that it is rarely achieved (Habermas cited in Steenbergen et al 2003: 44). Habermas’ six principles are that values acceptable to all can be discovered through debate open to all, that deliberation requires justification of assertions, that participants should consider the common good, that others are respected, that the process is constructive with participants at least trying to move towards consensus and that people say what they really think (cited in Steenbergen et al 2003: 25-26).

Deliberative democratic theorists agree on three fundamental principles: that deliberation is inclusive, judgmental (requires deliberation) and dialogical (that this deliberation happens in a public and open environment) (Pettit 2001). It involves the weighing up of different options – both people’s assertions and their stated reasons for having them. Deliberation consists of both consideration (internal reflections) and discussion (the discursive element) and it happens at both an individual and a collective level (Goodin and Niemeyer 2003). People decide individually their own position on an issue and then within a group debate different ways of resolving problems and challenging and justifying the positions of others and themselves (Goodin and Niemeyer 2003; Hartz-Karp 2004/05: 14). Deliberation involves the transformation of preferences that comes about through participants having to justify their positions (Elster 1998; Gutmann and Thompson 2004). In deliberative forums the goal is often to discover or move towards consensus.

Deliberative democracy scholars call for deliberation within participation practices as a method for improving the quality of decision making (Pettit 2001: 287). Deliberation is seen as a key process required for making “good” decisions in participatory processes (see Pettit 2001: 287). “Good” in this sense has several meanings: the views of citizens will be informed (Sunstein cited in Pettit 2001: 287), the process results in equitable decisions in the public interest (Ackerman and Fishkin 2002), and deliberation makes decisions legitimate leading to greater public acceptance of them (Pettit 2001: 288). Deliberation is also claimed to achieve equality between all participants and results in rational decisions (Dutwin 2003: 240). The “deliberativeness” of a discussion is really a measure of the quality of debate and how much rigorous consideration has been given to the decisions that are made. An increase in the level of deliberation within a committee is indicative that decisions
are more considered, and this can be interpreted as increased quality – and therefore level – of participation.

Although applied to parliamentarians rather than citizen participants, Steenbergen et al’s (2003) comprehensive analysis of parliamentary transcripts in the United Kingdom based on Habermasian theory is useful as it gives shape to deliberation. It identifies indicators of deliberation that can be adapted to a range of contexts. Their framework is slightly problematic, as the degree of inclusiveness is based on whether speakers acknowledged that they felt disturbed by interruptions or not. This fails to take into account which people are and are not participating, so this particular criterion is a crude measure of the level of deliberation. Steenbergen et al (2003: 43) note that one of its limitations is that it can only be used with discursive texts and does not take account of non-verbal clues or tone of voice etc. In the study presented in this thesis, the levels of deliberation were determined by observing meetings and analysing their transcripts and conducting in-depth qualitative interviews about the experience of Health Centre Management Committees.

**Influence**

Influence is an important criterion for assessing participation processes and has been used by other scholars (see for example Hannah and Lewis 1982; Carson and Hart 2005). “Influence” is very closely correlated with and is sometimes used interchangeably with the terms “power” and “impact”. There has been little empirical research into the influence that public involvement has on decision making, even in processes that are designed to bring communities into the decision making process (Waage 2003).

Lukes’ (1974) three dimensions of power – already discussed – are relevant for analysing the influence of lay citizen and other community representative members of the Cambodian Health Centre Management Committees. Lukes’ first dimension of power can be examined by understanding to what extent lay citizens’ and other community representatives’ views are represented in the decisions taken by the committees. Lukes’ second dimension of power can be explored by considering how the official and unofficial
agendas for the meetings are set, and who determines how meetings are run. How the interests of public members of the committee are shaped by the staff of the convening agencies is of interest for examining Lukes’ third dimension of power. Drydyk (2005: 263) notes criticisms that regardless of the decision making done by participants, the broader range of options has been set by the institutional agendas of convenors, and therefore participation can make communities just appear to be autonomous whereas their actions are guided by others. Following the lead of Hannah and Lewis (1982), in this study I will examine both the influence of community representatives over the committee’s decisions, as well as the influence of the committee on health centre management.

2.4 CRITIQUES OF NATIONAL AND INTERNATIONAL NGOs IN DEMOCRACY AND DEVELOPMENT

The empirical framework was used to identify what happened with power relations in the committees. It guided the questions asked in interviews and observable aspects of participation. However, this study was also informed by other factors and concepts that emerged as important during fieldwork, in particular, the role of international NGOs. This became evident during post-fieldwork analysis, and cannot be adequately accommodated within the empirical framework outlined above. Although the role of international NGOs implementing government participation policies has been minimally studied, in section 2.4 I draw on literature that examines the political nature of NGO work – especially that of international NGOs – and the tensions involved in international agencies performing political functions (see for example Pratap and Wallgren 2000 cited in Ulvila and Hossain 2002).

NGOs have been praised for being effective, flexible, innovative, having an ability to reach the poor and for being an important part of civil society (Kelpin 2001: 21; Markowitz 2001: 40). They are also seen as bodies that are able to promote local participation and democracy (Clarke 1998: 41; Markowitz 2001: 40; Choup 2003: 25). NGOs have generally been described over the last decade as ‘a force of democracy’ (Tvedt 2002: 364), and donors and academics alike have embraced NGOs as a democratising force (Clarke 1998; Mercer 2002).
NGOs are expected to contribute to democracy through challenging non-democratic practices, promoting democratic political culture and pluralising political space (Bratton 1989: 570; Clarke 1998: 49). NGOs also implement participation processes within their own practice (see for example Hailey 2001; Zweekhorst 2003).

NGOs are well regarded in much of the literature for their contributions to and role in participatory development. Kelpin (2001: 13) mirrors others when he says that NGOs are key agents in participatory development. NGOs have received favour from the political left and right, the former for their supposed role in empowering communities and the latter for decreasing the role of the state in an era of privatisation of government services (Bratton 1989: 569-570). One of the reasons for the prominent rise of NGOs has been the perception of a comparative advantage in community development that has been described as grassroots and participatory (Buckland 1998: 236). From the early 1980s onwards, donors channelled increasing amounts of funding into NGOs rather than governments (Clarke 1998: 37).

Although views of NGOs are generally positive, there exists an extensive academic literature critical of NGO work and of academic studies of NGOs and their practices (see for example Zaidi 1999; Mercer 2002), and it is these critical approaches that I focus on here. Mercer (2002: 6) is particularly concerned about the widespread acceptance of the assumption within much of the NGO literature that NGOs are democratic actors. Empirical research in Bangladesh and Nepal seems to support this concern; research by Ulvila and Hossain (2002: 152) suggested that NGOs there played no role in democratisation. However, their study did not consider the role of human rights NGOs, and this limits the strength of their findings as human rights NGOs are likely to play a key role in democratising activities, as they pursue political rights for citizens.

The literature on NGOs has been criticised for being activist in flavour, largely produced by insiders and providing too simplistic an analysis of development dilemmas, and for creating myths of NGOs as ‘independent, value-driven, participatory, and accountable and non-profit in nature’ (Nauta 2005: 149). The reliance on NGOs was being criticised in the mid-1990s particularly as NGOs took on some of the regulatory responsibilities of governments.
(Costa et al 1997: 141). It has been argued that NGOs do little to promote participation and their results in participation are unimpressive (Ulvila and Hossain 2002: 161; Platteau 2004: 224). Participation in NGO practice can often be a tokenistic process of legitimating decisions that have already been made within the organisation (Zaidi 1999: 266). Wiggins and Cromwell (1995: 417 cited in Zaidi 1999: 266) examined seed distribution in 19 NGOs in nine countries and found that although many of the programs included local groups of farmers in implementation, ‘the farmers had much less say in planning and policy making’, and NGO staff dominated these processes. Scholars are also concerned that NGOs are internally undemocratic (Kuzwe 1998), but the broader focus is on how they interact with and are part of broader democratisation processes. NGOs have been criticised for being staffed by elites, working in favour of elite interests and failing to see or address broad institutional issues of power and its relationship to poverty (Zaidi 1999: 269; Ulvila and Hossain 2002: 149).

In one of the few studies that examines the role of NGOs in the politics of development across the developing world, Clarke (1998: 40) raises concerns that studies of NGOs have been relatively apolitical whereas NGOs are inherently political, and this incongruence has led to an ‘inadequate, explicitly normative, interpretation of NGO ideology’. Ulvila and Hossain (2002: 150) echoed Clarke’s concerns but argued that this de-politicisation is insidious, enabling state bureaucratic power to be expanded through the spread of development discourse and practices. Traditional social hierarchical structures can be replicated in the relationships between NGO staff and community beneficiaries as dependencies on NGO assistance begin to occur, mirroring patron-client relationships (Costa et al 1997: 142).

International NGOs have been charged with deepening both democracy and civil society and have increasingly focused on civic education, capacity building of local civil society, lobbying and advocacy (Hickey 2002: 842). This civil society approach has been criticised though for being used to ‘transmit narrow neoliberal agendas to developing countries’ rather than supporting alternative forms of democracy within them (Hickey 2002: 842). Gary (1996: 150) noted the correlating trends in Africa between the proliferation of NGOs and structural adjustment, which rolled back the state. NGOs have ‘captured considerable
institutional space’ as government services and activities have increasingly been privatised (Malhotra 2000: 659; Keese and Argudo 2006: 115).

NGOs have received mixed receptions from governments. Bratton (1989: 569) demonstrated in the late 1980s how governments responded ambiguously to the involvement of NGOs in rural development, valuing the economic resources that NGOs can raise but resisting the political pluralisation. A common critique of NGOs is that they are unable to act on a large scale, so this has led to them trying to influence policy to increase the impact of their work and approaches (see Dawson 1993; Buckland 1998: 238). International NGOs are often involved in governance, that is, being involved in the policy process and making and implementing decisions about matters of concern (Brinkerhoff 1999: 59-60). Brinkerhoff (1999: 61) notes the power differential in favour of international NGOs when working with local counterparts and argues that the objectives of ‘the relatively stronger partners [in governance processes] tend to prevail’. International relief and development NGOs have large professional staffs, field offices in many countries, and worldwide budgets comparable to the smaller states in Africa (Bratton 1989 cited in Gary 1996: 150), putting international NGOs into the position of stronger partner. NGOs are important political players and their bargaining strength vis-à-vis government is much greater than that of ordinary citizens (Platteeu 2004: 227). The democratic capability of communities is extremely weak compared to national governments and international organisations (Linklater 1999, Porter 2001 and Nielsen 2003 all cited in Drydyk 2005: 264). The current resource transfer paradigm in aid has asymmetrical and often unaccountable power relationships (Malhotra 2000: 655). Although Malhotra relates this to the relationship between Northern and Southern NGOs, I will argue that similar relationships exist between international NGOs and host governments, particularly where the development relationship between them is one of resources transfer.

Ulvila and Hossain (2002: 161) have focused on the tensions implicit in the involvement of organisations operating with foreign funds (whether local NGOs funded by foreign donors or international NGOs) in local political activities related to governance, such as becoming involved with local elections through supporting candidates and similar actions. Firstly, their involvement challenges the national sovereignty of the country they are operating in,
as these overseas-funded agencies perform governance roles. Secondly, building up a political movement has a number of contradictions including fragmentation of the political movement to NGOs, and loss of a strong local political base (Ulvila and Hossain 2002, drawing on research by Pratap and Wallgren, and Isomaki).

Although decentralisation processes are feted for making government services more responsive, Charlick (2001) has found that this only happens where projects with strong NGO support are linked with local government and exert influence over policy at other levels of the political system. It has also been found that wealthier and more educated people join leadership positions where they are supported by NGOs ‘because of the attractiveness of outside funding (Plateau 2004: 227).

Kelpin (2001: 21) criticises studies for not paying enough attention to the interactions between NGO staff and both government and local people. NGOs play a key intermediary role between the government and local people (Kelpin 2001: 21) and analyses of this role and these relationships are lacking (Markowitz 2001: 42). As already mentioned, in Kohl’s (2003a) study of the role of national NGOs in the implementation of the Law of Popular Participation in Bolivia he found that the involvement of national NGOs brought benefits such as the provision of expertise and finances. However, their involvement was problematic and resulted in varied levels of public engagement as different NGOs approached citizen participation differently; consequently the participation policy in Bolivia did not achieve uniform implementation or results across the country (Kohl 2003a). Mattner’s (2004) study of the implementation of a participation policy in Vietnam included mention of the role of international NGOs in policy implementation but no significant analysis of this role and its implications. Examining the role of NGOs mediating the relationship between citizens and state in participatory processes remains under-studied, and the role of international NGOs in implementing government participation policies has until now rarely been researched. This thesis contributes to this gap in the literature.
CHAPTER THREE. CAMBODIAN DEMOCRACY, DEVELOPMENT AND THE HEALTH PARTICIPATION POLICY

In this chapter I detail the participation policy context. I begin with a brief history of Cambodia as it provides the context for modern development problems and programs. I then examine Cambodia’s social organisation, governance issues and relationships, its history and the status of participation, and its development context. I conclude the chapter by outlining the content of the participation policy.

3.1 A BRIEF HISTORY OF CAMBODIA

Cambodia is in South-east Asia, bordered by Thailand, Laos and Vietnam. Between the first and eighth centuries the people living in the floodplains of the area that is now Cambodia came under the centralised rule of the Funan and Chenla empires, before the Angkorian empire flourished between the ninth and thirteenth centuries (Conway 1999: 28). The power of this empire waned from the fourteenth century onwards, and the French colonised the area as part of French Indochina in 1863 (Chandler 1998: 5; Conway 1999: 30). Cambodia officially obtained independence from France in 1953, gained military independence the following year, and held their first elections in 1955 (Chandler 1998: 187). Although Prince Sihanouk won this election, he maintained power for the next fifteen years only through political coercion, by destroying opposition, and handpicking those who joined the National Assembly (Chandler 1998: 189).

In 1970, Prince Sihanouk was overthrown in a military coup led by General Lon Nol. Civil War followed. Lon Nol reigned until April 1975 when the Khmer Rouge came into power (National Institute of Statistics and Directorate General for Health 2001: 2). The Cambodian genocide perpetrated by the Khmer Rouge between 1975 and 1979 is well
known. It is accepted that around 1.5 million people were killed during this period (Conway 1999: 31).

In 1979, the Khmer Rouge were overthrown, strongly assisted by the Vietnamese government. The Vietnamese took power and installed a government made up of Khmer Rouge cadre who had deserted to Vietnam during the Pol Pot era (Conway 1999: 31). The government during the Vietnamese period was autocratic and ‘there was no place for democracy’ (Blunt and Turner 2005: 76). Cambodia was renamed the People’s Republic of Kampuchea and in 1989 when the Vietnamese withdrew it was again renamed, this time as the State of Cambodia (Chandler 1998: 227; National Institute of Statistics and Directorate General for Health 2001: 2; Blunt and Turner 2005: 76). During the period of Vietnamese invasion, international aid – mostly in the form of emergency relief – was significant and much of it was delivered by international NGOs (Conway 1999: 33; Lanjouw et al 1999: 230).

In October 1991 the Paris Peace Accords were negotiated (Conway 1999: 35); these established the United Nations Transitional Authority in Cambodia (UNTAC) (Hughes 1996: 19). Its mandate ‘was incorporated into the Paris Agreements on a Comprehensive Political Solution to the Conflict in Cambodia’ (Hughes 1996: 19). UNTAC operated for two years until October 1993 (Chandler 1998: 240). In 1993 elections were held under the supervision of UNTAC and Cambodia was renamed as the Kingdom of Cambodia (National Institute of Statistics and Directorate General for Health 2001: 2). Further elections were held in 1998; these were characterised by political intimidation and politically motivated assassinations (Conway 1999: 38). In 2002 the first commune council elections were held (Andersen 2004). Communes are one of the smallest administrative units and were created during French rule (Hean 2005), although until this century they were administered by appointed officials rather than being an elected local government body.
3.2 Cambodian Social Organisation

Cambodia is a strongly hierarchical society and has been characterised as such for many decades (Steinberg et al 1959; Cady 1966; Munson et al 1968; Bit 1991; Devan 1994; Hughes 2001). Relative positions of status are widely understood and acknowledged within Cambodian society (Oveson et al 1996). A key Cambodian social value is that ‘a minor must defer to a superior’ (Mak 1997: 168). Status is linked closely with age (Oveson et al. 1996). Older people are accorded more status and respect than their younger counterparts (Mak 1997: 164). Status is also related to wealth and connections with ‘friends-in-high-places’ (Marschke 2005: 31).

Cambodia is patriarchal (Phan and Patterson 1994: 3 and 36), with women having a lower social status than men (Beufils cited in O’Leary 2006: 30). A common attitude is that “men are always right” (Phan and Patterson 1994: 3). Women are expected to be demure and obedient (O’Leary 2006: 30). Women are ‘not considered… to be good enough for village official or political positions’ and men have much stronger political power (Mak 1997: 171). Ledgerwood (cited in O’Leary 2006: 30) suggests that male biases in Buddhism (for example, only men can achieve enlightenment) support male domination in the political arena.

Cambodia’s political traditions have centred on having a ruler, and therefore have not been ‘conducive to a participatory and representative process’ (Downie and Kingsbury 2001: 61). Decision making in public life has generally been done by those in official positions of authority (Vijghen and Ly 1996). Having a position in the government or within an organisation such as an NGO also accords its own status. Formal positions are an important component of high social status in Cambodian culture. Decision making power is concentrated in the hands of formal and informal community leaders, who enjoy greater status than lay citizens (Biddulph 1996). Village chiefs are widely respected authority figures (Phan and Patterson 1994). Villagers are expected ‘to demonstrate korob, kaud, klach – “respect, admiration, fear” – towards the local authorities and their civil servants’ (Ojendal and Kim 2006: 518).
The notion of public participation in government decision making challenges the hierarchical and status-based distribution of power. Marschke (2005: 30) cites a Cambodian proverb that illuminates power relations between those of different levels of status:

*Small people do the work, the big give orders; when the small will challenge then the big will kick.*

This proverb suggests some of the challenges that face participatory structures when those with low social status are expected to critique, as part of their role, those of higher status. Another key aspect of Cambodian life is the importance of maintaining social harmony (Daubert 1996: 4). Conflict is seen negatively and holding views different to those in positions of authority is discouraged (Marschke 2005: 30). It is considered more important to maintain stability than to cause conflict by questioning or challenging others (Marschke 2005: 30). This is particularly true in relationships between people of different status.

There has been much discussion and debate as to whether community exists in Cambodia (O’Leary 2006: 15). The Khmer Rouge regime damaged many social connections and eroded trust between people (O’Leary 2006: 16). However, there is strong support for the notion that community exists; van de Put (1997: 3) found that although secondary sources suggested that there were low levels of social interaction, Cambodians reported high levels of community. Most research about Cambodia is conducted by foreigners (Conway 1999: 69), who may have a limited understanding of Cambodian notions of community if they are unlike the researcher’s country of origin. There are few organised social structures within villages for example, yet this may be a reaction to forced collectivisation during the Khmer Rouge regime (Mak 1997: 181). Cambodians have identified that their spending leisure time together and participating in communal activities are key indicators of community (van de Put 1997: 2-3). Reciprocity exists within rural society (Mak 1997: 185; O’Leary 2006: 15-16), and the **wat** (temple) is a central component of village life (van de Put 1997: 3). My own experiences of living, working and conducting fieldwork in Cambodia support the notion that there are strong community bonds, including within the study area.
3.3 **Democratic Government in Cambodia – Discourse vs. Practice**

The government administrative structure in Cambodia is as follows. The smallest administrative unit is the group (around 10 households), then a village, and several villages are grouped together into a commune. The next three levels are district, province and nation. Village chiefs, district leaders and provincial governors are appointed positions (O'Leary and Simmons 1995: 148). At a commune level, those responsible for governance include the councillors, village chiefs and their assistants and potentially non-council members who are on council sub-committees (Nhean 2004: 39). The relationships between the state and the public have been hierarchical for many centuries (Turner 2002: 363). In this section I will examine elections and their associated functions. The discussion on community participation in government decision making will follow later in this chapter.

Cambodia appears at first glance to be a democratic nation. It has held national elections regularly since 1993, it has an independent media, and there is a prolific range of NGOs forming civil society. It has all the basic tenets of democracy. Yet, some scholars argue that although the discourse of democracy is very popular, there is little evidence of the government sharing power with the people or with other stakeholders in any democratic fashion (Beresford 2005: 139; Hughes 2005). McCargo (2005) argues that there is no democracy in Cambodia, but rather an empty performance of it; he notes that the structures of governance have changed in recent decades, but there is little change in how things are done.

In recent Cambodian political history, there is much to support McCargo’s argument. The National United Front for an Independent, Neutral, Peaceful, and Cooperative Cambodia (FUNCINPEC) party won the national elections in 1993. However, the Cambodian People’s Party (CPP) had been reigning and managed to negotiate an outcome in which power was jointly shared between them and FUNCINPEC (Springer 2005: 101). This outcome served to undermine public faith in democracy. The CPP keeps its power in the countryside through its control of patronage and government resources, mainly derived from international aid (McCargo 2005: 100). Despite there now being democratically elected local government in the form of commune councils, there has been little devolution
of decision making power to them (Blunt and Turner 2005: 75). Nhean (2004: 44) also found that despite occasional village meetings being convened by commune councils, their ‘decisions are grossly ignored by the decision makers’. Hughes (2005) examined an electoral education program that was ostensibly intended to open up spaces for voters to become involved in the political system through televised debates between candidates. The televised candidate debates were organised by an international NGO the National Democratic Institute. The debates were not an opportunity for citizens in the audience to ask questions and probe candidates, but rather, they were expected to be passive listeners as the candidates took the floor (Hughes 2005). Hughes (2005) was concerned that this structure was portrayed as democratic but was not because it did not involve citizen deliberation or dialogue with the candidates. These examples all demonstrate that the performance and appearance of democracy is not necessarily supported in practice.

Beresford (2005: 136) argues that the focus of donors aiming to bring about democratisation in Cambodia has been on installing democratic institutions – ‘periodic elections, administration reform, and dispute resolution via recourse to the law and judiciary’ – rather than on supporting indigenous democratic movements. The assumption is that Cambodians will be habituated into democratic practice through the establishment of these institutions. The emphasis on institutions is stressed more than ‘actual public participation in decision making’, to the cost of participation and resulting in a superficial democratisation process (Beresford 2005: 137, 139). In addition to the undemocratic nature of the televised candidate debates described above, Hughes was concerned about the heavy reliance on the international NGO that convened the debates to ensure political neutrality. She argued that this ‘risked reinforcing a prevalent view in Cambodia that democracy represents a gift of international democracy promoters’ rather than resulting from the struggles of the Cambodian people (Hughes 2005: 93).

3.4 Development and Non-Government Organisations (NGOs) in Cambodia

Cambodia has a population of almost 13 million people (National Institute of Statistics 2004). It ranks 131st on the Human Development Index out of 177 countries with data
Cambodia is a “developing country”, one of the poorest countries in South-east Asia (Royal Government of Cambodia, 2003: ii). Gross Domestic Product (GDP) per capita in 2004 was US$354 (UNDP 2006). Thirty-five percent of Cambodians live below the national poverty line, and 77.7% earn less than US$2/day (UNDP 2007: 239). The population is very young with 37.6% of citizens aged 15 or younger (UNDP 2007: 255).

There are major health issues in Cambodia. The population’s health status is among the worst in South-east Asia (Soeters and Griffiths 2003: 74) and the Western Pacific Rim (Grove et al 2002: 4). Its health issues have persisted since the 1950s (Annear 1998: 194) and have been compounded by a recent history that involves extensive years of civil war and genocide. The Khmer Rouge closed all health facilities and killed many medical staff (Noirhomme et al 2007), and the resulting poor medical services have contributed to poor health in Cambodia. Life expectancy at birth is 54 years (National Institute of Statistics 2004: 2). Cambodia has high rates of infant, maternal and under-five mortality rates (Royal Government of Cambodia 2003: 5). The Maternal Mortality Ratio is 437.0 per 100,000 live births, and the infant mortality rate is 95.0 per 100,000 live births (Royal Government of Cambodia 2003: 2). There are high levels of malnutrition, particularly among women and pre-school aged children (Royal Government of Cambodia 2003: 9). Preventative disease is prevalent (Annear 1998: 196). The government has few resources and allocates little to health. It spends 2.1% of GDP on health (US$7.43 per capita) and citizens spend an additional 8.8% of GDP privately on health (UNDP 2006).

In response to these development issues, Cambodia receives a lot of international assistance in the form of international aid and development programs. Aid has been a key source of national revenue in Cambodia since 1954, with successive governments remaining dependent on it (Lanjouw et al 1999: 230). In 2004 Cambodia received US$478.3 million in aid, or US$34.70 per capita (UNDP 2006), equal to 9.7% of GDP. Cambodia is one of the most highly aid-dependent countries in the world (Godfrey et al 2000: i; UNDP cited in Marschke 2005). Donors have particularly supported capacity building, public participation and governance reform programs in Cambodia (Blunt and Turner 2005: 77). Phnom Penh is the centre of an ‘aid-funded sub-economy that hinges on development agencies and projects’ (McCargo 2005: 102). Aid distorts the local economy as a high proportion of the
best educated Cambodian workers are employed by donors or international NGOs (Godfrey et al. 2000: 1).

International NGOs are one of the key recipients of aid monies, and national NGOs also receive significant amounts. Between 1992 and 2001, ‘the donor community has disbursed more than US$4 billion to – and through – NGOs’ (CDC cited in Richmond and Franks 2007: 33). International NGOs held prominent roles in emergency relief efforts throughout the 1980s (Conway 1999: 33), and since the early 1990s most money has been channelled into development programs rather than emergency relief efforts. Donors and international NGOs have ‘virtually taken over the funding of education, health care, social welfare, rural development etc.’ (Godfrey et al 2000: 1). This level of financial input provides them with significant influence within these sectors. Hughes (2005: 80) notes that internationally oriented NGOs focus on service delivery, but ‘their role in sponsoring and encouraging broad public participation in democratic debate is less prominent’.

International NGOs and donors play a significant role in the management of the health sector in Cambodia, through contracting and supporting the delivery of health services and national health programs (Save the Children Australia 2001). Since 1995, international NGOs have been contracted by the government to manage health operational districts in many areas (Soeters and Griffiths 2003). International NGOs are key players in implementing government policy and other development programs, including within the health sector. There are 98 NGOs working in the Cambodian health sector and of these, 49 are international NGOs (Medicam 2005). Most Cambodian health policy is formulated outside Cambodia and is Western in origin (Lanjouw et al. 1999: 231). The international development community assisted with the development of the community participation policy in the health sector (Ministry of Health 2003).

### 3.5 Participation in Cambodia

Participation has a mixed history in Cambodia. Traditional models of decision making are authoritative and participation is not encouraged (Biddulph 1996). Biddulph (1996) notes
that ‘a society where authority has been traditionally accepted has had silent acceptance reinforced’ by the terror people experienced under the Khmer Rouge. During the genocidal Khmer Rouge regime (1975 – 1979), all members of the public had to do whatever the government wanted them to, including attending daily meetings during which participants had to confess all the “bad things” they had done that day (Hean 2005). Members of the public were discouraged or actively prevented from participating in decision making, despite their forced attendance at meetings (Downie and Kingsbury 2001: 45). Wrong decisions could result in severe punishment or death, and it has been argued that this has resulted in a reluctance to make decisions in contemporary Cambodia (Downie and Kingsbury 2001: 51). During the Republic of Kampuchea (1979 - 1989), forced attendance at meetings also occurred and the public had no choice about participating in a charade of participatory decision making; their views were rarely taken on board (Hean 2005). Since the period that the Khmer Rouge came to power, village meetings have been ‘the forum by which decisions of the authorities have been transmitted to the people and been ritually approved’ (Biddulph 1996).

People are reluctant to come to meetings now because they have ‘been overdone’ in the past and members of the public see that they have little influence as the government has never responded to public concerns as a result of these forums (Hean 2005). Due to traditional power relationships and recent history, the public is generally afraid of those in authority (Grove et al 2002), and are unlikely to speak out against decisions they disagree with that have been made by those in positions of power (Biddulph 1996). This history has no doubt had lasting impacts on the degree to which citizens are willing to trust those in power and/or the government.

Despite the hierarchical nature of Cambodian society, there have been a number of protest movements that have challenged the role and dominance of the state and thus created new political space for citizens (Hughes 2001: 59). However, this public space has been increasingly constrained by the government (Springer 2005). Although Curtis (cited in Downie and Kingsbury 2001: 50) found that since UNTAC some people have displayed a new assertiveness rather than practising the traditional deference to authority, Downie and
Kingsbury (2001:47) argue that patron-client culture has been reinforced during this same period.

There has been a strong tradition of passive participation in Cambodia, in the form of volunteering. Volunteering is a part of traditional life, particularly through members of the public donating their labour and food to monks, in return for merit and status for their next life consistent with Buddhist beliefs (Hean 2005). The history of both involvement in meetings and volunteering has not been active participation in decision making. Rather, it has been about passively agreeing to decisions made by power holders and providing free labour.

Cambodia’s trends in development policies have mirrored those in international development discourse and practice. This has included an increase in participatory development; participation processes have become central to many development projects and government processes. In Cambodian government decision making, some of the areas the public are to participate in are: local governance, through the decentralisation program called Seila (Andersen 2004); co-management of natural resources in the forestry, fisheries and coastal management sectors (Marschke and Nong 2002; Ken 2003); and land-use planning through the Participatory Land Use Planning initiative (Turner 2002). The structures for participation across these processes vary, but include management committees (Marschke 2003) and one-off processes where the public is able to provide feedback to government decision makers.

International agencies have introduced a range of participation techniques to Cambodia, and there are a range of participatory technologies that have been used (Biddulph 1996). These include Participatory Rapid Appraisals and Participatory Rural Appraisals, which have been and continue to be used by many development agencies in Cambodia and by researchers (see for example Conway 1999). These forms of participation predominantly cast participants in the role of information provider rather than decision maker. Although Participatory Action Research has the potential to engage communities as co-researchers in development programs, Busza’s (2004) application of this method in Cambodia demonstrates that external researchers can remain in decision making positions and so-
called co-researchers can continue to act as information providers. There are also barriers to individual participation that have been identified in Cambodia. These include women’s illiteracy and exclusion from decision making, and poverty, which results in low income people spending all their time securing livelihoods and not having time available to participate (Hean 2005). This recent historical and contemporary experience of participation in Cambodia provides background about the context into which the participation policy in the health sector was introduced.

3.6 THE PARTICIPATION POLICY

Prior to 1995, health facilities in Cambodia were provided according to administrative boundaries between communes, districts and provinces. Communes were supposed to have their own clinics, each district a hospital and each province a larger hospital (Ministry of Health 1995). The resources available to the public health sector were insufficient to provide all the required facilities. There are 1621 communes in Cambodia, but resource constraints resulted in either un-staffed clinics or no buildings at all in many communes, leaving much of the population without a primary health care facility (Soeters and Griffiths 2003: 75).

In 1995 the Cambodian public health system was reformed (Ministry of Health 1997). The new structure was outlined in the Health Coverage Plan (Ministry of Health 1994). Commune clinics were abolished and for the purposes of health care the landscape was divided into operational districts and health centre catchment areas. There are 76 operational districts in the country (Soeung et al 2004: 9). The reforms were intended to provide facilities on the basis of population size. Health centres were to be provided for every 10,000 people, and a referral hospital for every 100,000 (Ministry of Health 1995). There is a tertiary hospital available in Phnom Penh. The area covered by each health facility is known as its catchment area.

These reforms reduced the number of required primary health care facilities by almost half to only 970 health centres nationally (Soeung et al 2004), meaning the government was
more able to staff and supervise the practice in the health centres. Each one serves between 10 and 25 villages, depending on how densely populated the area is. Although their official focus is preventative health care, for example administering national immunisation programs, conducting ante-natal checks and baby clinics and doing health promotion work, much of their workload is devoted to providing basic curative services. They have outreach programs, whereby health workers visit each of their villages on a monthly basis. During outreach the midwives do ante-natal checks and other staff offer general health clinics, mostly attended by children with minor illness or injuries. More serious patients attend the district referral hospital directly. Referrals are not needed but can be given by the health centre. Even in the late 1990s, the public system was underutilised. This is due to the large number of private alternatives, public health practitioners being known for their rude manner and health centres often being closed as the public health practitioners run their private practices (Beacham 2004). The main reason that public health staff run their own private practices is because their pay is ‘often set below the poverty line’ (Noirhomme et al 2007: 248).

The reform process also involved establishing community participation structures, the need for which was identified in one of the earlier reform documents (Ministry of Health 1995). The government’s position on participation is outlined in two parallel sets of documents. The first is related specifically to community participation and the second more generally to Primary Health Care. Each set consists of a “policy” and “operational guidelines”. The Policy on Community Participation in the Development of Health Centre was adopted as a national policy in 2003 (Ministry of Health 2003). The Operational Guidelines for Community Participation in Health Centres pre-dated the policy by two years (Ministry of Health 2001b). A final version of the operational guidelines has not been produced. The National Policy on Primary Health Care (Royal Government of Cambodia n.d.) was adopted around the same time and includes broader issues rather than just participation. The Implementation Guidelines for the National Policy on Primary Health Care provides more detailed information about that policy’s requirements (Inter-Ministerial Committee on Primary Health Care 2002). Both sets of documents detail the same participation structures and processes, with only one variation of note that I will return to when discussing the membership of management committees.
Unless stated otherwise, when I refer to the “participation policy”, I refer to the wording and page numbers in the Policy on Community Participation in the Development of Health Centre. The participation policy was co-written by the Ministry of Health and a United Nations agency (referred to in this thesis as UNC), with significant input from international NGOs and others in the international development community. The development of the participation policy will be examined in detail in Chapter Eight, but here I present the content of the policy documents.

The policy requires two participation structures at the primary health care level (Ministry of Health 2003). The first of these is Feed Back Committees; they are now known as Village Health Support Groups (VHSGs) and have also been known as Information Back Committees. All three terms were used by respondents in this research. The VHSGs include members from every village that the health centre serves. The role of the VHSG is to provide health centre staff with information on health issues in the community, provide the public with information on health promotion, and assist on outreach activities in the communes (Ministry of Health 2001b). The main purpose of the VHSGs is information exchange between the health centre and the community (Ministry of Health 2003: 12). They do not play a role managing the health centre but fulfil relatively menial tasks during outreach activities and are expected to educate the public about health issues. The second structure required under the policy is Health Centre Management Committees (HCMCs). These include representation from every commune that the health centre serves, and are about a third the size of VHSGs. HCMCs provide a forum that enables the public to play a decision making role in the management of health centres. Their purpose is co-management (Ministry of Health 2003: 12). This study focuses on the experience of HCMCs as they are a body that is to participate in government decision making, compared with the passive forms of participation required from VHSGs.

According to the policy documents, the strengths of community participation in the health centre speak to the aims of the policy and the tasks that community participants are expected to undertake. The strengths are:
• Increase utilization of services with improved quality through increased accountability and transparency of the health centre team in managing the health centre resources and feedback (comments/complaints) from community.

• Make the health centre services more responsive to the health needs and health problems of the community through their participation in the planning process at the health centre.

• Facilitate the delivery of health messages from the health centre to the community through Feedback Committee members [known as and referred to as Village Health Support Group in the study area and elsewhere in the policy documents] to keep community members informed about the health center activities.

• Increase the resources available for running the health centre and provide incentives for the health centre staff through user charges; in some places the community can make important contributions in terms of labor, land, materials.

• As community members pay for the services, the community has an important voice in running the health centre in terms of co-management and co-financing of the health centre, e.g. setting fee levels, identification of the poor community members for exemption (Ministry of Health 2003: 2 - 3).

As can be seen from the strengths outlined within the policy, there were varied types of participation that were desired. These ranged from passive participation (‘contributions in terms of labor, land, materials’ and ‘facilitate the delivery of health messages from the health centre to the community’) to active participation (‘an important voice in running the health centre’ and ‘participation in the planning process at the health centre’). This part of
the policy documents does not distinguish between what roles the HCMC and VHSG are to do but instead details the purpose of community participation overall.

The Terms of Reference for the Health Centre Management Committees provides more guidance on the type of participation expected from HCMCs. The operational guidelines to the participation policy provided a sample Terms of Reference (Ministry of Health 2001b), but in the participation policy the Terms of Reference for all HCMCs were supplied (Ministry of Health 2003), i.e. all HCMCs are to operate under the same Terms of Reference. There are four key responsibilities of the HCMCs listed in the Terms of Reference, and each has a number of tasks that are required. The first is:

- Participate in decision making over the overall management and development of the HC [Health Centre] services; ensuring the HC is functioning in the best possible ways and services provided are good quality and adapted to the health needs of the community (Ministry of Health 2003: 14).

The tasks to be completed to fulfil this responsibility are setting objectives for the health centre’s annual operational plan, monitoring the implementation of that plan, introducing and managing financing schemes, managing and using the health centre budget, maintaining the building and equipment, and organising the transport of patients between the village and both the health centre and the referral hospital (Ministry of Health 2003: 14).

The second responsibility is:

- Provide the link between the health services and the community and facilitate intersectoral coordination efforts – mobilizing the population and other sectors, in promoting community participation around health and health-related issues (Ministry of Health 2003: 14).
The committees are to obtain and act upon the complaints of the community regarding health services, ensure – ‘through the VHSG and/or other channels’ – that important health information is given to the population, and inform the community about services available at the health centre (Ministry of Health 2003: 15).

The third responsibility is:

- Promote community participation in the Health Centre activities through mobilizing the population and other sectors for a common cause (Ministry of Health 2003: 15).

The tasks required are participating in campaigns for health activities such as immunisation and communicable disease prevention, and encouraging people in the community to use health centre services (Ministry of Health 2003: 15).

The fourth responsibility is:

- Strengthen an effective functioning of the HCMC (Ministry of Health 2003: 15).

The tasks associated with this responsibility are reviewing the health centre’s monthly finance and activity reports, review feedback that has come from the VHSG about health service delivery, distribute the health centre report at the VHSG meetings, hold regular HCMC meetings, and use the minutes of previous HCMC meetings to follow up any outstanding issues (Ministry of Health 2003: 15).

There is a combination of passive and active participation required in the Terms of Reference. Although the HCMCs are to provide labour, for example in terms of promoting health centre immunisation campaigns (under the third key activity), there is also a significant role in managing health centres and being involved in government decision making. The first and fourth responsibilities predominantly require active participation, through involvement in planning and strengthening health centre services. In the present
study I particularly critique the level of active participation the committees achieve when the policy is implemented.

A Health Centre Management Committee consists of health centre staff, local authorities, and community representatives (Ministry of Health 2003). According to the policy there will be approximately twelve people on each management committee, although the specific number will depend on the number of communes that a health centre serves. There are in the order of three communes in a catchment area. From the health centre staff, the health centre chief, the vice-chief and a midwife are to be on the committees. The local authorities on the committees are commune councillors, and there is to be one per commune that the health centre serves. “Commune councillors” includes commune chiefs. These people are formal community leaders, and elected to their positions on the commune council but appointed to HCMCs.

For the community representatives, “community” is defined geographically, being those people living within the catchment area of the health centre (an area with approximately 10,000 people). The community representatives are to be one man and one woman from each commune in the catchment area (Royal Government of Cambodia n.d.). The participation policy further specifies that this man and woman are to be drawn from the Village Health Support Group members in that commune. This is the only substantive difference of note between the two policies in relation to the Health Centre Management Committees.

I will therefore now examine the membership criteria for the selection of Village Health Support Group members, as outlined in the participation policy. A VHSG is to comprise one man and one woman from each village in the health centre’s catchment area. There is a diagram included in the policy that shows the ‘population in community’ becoming VHSG members (Ministry of Health 2003: 13). There are a number of criteria specified for the membership of VHSG/HCMC members that come from each village and commune. The policy states that ‘[e]veryone among the villagers’ who meets certain criteria is eligible to stand for election (Ministry of Health 2003: 19). The criteria are:
• Live in the village where he/she stands for election
• Both female and male as one male and one female per village has to be selected
• Age 25 – 65
• Regardless [of] economic status
• Preferably be literate
• Be respected by the majority of villagers, good personality/relation/communication
• Be in good health
• Be motivated to work for the community benefits
• Have her/his own means of transport
• Personal history without any criminal record (Ministry of Health 2003: 19).

Elsewhere in the policy it states that poor people are to be included and there is to be a gender balance in the committee membership:

Principles of Community Participation in Health Centres
(3) Gender Balance
For the trade-off between male and female’s view, equal representation of men and women in any structures of community participation has to be realized. The female community representatives are to be encouraged, as women are more aware of the needs of their own health and their children’s and more concerned about family issues (Ministry of Health 2003: 8).

There is some contradiction within the detail of the policy about whether lay citizens or informal leaders are being targeted for VHSG membership.

The policy does not use the language of “ordinary villager” or “lay citizen”. However, policy writers confirmed that the intention of the policy was to include lay citizens/ordinary
villagers in the VHSGs (Mr Serey Phiriak, Interview; Mr Sam White, Interview). The diagram described above showing the “population in community” becoming VHSG members suggests that lay citizens are to be selected, and at first glance the criteria appear to call for open and broad representation of ordinary villagers. It can be argued that lay citizens were desired on the committees as there is an emphasis on broad representation, including a geographic spread of members, gender representation and involvement of the poor in the committees. There was no explicit mention of seeking existing leaders to be on the committees, and formal leaders were clearly called to be members of the HCMC as a separate category (commune councillors) rather than as part of the “community representatives”/VHSG component. Commune councillors were specifically excluded from the VHSG: ‘the representative of the Commune Council cannot be a member of VHSG’ (Ministry of Health 2003: 16).

However, on closer inspection of the criteria, some of them suggest a preference for the selection of informal leaders – ‘those who are respected by the majority of villagers’, and who have a decent level of affluence (own means of transport) and education (literate). I will return to the issue of lay citizen versus informal leader involvement several times in the remainder of this thesis.

The policy documents include indicators for success of the HCMCs (Ministry of Health 2001b). The indicators include:

- Number of HCMC meetings a year,
- Percentage of community representatives present/absent at meetings,
- Minutes taken and copies distributed,
- Decisions taken and acted upon, and
- Problems identified and solved (Ministry of Health 2001b).

No benchmarks or further information is given on how the performance of the HCMCs is to be reviewed or the levels of participation assessed. These indicators have the potential to determine how much control the committees have over the health centre and how effective
they are in identifying and solving health problems in their communities. However, they do not give an indication of how much influence community members have over the management of health centres. These criteria are output driven, rather than providing information about the quality of participation. The empirical framework developed in Chapter Two provides an alternative framework for analysing the levels of participation in the committees.

There has been minimal empirical research into HCMCs, and most of it has been evaluative in nature. Many international NGOs work in the health system, and some of these have reported on their experience of community participation (see for example Jacobs 2002; Main 2000). Their research has found that the majority of volunteers in the health sector fulfil passive rather than active decision making roles (Main 2000; Suehiro and Altman 2003). Research by Jacobs and Price (2003) compared HCMCs with members selected only from temple communities with HCMCs where members were selected from the community more broadly. They did not discuss the management roles of HCMCs, but rather judged their success on whether women in the villages felt comfortable telling HCMC members about their personal problems (Jacobs and Price 2003). Given the management functions that HCMCs are intended to perform, this choice of indicator for comparing the success of different HCMCs is irrelevant to the present study and speaks to the roles that the NGO programs the authors worked for sought to have the HCMCs fulfil. Turner (2002: 357) found that HCMCs had strong community involvement yet did not present evidence so it is difficult to appraise this claim. A group of student researchers have previously found that Cambodian health centre staff members resist the implementation of the participation policy, but more favourably approach the implementation of other health policies (Grove et al 2002). The researchers focused on the ways that health centre staff members respond to different policies that they are expected to implement. Unfortunately they did not consider why health centre staff members felt so apprehensive about the participation policy and included very little specific information on the participation policy (Grove et al 2002).

The Ministry of Health did a review of the impact of the public health sector reforms of the mid-1990s and found that the presence of HCMCs led to greater levels of income and
utilisation at health centres (Ministry of Health 2001a). Therefore the structure established by the community participation policy is meeting its objectives as set out by the Ministry. Higher levels of service utilisation are associated with improvements in public health (Mortensen 2005). This makes participation and the involvement of the public in health centre management through HCMCs desirable to the Ministry of Health and to a range of international NGOs and other stakeholders as it achieves key health improvement objectives. This study by the Ministry did not examine how effective the committees were, but only whether they existed. In 2006 the Ministry of Health with other agencies conducted a review of volunteers in the health sector. Although this included HCMC members, it focused on issues of four or five different types of volunteers that are found in villages (UNICEF et al 2006). It has no specific recommendations for HCMCs. In the present study I sought to conduct an in-depth study of the experience of HCMCs, particularly focusing on lay citizens, other community representatives, the government and agencies convening HCMCs. In Chapter Four I outline the methodology used in this study to examine the implementation of the national participation policy.
CHAPTER FOUR. METHODS AND METHODOLOGY

In this chapter I present the research design and methodology of the present study. I sought to understand whether the adoption of a national participation policy resulted in strong levels of lay citizen participation, and also to consider what factors affected the implementation of the participation policy. The research was designed to answer these questions most effectively.

I begin by outlining the choice for a qualitative approach to this study, and my research method informed by ethnography and grounded and adaptive theory. I also identify the processes of case selection, data collection and analysis. Cultural, language and ethical issues, as well as the boundaries and limitations of the research are also presented.

4.1 QUALITATIVE RESEARCH, ETHNOGRAPHY AND GROUNDED THEORY

Like all researchers, my decisions about techniques and tools were shaped by my ontological and epistemological positions. I take an anti-foundationalist ontological perspective; according to this there is no objective reality and the social world is socially constructed (Bryman 1998; Marsh and Furlong 2002). A study that is epistemologically interpretive – as this one is – requires culturally derived and historically situated interpretations of the social world (Crotty 1998). Research from this approach typically has a number of shared characteristics: a qualitative approach, taking the perspective of those being studied, detailing social settings, flexible research approaches and a preference for theory to emerge from the data (Bryman 1998). My ontological and epistemological position has greatly shaped my research design.

I chose a qualitative approach for a number of other reasons besides its traditional fit with my epistemological perspective. Firstly, the research is exploratory as there is not much theory and few existing datasets about participation in Cambodia, and little on the
implementation of participation policies, particularly by international NGOs. Secondly, pragmatic reasons dictated a qualitative approach focusing on a small number of cases. Cambodia’s postal system is unreliable and many roads are impassable in the wet season, making it more feasible to work in a small geographical area. Thirdly, the cultural context of the study makes a qualitative approach attractive in terms of validity of data. A number of concerns about accuracy arise when interviews are used to collect information. These issues are heightened in Cambodia where a number of cultural practices may lead to inaccurate answers being given, outlined in section 4.6. Ultimately, the decision to take a qualitative approach reflects the desire of this researcher to gain a deep rather than a broad understanding of the implementation of the participation policy in Cambodia’s health sector.

The research design was informed by both ethnographic and grounded theory traditions. Those doing ethnographic research primarily aim to ‘understand the social meanings and activities of people as they go about their everyday social life’ (McNeill and Chapman 2004: 92). I needed to make sense of the social worlds and institutional cultures of the management structures at each health centre, particularly in order to understand how participation was practised in each case and how power was negotiated between health centre staff, other committee members, and international NGO staff. There is a strong emphasis on fieldwork in ethnography. Extensive periods of time in the field are necessary for developing an accurate understanding of what is happening within it (Ellen 1984; Ely et al 1991). The research technique most associated with ethnographic inquiry is that of being a participant-observer (Hammersley and Atkinson 1983). I took on the role of a limited observer, whereby the researcher observes, asks questions and builds trust over time (Ely et al 1991). Ethnography relies on close observation of people in their normal activities (ten Have 2004). I lived in the research area with a Cambodian family who used the public health services, and in addition to my formal observation notes and interviews, I also conducted a number of informal observations through living in the research area and travelling past the health centres during my daily activities.

An approach based on grounded and adaptive theory was chosen for analysis, whereby theory emerges from the data. In grounded theory, data must be ‘systematically obtained
and analysed’ to generate a theory from data (Glaser and Strauss 1967: 1). Grounded theory assumes the researcher is informed only by the data, whereas adaptive theory includes an acknowledgement that the researcher has existing knowledge, and that this shapes how they conduct the research (Layder 1998; see also Hendriks 2004). There was an iterative process between data collection and analysis, with one informing the other and leading to the emergence of the themes presented in this thesis. These approaches to data analysis required me to have a flexible research design that allowed the data collection to be responsive to the ideas that emerged from the data. To generate theory it is desirable to compare different groups and collect the most theoretically relevant data (Glaser and Strauss 1967). In common with ethnography, the grounded theory approach begins with collecting as much data as possible on the situation until themes begin to emerge from the data, allowing a more focused inquiry (Glaser and Strauss 1967; Ely et al 1991).

### 4.2 Research Methods

The research methods were influenced both by the type of information that was sought and the philosophical approach already described. Research methods were needed that would capture the complexities of public participation and be responsive to the theoretical ideas that emerged from the data. Triangulation of data collection methods, sources and analysis techniques was used to ensure high levels of accuracy in the data and its interpretation (Hammersley and Atkinson 1983). As I was working in a cross-cultural environment, the need for triangulation intensified to ensure that data was accurately collected and interpreted. Ethnography is associated with observation, in-depth interviews and the analysis of documents (McNeill and Chapman 2004: 92). The data in my study were collected from three sources: interviews, observations and documents. Observations of a range of general health centre and NGO activities were conducted, including those collected while accompanying health centre staff on outreach activities. Health Centre Management Committee activities, particularly training and meetings, were also observed. Key documents related to HCMCs were reviewed, particularly the policy documents. I attended committee meetings and other community activities to better understand the social worlds of respondents.
4.3 RESEARCH DESIGN

4.3.1 The Research Questions

The overarching research problem was to understand the factors affecting the implementation of a participation policy. In line with the grounded theory approach, the specific focus changed as the study progressed. I originally questioned whether the participation policy resulted in strong citizen participation, but my fieldwork quickly showed that strong participation did not exist. I then shifted my analysis to understanding why lay citizen and other community representative involvement was so low. I began to focus on the role of international NGOs convening the HCMCs, as well as the dynamics of policy adoption. Overall, the two research questions that I sought to answer in the study were:

1. Does the adoption of a national participation policy result in strong lay citizen and community participation in government decision making?
2. What other factors shape the levels of lay citizen and community participation in government decision making, when the participation policy has been adopted in an aid dependent country?

4.3.2 Case Selection

The study was conducted in Cambodia for three key reasons: little is known in the literature about Cambodian public participation, my own experience living in the country and a desire to understand it better, and the recent introduction of a participation policy that I had been told anecdotally had inconsistent implementation. I chose the province where I had previously worked in the environmental sector.

I studied health centres in proximity to the provincial town in a central province in Cambodia, all within one health operational district. I studied the seven health centres that lie within a 12km distance from the referral hospital, which is at the town centre. I chose
this method of sample selection to ensure that I gained a more accurate representation of local experience than if I had done purposive sampling. The seven health centres within the study area covered a range of experiences in implementing the participation policy. For each of these health centres I interviewed a commune councillor and the health centre chief, and if they had a committee I attempted to interview all its members, although this was not always possible. The study focuses on the experience of the HCMCs in the period January to August 2006.

4.3.3 Interview and Observation Questions

Interview schedules were designed to elicit information about how and why participation differed in different health centres. The interview schedules were structured thematically. Questions were designed to gather information about the four criteria in the empirical frame that I developed in Chapter Two for measuring the level of participation of lay citizens and other community representatives in health centre management: operation, representativeness, deliberativeness and influence.

Field notes were made with reference to the themes identified in the observation schedule presented in Table 4.1. Table 4.2 below shows the questions asked of members of HCMCs across the different health centres. The HCMC meetings were observed and field notes and meeting transcripts analysed.

Table 4.1 Observation Schedule for HCMC Meetings

<table>
<thead>
<tr>
<th>Attendance</th>
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<tbody>
<tr>
<td>Agenda-setting – official and unofficial</td>
</tr>
<tr>
<td>Chairing the meeting – leadership style</td>
</tr>
<tr>
<td>Tone of the meeting</td>
</tr>
<tr>
<td>Relationship between health staff and public members of HCMC</td>
</tr>
<tr>
<td>Issues raised, discussed and resolved</td>
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</tbody>
</table>
Table 4.2 Interview Schedule for Health Centres

<table>
<thead>
<tr>
<th>For health staff only:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positions and length of duty of staff</td>
</tr>
<tr>
<td>Training and education of staff members</td>
</tr>
<tr>
<td>Attitudes towards knowledge, management and participation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>For all respondents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description of the health centre and its catchment area</td>
</tr>
<tr>
<td>Meaning of participation</td>
</tr>
<tr>
<td>Existing role of HCMC and its members</td>
</tr>
<tr>
<td>Selection of HCMC members</td>
</tr>
<tr>
<td>Issues that HCMC discusses</td>
</tr>
<tr>
<td>How meetings work</td>
</tr>
<tr>
<td>Resourcing of committee</td>
</tr>
<tr>
<td>Public pressure for and interest in involvement</td>
</tr>
<tr>
<td>Relationships between health staff and community members</td>
</tr>
<tr>
<td>Strength of the HCMC</td>
</tr>
<tr>
<td>“Proper” role for HCMC</td>
</tr>
<tr>
<td>Importance of participation</td>
</tr>
<tr>
<td>Factors affecting HCMCs’ work</td>
</tr>
</tbody>
</table>

Those from NGOs were asked about their programs and sustainability issues pertaining to their assistance and the performance of HCMCs. Staff working at levels higher than health centres within the government sector were asked to comment on the preliminary results of this study and about the conditions associated with strong and weak participation. Policy makers were also asked to comment on the initial findings, as well as to talk about the policy development process.

4.3.4 Ethical Considerations

It was imperative that the participants in the research freely gave their informed consent to participate in the research. Respondents were assured of their confidentiality, which was ensured through de-identification of the data as it was collected from both interviews and other sources. Respondents were invited to choose their own pseudonyms. All health centres were given pseudonyms derived from the names of fruit in Khmer, and NGOs
were given names adapted from the Khmer words for different marine animals. It is not possible for me to identify the province as this would compromise the anonymity of respondents, and particularly the international NGOs. The master list of pseudonyms and the code book were kept separate from the data set, and both data and code book were kept securely. It was not envisaged that conducting the research or publishing the results would endanger or disadvantage participants in any way. Respondents were treated with respect throughout the research process. The research received formal approval from the ethics committees at both The University of Sydney and the Cambodian Ministry of Health.

4.4 IMPLEMENTING THE RESEARCH DESIGN

Letters of ethical approval and introduction from both the Ministry of Health and The University of Sydney assured potential respondents of the legitimacy of the study and helped secure their involvement. Fieldwork was conducted over a 15-month period from June 2005 until August 2006. There were three phases of research. An initial four-week field trip was conducted in Cambodia in June and July 2005 to obtain documents and start building networks for the study. During this period I met with the operational district level in the public health administration, but not any health centres. This was when the process of negotiating access to the field began. Gatekeepers can give or prevent access to the field (Hammersley and Atkinson 1983). The Ministry of Health Ethics Committee and the provincial and operational district health offices were gatekeepers for this research, and I sought and gained permission from them early on. Access to the health centres was facilitated through my existing relationship with the local health operational district director, who had given his support to the study and had offered to assist with gaining access to the health centres.

The second phase of the project, from early January to late February 2006, involved gaining access to individual health centres, building rapport with their staff, and building up my understanding about the contexts and constraints shaping health centre work. In this phase, much time was spent developing relationships with health centre staff to gain access to the committee members as well as to gain a good understanding of the situation in different
health centres and their work. I went on outreach activities in five of the six health centres that conducted outreach programs.

In the third phase of data collection, from late February until the end of August 2006, interviews and formal observations of meetings were conducted. I observed committee training at three health centres and attended Health Centre Management Committee meetings in the four health centres in my study area that had them. I interviewed Health Centre Management Committee members (health centre staff, authorities and community representatives) and observers (from international NGOs, the health operational district, and administrative officials). In those health centres without committees, formal community leaders and health centre staff were interviewed. In addition a selection of international NGO staff who were involved in supporting Health Centre Management Committees in the health centres included in the study as well as policy makers were interviewed. A total of 60 interviews were conducted. In total, formal observations of 17 management committee meetings, training sessions and other activities were conducted across seven different health centres.

### 4.4.1 Adapting the Research Focus

I adapted my research focus as theory began to emerge from the data; patterns became recognisable in the data, about the domination by powerful individuals within the participatory forum and the manipulation of the Health Centre Management Committee process by international NGOs. As I became aware of these phenomena it shaped how I observed meetings and the questions I asked in interviews.

Initially I had chosen the province I did for the study as there was little international NGO involvement in the management of health centres. It quickly became clear that I had been misinformed, and the involvement of NGOs became more and more important in the study. I asked additional questions in interviews about the involvement of NGOs, and also decided to interview staff from the NGOs that were currently or had previously supported the committees in four of the health centres in my study.
4.4.2 Using an Interpreter

I employed an interpreter, selected for his language skills, almost full time from February to August 2006. This interpreter was used during the research both within interviews and meetings, and to transcribe the data in collaboration with me. Although I am proficient in spoken Khmer, I had not worked in the health sector or done political analysis in Cambodia before, and therefore lacked a lot of the specific Khmer vocabulary used during interviews and meetings. I am also illiterate in Khmer so my interpreter translated documentation associated with the health centres and their committees and management.

Although the interpreter did not have previous interpreting experience, I provided basic training in both interpreting skills and research principles (including confidentiality) and techniques, particularly transcription. I also spent a lot of time discussing the project and the key concepts that I was exploring in the study to ensure accurate interpretation, and this also improved my Khmer vocabulary.

Initially I attended all the interviews with and relied heavily on my interpreter, but as the research progressed and my language skills improved I began to attend interviews alone, and used the interpreter to listen to recordings of the interviews and assist during the transcription process to improve clarity. The interpreter attended all the management committee meetings with me.

4.4.3 Recording and Managing the Data

Interviews and management committee meetings were recorded as audio files using a digital recorder. Field notes are the traditional way to record observations in ethnography (Hammersley and Atkinson 1983). Field notes were written during formal observations of HCMC meetings and the training course as well as during other health centre and NGO activities that I attended and observed, including outreach visits. During my time in the field I also visited health centres as a patient and accompanied a friend’s sick child; I wrote field notes following these visits as well. Field notes were written up in full as soon as
possible following my participation in activities, generally on the day of the observation. Notes were also taken during interviews, but these were only used to check the transcripts, particularly if something was unclear in the recording.

The audio files from the interviews and meetings were transcribed in full. For the interviews that were conducted in Khmer, I wrote the initial transcripts, which my interpreter reviewed and improved before we would sit down together and complete a final check of the transcript against the recording. I transcribed those interviews conducted in English by myself. For the meetings, there was a lot more vocabulary that I was unfamiliar with compared to the interviews, so my interpreter transcribed them and we both did the final check. This systematic process ensured we improved the accuracy of the transcription.

4.5 ANALYSING THE DATA

I used both grounded and adaptive theory approaches to analyse the data. The process of generating theory resulted from a systematic and simultaneous process of data collection and analysis. Diary notes were made on a regular basis, which chronicled what I did. I also kept a separate file of thesis notes, which were far more analytical and included greater detail about my interpretation of what was happening in the field. Glaser and Strauss (1967) note that insights are useful in developing theory and should be considered as data. This ongoing analysis helped me to reformulate my research problem and develop additional interview questions.

Grounded theory involves generating firstly conceptual categories and their properties, and secondly hypotheses or generalised relationships among the categories and their properties (Glaser and Strauss 1967). Once all the data was collected, I analysed the data-set as a whole. This was done both manually and also using NVivo, a data analysis computer program. The first step was to code the data. In addition to coding the data according to the criteria identified to measure the levels of participation in each health centre, I used open and axial coding, where themes emerged from the data and then links were made between different themes. This coding allowed for theory to emerge from the data.
After coding, the next stage of analysis was to construct case studies of each health centre. Rather than presenting individual case studies for each health centre within the thesis, which would have been very repetitive, the results from the cases were constructed along themes. The data from each of the case studies are presented in this thesis under thematic headings to highlight the complexities in the experiences of health centres. The fourth step of the data analysis was to seek patterns across the case studies to explain how and why participation varies, and to understand some of the implications of this. These patterns were confirmed with respondents.

4.6 ACCURACY AND LEGITIMACY OF THE DATA

Aldridge and Levine (2001) discuss the social desirability problem as it applies to obtaining accurate information through overt social research. Particularly relevant to my study is the potential for respondents to give the answers that they think the interviewer wants to hear (Aldridge and Levine 2001). In addition to it being an issue in all social research, in Cambodia it is cultural practice to try and please other people.

Another social desirability factor is that respondents may want it to appear that they “do the right thing”. Conway (1999) presents an example from a study in Cambodia where a woman repeatedly denied ever doing any agricultural work. After being asked what happened when her husband was busy or away she conceded that she did all the agricultural work in that instance. When asked why she did not tell them earlier that she did agricultural work, she stated that it was a man’s job and women were not supposed to do it (Conway 1999). In this study, an awareness of social desirability’s impact on data accuracy was pertinent in ensuring a strong relationship was built between researcher and respondents. This is especially true for the responses of health staff members, as there is a policy requiring them to consult the public through HCMCs, so it can be assumed that respondents may try and overstate the performance of the HCMCs in their health centres.

Another concern I had in terms of gaining accurate information is the possibility that some people could have seen my research as a way to lobby for particular assistance. Conway
writes of interviewing a health volunteer who repeatedly denied receiving any training. Two trainers were at the interview and, exasperated, pulled out a photo of this woman at a training course the previous month (Conway 1999). My conclusion is that the woman was lobbying to receive (more) training. This is certainly an issue that may have affected the answers of some respondents, whereby community representatives and health centre staff could have tried to portray that they have had little support and are consequently performing poorly, whereas this may not be an accurate picture of the local situation.

A key strategy to improve accuracy is to build rapport and develop trust with the respondents (National Institute of Statistics 2005). The choice to focus on a small number of cases enabled me to build rapport and trust with respondents, and consequently mitigate some of the social desirability problems. Although using an interpreter can provide a barrier as there is an intermediary in the relationship between researcher and respondent, even initially my Khmer language skills were sufficient to build rapport with respondents and thus minimise the negative aspects of using an interpreter.

Triangulation of data collection methods, sources and analysis techniques was very important in order to ensure data was accurate, as was assuring respondents of confidentiality of both themselves and their health centre. I adopted other specific techniques that are recognised for reducing the impact of the social desirability factor on results. These include: asking specific rather than hypothetical or general questions (for example I asked about a decision the committee had made that year rather than about decision making generally), asking indirect questions about sensitive topics, and avoiding leading questions (Aldridge and Levine 2001).

Credibility of this research was enhanced by an extensive period of time in the field and involvement in a range of committee and health centre activities. To ensure the validity of my interpretations I also checked my analysis with respondents and others in the Cambodian health sector. This happened both informally as my ideas were forming and formally. At the end of the fieldwork period I presented the results and my analysis to all respondents, who were asked for their feedback. I also gave a presentation of my findings at a meeting of the umbrella agency for all NGOs working in the health sector in
Cambodia. This allowed me to confirm that my interpretations accurately reflected the experience of management committees as understood by their members and others affiliated with them.

4.7 LIMITATIONS AND BOUNDARIES OF THE RESEARCH

It is important to consider the boundaries of this research. As there is so little research available on the experience of HCMCs, it was not possible to conduct a useful quantitative study on a national scale in the time frame available, due to logistical and cultural reasons. It is also important to clarify that this study did not examine the effects of participation or its costs and benefits, which has been done elsewhere. The focus of this study was to identify what factors affected the levels of participation in health centre management in different health centres. If a different time period was chosen, it is possible that different results and theoretical explanations of the practice of participation would have emerged.

In this study I only examined health centres in one health operational district in central Cambodia. Although this district is not atypical it cannot be assumed that the cases are representative of the experience in Cambodia, although this possibility is supported anecdotally by those working in the health sector. I sought to mitigate some of the limitations of examining health centres in only one health operational district by complementing the micro-level research with interviews with national policy makers about the experiences of not only policy development but also on issues with policy implementation. The results of the present study will put other researchers in a better position to conduct an extensive quantitative study in health centres across Cambodia to determine if the findings of my research hold true nationally.

McNeill and Chapman (2004: 121) note that although case-studies do not provide statistically representative and therefore generalisable results, the production of a ‘vividly told story’ is a useful contribution to knowledge. This is especially true when little research has been done in that area. Despite the limitations already outlined, my examination of international NGOs implementing a government participation policy and the relationship
between policy adoption and implementation processes in an aid dependent country make this study an important contribution.
CHAPTER FIVE. COMMUNITY PARTICIPATION IN CAMBODIAN HEALTH CENTRE MANAGEMENT COMMITTEES (HCMCs)

In this chapter I consider whether a participation policy was enough to ensure lay citizen and community participation in government decision making. I do this by examining the experience of HCMCs in the study area. Although I further consider the experience of committees in subsequent chapters, here my focus is on the extent to which community representatives, particularly lay citizens, were involved in health centre management. I begin by providing some background about the work of the seven health centres included in the study and a brief history of HCMCs in the province. I then consider the experiences of HCMCs in 2006 in the context of the empirical framework outlined in Chapter Two. I conclude by considering some of the factors that enable committees to be operational and particular individuals to participate.

5.1 THE WORK OF HEALTH CENTRES

The following descriptions of the work of health centres draw on my observations, and are provided to help locate the work of the management committees within the context of the health centres’ daily operations. Health centres are charged with providing both preventative and curative services, and they deliver a Minimum Package of Activities – a set of basic health services. Health centre budgets are small, they arrive irregularly, and they are often several months late. This affects staff salaries as well as the amount of medicine available in the health centre at any one time. During the study period, all the health centres in the study area were receiving international NGO support of some description.

Health centre buildings have similar designs across the country; they have three or four rooms and a covered veranda at the front used as the patient waiting area. Most are located
on the main road in their catchment area. The health centre chief is always the most highly qualified staff member, usually holding secondary nurse qualifications (equivalent to registered nurses). They are responsible for managing the health centre as well as providing clinical services. One of the rooms in the health centres is the office of the health centre chief, who usually also provides consultations from here. There are between 8 and 16 staff members in each health centre, but less than half of these are clinical (the chief, primary nurses and midwives). Other staff members work in the pharmacy, patient reception, and clean the facilities. The staff salaries average US$20 a month, and vary depending on the role. Health centre chiefs have the highest salaries (US$32 a month), and midwives receive $30 a month. These wages are not enough to live on. Many clinical staff members have second jobs in the medical industry, operating private clinics or owning pharmacies. They often arrive late to work in the public health centres because of commitments to their private patients.

Health centres are officially open for consultations between 7:00 and 11:30 a.m., and from 2:00 to 5:00 pm. It is rare for consultations to begin before 8:00 a.m., because of the tendency for clinical staff members to be late. One staff member works in the reception area (a table placed in the middle of the veranda at the front of the health centre), greeting patients. When patients arrive they pay a fee to the receptionist. If they have a condition that they have not consulted the nurses about before, they pay the fee for a basic consultation. If they are an ongoing patient with a condition/service with a designated fee (there are seven conditions/services with their own fees) then they pay that fee. For example, delivering a baby costs around 10,000 riels. Consultation fees do vary slightly in each health centre, for reasons that will be explained. The basic consultation fee for an adult was the same in all the health centres I studied: 500 riels, or 12.5 US cents; a child’s basic consultation fee was either 200 or 300 riels depending on the health centre. As they pay their fee, the patient’s name is written down in the patient log and they are given a number, written on a piece of paper that is stapled inside a plastic bag. The basic consultation fee covers the initial consultation, all medicines prescribed during treatment and one follow up consultation if required. Patients then wait until their number is called. It often takes several hours to be seen, and I spoke to some patients as they left in frustration without having seen a medical professional.
Usually three clinical staff members – the secondary nurse (health centre chief), a primary nurse, and a midwife – provide consultations simultaneously, each in a different room within the health centre. The doors are left open during consultations, and the health centre chief’s room is within earshot and sight of the patients in the waiting area, so privacy is almost non-existent for patients they are examining. Ante-natal appointments are conducted by a midwife in a room inside the health centre, and although the door is left open, there is a screen alongside the bed that offers privacy when physical examinations are required. Health centre staff members keep health records in the health centre. Parents also keep a copy of their young children’s medical records at home, which include height and weight data as well as an immunisation record.

Health centre staff members also conduct outreach clinics in the villages in their catchment areas. The health centres in the study area served between nine and 22 villages each. Every month they are officially required to visit each village once. Some villages are up to a day’s travel from the closest health centre, so it can be difficult and expensive for patients to travel to get medical treatment. Jaik Health Centre does not supply outreach services and Kroich Health Centre provides only limited outreach because their catchment areas are highly urbanised so patients only have to travel short distances to reach them. In the other five health centres, outreach is provided in all villages except those closest to the centres, and it is highly appreciated.

In the week or two before the outreach day, the village chief is notified of the date, and they inform the villagers so that everyone knows the health service is coming. During these visits health staff members provide clinics, with a particular focus on ante-natal checks. Two health centre staff members go on outreach – a midwife and a nurse. The ante-natal checks are conducted inside the home of a villager, usually the home of the village chief. Only women go into the house and relative privacy is created in this way. Most Cambodian houses are built on stilts, and while the midwife sees ante-natal patients upstairs, the other nurse examines patients under the house. Many of the patients brought to them are children. I did not ask about fees but never saw them collected during outreach activities. VHSG members – discussed in Chapter Three – sometimes assist the medical staff during outreach, helping to organise patients.
Outreach clinics provide an opportunity for the health centre staff members to experience the living conditions of their patients and to identify specific health concerns. In one outreach clinic that I attended with Lahong Health Centre staff, an outbreak of malaria was discovered: one child had recently died, and several more were very ill. The nurse conducting the clinic, who happened to be the health centre chief, immediately notified the Ministry of Health in Phnom Penh by phone and organised for insecticide-treated mosquito nets to be delivered to the village. He also inspected water storage jars, which are renowned sites for mosquito breeding. He talked with several villagers about the importance of cleaning mosquito larvae out of them. As well as outreach clinics, health centre staff members also went to the villages to conduct immunisation drives, with the assistance of VHSG members.

5.2 HCMCs in the Study Area from 1998 to 2005

In 1998, prior to the participation policy being adopted, an international NGO called KADARM established a health program in one administrative district in the province. When it began its program, staff wanted to investigate the possibilities of establishing community participation structures in the health centres in KADARM’s target area. They organised a study tour to visit the pilot project of UNC, a United Nations agency, which was trialling participatory structures:

In 1998 we invited [staff members from] the operational district and the provincial health department to visit the work of UNC in another Province. We had a team visit the health centre supported by UNC. So after we returned, KADARM and the operational district as well as the provincial health department worked together to develop practical guidelines to develop both health centre management committees as well as the feedback committees [since re-named the Village Health Support Group]. So a health centre management committee was established at every health centre that KADARM supported in the Province. KADARM supported less than half
KADARM’s target area included Pom, Lahong and Owluk Health Centres. KADARM organised elections in the health centres it supported to select both VHSG members and HCMC members:

*There were two parts to the election. First was the voting for the Information Back Committee [since re-named the Village Health Support Group]. When they were at the health centre, all the 12 villages in the catchment area voted again to select the management committee* (Mr Pra Dtom, Pom HCMC, Interview).

KADARM’s election process was problematic. The participation policy specifies that the whole community must vote (Ministry of Health 2001b), but the international NGO invited only those nominated by village and commune chiefs and formal and informal community leaders to be both candidates as well as forming the electoral college. This greatly increased the chances that persons already among the elite would be put forward as candidates and subsequently selected.

When the operational guidelines to the policy were released in 2001, HCMCs were established by the provincial health department and operational district in all health centres in the province where KADARM had not already established them. In the study area this was Jaik, Kroich, Mian and Saomao Health Centres.

*In the policy of the Ministry of Health, and from before until now, in all health centres we have the Health Centre Management Committees. We have this one structure that was created at all health centres. There are names, there are photos of the Health Centre Management Committees* (Mr Dem Vuthy, the Deputy Director of the Provincial Health Department, Interview).
The photos of the original committee members were still up in 2006 in the patient waiting areas in all seven of the health centres included in this study.

In 2001, fees for public health services were being introduced to Cambodia for the first time. Prior to this, health centre services were free for patients. The HCMCs in all of the health centres in the province were involved in a major decision: setting the level of user fees. All seven health centres included in this study reported on the HCMC involvement in this process, and a similar process was used in all:

*The health centre fees were set by the committee election [the process is explained further below]. They held the meeting to choose the health service fees* (Mr Keo Vanny, Kroich Health Centre, Interview).

The health centre chief, operational district vice-director and both the VHSG and HCMC members attended these meetings (Mr San Maleng, Jaik Health Centre Chief, Interview). In the health centres supported by KADARM (Labong, Pom and Owlok), the international NGO staff also attended and played a key role in convening these meetings. The meeting attendees voted on proposed fees for each type of health service. The voting process worked as follows:

*Before they did the voting on the fees, I said vote once for each type of service, and not to do all of them at once. I gave the example that now we choose the consultation for diseases, to consult and treat the diseases. Therefore I wrote on the board 1,500 riels, after that I put 1,000 riels, after that I put 800 riels, after that I put 500 riels, after that I put 300 riels. I wrote up these five options and then offered for them to choose* (Mr San Maleng, Jaik Health Centre Chief, Interview).

The fees that were decided in these meetings were painted onto information boards; they still hang in each health centre’s patient waiting area. One percent of the fees are a tax that is paid into the national treasury, 39% stay with the health centre for operational costs, and
60% are allocated to the staff in performance related pay. HCMC involvement in fee setting therefore affected each health centre’s level of income.

Those health centres that until the end of 2005 had no assistance from an international NGO for HCMCs – Jaik, Kroich and Mian Health Centres – only ever held one management committee meeting prior to 2006, to set the health centre fees:

*The HCMC committee had one meeting with the Information Back Committee [Village Health Support Group] to choose the fees, but since then we didn’t call them to come to the meeting. We have never called the management committee* (Mr Keo Vanny, Kroich Health Centre Chief, Interview).

*For five years already, the management committee has not had a meeting* (Mr San Maleng, Jaik Health Centre Chief, Interview).

In 2006, all that remained of the committees in Jaik and Kroich Health Centres were the peeling photos in the patient waiting areas of the long defunct HCMC’s members.

Saomao’s HCMC members were appointed by the government in May 2001. In 2005 the international NGO BONGKIA began supporting them. The HCMC and VHSG performed identical functions and always performed their duties together. They met for a monthly health promotion session and assisted with outreach activities including immunisation drives in the villages. Although committee members existed and met in 2006, the HCMC differed from the Village Health Support Group in name only:

*The duties of the Village Health Support Group and the Management Committee are the same. They help to bring information from the village to the health centre and learn about the health education from the health centre and provide it to the community* (Mrs Oich Kimleng, Oxluk Health Centre Chief, Interview).
Many of the HCMC members at Saomao did not even consider themselves to be on the management committee:

_There is no management committee in this health centre. There is only us_

(Mrs Chan Naree, Saomao HCMC member, Interview).

Saomao’s HCMC could not be considered active or operational during the fieldwork period as it neither fulfilled management functions nor had its own dedicated meetings.

KADARM supported the committees in its target area for four years. In 2002, its program finished and it stopped supporting all HCMCs including those in Pom, Lahong and Owluk Health Centres. Its support had included financial recompense to the committee members for attending meetings. The Pom and Lahong HCMCs stopped operating. Owluk HCMC continued to meet on a monthly basis, but without direct payments to committee members:

_After KADARM left, the Health Centre Management Committee kept the same members, and got the funds from the health centre. We spent 1000 riels for each person per meeting to buy refreshments_ (Mr Sen Peom, Owluk Health Centre Chief, Interview).

The only committee in the study area that was operational between 2003 and 2005 was Owluk’s.

5.3 HCMCs in the Study Area in 2006

The empirical frame developed in Chapter Two is used here to analyse the levels of participation in the committees, particularly those that were operational. The framework has four criteria derived from the literature on participation: operation, representativeness, deliberativeness and influence. It is particularly applied to the involvement of lay citizens but also other community representatives.
As outlined in Chapter Two, an operational management committee would have committee members, regular management committee meetings, and would adhere to procedures such as minute taking. Without an HCMC, it is possible that members of the public could participate in health centre management, for example through lobbying the health centre staff directly. However, the participation policy called for the establishment of management committees to provide an institutional space for these interactions between the community and the health centre staff. Having such a space provides citizens with a point of access to participate in government decision making. Without such a space, the opportunities for community members to be involved in government decision making are reduced.

In 2006, the international NGO DRAY came to the province and supported HCMCs in nine health centres, including Mian, Pom, Lahong, and Owluk Health Centres. These four health centres were the only ones in the study area that had dedicated management committee meetings in 2006. Meetings provide a forum for ordinary villagers, representatives of the community and authorities to have some input into health centre management. Having regular meetings was important for HCMC members:

*For the health centre management committee to be strong, they must always do the work and hold the meetings often. If we hold the meetings often it is good* (Mr Chun Lee, Owluk HCMC, Interview).

In HCMCs that had never had regular committee meetings prior to 2006, or had not had meetings since KADARM’s support ceased in 2002, found the lack of meetings frustrating:

*At the moment it is not difficult for the management committee to do the work, because we can share the ideas because the health centre chief and DRAY helped, so we can monitor and implement. Before we just had the names of the committee members but we didn’t do anything. It was a difficult problem when the committee just had the names* (Mr Lon Ching, Mian HCMC, Interview).
This quote illustrates the importance of meetings for providing a space in which community members could be involved in the machinations of the management of health centres, as without the committee meetings the HCMC could not ‘monitor and implement’ or ‘do anything’. It also explains why Saomao, without management meetings, cannot be considered operational.

Table 5.1 shows the levels of operation for each health centre included in the study. All the committees with meetings kept minutes.

**Table 5.1 Operation of Committees in 2006**

<table>
<thead>
<tr>
<th>Health Centre</th>
<th>Current management committee members?</th>
<th>Dedicated management committee meetings?</th>
<th>Minutes?</th>
<th>Meeting how often?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jaik</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Kroich</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Mian</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Approximately bi-monthly</td>
</tr>
<tr>
<td>Pom</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Approximately bi-monthly</td>
</tr>
<tr>
<td>Lahong</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Approximately bi-monthly</td>
</tr>
<tr>
<td>Saomao</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Owlk</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Approximately bi-monthly</td>
</tr>
</tbody>
</table>

As already discussed, although five health centres had selected committee members, Saomao’s HCMC members did not have management committee meetings. Jaik and Kroich Health Centres had not had an HCMC meeting since the initial one to set health centre fees in 2001 and 2002. Four health centres – Pom, Mian, Lahong and Owlk – had operational committees in 2006: they had members, regular meetings, and also took minutes. The other criteria in the empirical frame will be used to assess the levels of participation in these four operational committees only.
Committee Members and Observers

The committee at Oumluk had been operating since it was established in 1998. In Lahong, Pom and Mian Health Centres, the committee members were appointed in January 2006. Lahong Health Centre's acting chief Mr Sen Chhung explained the process:

*The way we selected this management committee was we discussed with the commune and the operational district and the health centre, and we selected members to come from the ajar wat [the lay person in charge of a temple], from the teachers, from the commune council and from the health centre.*

DRAY also had significant input into the selection of committee members. Formal and informal community leaders, Traditional Birth Attendants (TBAs), and some people who had previously been elected to the committees during the period of KADARM support were appointed to the committees in 2006.

As discussed in Chapter Two, representativeness relates to the membership profile of committees. Table 5.2 shows the prescribed and actual members of the committees. There were a total of 34 members of the HCMCs across the four health centres. Of these there were eight health centre staff members, 11 commune councillors and 15 community representatives. There were fewer HCMC members than the policy required, particularly fewer health centre staff and community representatives.

The term “community representatives” masks the limited membership of lay citizens. Table 5.3 shows the composition of the “community representatives” by their occupation or role outside of the committee.
Table 5.2 Membership of Committee – Policy Compared with Practice

<table>
<thead>
<tr>
<th>Health Centre</th>
<th>Number of Communes it Serves</th>
<th>Health Centre Staff</th>
<th>Commune Councillors</th>
<th>Community Representatives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number required by the policy</td>
<td>Actual Number</td>
<td>Number required by the policy</td>
</tr>
<tr>
<td>Lahong</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Mian</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Owluuk</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Pom</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12</strong></td>
<td><strong>8</strong></td>
<td><strong>10</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

Table 5.3 The ‘Community’ Representatives

<table>
<thead>
<tr>
<th>Health Centre</th>
<th>Type of Community Member</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>VHSG Member</td>
</tr>
<tr>
<td>Lahong</td>
<td>0</td>
</tr>
<tr>
<td>Mian</td>
<td>0</td>
</tr>
<tr>
<td>Owluuk</td>
<td>0</td>
</tr>
<tr>
<td>Pom</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

The 15 community representatives across the four operational committees fell into one of three categories: informal leaders, lay citizens (other than VHSG members) and Traditional Birth Attendants. Informal leaders included a school principal, a retired health centre chief, monks, and ajar wats. Although the committees were ostensibly meant to be a place where ordinary villagers and health centre staff talked to each other and solved management issues together (Mr Sam White, Interview), the members of the committees were mostly official and unofficial community leaders. Only six committee members (17.6% of all members) were lay citizens, and none of these were VHSG members.

Members of the Pom HCMC, which had the highest proportion of lay citizen members, felt that the involvement of ordinary villagers was important:
If we just work with the authorities – only the commune, health centre and important people – we can’t control information in the community. It’s not good. Therefore we should select from the village, to make them help us (Mr Ree Saing, Health Centre Chief, Interview).

The positive thing about this management committee is that it combines the suggestions, the ideas, the relationship and applies pressure to the work of the health centre between the high level and the low level people (Mr Pon Sarith, Pom HCMC, Interview).

Recall that lay citizens are those without expertise in the issue being discussed and those not usually involved in decision making (Hogg and Williamson 2001). Although no other HCMCs included many lay citizens, members of both Mian and Lahong HCMCs argued that their committees did include ordinary villagers. Mr Chea Pirun, Chief of Mian Health Centre argued that ‘the traditional midwife is a villager, and the ajar wat is a villager as well’. The HCMC chief/commune council chief at Lahong Health Centre spoke of the community representatives, stating that:

They are the public, but they are the ones who had important jobs before, so they have the experience in those roles (Mr Chan Roth, Lahong HCMC, Interview).

These people were selected because of their expertise or community leadership experience and therefore cannot be considered lay citizens.

Despite trying to claim significant lay citizen representation, people in the HCMCs at Lahong, Owuk and Mian Health Centres extolled the virtues of selecting leaders to be on the HCMCs. Mr Run Mak, the former chief of Lahong Health Centre discussed the importance of having formal and informal community leaders on committees, in lieu of ordinary villagers:
We chose the ordinary villagers one time already during the period that KADARM supported the HCMC, but the problem was that the public didn’t pay attention to them or believe them. Most of the HCMC members were from the VHSG. Most of the HCMC now are the workers and the public are in the VHSG roles only. The health centre management committee is stronger now than before because before they didn’t have local authorities. Now they have only the commune authorities and village authorities and leaders, those who are the uppers. When the uppers speak, the public listen. We just choose people who have positions in the village to be members of the HCMC. We don’t really have ordinary people. If they are ordinary people, when they are spoken to in committee meetings, they don’t pay attention.

During the period that KADARM had provided assistance, using lay citizens had proved unsatisfactory for the staff in Mian, Lahong and Owluk Health Centres. Instead ‘uppers’ were sought, those of higher social status. As committee members had resigned they were replaced by the appointment of leaders, as even KADARM staff had become disenchanted with the involvement of lay citizens on management committees (Mr Pok Tekla, KADARM, Interview). The reasons provided by Mr Run Mak above were only two of many given to support the common assertion among those connected with HCMCs in Mian, Lahong and Owluk Health Centres that it was better to have formal and informal leaders rather than ordinary villagers on committees:

We only have the people with the key positions because they do more outreach than the ordinary public do, they can report quickly, they listen to their people, they come and bring problems to discuss with each other, and when the people complain about some things they bring the problem to solve together. So it is difficult to select the ordinary people (Lahong Health Centre Acting Chief, Mr Sen Chhung).

It is difficult to have ordinary villagers because there is no budget to support their costs such as transportation (Mrs Dork Rana, Owluk HCMC, Interview).
We selected the people who are clever and who the public love, and at events they use the microphone to tell the public to come and use the health centre services, and the public listens. And when they join the meeting they can know the plan, they know in the capacity of their other positions, such as the ajar and as the monk as well. It is the strategy of the Health Centre Management Committee, that when the monk finishes the Buddhist doctrines they take the time to say about the work of the health centre, for using services, pressure our public to utilise the services, and avoid buying the medicines that are illegally sold by vendors (Mr Meas Yon, Oowluk HCMC, Interview).

If authorities are selected, they will do the work. Because they have networks in the commune... they can know information necessary to fulfil their roles on the management committees (Mr Da Saravuth, Lahong Health Centre, Interview).

Authorities and other leaders as such have a number of perceived advantages that precluded lay citizens being selected to be on the committees. Even those health centres without committees have found it important to work through local authorities:

We can’t work in areas when the authorities don’t know about it. We need to develop our work in order. We have the order and the levels. If we want to do work in a community, for example do an immunisation drive, we give the information to the District administration, they provide it to the commune level, and the commune level provides the information to the village level, who tells the population. We need to work in order. If we follow the order our work is recognised and it is the right thing to do (Mr Keo Vanny, Kroich Health Centre Chief, Interview).

Commune councillors have been responsible for spreading information about and assisting with outreach days (Mrs Li Tin, Oowluk HCMC, Interview). Having ready access to these authorities within committees makes logistical sense.
The inclusion of lay citizens is one of the most important features of representativeness in the empirical framework used in this study. However, I now turn to consider other aspects of representativeness. I specifically examine the extent to which members’ characteristics mirrored the demographic features of the broader population in terms of gender, the inclusion of young and poor people, and a geographical spread of members throughout the catchment areas. These aspects of representation were required by the policy and are also advocated by democratic theorists (Ministry of Health 2003; Phillips 1991; Carr and Halvorsen 2001).

Phillips (1991) argues for women’s involvement in democratic structures based on the notion of equality for all and the idea that representation should “mirror” society i.e. be demographically representative. Universal values of democracy are that all people are equal, but the experiences of democratic processes are gendered (Phillips 1991: 6). Although the policy required equal representation from women and men, only one third of members (11 out of 34) and one third of community representatives (5 out of 15) were women in 2006. There were a lot more women than men in VHSGs; these positions were considered appropriate for women as they were not decision making roles (Mr San Maleng, Jaik Health Centre Chief, Interview; Mr Rek Yon, Lahong HCMC, Interview). Although some respondents wished that there were more female members, others stated that women were less capable of fulfilling the duties of the management committees:

Mostly men have more knowledge than women, and the Khmer woman’s habit is always to be shy, they have no willingness… oh, they have the willingness, but they are just very shy for speaking or relating to others (Mr Sek Vontha, Pom HCMC, Interview).

The most common reason given for the smaller number of women in the committees was that they were busy with their domestic duties. Responsibility for child-rearing in Cambodia, like many countries, chiefly rests with women and therefore women may have greater barriers and costs for participation. However, the question of female involvement also relates to cultural notions about appropriate behaviour in the public sphere. In Cambodia men are much more involved in public decision making processes (Phan and
Patterson 1994; National Institute of Statistics and Directorate General for Health 2001), and women are expected to operate in the private, domestic sphere (Institute for Popular Democracy 2007: 7). Women rarely spoke in committee meetings, with the exception of Owluk’s Commune Chief. I noted:

Women had to be prompted for their input almost exclusively throughout the meeting. Midwife (although arriving late), didn’t really speak until the end, an older woman lay citizen committee member did not really speak at all (Pom Health Centre Observation Schedule, February 2006).

Few of the women were in high status positions. The 11 women on the committees had the following external roles or occupations: one was a commune chief, one a commune councillor, four were health centre midwives, two were Traditional Birth Attendants, one was a women’s association representative and two were lay citizens (a rice farmer and a vendor). Mrs Li Tin, as HCMC/commune council chief on Owluk’s HCMC, presided over the management committee meetings. She was more vocal than her male counterparts in other health centres. The position-related status of female committee members appears to have been a more important factor affecting their participation rather than their gender. However, the low number of women in high status positions, coupled with the decision to recruit leaders rather than lay citizens, means that there were few women included in HCMCs.

People can be selected to serve as committee members ‘regardless [of] economic status’ (Ministry of Health 2003: 19), but the policy also specifically calls for the involvement of representatives of the poor:

It is important to note that the representative of the poor living in the community should be provided an opportunity to have a “voice” in community participation process (Ministry of Health 2003: 8, emphasis in original).
The needs of poor people for access to public facilities are different from wealthier people, who have enough resources to access private health care. The policy outlines that one of the key working principles of the Ministry of Health is to be “pro-poor” (Ministry of Health 2003: 5 and 6). However, in participatory processes across cultures and contexts, middle-class residents participate to the exclusion of others (Petts 2001: 214). Likewise in this research there were no wealthy or poor Cambodians participating. Almost all committee members were waged or had their own businesses. It was widely acknowledged by interviewees that the very poor were not sought out for committee membership. The reason given for their exclusion was that they had to devote their time to pursuing a livelihood. Exclusion of the poor was also justified by their lack of education and a lack of knowledge concerning fellow community members. The lack of low-income members limited the opportunities for the Ministry of Health to be pro-poor and for the poor to have their voices heard.

The policy stipulates that the minimum age of committee members is to be 25. The youngest committee member was 35; most were significantly older than this. These results are similar to the findings of other research; for example, Petts (2001: 214) found that most participants in committees were middle-aged and it had been difficult to recruit young people. The reason given for the exclusion of young people in HCMCs was that:

*If there are young people the villagers don’t listen so mostly they choose the old people because the villagers like listening to them. This is the habit of Khmer tradition* (Mr Sam Rith, District Administrator, Interview).

If the role of the committees was as per the policy, then villagers would not need to listen to HCMC members as the latter’s role would be limited to decision making. The desire for this trait highlights the role that the HCMC members were expected to play in promoting health centre services in the local area.

Representation from villages across the catchment area should enable the specific needs of those living in isolated and more remote communities to be heard and considered. However, those in more isolated locations had no representation on the HCMCs. Although
the policy required a geographical spread of members from throughout the catchment area, most of the committee members came from those villages closest to the health centres.

The profile of committee members as older, male and well-off people reflects the profiles of committees and participatory processes elsewhere (Carr and Halvorsen 2001: 114). In Cambodia it is the result of the decision to recruit primarily official and unofficial leaders to committees:

> The management committee has more old people than young people because it has a lot of workers like the village chiefs, commune chiefs, commune councillors, and the authorities in the villages. Most of these authorities are old

(Mr Sam Daravuth, Lahong HCMC, Interview).

In addition to committee members, several other people attended HCMC meetings. Regular observers included DRAY staff and Mr Lek Vuthy, the vice-director of the operational district office, the next level above health centres in the national health system. On one occasion an observer from the District Administration Office, the level of government above the commune council, attended. Owing to their formal positions outside of the committee, all observers enjoyed a status higher than that of committee members including health centre staff. These people were all considered to be “uppers”, i.e. they had a high social status (Mr Thim Paly, Owluk HCMC, Interview).

**Committee Meetings**

On the day of a committee meeting, the health centre staff would already be in the centre. At the time when a committee meeting was scheduled to begin, the ordinary villager members would turn up, followed a bit later by the informal community leaders and then the formal leaders. The meetings would begin when the staff from DRAY and the operational district vice-director would arrive, sometimes up to an hour after the scheduled starting time. Some of those who arrived on time for meetings expressed frustration to me about having to wait for a long time for the meetings to begin.
Baogang He (2006: 140) has identified the ways that formal relationships of power are replicated in the seating arrangements in participatory processes. In China leaders would sit either at the heads of tables or at raised tables, reinforcing the inferior positions of other participants through this physical arrangement of the participatory space (He 2006). In the HCMCs, the distribution of power was evident through the way that people were physically situated in groups, with a separation between high-status and low-status members during both formal and informal proceedings:

There was a separation in the seating of the meeting and in the break when people congregated in groups to eat snacks. This separation was between the external people and everyone else. The external people were the operational district vice-director, the DRAY staff and the health centre acting chief. ‘Everyone else’ was the HCMC community representatives and commune councillors. The externals and the commune council chief ran the meeting (Lahong Health Centre Observation Schedule, August 2006).

During meetings, the chairs were organised into a circle. Its perimeter included one table. The health centre chief, the commune council chief, the operational district vice-director and DRAY staff sat along three sides of that table. No other committee members sat at tables.

One of the commune council chiefs was appointed as the chief of the HCMC. In all meetings, that HCMC/commune council chief formally opened the meetings by standing and welcoming everyone. There were usually around six items on the agenda. Lay citizens and other community representatives did not set the agendas or contribute agenda items in any of the meetings attended during the study period. The agendas were set by DRAY staff in Mian, Pom and Lahong HCMCs and were issue based; commune councillors did not have any input into the written agendas in these health centres either. The effect was that rather than giving lay citizens, other community representatives and local authorities opportunities to raise their own concerns about their local health services, the proceedings in all locations became homogenous. I noted:
The issues discussed in the meeting seemed much the same as the meetings held at the committee meetings at the other two health centres that have already met this month. Given that they all came from the same (NGO) agenda, this isn’t surprising (Lahong Health Centre Observation Schedule HCMC Meeting February 2006).

Even in Owluuk Health Centre, where the agenda was written by the commune council/HCMC chief, Mrs Li Tin, similar issues were raised. This occurred because the agenda always included ‘DRAY’s representative to address the meeting’.

The commune chief who had been appointed as HCMC chief was usually given the official role as chairperson of the committee meetings. At Owluuk Health Centre, the commune council chief did perform this role, but in other HCMCs this function was taken over by the staff from DRAY or the operational district vice-director. The minute taker was declared at the start of these meetings, and this was a commune council member in Owluuk, and the health centre chief in the other health centres. The minutes in HCMC meetings in all health centres were kept in the notebook of the person taking them, and were not copied or circulated after the meeting.

Meetings began with the health centre chief providing his report (they were all men) on the known health statistics for the area. Written reports were only provided twice to HCMC members during the study period: at Pom’s and Lahong’s August meetings. Even when provided in written form, the reports were also verbally delivered, as they were in all other meetings. The following excerpt from Mian’s June meeting gives the flavour of the reports:

We provided vitamin A to 21 people, and treated three people for TB in the health centre, but they’re not better yet. We had 12 people with sexually transmitted diseases, we didn’t have malaria, and this month 21 people gave birth, 12 in the health centre, 6 with a medical midwife at home and 3 with a traditional midwife at home (Mr Chea Pirun, Mian Health Centre Chief).
This report proceeded in a similar manner for 15 minutes, reading first the June statistics and then the July ones, with no comparison provided by Mr Chea. HCMC members were then asked by the operational district vice-director to comment about whether the health centre chief was telling the truth or not in these reports. Given that volunteers were not provided with written reports and did not have the opportunity to verify the reports with people in their local area, for example about the rate of pregnancies or outreach clinics, this was an unrealistic expectation. Mr Sok Samnang from DRAY had demonstrated the importance of using reports to track health centre performance in Mian HCMC’s February meeting:

Do you know how many people in the catchment area, for example 11,000 people, and then think about how many people use the health centre. And like the pregnant women also, if there are 200 of them, how many died during delivery? If 50 of them died, then we know there is a problem. So if the committee sees any problems at all, problems with the community coming to use health centre services, the health centre must solve this, do whatever is necessary to do this.

On a few occasions, health centre reports were followed by HCMC members providing verbal reports on the health statistics for their own areas but more often these reports were provided in written form only. These reports were of the numbers of pregnancies and different types of diseases known in the community:

The management committee is for collecting information on all the public in the communes, to inform the health centres about which villager has what diseases, which will report to the health centres so that the health centre can cure the patients (Mrs Sen Rani, Lahong HCMC, Interview).

In all the health centres, after the health centre chief’s report, the next item on the agenda was addressed. In Oowluk this was the next designated speaker, who would be invited to address the meeting. The commune council chief, Mrs Li Tin, was the only person besides the staff from the health centre, operational district and DRAY who had time dedicated
within the agenda for her to address the meeting. In Pom, Mian and Lahong Health Centres the next items on the agenda were issue-based. Meeting content and HCMC input into management of the health centres will be discussed shortly, and further analysis of the issues raised in meetings will be presented in Chapter Seven.

Those with higher status dominated meeting proceedings, particularly the so-called “observers”. At one point in Pom’s August meeting, the operational district vice-director gave a 20-minute speech. It was not unusual for either him or the DRAY staff to speak for such long periods. Most meetings were similar to my observations of Mian’s February meeting:

*Community representatives seldom spoke in the meeting – only when they were asked for specific opinions… They were quite passive. The health operational district vice-director dominated the meeting, and most of the meeting was a three-way conversation between the health centre chief, DRAY and the health operational district vice-director. It felt like an observed supervision visit (conducted by DRAY and the health operational district) (Mian Health Centre, Observation Schedule).*

This field observation calls attention to the way that those with status and power spoke almost solely to others with similar status and power, thereby restricting the participation of lay citizens and other community representatives. It was 22 minutes into this meeting that a community representative spoke for the first time. Even the formal community leaders spoke relatively little within meetings. This experience was consistent across all meetings and in all of the health centres included in this study.

Although their input was often minimal in the context of a committee meeting, I will now examine the role of lay citizens and other community representatives including their interactions with higher status members.

One issue frequently raised in all the committees by DRAY was the need to get women to give birth in health centres rather than with the assistance of Traditional Birth Attendants:
In the management committee meeting we discussed about the difficulties in transferring the pregnant women to give birth in the health centres. It is a difficult problem. We discussed it a lot. We often discuss but have no solutions, it is difficult (Mr Pon Sarith, Pom HCMC, Interview).

Many women prefer to give birth at home with a TBA because it is more convenient, health centres are often too far away, and there are concerns about the quality of the health centre services including that they are unattended for many hours in a day. DRAY staff wanted women to give birth at health centres because they perceived home births and traditional birthing practices to be more dangerous for the mother’s and baby’s health. Community representatives and commune councillors were not asked for their views on alternative methods for encouraging greater numbers of women to give birth in health centres. Instead they were made to understand the importance of this issue from DRAY’s perspective, and they were told to pressure the public to give birth in the health centres. In this way their role was limited to passive participation.

Occasionally within meetings, the community representatives and commune councillors would be asked what they identified as problems in the health centre. These were rarely discussed or followed up with action. For example, in Lahong’s February meeting, the health centre problems raised by the community representatives were written down by the operational district vice-director Mr Lek Vuthy, who thanked them for their input, yet these issues were not discussed or re-visited in later meetings. In another example, Mr Chan Pen, a commune councillor on Mian HCMC felt the most important issue for the Mian Health Centre was the lack of medicines in the health centre; he felt that this forced people to attend private clinics in order to get medical care (Interview). This issue was raised in the August meeting, but was not discussed; neither were any solutions proposed to solve the problem. In a third example, in Lahong HCMC’s February meeting, Mr Da Saravuth suggested that students and their families be given health fee exemptions to encourage parents both to send their children to school and seek treatment in health centres. Again, this issue was not discussed within the meeting nor revisited in subsequent meetings.
In the few instances where issues raised by committee members were responded to, the responses were used to discount misperceptions of the committee members and to convince them that the expectations of the public were unrealistic. For example, in Pom’s February HCMC meeting, Mr Pra Dtom, a lay citizen committee member, complained that health centres always opened late. Recall that the official opening time was 7:00 am. Mr Ree Saing, the health centre chief responded to this complaint in the following way:

*I admit, on Saturday or Sunday I don’t ensure that the doors open on time. I don’t ensure. But for working days, it is never later than eight o’clock. If you don’t believe me, please come and see. The management committee come and see at eight o’clock. It is rare for this centre if you come at eight o’clock and you don’t see the doors open* (Pom HCMC Meeting Transcript, February 2006).

He asked the committee to tell the community not to be angry with the health centre and told me in an interview that the management committee needed to consider that the staff members were not very late. Despite dismissing the complaint in the HCMC meeting, Mr Ree relayed this complaint in a staff meeting, and counselled all the staff to arrive at work before 8:00 a.m. (Mr Ree Saing, Interview). This action was not reported back either to Pra Dtom or to the HCMC at the subsequent meetings. This is the only example I either observed or had reported to me during the study period of a complaint or issue raised by the community representatives in an HCMC meeting that had any action taken by health centre staff.

In the same meeting Mrs Nu Peorn, also a lay citizen committee member, raised a complaint from the public, that the health centre staff gave medicines that were not effective, and would only give three days of medicine at a time to patients. Her complaint, like that of late opening hours, was responded to as though it were the fault of the patients rather than a health service delivery issue:

*Mr Ree Saing (health centre chief): These medicines are not produced by the staff. We receive medicines from the higher level, the same as in other health*
centres. Being cured depends on the time, and sometimes diseases are serious and can’t be treated in health centres. So we can’t cure very serious problems, but if it is an average disease then we can cure, because we only have the pill medicines. We don’t have IV drugs in the health centre.

Mrs Nu Peorn (lay citizen member): But when it is a serious disease, they are not given enough medicine.

Mr Pon Sarith (lay citizen member): The villagers come only one time and they say it’s not effective.

Mr Ree Saing (health centre chief): So it is their mistake themselves, so you need to help them understand. We limit our treatments to three days. If they are not better then they must come to the health centre for a follow up consultation. If they are not better after three days, then we will search for a new medicine, to change their treatment.

Mr Sok Samnang, (DRAY representative): It’s not the mistake of the medical staff.

Mr Ree Saing (health centre chief): Yes.

Mr Sok Samnang (DRAY representative): It is the mistake of the management committee, all together. This is an issue that you need to think about when complaints are raised by the community: is it the problem of the health centre or caused by people not understanding yet?

This exchange shows how the structural causes of the problem were denied. The blame was squarely shifted away from the medical staff: ‘It’s not the mistake of the medical staff’. Neither changes to the communication practices between medical staff and patients nor changing the way that health services dispensed medicines, including increasing the number of days of medication given at one consultation, were discussed. Instead, the problem was
reconstructed by the health centre chief with the patients’ lack of understanding as its cause. This reinterpretation was supported by DRAY. This exchange also demonstrates the role that the HCMC was expected to play in educating the community, ‘to help them understand’. Community representatives and commune councillor committee members were often urged to educate the public about specific issues such as that clients should return if their illness had not passed after the initial medication.

Although the participation policy does not require deliberation in committees, the degree of deliberation is an important measure of the quality of participation (see for example Carson and Hart 2005). As mentioned in Chapter Two, in Habermas’ ideal speech situation, all participants are to be viewed as equal, all assertions justified, and participants must respect others, pursue the common good, try to move towards consensus, and say what they really think (Habermas cited in Steenbergen et al 2003: 5). It is rarely, if ever, realised. However, deliberation can still exist even when this ideal situation is not achieved. The critical element of deliberation is the ‘collective “problem-solving” discussion’ (Abelson et al 2003: 241), where people reason and debate different ways of resolving problems (Goodin and Niemeyer 2003).

Deliberation needs to be ‘nurtured by an awareness of the conditions necessary to enable argument and challenge’ (Barnes et al 2004: 106) These conditions include recognising and legitimating different types of knowledge, using and allowing different modes of expression, and respecting others (Barnes et al 2004: 106). Deliberation therefore requires the creation of a space for people to talk and discuss key issues. Facilitation is a key component of deliberative practice, particularly when there are few procedural rules specified for the participatory structure (Kapoor 2002: 106).

If deliberation happened in the Cambodian committees, there would have been evidence of collective problem-solving. Members would have carefully considered different ways of resolving health issues and health centre problems. All – or at least most – attendees would have been invited to provide and justify their opinions. Committee members would have challenged each other’s views.
In practice, the participants did demonstrate one criterion of the ideal speech situation: showing respect to each other. People showed respect by not challenging those of higher status or others of similar status. The community representatives and commune councillors spoke only when invited to. However, this respect was detrimental to the criterion of all participants speaking equally. This preference of deferring to those of higher status was not countered by the facilitators of meeting discussions. Those playing key facilitative roles – DRAY staff and the operational district vice-director, and Mrs Li Tin at Owluk Health Centre – did not encourage community representatives to speak to other meeting attendees. Although community representatives and commune councillors were on limited occasions prompted by the operational district vice-director to say what they really thought in terms of what the health centre problems were, this cannot be interpreted as achievement of another criterion of the ideal speech situation: that people say what they really think. Notions of respect in Cambodia ensured that participants were unwilling to speak too strongly against bad practices in the health centres.

The HCMCs never attempted to reach decisions. There was therefore little incentive or opportunity for reasoned argument amongst participants. The facilitators did not encourage debate within meetings at all. Committee meetings had ‘some discussion, but not very much’ (Lahong Health Centre, HCMC Observation Schedule February 2006). Instead, in the meetings of all four HCMCs:

*The speaking was characterised by long monologues, rather than discussions…*  
*The meeting didn’t have much dialogue; rather it was a case of long speeches and reporting back* (Lahong Health Centre Observation Schedule HCMC Meeting August 2006).

The committee meetings were not deliberative spaces in any of the health centres.

Meetings lasted approximately two hours before they were formally closed by the commune council chief in a similar manner to their opening. After the meetings, a DRAY staff member set himself/herself up at a table to one side of the patient waiting area and paid all of the HCMC members, including health centre staff, their *per diems*. These are allowances
paid to participants; community representative and commune councillors were paid 14,000 riels per meeting, equal to US$3.50 (Bun Michoo, Mian HCMC, Interview).

Committee Involvement in Management Decision Making

Committee members are to participate in decision making about health centre ‘management and development of health centre services’ (Ministry of Health 2003: 14). The management tasks of the health centre chief were:

- The administration component
- Financial component
- Accounting component
- Immunisation component
- Consultation component

[and] maternal health
- including pregnancy examinations (Mr Keo Vanny, Kroich Health Centre Chief, Interview).

The HCMC members are to contribute to the non-clinical components of this role. Involvement in strategic planning for health centre services is also an HCMC responsibility; this includes overseeing the development of the Annual Operational Plan for each health centre. These plans were developed during the fieldwork period. The HCMCs were not informed that this process was occurring, invited to have any input into it, or given information about the recommended plans for each health centre.

The management committees did not have any input into how health centres’ budgets and the income from user fees were to be spent. One of the reasons given was because the HCMC members lacked the techniques to analyse budget expenditures:

- The health centre just reports the income to us so we can listen. We don’t know well the techniques to make decisions about the health centre budgets (Mr Da Saravuth, Lahong HCMC, Interview).

This contrasts with participatory budgeting processes mentioned in Chapter Two, where communities have significant input into shaping municipal budgets (Cabannes 2004). The
budget of health centres was already fixed and was insufficient to address problems in the health centres:

_When we hold the meetings, we continue to raise more problems, those problems that haven’t been solved yet. But we don’t have a budget. When we don’t have a budget, we don’t know what to do. We don’t have a budget for solving problems. The budget that we do get [the 39% of user fees allocated to health centre operations] are already allocated to look after the centre, keep it clean and to do minor renovations. We also use this money to buy the medicines, do photocopying, buying the prescriptions. We don’t have money to pay to solve the problems; therefore we still have the problems_ (Mr Sen Chhung, Lahong Health Centre Chief, Interview).

Therefore the HCMC could not exercise discretion or influence budget expenditures within the health centre. HCMCs also lacked a budget of their own, and this combined with the inability to influence health centre budgets severely limited the ability of HCMCs to be meaningfully engaged with decision making.

Rather than playing active decision making roles, management committees fulfilled other functions. Although acting as an “information bridge” between the health centre and the population was required of the Village Health Support Groups in the policy, in practice it was also required of HCMC members in the study area:

_This health centre has a health centre management committee because it is easy to give information to villagers. It is easy to tell clients in the village, so they can understand about the health centre’s program, for example the dates when they will come to immunise in the village, but also for understanding about the dangers associated with different diseases and pregnancies. And it is also easy to get information back, to report to the health centre_ (Mrs Rin Chenda, Mian HCMC, Interview).
Pressuring the public to attend health centres was a key task of the committees; some thought it the most important task (Mr Pong Taing, Mian HCMC, Interview). HCMC members were also expected to play a role in spreading information about upcoming immunisation drives (Mr Chan Pen, Mian HCMC, Interview). These were the issues that committee members focussed on, rather than involvement in decision making. There was a common perception that the HCMCs had been established:

To be the eyes, nose and ears of the health centre. Because the health centre can't see enough, they must have the committee members in the villages to help, to give the information and where necessary collect the information and give it to the health centre (Mr Pra Dtom, Pom HCMC Meeting, February 2006).

As such, HCMCs provided labour to health centres and the focus was therefore passive rather than active participation.

Some HCMC members felt they were limited by what they were told they would be able to do, and what they felt were the boundaries of their role implicit in the policy. Mr Da Saravuth, a school principal and member of Lahong’s HCMC noted that:

We are afraid to raise any significant points in the management committee meetings because we don’t know their and our roles clearly. If we make strong points, it can be wrong according to the policy. So we don’t know how much the Health Centre Management Committee should say, how much we should tell them. Until now, we’ve just listened to the reports, and never gone to sit and discuss with them. If we went to investigate the reports and the problems, if we conducted interviews with the public, we would know the moralities of the doctors [i.e. whether they are polite to patients and hard working]. When we understand these roles, we will be brave and speak. But if not we are afraid about whether the operational district or the health centre staff are frustrated with us. So we just listen in the meetings. Just sit and listen… For the Health Centre Management Committee and the health centre to be strong,
it depends on the relationship between them. But at the moment we just listen to the reports from the health centre so it is weak.

Mr Da clearly found being divorced from decision making and playing a passive role frustrating.

Influence is the degree to which participants affect decisions about the issue that they are discussing. The purpose of participation is for the community to influence government decision making (see for example Redell and Woolcock 2004: 78). If the lay citizen and other community representative committee members were influential, they would have written or contributed to meeting agendas, issues raised by them would have been considered and committee decisions would have reflected their views. The committee decisions would in turn have resulted in changes to health centre practice.

None of this happened in the HCMCs. Committees never discussed meeting procedures and so community representatives had no input into them. Neither did they choose facilitators or meeting chairs – DRAY and the health centre chiefs appointed committee chairs in line with the policy. Although the HCMCs had been involved in setting fees in the health centres almost a decade earlier, this was their last substantial decision making or management role. The lack of influence of community representatives over agendas and decisions combined with the non-existent committee budget, lack of influence over health centre budgets, and exclusion from health centre strategic planning processes all demonstrate the limited influence of community representatives and HCMCs on the management of health centres.

*Summary of Levels of Community Participation*

In summary, the level of participation of lay citizens and other community representatives in the management of health centres was low, although the practices within health centres varied slightly. The results are summarised in Table 5.4 below.
Table 5.4 Summary of Levels of Lay Citizen and Other Community Representatives’ Participation

<table>
<thead>
<tr>
<th>Criterion: Health Centre</th>
<th>Operation</th>
<th>Representativeness (proportion of lay citizen members)</th>
<th>Deliberativeness</th>
<th>Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jaik</td>
<td>Nil</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Kroich</td>
<td>Nil</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Pom</td>
<td>Medium</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Mian</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Lahong</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Saomao</td>
<td>Low</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Owluuk</td>
<td>Medium</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
</tbody>
</table>

5.4 ENABLING FACTORS FOR PARTICIPATION

Clearly a participation policy was not enough to ensure strong community participation as this did not exist in any health centre included in the study area. However, it is possible to identify several factors that were important in establishing participatory structures and/or affected individual involvement.

Status

Status is a socially defined position or rank (Tyson 1998). It is largely determined by a person’s official role either within a group or in society (Napier and Gershenfeld 1999), and usually correlates with a person’s place in the social hierarchy. There have been few empirical studies of the impact of status on participatory processes and these have largely been conducted in the context of Western countries. Most have found that those with status are over-represented in participatory structures including committees (Irvin and Stansbury 2004; Marshall and Jones 2005; Chambers 1994; for an exception see Dutwin 2003). Status also affects interactions between group members (Johnson and Johnson 1997; Tyson 1998; Napier and Gershenfeld 1999). Participants do not have equal status outside of the participatory process and their actions within it are affected (Campbell 2005b). Group discussions in participatory processes are spaces where informal hierarchies of status affect interactions (Murthy and Klugman 2004; van Stokkom 2005). More than one status
hierarchy can operate within a group at a time; for example, one based on formally allocated positions within the group and the other on informal characteristics that the group members deem important (Tyson 1998). Even in structures that assume equality of members – such as juries – people’s status within the group mirrors their status in society (Napier and Gershenfeld 1999). There are significant differences between how high-status and low-status people interact in a mixed-group setting, with high status people being far more actively involved in discussions (see for example Beebe and Masterson 1994; Tyson 1998), and they also have the ability to influence others.

The findings of the present study support these broader claims about the impact of status on participation. Status was the most important factor shaping who attended and how they participated in the process and interacted with each other. According to the participation policy all members of the HCMCs were to be considered equal participants and were to have an equal ability to contribute to discussions and decision making (Ministry of Health 2001b). In this, the purpose of Cambodian committees is consistent with the presumption of equality in deliberative theory (van Stokkom 2005).

Although the participants’ status within the HCMCs is officially equal, this stands in marked contrast to the social hierarchies that determine a person’s status. Cambodian society is hierarchical and relative positions of status are widely understood and acknowledged (Oveson et al 1996). Despite the presumption of equality stated in the policy documents, I found that both the selection of committee members and their subsequent participation were shaped significantly by their status in society. Similar results have been found in China, where ‘participants theoretically enjoyed equal “rights” but were usually forced into traditional and highly unequal power relations’ in participatory processes (He 2006: 140).

A range of informal hierarchies were revealed in both committee membership and in the behaviour of all attendees within committee meetings. The most prominent hierarchy of participation within committee meetings was determined by people’s occupations and is as follows (listed from those with the most power in committees to the least):
1. DRAY staff/health operational district staff
2. Health centre chiefs
3. Commune chiefs
4. Commune councillors
5. Village chiefs
6. Informal leaders (non-religious)
7. Health centre midwives
8. Informal leaders (religious – monks and ajar wats)
9. Lay citizens/Traditional Birth Attendants

This hierarchy parallels the status and power of people outside of the HCMCs with respect to decision making about community issues and health centre management. People near the top of this list were referred to as “uppers” during interviews, and those near the bottom as well as the general public were referred to as the “lowers”. The importance of status in the HCMCs demonstrates the way in which existing norms were replicated in the practice of committees:

However participatory a development project is designed to be, it cannot escape the limitations on this process that derive from the power relations in wider society (White 1996: 13).

Status is not a peculiarly Cambodian phenomenon, and its impact on participation has been researched in Western contexts as already cited (see for example Murthy and Klugman 2004; van Stokkom 2005). The present study contributes an empirical examination of how status operates and its effects on community participation in committees and in a non-Western context. Status emerged as the key factor determining the participation of individuals in the HCMCs; it largely operated to the detriment of lay citizens and other community representatives.
International NGO Support

International NGO support has only been identified as important to the implementation of a government’s participation policy in one study (Mattner 2004). Such support proved the key factor enabling the establishment of institutional spaces for participation in the Cambodian health sector. Most respondents noted that external assistance from international NGOs was the key factor resulting in the establishment of health centre management committees. Staff members from health centres with and without HCMCs, those working in higher levels of the health bureaucracy, and staff members of the international NGOs themselves all identified the importance of international NGO support, as shown in the quotes taken from interviews in response to the following question:

Researcher: Why do some health centres have a management committee and some health centres don’t have a management committee?

Mr Lek Vuthy, Operational District Vice-Director: Some places that have an NGO helping, providing the money, they can have the meetings, and the staff of the NGO join the meetings. When there’s no money, it’s over.

Mr San Maleng, Jaik Health Centre Chief: I don’t have the meeting because I don’t have the budget. We don’t have NGOs helping. At other health centres they have NGOs assisting and so they can have committees… This health centre doesn’t have anyone helping.

Mr Pra Dtom, Pom HCMC: The reason this health centre has a management committee is because before it was supported by KADARM and now it is supported by DRAY. Some health centres don’t have an organisation to help, so they don’t have a management committee.

Mr Thy Nem, PEAKHEALTH Director: Health Centre Management Committees function well only in the areas where NGOs support them.
The history of HCMCs in the study area – with the exception of Owluk – corroborates this position. In the other six health centres in the study, beyond the initial meeting to set fees, HCMCs only operated when either KADARM or DRAY was supporting them; in 2006, all of the operating HCMCs were supported by DRAY. However, Owluk’s experience does not refute the importance of international NGO support. Although Owluk’s HCMC continued to operate without external assistance between 2002 and 2006, it had been established by KADARM. I will shortly explore the other factors that enabled Owluk’s HCMC to *continue* operating.

Having an international NGO support the work of a health centre is not in itself sufficient for the establishment of HCMCs. Saomao, Jaik and Kroich Health Centres were all without operational management committees, yet all three received some assistance from international NGOs during the study period. This assistance was for the work of VHSGs rather than for the establishment and management of HCMCs. Therefore, in all health centres, targeted support by international NGOs for management committees ensured that they were established, and in most health centres HCMCs remained operational only with ongoing international NGO support.

*Owluk: Health Centre Leadership, Membership Profile and Time*

Owluk HCMC’s experience differed from other health centres as it had *continued* to convene an operational committee for three years without international NGO assistance. Mr Sen Peom, Owluk Health Centre’s chief, told me why:

>This is the idea of the leader level. We didn’t want to break off the work that we had collaborated on before. We want to keep this, because we want to get the benefits from those people who came to connect with us. We can’t do the work of the health centre alone, without these people, the HCMC members…

For in my opinion, the management committee is the chief of the health centre. *We think that their work is very important and without them it is difficult for us to work.*
Mr Sen was widely respected and his leadership style and ability was identified by the operational district vice-director as the reason that Owluk had maintained a committee (Interview). The provincial health department deputy chief also praised the leadership of Mr Sen:

*The reason that Owluk HCMC is better than the others is because the health centre chief is well organised. He has a lot of experience; he knows how to be creative and how to use the money from the financing of the health centre* (Mr Lontha Pheap, Interview).

I was unable to identify any reasons why Mr Sen’s attitude towards HCMCs was significantly more favourable than that of his counterparts in other health centres. However, his leadership was clearly the factor that had the largest impact on the management committee at Owluk Health Centre continuing to meet.

Another factor that could have contributed to Owluk’s HCMC being able to remain operational without international NGO support was their membership profile. When KADARM left the province, other health centres still had a proportion of lay citizens amongst their membership. Prior to 2006, Owluk HCMC members were from the commune council, from the religious community, and from health centre staff (the Traditional Birth Attendant was not recruited until 2006). All these members were in occupations where they either received a wage or had their needs provided for (in the case of monks and ajar wats). These occupations required them to work for the community, which would have enabled them to see being on the HCMC as part of their role. Mr Sen Peom, Owluk Health Centre’s chief, noted that:

*For the selection of the HCMC members, we verified for each volunteer whether they would work without demanding a salary, or any money, except when an NGO is able to provide some money. We asked for the members to think about the days that they have money and the days that they didn’t have money, they still needed to come along and join the meetings at the health centre.*
Having these occupations meant that Owluk HCMC’s members were able to attend committee meetings with little or no personal cost. This compares with unsalaried committee members who have their own businesses such as a veterinary practice, farm or shop (as per the lay citizen committee members of Pom Health Centre). Such members have to participate in the committees in addition to their occupation. The need to remunerate lay citizen members was noted as a barrier to their involvement in other health centres:

> If ordinary people were selected, they would have had great difficulties. So village chiefs and the commune chiefs were selected because those people have the salaries. So they can travel. They can go to and return from meetings. If ordinary people were selected, they couldn’t do the work because they wouldn’t be able to look after their living standards (Mr Chan Pen, Mian HCMC, Interview).

In Owluk, although it appeared that committee members other than health centre staff had higher levels of participation than in other HCMCs, on closer inspection it was only Mrs Li Tin who was more involved than any of her counterparts in other health centres. The time that the committee had been operational may have been a factor enabling her stronger involvement in chairing and in setting the meeting agendas. It takes time for relationships to form between members of a group (Saunders 2005: 60), and possibly it took time before Mrs Li had the confidence to become so involved in HCMC operations. Time was apparently a factor for the committees in other health centres. Mrs Chun Sophal, who was a member of the Pom HCMC when KADARM supported it and rejoined the committee in 2006, had this to say:

> In 2006, we still haven’t solved any problems and we don’t know some information yet, don’t know about the people, still don’t know about the plan, like before they set the plans about how many babies were born, and I still haven’t provided the information yet (Mrs Chun Sophal, Pom HCMC, Interview).
The short time that the committees operated in 2006 coupled with the three year period of non-operation in Pom and Lahong Health Centres contributed to the limited knowledge and skill base of the committee members. Mr Run Mak on the Lahong HCMC also commented on the need for time to develop their skills:

*I think the committee is weak at the moment, because we just joined the meeting three or four times.*

If time is an important factor for the greater involvement of at least commune councillors if not lay citizens and other community representatives, then the duration of international NGO support for participation processes needs to be considered.

*A Missing Factor: A Word on Trust*

As well as status being a factor in lay citizens and other community representatives having such little voice in the HCMCs, it is likely that a lack of citizen trust in the process and particularly in the government also played a role. Trust is ‘a psychological state that enables individuals to accept vulnerability and place their welfare in the hands of other parties, expecting positive intentions or behaviours from other parties’ (Yang 2006: 574). Trust is a key requirement for building social capital (Lelieveldt 2004), and has been identified as a key variable shaping individual behaviour in the workplace (Gramson in Driscoll 1978).

Trust is not widely written about in deliberative or participatory democracy. The impact of citizen participation on citizens’ trust in government has been examined (see for example Beirele and Konisky 2000; Wang and Wan Wart 2007: 276). Trust in government agencies has been used as a measure of success of a participatory program (Beirele and Konisky 2000: 588). Participation can increase public trust in the government when the participation leads to an improvement in public services or when it improves the ethical behaviour of government administrators (Wang and Wan Wart 2007: 276).
The impact of citizens’ trust in government on the outcomes of participation has not been researched to the same degree as the impact of participation on trust. Lubell (2007: 249) shows that the basis on which citizens trust or do not trust a participatory process or the government agency convening a participatory process changes, depending on the spatial scope of an institution’s work. For institutions that are spatially distant from citizens (i.e. national institutions), citizens must rely both on stereotypes and their general feelings of trust towards government (Lubell 2007: 249). For more local institutions, if individuals have had interactions with them, individuals’ views about whether to trust will be based more on their past experiences with that institution (Lubell 2007: 249).

In general, people do not automatically trust convenors of participatory processes, and for very good reasons given the extensive history of manipulative and tokenistic forms of participation discussed in Chapter Two. If the results of the participatory process are to have any credibility and are to be trusted by the broader population, then the public also needs to trust the process design of the participatory process. In Cambodia, people have been over-consulted for decades in non-participatory processes that have been conducted in the name of participation, but that have delivered so little. A distrust of government and political processes in Cambodia is likely to have limited the involvement of lay citizens and other community representatives to a significant degree.

5.5 Conclusion

There is a significant difference between what HCMCs were meant to achieve for lay citizen and community participation in government decision making, according to the policy, and what they actually did in the study area. There are three key findings emerging from this chapter. First, there were low levels of lay citizen and community participation in health centre management. Second, status had a dominant role in shaping interactions within committee meetings. Meetings were dominated by observers from the health administration and DRAY. Third, the existence of operational HCMCs is almost completely dependent on the support of international NGOs.
In Chapter Six I will consider how the process design contributed to the low levels of lay citizen and community participation, and how the lack of institutionalisation of the HCMCs within the practices of the Ministry of Health ensured that committees were not established and rarely operated without international NGO support. In Chapter Seven the role of DRAY within committee meetings in the study area is considered, as I consider the reasons they sought to establish and support HCMCs and the impact of international NGOs on participation processes and the implications of their support.
In this chapter, two key factors that have limited the involvement of community members in health centre management are examined. First, I ask how process design – both that detailed in the policy and that done in practice – affected the levels of participation. Second, I examine how the lack of institutionalisation of the policy within the practices of the Ministry of Health also contributed to the limited public involvement. I focus on these issues to help explain why some health centres did not establish committees and how status dominated meetings when they were created. I conclude the chapter by exploring some of the constraints facing the government, and I question whether or not they intended to involve citizens in their decision making.

6.1 Process Design

Good process design is fundamental to ensuring that the objectives of participation can be achieved (Irvin and Stansbury 2004; Edelenbos and Klijn 2005), and having a significantly robust process is vital to cultivating trust (Haight and Ginger 2000). Designs need to be appropriate for a community’s needs and abilities in order to be effective (Irvin and Stansbury 2004). There are a broad range of design choices that must be made when designing a participation process, including why the process is being instituted, who and how people should be selected, how meetings should be conducted, the scope, and the level of authority the participatory body will have (Fung 2003).

The design of participatory processes has been criticised for ignoring or trying to neutralise ‘the role of power within political institutions’ (Abelson et al 2003: 244), and ignoring broader social relations and their interaction with participatory structures. There is a tension between traditional power relationships and the new relationships required by participatory
processes. Good design may not be enough to overcome existing cultural relations such as status and hierarchical patterns of interaction.

Designs for participation need to include enough detail so that they are able to decrease the impact of status and ensure community members have both a voice and influence. Participation is a political process, but strong technical designs are needed in order to transform existing power relationships and displace elites from their exclusive decision making roles. However, there is a tension between creating structured designs that can interrupt status and improve legitimacy, and the possibility of over-designing processes (Kapoor 2002; Learner 2007). If structures and processes are introduced with extensive stipulations about how participation must happen, they can restrict participation and stifle processes for political involvement that may be preferred by the public. A balance must be struck between preventing elites from dominating participatory processes and empowering the general public to participate in a meaningful way in their own governance.

The processes prescribed by official policy and others introduced by implementing agencies are considered in this chapter. This recognises the significant differences between what the policy specified and how it was implemented, as well as the key role played by those who are responsible for making changes to their practice in order that policy is implemented (Lipsky 1979; Hill 2003; Schofield and Sausman 2004). ‘Street-level bureaucrats’ contribute to the design of policies through the ways they choose to implement them (Lipsky 1979; Younis and Davidson 1990). In other policy settings, street level bureaucrats have been key decision makers in how policy is implemented. Resources at street level, that level where the government agency interacts directly with the public, are inadequate to do all that is required. This results in street level bureaucrats prioritising activities, rationing services and controlling clientele; all of these activities constitute policy-making (Younis and Davidson 1990: 8). Research previously conducted in Cambodia’s health sector demonstrates that health centre staff members significantly shape public policy’s implementation, through resisting, adapting or manipulating policies (Grove et al 2002). In this study, international NGOs were also able to significantly shape process design. I ask how the participatory designs in the Cambodian committees constrained or enhanced the status and role of lay
citizens and other community representatives, and hence the extent and quality of their participation in decision making.

6.1.1 Design of Selection and Representativeness Mechanisms

Institutional design has significant effects on who participates (Lavalle et al 2005: 960). In Chapter Five I discussed how committee members were selected when the committees were supported by KADARM and by DRAY, as well as discussed what the policy required in terms of representation of groups such as women and the poor. My purpose here is to examine the impact that process design had on the committees being so poorly representative, particularly in relation to the limited involvement of lay citizens, or “ordinary villagers”.

As discussed in Chapter Three, the policy documents are internally inconsistent with regard to who the community representatives were to be. The policy requires that all villagers vote for the committee members (Ministry of Health 2001b). The election process described in the policy had never occurred in the study area at the time of fieldwork. Although elections are common ways of legitimising representation, elections usually result ‘in the “usual suspects” becoming representatives: middle-aged men skilled in mobilising support within their communities’ (Young cited in Smith and Stephenson 2005: 334).

KADARM’s selection process pre-dated the policy being formally adopted. It used a different methodology than that included in the policy documents, which was presented in Chapter Five. The election process used by KADARM had been problematic; only elites and those connected to them were included in the candidate pool and voters. Only the “usual suspects” (Young cited in Smith and Stephenson 2005: 334) were recruited: elites and those close to them.

Neither the election process implemented by KADARM nor that included in the policy offsets the prevailing preference for representatives who have high social status. It is therefore not surprising that the choices of voters were influenced by the status of candidates, resulting in higher status people being elected, to the exclusion or limited
involvement of lower status people. As reported in interviews, the elections resulted in a greater number of older compared to younger people on the committees, as well as the exclusion of the poor. Current HCMC membership policy leaves undisturbed traditional social hierarchies. It shows how status operates as a factor enabling individual involvement in participation processes; a status-blind approach takes no account of how status effectively runs counter to the goal of participatory democracy.

DRAY did not adhere to the selection process detailed within the policy. In 2006, HCMCs included leaders and Traditional Birth Attendants (TBAs) appointed to committees, as well as people who had previously been elected to the committees when KADARM supported the committees. The decision to appoint leaders and TBAs in 2006 resulted in the very limited involvement of ordinary villagers in the HCMCs.

Alternative design choices could have been made. Fung (2003: 342) identifies three potential methods to overcome the domination of participation by elites, including: using descriptive representativeness as a way to select participants; using affirmative action in recruitment; and ensuring that the participatory structure has a mandate to consider the issues of the disadvantaged, thus attracting them in greater numbers than the privileged.

6.1.2 Informed Citizens and Training

The degree to which participants are informed about both the participation process as well as the topics being considered has been used as a measure of the quality of participation by both scholars and practitioners (Heberlein 1976: 199; Harrison and Mort 1998: 63; International Association of Public Participation n.d. b). Implicit in this criterion is the assumption that participants need to be informed in order to participate effectively in decision making (Abelson et al 2003). In this way the educative function of participatory processes becomes not an end but a means to achieve good decision making/public input. There have been cases where little effort was spent informing the public about the participation process; this poverty of information led to very low levels of citizen
participation and engagement (Wilson 1997: 6). This highlights the importance of having informed participants.

Petts (2001: 209) argues participatory processes need to provide participants with access to knowledge, interpretations of understanding, and processes for resolving disputes about knowledge and for checking the authenticity and sincerity of claims. The learning and training of participants then must be ongoing so that their skills are continuously being enhanced. However, it is not only the community representatives who need training, but also staff members and facilitators who must develop skills in convening participatory processes (Rockloff and Lockie 2006: 264). Capacity-building around the skills for participation and knowledge about health management issues becomes vitally important for effective participation. Training is also identified in the literature as a key factor for ensuring project sustainability once donor funding ceases (Bossert 1990: 1015). Being on committees as an “ordinary citizen” can be daunting. Lay citizens involved in participatory processes have reported being easily overwhelmed by technical information (Wilson 1997: 7), and by the knowledge (perceived or actual) that officials and staff have. This same phenomenon can be expected with informal community leaders, but to a lesser degree than with lay citizens. Training could develop participants’ confidence so that they are more willing to speak in meetings, particularly as to do so challenges cultural norms.

Informed participation is not evident in the discourse surrounding HCMCs, and was largely absent from their practice. Committee members are not invited to observe health centre activities or outreach days to orientate themselves with the operational challenges facing health centre staff. According to the participation policy (as opposed to the Primary Health Care policy), HCMCs were meant to select VHSG volunteers to be their members. The VHSG volunteers assist the health centre staff with outreach activities, and therefore have some knowledge of the health issues and working conditions of staff. In practice no operational committee had VHSG members and members of the management committees do not have similar operational experiences to draw on, so lack this broad knowledge of health service delivery issues. Although official leaders sometimes play a co-ordinating role for outreach activities, most of the committee members would not have been exposed to health centre activities, except as patients.
In an interview with the program manager of DRAY in February 2006, which was after the first meeting of the HCMC committees, I asked how they intended to approach the training of committee members:

*Researcher: So how will you support training for HCMC members?*

*Mr Sok Samnang: This one still requires direction from talking with the operational district director, [to consider] what kind of topic we will support with training. Because we will do a needs assessment, a training assessment of them. In my plan, I plan to give the knowledge about management techniques, HCMCs, and to make them understand about primary health care issues at the village level.*

There was one training day provided to each committee in early 2006, a couple of months after the committees had been established. The training days were run by the international NGO DRAY, with some input from the operational district administration. They were funded by DRAY, with all attendees receiving a *per diem*. I attended the full-day training at three of the four operational HCMCs. The key training need identified in the assessment was that HCMC members ‘…did not know clearly about the roles and responsibilities of the HCMC’ (Mr Sok Samnang, DRAY, Interview). This was officially the focus of the training days, but as I will show in Chapter Seven, the training was used to achieve more than this.

The content of the training courses at all four health centres with operational management committees was identical, suggesting that individualised training courses tailored to the needs of participants had not been put together. The quotations below are extracted from my field notes taken during the training at Pom Health Centre, and give an overview of what happened during the training courses:
Pom HCMC Training

Participants first filled out a pre-training questionnaire, then operational district vice-director stood up and introduced himself and his job, participants did the same. They explained the health sector reforms and the changes to delivery of health services and distribution of facilities that has occurred in the last 10 years. While operational district vice-director is giving the training, the program manager from DRAY is in the room. It’s a nice atmosphere with a bit of joking, and the operational district vice-director is asking for input into various questions. DRAY started handing around an attendance sheet. The operational district vice-director said the law and regulations about the duty and role for health staff and the health centre are set from the national level.

After a break, a training book is handed around and the training session is then delivered by the program manager from DRAY. The trainer asked people to read bits out loud. They went through different participation structures at the commune level and the role of the HCMC to improve the health. HCMC hold the meeting at least once every six months but the program manager from DRAY told participants how he himself changed the meetings to once every two months.

In the afternoon, members played a game after they were divided into two teams. They had to make a vessel in which they could safely place an egg and throw the whole package without the egg breaking. This was then used as a discussion starter to ask what is needed to make sound and successful decisions and solve problems: studying, knowledge and experience.

The question was asked, what does the health centre need? Needs the community to join, and spread the information. Must know the needs of the community, don’t just hold the meeting again and again without knowing anything from the community. Health centre must know to solve problems between the community and the health centre management committee.
The training courses in Mian, Lahong and Owluk Health Centres were run either by DRAY staff or by the operational district vice-director, depending on the availability of the staff of each organisation. The training course focused on the historical provision of services. This background may have been provided to emphasise that community involvement was crucial, and possibly to assist promotion of the health services by equipping management committee members with information to share with disgruntled villages about why commune clinics had been closed (the focus of the old system), even though these institutions often operated in name only. Minimal information was provided on key health issues facing the sector or the population in the particular catchment area. Although the roles and responsibilities of HCMCs were outlined, there was little focus on the skills required by them to fulfil their roles. No training was provided on how to analyse health centre practices and no health information was provided to participants.

The need for an informed group of participants to enable effective citizen participation, although identified by scholars and practitioners, was not reflected in the design of the policy or in the practice of the HCMCs. Although there was an initial training course, there was no ongoing training provided to the committee members of the operational management committees. Only the Saomao HCMC members were given any ongoing health education, yet this committee had no management responsibilities or meetings. The minimal number and poor content of training opportunities to inform citizens or staff is problematic for the quality of participation in HCMCs.

6.1.3 Design of Meeting Processes

How meetings and discussions are organised is a key aspect of the design of participatory institutions (Fung 2003: 343). Habermas’ (1990) ‘ideal speech situation’ does not provide much guidance in the details of good participatory design (Fung 2003: 344). One aim can be to ‘provide a space in which individuals can reach their own considered views and gain confidence in their own perspectives’ (Fung 2003: 344), but some critics have said that those who speak less well or in ways that are devalued by the dominant culture are disadvantaged in deliberative forums (see also Young 1990; Phillips 1991: 15). Cooke (2001)
notes that group process theory is often ignored in designing participatory processes used in international development; as a result negative group processes can prevail that result in poorer quality decision making.

The participation policy is virtually silent on how meetings are to be run. When procedures for participation processes are not codified, fair and equitable outcomes are less certain and participation processes are more open to abuse (Kapoor 2002). The policy and its guidelines do explicitly reflect some of the issues raised by theorists, including the specification that all members should be able to speak freely at meetings and should be treated as equals:

… it is hoped that the elected representatives are able to express freely and openly their views and concerns (Ministry of Health 2003: 7).

The members of the HCMC have the same rights and have the right to put topics on the agenda of the HCMC meetings (Ministry of Health 2001b: 26).

If they are accepted as full counterparts, the CRs [Community Representatives] will cooperate better (Ministry of Health 2001b: 49).

However, there is a ‘disjuncture between formal and actionable rights’ (Heller et al 2007). No technical provisions are made to account for the status of different people at the meetings, which in turn affects their ability to speak. Such provisions might include time limits on speaking or a requirement for everyone to make a report or give an opinion on each issue or using methods such as nominal group technique (see for example Horton 1980, Gastil 1993). Therefore those participants with less status largely remained silent in meetings and had minimal input into discussions. Those who attended ostensibly as observers dominated committee meetings, in both the amount of time they spoke as well as their active roles in setting agendas and chairing meetings. Elites were able to dominate as there were no limits on their domination within the process design.
The following anecdote highlights how those with low social status were reluctant to criticise high-status people in front of others. Mr Pra Dtom was a lay citizen management committee member at Pom Health Centre. He reported how he raised one issue of concern when he was approached by villagers who had not received clear information on their diagnosis and treatment after consulting the staff at the health centre. We had the following exchange.

Researcher: And so have you discussed this at the management committee?

Mr Pra Dtom: No. We already discussed with the health centre chief.

Researcher: Next month will you discuss this problem with the management committee?

Mr Pra Dtom: No.

Researcher: Why not?

Mr Pra Dtom: The reason is because I want to correct staff members calmly and secretly.

Researcher: Why calmly and secretly?

Mr Pra Dtom: If they do this again, we will have a big discussion, in the big meeting, the meeting of the management committee.

Researcher: So do you do a lot of work calmly and secretly with the staff of the health centre? When the staff, health centre staff, have problems?

Mr Pra Dtom: I never wrote the letter but through speaking.
Researcher: About the problem we were discussing before, is talking to the staff secretly and calmly a strategy?

Mr Pra Dtom: It is a strategy of mine, for me.

This excerpt demonstrates that the meeting processes and structure of committees is designed in such a way that it does not enable community members to be active within the committee meetings, yet some still exercise influence outside the formal processes. Mr Pra Dtom was the only volunteer who reported such action. Since the policy did not provide guidance on enabling all members to have equal influence within meetings, lay citizens continued their traditional deference to formal and informal community elites within meetings.

6.1.4 Incentives for Community Representatives

Motivation and incentives are key issues for participatory processes. People’s motivations affect the way they participate (Eversole 2003: 791-2). The perceived benefits of participating must be seen to outweigh the costs of participating in order for people to volunteer their time. This is as true of health centre staff members as members of the public. The biggest barriers to participation are lack of resources and influence. When the process is not influential, the costs of participating are not proportional to the benefits (Rockloff and Lockie 2006: 258). Tokenistic consultation reduces the motivation of the public to be involved (Rockloff and Lockie 2006: 260). Payment is not the only incentive that can motivate people to participate. People can be motivated by the intrinsic benefits of participation as well as extrinsic factors such as the opportunity to attend training. One policy maker identified the importance of incentives:

Motivation is very important; need to look at how to motivate the health centre staff or the volunteers to work at the village level. Sometimes we talk a lot about the work but we don’t provide any motivation to them, so the motivation
that I mention is not the money. You can motivate them by providing training, by the education program, or to ask them to help implement a national health program. So when we ask them to participate, so this is a kind of motivation too (Mr Soern Choup, Policy Maker, Interview).

The policy has identified a number of incentives that can be used to motivate community members to join HCMCs. The provision of training is one of the key incentives (Ministry of Health 2003: 7). Reimbursement for travel expenses is possible and other incentives identified in the policy are:

- free treatment in the Health Centre, personal dignity for being elected to represent their village, gaining knowledge on health education (Ministry of Health 2003: 7).

*Per diems* are another form of incentive. They are daily honorariums, paid with the intention of covering lost income and the incidental costs of participation. One of the key areas of concern about the payment of *per diems* is ethical. Some argue that people should be provided with compensation (Ackerman and Fishkin 2002), for contributing their values and opinions to the decision making process. *Per diems* can reduce the financial barriers that some lower-income people face attending participatory processes and therefore make participation more equitable. However, there are also concerns about creating a panoptican environment (Foucault 1977), where participants will not speak against what they believe the preferred views of the convening agency are. This possibility of self-policing was recognised within the policy as a risk associated with any financial incentives. The policy specifies that if transport costs are to be reimbursed, where possible these should be paid by the commune council ‘in order to keep community representatives and their opinions independent from the Health Centre’ (Ministry of Health 2003: 7).

The policy says that financial incentives in the form of *per diems* should not be used (Ministry of Health 2003). However, international NGOs often choose to pay *per diems*: 
The VHSG and HCMC get incentives because it is recommended in the policy document, but not financial incentives. So some NGOs they say: “We follow the Ministry of Health policy, so the HCMC or the Village Health Support Group, we cannot pay the incentive for you because the policy recommended no financial incentive”. But in practice some NGOs, in order to accomplish their project objectives, they pay them. And the other village volunteers who are recruited by the other ministries they also receive financial incentives (Mr Serey Phiriak, Policy Maker, Interview).

Per diems were paid by DRAY. In Chapter Seven I will examine the ways that the incentives affected the HCMCs in practice and the implications for the sustainability of HCMCs.

6.1.5 Design to Maximise Influence of the Committees on Health Centre Practice

A final aspect of design that affects the quality of participation and degree of influence that the public is able to have over the practice of health centres is determined by the extent to which the practice of health centres and their staff members are connected to the establishment and performance of HCMCs. There are no formal structures that link the committees and their decisions to the management decisions in different health centres. The committees themselves have no budgets, and therefore have no resources to implement their own decisions. The level of influence of the public is also affected by whether or not the committees have decision making powers. Fung (2003) argues that “minipublics” should not have decision making powers without a clear mandate. The Cambodian policy provides a clear mandate to HCMCs (Ministry of Health 2001b).

There are a number of reasons for establishing community participation structures (both VHSG and HCMC) listed in the policy guidelines, but as discussed in Chapter Three these relate to access to labour and similar menial components, rather than benefits relating to decision making. There are no incentives or disincentives built into the policy that would encourage health staff to follow the advice or adopt the decisions of the committee. There
are no “pay for performance” incentives for staff regarding the HCMCs, relating to either individual pay or health centre budgets.

6.2 POLICY INSTITUTIONALISATION

Poor design of the committees alone does not explain the low levels of community participation in the management of health centres. In order for well-designed structures to achieve high levels of participation, local leaders in political and governmental organisations need to demonstrate ongoing commitment and local people and bureaucrats need to gain the necessary skills to participate effectively (Spallek 2000: iv). This commitment would be demonstrated through the way the policy is institutionalised within the practice of the Ministry of Health. Institutionalisation is when a new process becomes a standard procedure within the practice of agencies (Shedic-Rizkallah and Bone 1998: 92; Inhetveen 1999: 405; Carson 2001: 17). Institutionalising participation is a complex and slow process because it involves changing power relationships, norms and procedures (Kombe 2001).

One danger of institutionalising policies is that they can bureaucratise participatory processes (Miraftab 2003: 230), and result in them stifling more radical forms of participation. However, without participation embedded in institutional practice, there is an even greater danger that there will be no avenues available for community participation in government decision making.

Assumptions about the ‘black box’ nature of policy implementation (Younis and Davidson 1990: 3) led to poor implementation, as bureaucrats did not necessarily have access to adequate resources and organisational support to execute the policy (Stich and Eagle 2005: 322). Scholars of principal-agent theory and examinations of street level bureaucrats have demonstrated the key role that those responsible for implementing policy play, and the disjuncture that can occur between those who develop policy and those who implement it (Lipsky 1979; Alvarez and Hall 2006).

Participation programs are usually implemented on a large scale when ‘they form a component of governmental policy, are implemented through bureaucratic mechanisms,
[and] receive regular programmatic support and resources' (Zakus 1998: 475). Although the HCMC meetings studied were held at the health centres, within Ministry of Health buildings, this symbol of being part of the Ministry of Health was not translated into practice in any meaningful way.

6.2.1 Dissemination, Training, Supervision and Resources

Although every health centre in the study area and province had a committee convened to establish fees in the late 1990s, the policy has largely not been institutionalised into the practices of the Ministry of Health. The policy documents were developed in Phnom Penh by the Ministry of Health and international NGOs and organisations. The policy makers said:

\[
\text{At the central level, we provide the policy documents [to government health staff based outside Phnom Penh], and then if they need any assistance from us, we will respond to this (Mr Serey Phiriak, Policy Maker, Ministry of Health).}
\]

However, none of the health centre chiefs in the study area had copies of the policy documents. The interview with the chief of Pom Health Centre identifies how this happened despite the dissemination by the Ministry staff in Phnom Penh:

\[
\text{Researcher: Do you have a copy of the policy here?}
\]

\[
\text{Mr Ree Saing: No, because when they prepared the policy, the former chief was managing the health centre. I only replaced him five years ago so I don't have the policy.}
\]

Mr Ree Saing was in this position when the policy itself was adopted, and he must have been referring to the operational guidelines that were written in 2001. Other health centre chiefs interviewed in this study had mislaid the documents since they had first been
distributed. This single-distribution approach has left health centres and their staff without policy documents. For a policy to be implemented, staff members need to know what is required of them, particularly those who will be responsible for its implementation.

The policy had not been disseminated amongst NGOs establishing and supporting HCMCs. DRAY only had the policy’s operational guidelines, but not the policy itself. Local administration, civil society and community organisations were also without copies of the policy. This limits the knowledge of members of the public and the administration about how they are meant to be included in health centre management, and limits the likelihood that they would lobby for the establishment and improved performance of the participatory structures required in the policy.

Dissemination needs to be accompanied by training to ensure staff members have the skills and knowledge required to establish committees. Although I have already discussed the design of the training used by DRAY, here I consider the training that the government (in the form of the Ministry of Health) provided to its staff. Learning about policy, what it means and how to implement it is a fundamental factor affecting policy implementation (Hill 2003). Korten (cited in McGrath et al n.d.) identifies training as a key factor that enables the institutionalisation of participatory processes. Training also enhances the chances of development projects becoming sustainable (Bossert 1990: 1015). Training has contributed to the success of volunteer health worker programs in Cambodia (Suehiro and Altman 2003: 354). I asked a policy maker at the Ministry of Health in Phnom Penh:

Researcher: Was there some training given to the Provincial Health Department level about the HCMCs [after the policy was developed]?

Mr Serey Phiriak: No. No training.

The government had not provided any training on HCMCs since the policy had been adopted. Training on HCMCs has never been resourced at a national government level, nor were training modules created as they have been for other health centre duties (see for example Ministry of Health 2000). The lack of government training packages is both an
indication of and a contributor to the lack of policy institutionalisation within the Ministry of Health. During the study period, the government continued without providing its own training program about HCMCs, although the operational district office did assist in the delivery of DRAY’s training program, with its focus on community representatives and formal leaders. Only the health centre chief from Mian Health Centre recalled any relevant training:

Mr Chea Pirun: Before, we went to study, trained for preparing plans, preparing the committee, preparing the health support group, the operational district vice-director met us, and came to help us for three or four villages, then offered for us to do the work.

Researcher: When did they train you about the management committees?

Mr Chea Pirun: They taught [us] in 2000.

He could not recall who provided the training, but it is important to note that it covered a range of health centre activities, not just the management committee, and was provided well before the policy or even its operational guidelines had been adopted.

The composition, complexities and actions of bureaucracies are partly determined by the motivations of their staff (Morton 1996: 1449). The quality of health facilities in Cambodia is determined by staff motivation and remuneration (both its link to performance and salary levels) (Soeters and Griffiths 2003). Staff members of Cambodian health centres are motivated by both enforced directives from their superiors and financial incentives. Suehiro and Altman (2003: 354) show that supervision is a critical factor in the success of health volunteer worker programs in Cambodia. Supervision is needed to ensure that the committees are operating in an effective way. However, there are no requirements about the existence or performance of HCMCs within the checklists completed by the operational district staff on their supervisory visits. Although the operational district vice-director did attend the HCMC meetings, he did not do this as a supervisor but rather as an observer of the process. Supervision has its own costs in staff time; however, there are also benefits in
ensuring good practice and quality improvement through effective feedback on participatory practices.

Until Ministry of Health supervisory staff members check for the implementation of the participation policy, there is little possibility of linking the performance of management committees with the resource allocation to health centres. Scheirer (2005: 339) notes that ‘… when staff members or key stakeholders could perceive benefits to themselves and/or to clients, the program was more likely to be sustained’. The health centres studied suggest that with the exception of Owluk Health Centre’s chief, health centre staff members do not value the possibilities of HCMCs, as no health centre established HCMCs and the input of lay citizens and other community representatives within the committees was not encouraged.

Participation programs require adequate resources to be implemented on a large scale (Zakus 1998: 475). This includes both human resources (Zweekhorst et al 2003) and funding. If policies are viewed as effective they are more likely to be allocated political and administrative resources (Lubell 2003). Significant resources are required to implement the policy. *Per diems* are the largest financial expense. If committee members are to be drawn from different villages, transport costs are also significant. The health centre needs to cover these costs in order to treat committee members equitably and secure the participation of those from more remote villages. Staff time must also be provided. Incidental costs include training materials and refreshments for meetings. Although not called for in the policy or provided in any of the health centres studied, another cost that can significantly enhance the influence of HCMCs is the allocation of a budget that the committees are able to spend on implementing improvements in the health centre. Financial incentives to staff are another cost that could encourage wide-spread implementation of the policy.

Health systems in less developed countries ‘often face substantial problems resulting from resource shortages and the inefficient and inequitable use of resources’ (Oliveira-Cruz et al 2003: 42). The costs of establishing HCMCs are not included in the policy documents. The management staff members in those centres without committee meetings identified a lack of resources as the key constraint preventing the implementation of the policy:
We don’t have the money so we can’t do [establish and run the health centre management committees] (Mr Sam Maleng, Chief of Jaik Health Centre).

The national government’s neglect of institutionalising the participation policy enabled health centre staff to avoid implementing the written policy with no negative implications.

Although the policy had not been institutionalised, international NGOs had done little advocacy to have the policy implemented, as my interview with director of the NGO peak body PEAKHEALTH demonstrates:

Researcher: It seems to me that the advocacy stops once the policy has been adopted, and there doesn’t seem to be any advocacy for the implementation, not just for the participation policy. Is that an accurate reflection?

Mr Thy Nem: I think we are doing both. There are policies that are not operationalised, and that’s a thing we looked into, what are the policy bottlenecks, and identified what are these issues, and we can advocate for policy change, including the existing policies that are not operationalised, or developing the new policies, and that’s what we do both.

Researcher: And do you know, for the community participation policy, has there been advocacy to implement it?

Mr Thy Nem: Not to my knowledge.

This suggests that international NGOs are not interested in policy implementation at a national scale.
6.2.2 The Question of Government Intent

There is no doubt that the policy was not institutionalised into the practices of the Ministry of Health. The impact is that the policy is not uniformly achieving its ostensible aim of involving the public in the management of health centres throughout the country. The analysis presented in Chapter Five clearly demonstrates that the lay citizens and other community representatives were largely excluded from government decision making, but did the Ministry of Health ever intend it to be any other way? The motivations of the Ministry of Health would have affected how they approached policy adoption and implementation (Lubell 2003). Although the policy was developed by both government and the international development community, here I will consider only the intent of the former since I examine the role of the international NGO community in chapters Seven and Eight. “Government” is not a homogenous entity and I will examine the actions of those within the national, operational district and health centre levels within the Ministry of Health.

There are a number of reasons as to why the policy may not have been institutionalised. Institutionalisation can happen when there is an enabling leader within the bureaucracy (Carson 2005), championing participation (Morton 1996). This did not exist in the context of HCMCs. As discussed in Chapter Two, developing an agency culture that supports participation has been identified as a key factor that enables community participation (Curtis and Lockwood 2000: 70). This did not happen in the Cambodian Ministry of Health. The lack of supervision checks and incentives for health centre staff to establish health centre management committees suggests that the government staff at the operational district level were not committed to implementation. Interviewees blamed the lack of resources for government not implementing the policy. Although the government has not funded HCMCs, it is possible that their failure to do so is due more to the significant health and financial problems facing the Ministry of Health rather than a lack of interest in participation.

However, there is also evidence that the government had little interest in implementing the policy. It is possible that the policy could have been implemented with little financial outlay for the Ministry of Health, had international NGOs not created expectations of *per diems.*
Owluk for example had successfully had community leaders attend meetings without financial incentives when there was no international NGO support. What is striking is that the government never tried to implement the policy without *per diems*, and showed little interest in even attempting to institutionalise or implement the policy, beyond the initial meeting that the government convened in each health centre to set fees.

Culture plays a significant role in the interplay between bureaucracy and policy, and it affects policy implementation successes and failures (Morton 1996: 1441). Harmony is valued in Cambodian culture and it is built on consensus and conformity (O’Leary 2006: 52). A desire for harmony has ramifications for understanding the adoption and lack of implementation of the participation policy. Members of French colonial society in Cambodia found that:

‘... the natives always say yes to whatever recommendation we give, but hardly ever follow them once we turn our back’ (a French doctor quoted in 1913, cited in Trankell and Oveson 2004: 98).

In a society in which “keeping face” is important, saying “yes” is a way to maintain harmonious social relations. Actions are what demonstrate actual interest in an initiative that someone supposedly agrees with. This was a cultural behaviour apparent during my own time working in Cambodia. Given the lack of institutionalisation it appears that the Ministry of Health may have had minimal interest in the participation policy, and could have been agreeing to adopt the policy to “keep face” with the international NGOs and donor community. This will be examined further in Chapter Eight.

6.3 Conclusion

The research findings indicate that the low levels of lay citizen and community participation in committees was partly a product of both poorly designed participation processes and a lack of institutionalisation of the participation policy within the practices of the Ministry of Health. The design of the HCMC processes did not mitigate the impact of status on
relationships between people and prevented the committees from having greater influence over health centre management. The lack of institutionalisation belies both a lack of government will and a dearth of resources available within the Ministry of Health. However, even in the committees supported by an international NGO, low levels of participation also prevailed. Process design is partly to blame, but the role of the convening international NGO DRAY also needs closer examination.
In Chapter Five I demonstrated that international NGO support was the key factor enabling the establishment of operational HCMCs. The reliance on international NGOs to implement the national participation policy was largely a result of the lack of institutionalisation of the policy within the Ministry of Health structures. In this chapter I consider the motivations of international NGOs, their impacts on HCMCs, and the implications of their support.

As mentioned in Chapter Two, the privileged position that NGOs have traditionally enjoyed in scholarship has been countered by critiques that challenge their authority and legitimacy (Lorgen 1998; Zaidi 1999). The lack of attention to the power that NGOs exert has been the focus of key critiques (Tvedt 2002: 366; Campbell 2005a: 700). NGOs are powerful political bodies and need to be analysed as such rather than in normative, moral and value-laden terms (Tvedt 2002). Although participatory processes are often depoliticised, White (1996: 15) asks what interests are served by treating participation as ‘non-politics’, and who might be suppressed by such an approach. More interesting is the question of whose interests the depoliticisation of participation advances.

Participatory techniques have become methods that can either promote participation or, paradoxically, increase the control of agencies over local governance and decision making (Craig and Porter 1997: 230). Townsend et al (2002: 833) note that the legitimacy of NGOs is based ‘on ‘listening’, ‘participation’, the ‘local’ and the ‘appropriate’, but [they] employ techniques that tend to exclude these desirable goals’. Although participation was partly developed as a way to counter the traditional critique of development that ‘outsiders and experts set the agenda and made the decisions’, so-called participatory approaches have sometimes had the same result (Christens and Speer 2006: 7). Participation can be tyrannical as multinational agencies and donors continue to dominate development, but this is hidden behind the rhetoric of participation (Cooke and Kothari 2001b: 4). Development
agencies have been criticised for ‘implementing participatory practices in ways that serve their own agendas’ (Christens and Speer 2006: 3).

After considering the ethics of academics exposing NGO failure in terms of the possible implications for their funding and the resultant impacts on the poor, Townsend and Townsend (2004: 271, 274) decide that the work of NGOs must be openly critiqued. Although it is unpopular to critique NGO practice (Hancock 1989), I do so here for three reasons. First, international NGOs working in the health field are interest organisations as they seek particular outcomes. How they pursue these outcomes and with what impacts on community participation is important. The joint role of interest organisation and convenor of a participatory process deserves examination. Second, development agencies affect power structures within Cambodian society (Oveson et al 1996: 80), and their impact on development interventions is largely unexamined. Third, the role of international NGOs implementing government participation policies has barely been researched. This justifies an in-depth study of the practices of international NGOs fulfilling such roles.

Although I focus mostly on the role of DRAY as I directly observed its work with HCMCs, I do refer to the experiences of KADARM and to Ministry of Health staff where appropriate. I begin by contextualising the international NGO support for HCMCs by locating this support within their broader health programs. I then outline the type of support and the ways that international NGO staff members shape the HCMC process and outcomes. I consider what motivates them to support HCMCs and shape their experiences before focusing on the implications of the roles that international NGOs play.

7.1 HOW INTERNATIONAL NGOs SUPPORT AND SHAPE HCMCs

Where interest organisations have been considered in relation to participation, they have been defined as entities that seek a specific policy outcome from the state, including NGOs (Hendriks 2004: 4). That definition should be broadened to include those agencies that seek a particular substantive outcome from a participatory process, regardless of whether that outcome is sought from the state or from other actors involved in the participation process.
The international NGOs involved with HCMCs in the study area were interest organisations as they sought particular objectives; DRAY and KADARM pursued similar outcomes with their programs in which they supported HCMCs. DRAY’s program was on the community management of childhood illness and its goal was to ‘reduce childhood deaths and the infant mortality rate and provide knowledge to mothers’ (Sok Samnang, Interview). The project had three main objectives: ‘to improve the nutritional status of children under five, improve health-seeking behaviour for sick and malnourished children and to improve the link between the community and health facilities’ (Sok Samnang, Interview). The program had several interventions including training Traditional Birth Attendants, providing medicines to the health centres, and establishing and supporting HCMCs. This program worked with nine health centres in the province including Pom, Mian, Lahong and Owlok Health Centres. KADARM had supported ten health centres in the province between 1995 and 2002 and its program also aimed to improve maternal and child health. KADARM focused on birth-spacing, pre-natal care, immunisations for children, and health systems strengthening including service utilisation (Mr Yem Sovann, KADARM, Interview). In 1998, it introduced HCMCs into the ten health centres that it supported, including Pom, Lahong and Owlok Health Centres.

Steckler and Herzog (1979) have spoofed how citizen management boards in the health sector in the United States, which are similar to HCMCs, can be manipulated by government agencies. Through parodying the convening of participation structures, by offering advice to the beleaguered executive director who must implement a participation process, their satirical work takes familiar strategies to the extreme. Steckler and Herzog (1979) identify four ways that boards can be rendered ineffective: through controlling the rules of selection and selecting members who will acquiesce; through ‘creatively’ dividing the responsibilities between the board and the executive director of the organisation; through controlling the type of staff who will resource the members and ensure they provide historical and technical expertise rather than community organising; and managing the board meetings through controlling the chair and the agenda. Although these strategies were extreme satirical behaviour to Steckler and Herzog (1979), as I will demonstrate, some of these actions and variations of them were found in the practices of international NGOs in Cambodia.
7.1.1 Leadership, Financial and Technical Support

The ability to establish a participatory institution for citizens to interact with their state provided DRAY with ample opportunities to shape the participation process. Mr Sok Samnang, the program manager at DRAY, said:

*The HCMCs had no meetings for a long time, so I set them up. I set up the schedule with the operational district director* (Interview, emphasis added).

Supporting the findings from the seven cases studied in-depth, interview respondents in national level organisations noted that across Cambodia, HCMCs only become operational with the support of international NGOs (Mr Thy Nem, Interview; Mr Rem Suni, Interview). Staff members of international NGOs provide both the leadership and the logistical support for the establishment and operation of HCMCs.

International NGOs provide governments and communities with access to significant resources in the form of financial contributions and technical assistance. DRAY’s support for HCMCs included:

*Per diems, refreshments, materials like books and pens, and DRAY provides training, initial training* (Mr Sok Samnang, DRAY, Interview).

KADARM previously provided similar levels and types of support (Mr Sen Chhung, Lahong Health Centre Acting Chief, Interview). The level of resources that international NGOs had, particularly vis-à-vis the health centres and operational district, placed them in a position where they were able to establish HCMCs.

Most health centres experienced a significant increase in HCMC activity with the advent of DRAY’s support. An operational committee was established for the first time in Mian Health Centre since the initial meeting to set health fees in the late 1990s. HCMCs were re-established after a three-year hiatus in Lahong and Pom Health Centres. Although Owlu
had continued to have monthly meetings once KADARM’s support had ceased, DRAY only supported bi-monthly meetings. As a result, the number of meetings at Owluk reduced with the re-introduction of international NGO support, as the health centre began to follow the schedule set by DRAY rather than continuing with its own more frequent schedule of meetings.

7.1.2 Member Selection and Attendance

Shaping the rules of selection of members and ensuring that chosen members will acquiesce to the interests of the convenor is one strategy that convening agencies might use if they want to manipulate boards. DRAY played a leading role in selecting committee members in 2006: ‘we selected them [the new members] and set up the schedule in February’ (Mr Sok Samnang, DRAY, Interview). The operational district office and health centres also played a minor role in selecting members. The HCMCs all had slightly different membership breakdowns, as shown in Chapter Five. DRAY staff members noted that this was because some members from the committees established by KADARM were still considered to be HCMC members, although most of the committees had been inactive for three years. DRAY staff sought a particular membership profile:

*The HCMCs already had some members when we began our program, but there were only a few existing members. We needed members from the commune council, so they came to join the HCMC group automatically, without elections… We just put in the key people, not the poor, just the key people. The key people are more proactive and willing to work with us* (Mr Sok Samnang, DRAY, Interview).

These key people were commune council representatives and informal leaders. As discussed in Chapter Five, the membership was not chosen according to the policy in terms of who and how members were selected. Although the members chosen in 2006 were not selected specifically because they would be ‘safe, non-interfering consumers’ (Steckler and Herzog 1979: 809), nevertheless they were selected for particular attributes that DRAY staff
deemed useful. Formal and informal community leaders were desired because they were expected to collaborate with DRAY and have access to networks and influence within their communities. These attributes were important given the information collection and dissemination that was the focus of HCMC work under DRAY’s direction. DRAY also included Traditional Birth Attendants in two HCMCs: ‘Before DRAY came the traditional midwives were not on the committees’ (Mrs Keo Buntha, Lahong Health Centre Midwife, Interview). The involvement of this group was not specified in the policy. DRAY also trained TBAs in a separate program, and their inclusion in HCMCs provided DRAY additional opportunities to work with them.

Although I have already considered *per diems*, in Chapter Six my focus was on the pros and cons of financial incentives in the process design. Here I specifically consider DRAY’s *per diems* and their impact. DRAY paid *per diems* for people to attend the training course and the regular HCMC meetings. Table 7.1 lists the levels of *per diems* paid by DRAY for attendance at HCMC meetings, relating this to the average monthly salaries of different members and the number of days they would need to work in their job to earn the same amount.

### Table 7.1 Levels of Per Diem Pays

<table>
<thead>
<tr>
<th>Type of member</th>
<th>Average monthly salary in riels</th>
<th>Per diem amount</th>
<th>Per diem is what percentage of monthly salary</th>
<th>Number of days’ work that the per diem is equivalent to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay citizens</td>
<td>No salaries</td>
<td>14 000</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Village chief</td>
<td>22 000</td>
<td>14 000</td>
<td>70%</td>
<td>12 days</td>
</tr>
<tr>
<td>Commune councillor</td>
<td>70 000</td>
<td>14 000</td>
<td>20%</td>
<td>4 days</td>
</tr>
<tr>
<td>Health centre midwife</td>
<td>120 000</td>
<td>14 000</td>
<td>11%</td>
<td>2.3 days</td>
</tr>
<tr>
<td>Health centre chief</td>
<td>130 000</td>
<td>20 000</td>
<td>15%</td>
<td>3 days</td>
</tr>
<tr>
<td>Operational district vice-director</td>
<td>230 000</td>
<td>30 000</td>
<td>13%</td>
<td>2.5 days</td>
</tr>
</tbody>
</table>

This table shows that *per diems* were a significant amount of money for a two-hour commitment. Note that *ajar wats* and monks have not been included in this table as they receive no income although their basic needs are met by their religious communities. Lay citizens, all who had their own small businesses – farms, veterinary practices and a corner store – were not able to provide estimates as their incomes fluctuated. Traditional Birth
Attendants were in a similar position. As mentioned in Chapter Five, health centre staff and formal leaders were paid their normal monthly salaries as well as collecting the *per diems* for each meeting they attended, whereas those committee members with their own businesses had to give up potential income-earning time to attend meetings. The higher *per diem* rates were paid to the high status and high income members who were members of the health bureaucracy. Although this may have been intended to reflect the need for greater degrees of preparation for meetings, it also reinforced their positions as high status members.

Although *per diems* were recognised as being vital for securing community involvement as they ensured people had enough money for transport to the activity, transport cost far less than the amounts paid. Some committee members even rode their bicycles or walked to the meetings, incurring no cost and yet they were paid the same amount as other members. Even those using motorised transport and coming from further away did not spend amounts approaching the *per diems*. *Per diem* payments ensured that HCMC members attended meetings, as to miss one would be to forfeit a payment:

*If we have the money to support the meetings, they come. But if we have no money then it is really difficult. Some health centres have an organisation helping, but if the health centre doesn’t have the money to invite the committee members, it’s not easy to call the meetings* (Mrs Som Nang, Pom Health Centre Midwife, Interview).

The *per diems* ensured that DRAY’s program appeared very successful as there were high rates of attendance amongst committee members:

*Of course, where you have support from an NGO, things go rather well. When NGOs give specific incentives for people to come, of course they will come and have regular meetings* (Mr Rem Suni, UNC, Interview).

*Some NGOs, in order to accomplish their program objectives, they pay them* (Mr Serey Phiriak, Ministry of Health, Interview).
The result of the *per diems* for participants is that the focus became on attendance rather than on active participation. In 7.1.4 I will consider other effects of the *per diems*.

### 7.1.3 Training

Although I have outlined the training in detail in Chapter Six, my focus there was on the creation of informed citizens. Here I examine how DRAY shaped the training process and outcomes. Steckler and Herzog (1979) satirised the ways that training could be used to manipulate committees. Four strategies were outlined in their work. The first is to give lectures on the history of the healthcare system for a significant period of time. As already discussed, in the HCMC training much time was spent detailing the history of the healthcare system and its reforms, taking away the opportunity to discuss other aspects of health centres and their management, which could have better assisted committee members to fulfil active management roles. The second strategy is to avoid group process training including skills such as how to work as a group and deal with conflict. There was some group process training for HCMCs in the game described in Chapter Six, throwing an egg safely and the discussion that followed on teamwork. Steckler and Herzog’s (1979) third strategy is to ensure over-provision of information to committee members so that they become overwhelmed by it. As opposed to this approach, limited information about healthcare issues was disseminated to HCMC members, either in written or verbal form.

The fourth strategy is to encourage health care providers not to attend the training as it ‘gives the impression that the only group which needs to be changed is the consumer group’ (Steckler and Herzog 1979: 810). Health centre staff attended the training but they did not do so as trainees. They positioned themselves as ‘teachers’ and ‘organisers’ throughout the training. At Mian Health Centre it was the health centre chief who opened and reorganised the training room. He also picked up the pre-training questionnaires from each of the participants and answered questions from other committee members about health service delivery. Similar tasks were performed by health centre staff in all the health centres studied. This positioned the staff as people who did not require training. It therefore gave the message to participants that it was the public rather than the bureaucracy
that needed skills development; the emphasis was on what the public needed to learn to work within the government’s decision making processes.

This positioning left no opportunity for health centre staff to develop skills in participation. It also reinforced the hierarchical relationship between health centre staff and other committee members; this continued to shape dynamics in committee meetings.

As well as using training to limit the critical engagement of committee members, DRAY used the training course to shape the agendas of committee members. Repeatedly in the training sessions, attention was drawn to the key issue identified by DRAY in their child mortality program: the need for women to give birth in health centres. My field notes taken during the training at Mian Health Centre demonstrate this:

*After the morning break, Sok Samnang seems to have hijacked training to yet again talk about Traditional Birth Attendant (TBA) issues. Why do women use TBAs and not health centres to give birth? TBAs are close to home, and women don’t understand the importance of attending health centres. The main point made in this discussion is that: the habits of people are not changed on their own; giving birth supervised by a TBA is more expensive and unsafe than attending a health centre. Lots of examples were given in the training about safe delivery etc.*

DRAY staff members utilised the training as a forum to discuss the issue they had identified as the most important for maternal and child health. The training of committee members emphasised the importance of a particular issue rather than skill development. This impacted on the behaviour of committee members in meetings.

### 7.1.4 Agenda Setting and Domination of Meetings

Controlling the agenda can shape health boards. Callahan (1999: *iii*) identified the desire of officials to control the agenda of committee meetings in the United States as a key obstacle
to effective citizen participation. There are three spheres or dimensions of power relating to agendas: making choices from an agenda, setting the agenda, and affecting the structures that shape agenda setting (Dahl 1991: 20-25; these spheres of power loosely correlate with Lukes (1974), when Lukes’ dimensions are applied to agenda setting).

DRAY staff members did not make choices from a set agenda. However, they set formal agendas and through training shaped the informal agendas of committee members. DRAY staff placed on the agendas and repeatedly raised three issues in committee meetings and training in all the HCMCs. These issues were related to their program objective of reducing child and maternal mortality. The dominant one – the necessity of women giving birth in health centres – has already been mentioned. The two other issues were the need to collect and analyse health statistics and the illegal selling of medicines:

In the management committee meeting we discussed about the illnesses, do the illnesses increase or decrease? The organisation raised [the issue]; what illnesses, blood illnesses, malaria, whooping cough and they asked the management committee and raised the issue: this month how many people died, how many births. They asked us to report to them, to report to that organisation [DRAY] (Mr Thim Phaly, Ovluk HCMC, Interview).

In today’s meeting we discussed about problems like using illegal medicines. The health centre, the operational district and the ministry, they are pressuring for reducing illegal medicine. They will stop the people who sell illegal medicine. If people have the licence they are allowed to sell them. So now at our health centre, our committee also knows. Because when the pregnant women use illegal medicine they have many problems (Mr Mem Pheap, DRAY, Mian HCMC February Meeting Transcript).

These issues were raised not only by DRAY staff members and the operational district vice-director, but were also internalised by committee members, who often only raised points relating to these issues:
The big problem is the delivery. It is difficult for us to pressure them to give birth in the health centres (Mr Thim Phaly, Oowluk HCMC, Interview).

This is an example of Lukes’ third dimension of power in operation, where the issues identified by the community representatives were shaped by DRAY.

DRAY staff members attempted to portray that they had no influence over the agenda. As Mian HCMC’s February meeting began, DRAY staff member Mr Mem Pheap addressed the meeting:

Now I want the health centre to raise the agenda problem in the meeting today by itself, because DRAY doesn’t raise. Because DRAY offered for the management committee to raise by themselves, what you must do to make the community progress well, to make the community use the health centre services a lot, speak about the problems in the health centre. So in the agendas we want to know about the HCMC, these are the problems about the women giving birth. Report to tell the chief and raise the agendas to put in the meeting.

At the same time as they insisted that they themselves had no role in setting the agenda, DRAY staff suggested a number of issues that they wanted the committee to consider in the meeting. However, the duplicity was greater than this. Just before Mr Mem had addressed the meeting, his manager Mr Sok Samnang dictated the meeting agenda to the health centre chief, as my notes from my observations at a meeting at Mian Health Centre show:

As per Pom Health Centre, before the meeting, the DRAY program manager read out his own agenda (this was read out from exactly the same notebook page he had read it out from at Pom Health Centre on Friday last week). When the meeting started, the Health Centre Chief read out his own [identical] copied-down agenda.
The same happened again in Lahong HCMC as my field notes taken during its February meeting show:

[Mr Sok Samnang from DRAY] sat down before the meeting with the Acting Health Centre Chief and gave him the agenda. The Acting Health Centre Chief put this in his own notebook and announced it as the agenda during the meeting. So, the agenda was very clearly set by DRAY.

The effect of DRAY setting an identical agenda in the HCMCs in Pom, Mian and Lahong Health Centres was that, rather than giving lay citizens and other community representatives an opportunity to speak about their own concerns about their local health services, the proceedings became homogenous:

The issues raised, discussed and resolved seemed much the same as in the other health centres. Given that all the issues came from the same NGO agenda, this isn’t surprising (Lahong HCMC’s February Meeting Observation Schedule).

This suggests that DRAY was not interested in advancing active citizen participation but rather promoting particular issues.

The payment of per diems could have negatively impacted on the extent to which participants would raise issues. If people are paid to participate, they may feel they must provide a particular view (see Kapoor 2005: 1212, drawing on Foucault 1977). Panoptic behaviour can happen in participatory processes even without financial incentives, as participants modify their views in line with cultural norms as they are being watched by community leaders. Per diems can further distort the behaviour of participants.

In the HCMCs, the dominant response in the panoptic environment was for ordinary villagers and even formal and informal leaders to largely remain quiet. However, the method of working secretly and calmly described in Chapter Six – where one lay citizen approached the health centre chief about an issue outside of the committee meetings – is an
example of a participant seeking to operate outside the scope of the panoptic view. Working outside the meetings confirms that committee members modified and policed their behaviour within the public forum of HCMCs. Community representative members of HCMCs did not contribute agenda items, and this is another example of how they self-policing to ensure they did not upset “the hand that feeds”. As already described in Chapter Five, local issues were rarely raised. Even health centre staff did not raise issues particular to their own health centre. For example, the malaria outbreak in Lahong Health Centre’s catchment area, described at the start of Chapter Five, was discovered on outreach only a few days before the HCMC meeting. Yet this issue was not raised with or by the HCMC, despite this being an important local health issue.

Some committee members believed it was DRAY’s program that they were implementing, rather than committee members themselves having active involvement in the management of health centres:

> DRAY organisation helped in providing the strategies and recommendations. 
> It is their program that is implemented… our committee implemented it (Mr Lon Ching, Village Chief and Lahong HCMC, Interview).

Townsend and Townsend (2004) examined a committee in Old Delhi, and found that only one idea was generated from within the committee but most ideas were generated from outside by the council staff and by NGO partners. They found that NGOs acted as gatekeepers and managing agents and many ‘users and intermediary staff [felt] powerless in the face of gatekeepers’ (Townsend and Townsend 2004: 278-281).

DRAY staff members dominated meetings as they spoke for long periods of time, set agendas, pushed committees through the agenda items, and interrupted committee members. An example of this latter behaviour comes from Mian HCMC’s August meeting. A DRAY staff member from the overseas head office was attending the meeting. My observation notes (supported by reference to the transcript) show, at one point after Mr Sok Samnang finished speaking:
The Commune Council Chief Mr Pong Taing prodded Mr Lori Pen, the ajar wat community representative, to speak. But Sok Samnang interrupted after a minute of two, instead discussing the issue with the budget and inviting the HCMC to have input (Observation Schedule, emphasis in original).

That Sok Samnang waited until his superior had left before he overtook the meeting suggests that he was trying to create an appearance of being participatory in the eyes of his superior. Usually there were no limits on this behaviour.

7.2 INSISTED SPACES: WHY INTERNATIONAL NGOs SUPPORT AND SHAPE HCMCs

As discussed in section 7.1, DRAY shaped committees in various ways. DRAY staff did not actively pursue low levels of community participation, but their pursuit of program objectives side-lined lay citizens and other community representatives from health centre management.

International donors and NGOs can have significant influence on government health policy (Lorgen 1998: 330). In Cambodia this influence was used to create insisted spaces within the formal structures of the Ministry of Health in the form of HCMCs. Insisted spaces are those participatory structures that social movements demand for citizens to participate in public decision making (Carson 2008, building on the concept of invited spaces developed by Cornwall 2004). International NGOs first created an enabling policy environment, helping to develop the participation policy and ensuring that the Ministry of Health adopted it. Secondly, DRAY and other international NGOs have used this policy context to establish HCMCs. Although the insisted spaces of HCMCs were created using the rhetoric of participation, DRAY used them to pursue other ends, as described below.

The committees were used as an ‘educative space’, to educate community leaders about the key health issues related to child and maternal mortality. The education persona and role was taken on by DRAY staff and the operational district vice-director to teach and lecture committee members about DRAY’s issues. This excerpt from the transcript of the
February meeting at Lahong Health Centre demonstrates how HCMCs were used as an educative space:

Mr Lek Vuthy: We teach today, teach to know how to monitor.

Mr Da Saravuth: So the teacher clears the canal [a Khmer saying meaning “leads the meeting”].

Mr Lek Vuthy: Thanks. I have listened to the report of the health centre and I will provide some suggestions the same as some of the other members. The roles, the duties for the management committee have already been given, but I will remind you of them to impress them upon you. The main roles of the health centre management committee include discussing the progress of the health centre. Now the progress of the health centre, is it easy? Did it run well? Did it serve the people in the coverage area? (Lahong Health Centre, February meeting transcript).

Although he tried to position his input as being ‘the same as some of the other members’, he took on a very different persona from committee members. He listed HCMC duties and then proceeded to deliver a 13 minute lecture to the committee members on how to monitor the work of the health centre. This included a significant focus on their need to monitor the proportion of women giving birth with Traditional Birth Attendants as opposed to delivering their babies in the health centre itself, and the importance of changing this behaviour. This demonstrates how DRAY’s agenda was adopted by others attending the meetings who also had high status and dominated meetings themselves. DRAY also treated committee meetings and training as educative spaces, taking a similar approach to the operational district vice-director. It was primarily the commune council and community representative committee members who were targeted in these lectures, rather than health centre staff.
HCMCs also functioned as a ‘lobbying space’. DRAY staff used committee meetings to lobby health centre staff. They advocated for two main outcomes. First, in line with the rhetoric of participation, they advocated that health centres be accountable to the community:

*The key purpose that we support HCMCs is because HCMCs are the top level for management issues in the Ministry of Health structure. The Ministry wants to decentralise power to the local community. And the HCMC can facilitate or coordinate between the community and the health centre… When we create HCMCs, when we conduct the meeting, the health centre staff will be responsible to the community, we can advocate this* (Mr Sok Samnang, DRAY, Interview).

Second, they advocated – both directly through speaking to staff and indirectly through telling community representatives about health issues – for improvements to health service delivery. The HCMCs also gave international NGOs direct access to health centre chiefs. Prior to the establishment of HCMCs, DRAY had little access to managers so lacked a forum to engage with them about health issues. The management committees gave regular bi-monthly access to the health centre chiefs and midwives inside the management committee meetings.

DRAY also used HCMC meetings as a ‘mobilising space’. They were used to inspire and encourage formal and informal community leaders to perform tasks to advance DRAY’s program objectives. This included mobilising committee members to promote health centre services and to encourage women to give birth in them. In the final comment made in Mian HCMC’s February meeting, Mr Mem Pheap from DRAY addressed the committee as follows:

*Thank you everyone for coming today. I am the DRAY representative and I expect that when you go back you will help to pressure the community.*

The focus was on performing pre-determined tasks rather than engaging community members to identify and act on their own issues.
DRAY staff successfully used the insisted spaces of HCMCs as forums to educate the community, lobby health centre staff, and mobilise community leaders about their key issues. Even though the HCMCs did not exert much influence over health centre management, the HCMCs provided multiple opportunities for DRAY to improve the efficiency of its program.

7.3 IMPLICATIONS OF INTERNATIONAL NGO SUPPORT

There are a number of implications that arise from international NGO support being the key enabling factor for the establishment of operational HCMCs and that emerge from the role that DRAY played in shaping committees. Here I consider: issues of sustainability; the construction of participation as a gift from the West; the tension between pursuing program objectives and promoting active participation; and international NGOs being involved in Cambodian local-level governance.

7.3.1 HCMC Sustainability

Given that international NGO support is the key enabling factor for the establishment of operational HCMCs, sustainability is a key issue for the participation policy. There are numerous ways that sustainability can be measured: through the presence of continued program activities, continued benefits or outcomes for new clients, the maintenance of health benefits achieved through a specific program, the level of institutionalisation of a program within an organisation and the level of capacity building in the recipient community that enables them to develop future programs (Shedic-Rizkallah and Bone 1998: 87; Johnson et al 2004: 136; Scheirer 2005: 320). Developments that occur after funding ceases are a constituent part of all definitions of project sustainability (Stockmann 1997: 1768). Ensuring sustainability is about much more than just finding replacement donors when funding for a particular program stops (Brown 1998: 55; Scheirer 2005: 325).
Aspects of the project design and characteristics, organisational setting and broader community factors all affect the level of sustainability of a program (Scheirer 2005: 325). Key actions that improve sustainability are the ability to modify programs at the local level, integrating program activities into established administrative structures, significant levels of funding from national sources (budgetary and cost-recovery) during the life of the project, diversified funding sources including fees from the population, a project champion, strong leaders who embed the project in networks of local supporters, visible or acknowledged benefits to individuals or organisational staff, a strong training component, and a fit between the program and the organisational mission (Bossert 1990: 1015; Stuer 1998: 271; Scheirer 2005: 338-9; Stevens and Peikes 2006: 154). It is also suggested in the literature that the origin of the project idea – particularly when it is supported by funding – is important to sustainability (Daubon and Saunders 2002: 185). For example, Mannion and Brehony (1990: 169) found that projects that originate from expatriates, particularly where they are not very relevant to villager lives, often cease once external funding finishes.

There is debate in the literature as to whether governments or NGOs are more able to provide sustainable outcomes (Zaidi 1999; Lorgen 1998: 329). The argument that NGOs are better at delivering sustainable programs is less convincing. Fowler (in Zaidi 1999: 262) argues that NGOs have advantages over government in two key areas that lead to greater sustainability: NGOs are more able to be participatory and they are considered to be in partnership with the local community. The ability of NGOs to deliver sustainable projects has been challenged partly on the grounds that NGOs cannot ‘necessarily guarantee continuity of their inputs’ (Lorgen 1998: 329). Early research on sustainability found that factors such as the ‘length and size of projects [and] the type and time period of technical assistance’ did not impact upon project sustainability (Bossert 1990: 1022). However, more recent work has found that projects that are funded for a short time period have had difficulties achieving sustainability (Zaidi 1999; Busza 2004: 201). NGOs often focus on short term solutions rather than structural change (Lorgen 1998: 329). All of these factors raise questions about the sustainability of their interventions. The links identified by Bossert (1990) between institutionalisation of a policy into administrative structures and sustainability also place the government in a better position to develop sustainable (ongoing) programs compared with NGOs.
Sustainability was an issue considered by policy makers in Cambodia as they developed the participation policy. The operational guidelines to the participation policy consider how to ‘organize the community participation in a sustainable way’ (Ministry of Health 2001b: 45). This part of the guidelines reads:

A few basic principles have to be followed to secure sustainability:

1. The Community Representatives (CRs) have to be elected (not appointed)
2. Make the CRs clearly understand their role
3. Don’t ask a volunteer to give more than 1-2 days/month of his/her time
4. Express the importance of their involvement regularly
5. Make the meetings which they attend beneficial for the CRs
6. Be open to the CRs in all aspects (Ministry of Health 2001b: 45).

These principles are based on sustaining the interest and involvement of those members who are not health centre staff. Each of these strategies above has several paragraphs written on it to give the rationale for why it contributes to sustainability and provide more detail to health centre staff on how to achieve these principles. For example, a way to make the meetings beneficial for the community representatives is to provide health promotion sessions, as the guidelines state that they enjoy receiving training (Ministry of Health 2001b: 47).

DRAV’s practice can be examined in light of the sustainability issues raised in the literature on sustainability, and compared with the sustainability strategies suggested in the participation policy and its discourse. Although the policy included strategies for making committees more sustainable, committee members had been appointed rather than elected, there were no ongoing health promotion sessions, and the importance of committee member involvement was rarely expressed in meetings. There was no local champion, with the exception of Owluk Health Centre’s chief, and the training was poor.
DRAY’s program was only 12 months; KADARM’s had operated for four years. Time was also potentially a factor enabling the greater levels of participation in Owuluc HCMC, so again DRAY’s short program duration was problematic. DRAY’s project was due to end shortly after my fieldwork, in October 2006:

DRAY’s representatives set the program, make the program. Why did I set it until October? Because my program will end. I need to close the program, so at least I can join the meeting three times, we can have three meetings of the management committees (Mr Sok Samnang, DRAY, Mian’s June HCMC Meeting Transcript).

The schedule for committee meetings had only been set until the period that DRAY ceased supporting the committees. It was likely that when DRAY left the province, the committees in all health centres except Owuluc would stop operating:

In my opinion, when DRAY goes it will not be different from KADARM. Because when KADARM supported they held the meeting, so our relations with the community were good. But after, [when] we had no supporter, when they left us, the activities stopped when KADARM left (Mr Ree Saing, Pom Health Centre Chief, Interview).

HCMCs stopped operating when KADARM had ceased its support, even though that international NGO had also made attempts to ensure that its program was sustainable, as will be discussed shortly.

The role of international NGOs is not considered in the policy documents. However, one of the policy makers made a distinction between HCMC budgets coming from the health centre or from an international NGO in terms of sustainability:

[One of the enabling conditions for having HCMCs established is that] there is support for transport costs either by the health centre itself from
user fee incomes, which is the best scenario for sustainability, or by an NGO or international organisation (Mr Rem Suni, Policy Maker, Interview).

Mr Rem Suni sees sustainability as the ability for projects to continue without external assistance. Concerns about the sustainability of international NGO support for HCMCs were raised by respondents, including Mr Thy Nem of PEAKHEALTH:

*The Health Centre Management Committees function well only in the areas where an international NGO supports them. In terms of sustainability you have to distinguish between international and national NGOs. International NGOs are not here for the long term, whereas local NGOs are here for a long time. But NGOs are working here and there, they are small scale, and not long term. So about sustainability, unless the government sees community participation as important and provides financial support…* (Mr Thy Nem, PEAKHEALTH, Interview).

Mr Thy’s point is that international NGO’s programs are not sustainable as they only work for short periods and in limited locations. International NGOs are thus inappropriate for implementing a national participation policy, as it should be implemented everywhere and be ongoing. He argues that the policy cannot be sustainable without institutionalised government support, including resources to implement the policy.

One reason that HCMCs had not been able to continue their activities was that KADARM, like DRAY, paid significant *per diems*:

*The activities stopped for three or four years because when KADARM left, KADARM stopped, we didn’t have the per diems for the meetings* (Mr Sen Chhung, Lahong Health Centre Acting Chief).

Paying *per diems* raised the expectations of participants for financial incentives. If international NGOs had never been paid these incentives the withdrawal of funds would not have concerned participants. However, DRAY staff would argue that without *per diems*
it would not have been possible to establish HCMCs. The key problems of the sustainability of the policy implementation are linked to the lack of institutionalisation (Shedic-Rizkallah and Bone 1998; Johnson et al 2004; Scheirer 2005). As demonstrated in Chapter Six, the committees were not institutionalised within the Ministry of Health, and there was no budget for health centre staff to establish and manage them and DRAY, like KADARM before it, had also raised expectations of participants about the level of financial incentives thus increasing the resources required to manage committees. When international NGOs stop supporting HCMCs, the government lacks the resources to cover the costs of committees. HCMCs are therefore unsustainable development interventions.

**Strategies Used in the Study Area to Make HCMCs Sustainable**

A number of strategies were used by those involved with HCMCs to try to make them sustainable. As DRAY’s program began to wind down, interview respondents began asking me for assistance in finding another international NGO to support the HCMCs. This happened even in Owluk:

> We don’t know if, when DRAY leaves, we will continue or not. I would propose that we ask the student [this researcher] to help connect the health centre with some organisation for providing the budget to the health centre (Mr Meas Yon, Owluk HCMC, Interview).

However, as already discussed, sustainability means more than finding another external donor; otherwise the same issues will happen when their support ceases (Brown 1998: 55; Scheirer 2005: 325).

A government respondent highlighted the need for international NGOs to have a sustainability strategy to ensure that their project activities continue once their support is withdrawn:
It is important that international NGOs have a clear sustainability strategy, what should be done when they phase out, including consideration of per diems. They cannot just do it for only a few years when they are in the health centre and when they leave they leave it for us to solve this problem. I don't think that's sustainable. It shouldn't happen like this (Mr Soern Choup, Ministry of Rural Development, Interview).

Sustainability was an issue considered by DRAY staff. They looked at creating incentives beyond per diems in the form of a ‘health insurance card for the HCMC members’. This incentive could be provided indefinitely by the health centres with no financial outlay from them. DRAY staff spoke of building the capacity of HCMCs so that they would become sustainable as well as working to ensure they were not financially reliant on DRAY:

Our NGO just supports them for a very short period. It’s a very short period of support. We have a short duration from start to stop. So what we are doing, we are providing the capacity building to them and brainstorming ideas about how they can be sustainable, so that they can work by themselves in the future (Mr Sok Samnang, DRAY, Interview).

As their program was in its final months, DRAY staff began these brainstorming discussions with committees, to encourage committee members to think about issues of sustainability and instil in them the importance of commitment to their roles as HCMC members. In Owlok HCMC’s August meeting, Mr Sok Samnang addressed the meeting for 20 minutes on the issue of sustainability and continuation of the HCMCs once DRAY’s support ceased (Observation Schedule). In the same meeting, he implored the committee members:

You shouldn’t be lazy. You have to do everything on time. Never focus on the money only. The important thing is our public’s health, because they absolutely depend on you.

In Mian HCMC’s August meeting Mr Sok Samnang said:
All the committees always ask my organisation for help, but they never help themselves.

Capacity building was another strategy that DRAY staff members used to try to make their program sustainable. DRAY staff argued that their initial role was focused on ‘just building the capacity of them [the members]’ (Interview). I discussed this strategy with DRAY staff and observed it in action. As we waited for Lahong HCMC’s February meeting to begin:

I chatted with Sok Samnang for approximately half an hour. I asked him who set the agenda and he said they (DRAY) did for now, but in the future when the leadership is developed (after training) then the HCMC will set its own agenda (Lahong HCMC’s February Meeting Observation Schedule).

DRAY staff said that they needed to build the capacity before they could let HCMCs manage themselves. It takes time for people to learn new skills and challenge existing hierarchies. However, the emphasis on capacity building also justified DRAY’s extensive involvement in shaping the committee processes, and its methods of capacity building were somewhat suspect. DRAY never gave training to committee members in writing agendas or fulfilling other tasks of running the committees. DRAY continued to have the same level of involvement in all HCMCs over the extended period that I observed them, suggesting that capacity building served as a justification for DRAY’s manipulation rather than as a strategy for sustainability. Ultimately, DRAY staff members were unwilling to relinquish their control, a phenomenon that has been associated with those who establish democratic structures (Blaug 2002: 113). Rather than building analysis skills of participants and encouraging them to raise their own areas of concern, DRAY focused on committee members understanding the importance of their three key issues.

Unfortunately, such an approach to capacity building is widespread amongst international NGOs in Cambodia. The director of the umbrella agency for health NGOs noted that:
I don’t see that local capacity building is really happening in the Cambodian health sector at the moment. The way to build capacity of the community, it will take time and you have to be patient. But if you only want to achieve quick results, it achieves quick results with funding but it does not achieve long term results for this country (Mr Thy Nem, PEAKHEALTH, Interview).

DRAY did use financial incentives to ensure quick results in terms of high levels of attendance. Capacity building is a slow process that can take several years (Crisp et al 2000; Chavis 1995), and Mr Sam Rith from the District Administration Office expected it to take between one and two years before the committee members would become more proactive in meetings (Interview). Again DRAY’s short program duration, and its approach to capacity building was problematic for sustainability.

7.3.2 Participation as a Western Gift and Dependence on International NGOs

The origin of democratic programs introduced by international agencies can be problematic for developing democratic culture. Hughes (2005) studied two programs that were funded by international agencies that intended to introduce democratic institutions and practices into Cambodia. But she found that the heavy reliance on international individuals and agencies:

risked reinforcing a prevalent view in Cambodia that democracy represents a gift of international democracy promoters, rather than stemming from the struggles of the Cambodian people (Hughes 2005: 93).

There are many grounds for arguing that the 1993 national elections in Cambodia were not democratic, including that they were not free and fair and the result was not adhered to (Springer 2005). However, Roberts (2002) has argued that the primary reason that they did not make Cambodian culture democratic was because they were imposed by international
agencies. The Cambodian democrat Lao Mong Hay warns that because many political reforms and democratic developments in Cambodia – such as encouraging freedom of expression through demonstrations and regular elections – have come from outside Cambodia rather than from within, ‘any relaxation on the part of [foreign] donors could well have adverse effects on democratic gains’ (Slocomb 2006). Both Roberts (2002) and Hughes (2005) also argue that democratic consolidation is difficult when the institutions have been introduced by foreign agencies.

International NGOs were so instrumental in developing the participation policy and particularly in implementing it that HCMCs had largely come to be seen as an international NGO activity, rather than a government one. In one example, Mrs Nu Poem, an HCMC member at Pom Health Centre, felt that she was being paid a salary by DRAY to attend meetings and perform other committee work as she was paid a per diem (Interview). She also said that DRAY controlled the HCMCs ‘because DRAY makes the program and continues the program’ (Interview). In Cambodia, the introduction of democratic culture is perhaps most limited by DRAY’s manipulation of the participation process. However, the perception of HCMCs – and possibly by extension participation – as a Western concept and possibly as a gift, also limits the likelihood of HCMCs contributing to a more democratic culture.

Perceptions of projects as external to the community can also affect their sustainability. In their study region in Ecuador, Keese and Argudo (2006: 125) found that project ideas and funding usually originated from NGOs and local people rarely took ownership of NGO projects. The population ‘generally accepted the projects as they did not want to lose the financing’, but once external assistance ceased, the projects usually stopped too (Keese and Argudo 2006: 125).

International NGOs were aware of this common and accurate perception about the origins of HCMCs, and attempted to re-position them in the minds of committee members. KADARM staff members were concerned that HCMCs not be seen as an international NGO program:
We did not want the people seeing that the health centre management committee or the feedback committee [now the VHSG], that these committees belonged to KADARM, because any activities that are related to these committees are collaborative work. We had the participation from the operational district and the health centres. But we are the supporter, the facilitator to the operational district and health centres. And every time there was a committee election we have the presence of the operational district health staff as well as the health centre, as well as KADARM (Mr Pok Tekla, KADARM, Interview).

KADARM staff had hoped that by including Ministry of Health staff in the development of HCMCs and by ensuring that they were visible at key HCMC activities that the committee members would be convinced that it was a program in which the government was involved.

DRAY staff members shared this concern, but used a different strategy. They were careful to publicly emphasise that it was a government program, and one that was implemented by health centres:

_The health centre is the preparer. The health centre is the preparer_ (Mr Mem Pheap, DRAY, Lahong HCMC February Meeting Transcript).

By contrast to committee members, health centre staff members were aware that the policy requiring management committees had come from the Ministry of Health. However, they still noted the reliance on international NGOs to implement the policy:

_The reason that this health centre has a health centre management committee is because there is a policy from the Ministry; they organised the plan. But previously KADARM was the supporter... It is the structure from the Ministry level to the province level, and our operational district collaborated with KADARM to prepare. We can't do it by ourselves in the health centre_ (Mr Ree Saing, Pom Health Centre Chief, Interview).
Respondents were concerned by this reliance on international aid, even those directly funded by it. In an aside to me during training at Mian Health Centre the program leader of DRAY, Mr Sok Samnang, commented:

_In Cambodia, everything is supported by aid, when go out [when the aid is no longer provided], everything is destroyed._

This concern was also related to the development of the participation policy and the reliance on the international community to provide assistance at both the policy development level and its implementation:

_Sometimes I feel that we are making Cambodians more dependent. We have a way to go in making Cambodians more responsible, have ownership. In the community, people feel that, people become vulnerable that way, to dependency on others. So if NGOs or international community really keen about that, we have to teach people to take initiative, to make decisions, to empower them, to make them have a sense of ownership of what their community is and really let dependency. Now the community have perspective, oh very poor, because they don’t have support from Australia, UK, etc. How did people survive 200 years ago before the aid came to Cambodia? (Mr Thy Nem, PEAKHEALTH, Interview)._  

This creation of feelings of dependency was a very real implication of the reliance on international assistance. Interestingly, this dependency was displayed even in Owluk Health Centre, which had shown itself most capable of operating without international NGO support:

_The biggest problem at this health centre is that we have to make our service stronger. We can do this by DRAY collaborating together with the health centre chief. The health centre can’t do it by itself, it needs the organisation. We need the organisation because we are still poor. So I see here at Owluk, that the health centre is not able to provide other services for the population,_
but if we have an organisation, it can help build these services. The health centre lacks the budget, lacks the medicines, but an organisation can help. We must have the organisation to provide the medicines for the children (Mr Chun Lee, Owohuk HCMC).

In Chapter Eight I return to consider the construction of HCMCs as a Western product, but here I have briefly canvassed the issues of positioning participation as a gift and creating dependency on international donors for assistance.

7.3.3 Tension between Pursuing Program Objectives and Participation

Participation has come to be seen as a technical exercise – one that will improve program efficiency for NGOs. There is a ‘natural tension between the objective of empowering communities’ and seeking to achieve particular outcomes (McKinlay 2006: 496). The difficulty in achieving both ends was evident in DRAY’s work. Like participatory development, international NGOs usually fail to engage with the discourse of citizen formation (Hickey 2002: 853). Francis and James (2003: 326) suggest that the tension between citizen participation and the achievement of externally determined objectives may not be able to be resolved, meaning that organisations have to choose between achieving one or the other. International NGOs tend to constrain participation within the project framework, so that participation provides a means to achieve pre-defined goals, rather than being an end in itself (Hickey 2002: 843).

Once participation becomes a means to an end, better ways to achieve the same end are discovered. DRAY’s program leader told me that they acted according to the policy guidelines:

_At the first meeting, we select them to be members. We vote for the new chief of the HCMC because in national health policy, the Primary Health Care [Policy], at that time the chief of commune had to be the chief of HCMC at each location. So we followed the structure of the national policy, ah,
However, they deviated from the policy in various ways, as were outlined in Chapter Six. This suggests that implementing the government’s participation policy was not their key purpose in supporting HCMCs. KADARM’s program manager had explicitly told me that the organisation introduced HCMCs because it was a ‘program objective of KADARM’ (Mr Yem Sovann, Interview). The same was true of DRAY, but its staff always maintained their rhetoric of following government policy and “doing” community participation. Decisions were made in the implementation of the policy that undermined the ability of lay citizens and other community representatives to exercise power. DRAY’s extensive manipulation of the process was done in order to achieve its project objectives.

DRAY was able to significantly shape the committee process because international NGOs had power and influence over all levels of the Ministry of Health in Cambodia. Coston (1998) created a typology of relationships between governments and NGOs, yet in all her models NGOs have less power than the government. This does not account for the relationships such as that between international NGOs and the Cambodian Ministry of Health. In partnerships, power can be exercised on the basis of political or financial coercion (Buse and Harmer 2004: 52). Differences in the levels of stakeholder influence can be explained by variations in resources such as money and information; the skills people have in using these resources; and whether people use these resources for political purposes (Dahl 1991: 35-36). Walt et al (1999: 215) note that Ministries of Health often are or feel less powerful than donors, as donors often fund NGOs directly rather than providing support to the state. The international NGO and development community working in the health sector in Cambodia had significant potential to exercise power over the government because of their financial position and their willingness and ability to use it to effect policy change.
7.3.4 International NGOs Doing Governance

When bodies other than the state are involved in aspects of governance, there are questions of their legitimacy and purpose in being involved. There are tensions associated with the NGO role in the process of ‘government’ (Bryant 2002: 269). Coston (1998: 368) notes that:

> although services can be contracted out, governance cannot. In other words, government cannot shift its entire responsibility to the private and third sectors. Government is irreplaceable as a mechanism for collective decision making…

If an NGO has convened a governance function such as a participatory forum, when they withdraw their support, citizens lose their access to government decision making.

DRAY is an international rather than an indigenous NGO and is involved in Cambodian governance at the local level. This raises additional questions to those above about general NGO involvement. One of the concerns about international NGOs is that they ‘are, simply, foreign’ (Lorgen 1998: 328). International NGOs have no accountability to the national population and therefore lack the legitimacy to perform governance functions. International NGOs conducting government participation programs thus perform a neo-colonial governmental role (Lorgen 1998: 328).

This situation also highlights the shaping of local and national political agendas by foreign and international interests. ‘Political globalisation’ is a term that was first conceptualised by Cerny (1997: 253; see also Shelley 2000). Political globalisation:

> … refers to the shaping of the playing field of politics being increasingly determined not within insulated units (such as a particular state) but rather deriving from complex multi-level games played on multi-layered playing fields, above and across as well as within state bounds... political globalisation, in this sense,
has had the effect of promoting aspects of liberal-democratic political culture and political practices (Shelley 2000: 223).

Shelley (2000) analysed the activities and effects of the village self-governance programs of three American NGOs in China and interpreted them as demonstrations of political globalisation. She found that there were multiple layers of power and interests at play in the Chinese villages and that national and international political actors ‘promoted and exploited’ rural political reforms in China (Shelley 2000: 225).

Tvedt (cited in Porter 2003: 142) argues that NGOs transmit Western concepts of development to the Third World. The World Bank and other donors have promoted ‘good governance’ and democracy by both making funding conditional on political change and funding ‘institutions and procedures presumed to encourage democratisation’ (Gary 1996: 153). ‘Democracy’ and participation, through the practice of HCMCs, become not so much a gift from the West but an extension of Western modes of governance. It is a prime example of political globalisation as the policy made possible new political spaces that international NGOs used to advance their own objectives and influence government decision making at the local level.

7.4 CONCLUSION

There are a number of implications of international NGO support being the key enabling factor for the establishment of HCMCs. The HCMCs are unsustainable, are positioned as a non-Cambodian institution, provide an international agency with access and influence over local governance, and highlight the tension between achieving community participation and achieving project objectives. In this chapter I have demonstrated why an interest organisation convening a participatory forum is problematic. Although international NGO support was the key factor enabling the establishment of HCMCs, DRAY’s manipulation of the participation processes directly contributed to the low levels of lay citizen and community participation. DRAY’s goal of reducing child mortality is laudable. However, it pursued this goal while adopting the rhetoric of citizen participation. DRAY, as an
international NGO, used the HCMCs to create new spaces to advocate, educate and mobilise health centre staff and community leaders about its key issues. This research shows how powerful international NGOs are in Cambodia: they not only have significant resources but shape policy and participatory agendas. In Chapter Eight I will consider the broader context of the participation policy’s development to discern why the Cambodian government was willing to let international NGOs create the policy within the Ministry of Health and establish HCMCs at the local level.
Although in Chapter Five I showed how the policy failed to achieve participation, I have used the remainder of the thesis to this point to explain aspects of why this happened. Poor process design and lack of institutionalisation of the policy into the practice of the Ministry of Health (Chapter Six), and international NGO influence over and within the HCMCs (Chapter Seven) have all played a part. Although I have gone some way in these chapters towards explaining why events unfolded as they did, the explanation remains incomplete. Why did all this happen: the failure of the policy as well as all the contributing factors already outlined? Here I address this question, by examining a dimension of power.

Lukes’ (1974) third dimension of power is the underlying political landscape that shaped the actions and motivations of different actors. Here I focus on the political power plays underlying the relationships between government and the international development community, as they were the predominate actors involved in the adoption of the participation policy. The dynamics between them at the national level affected what did (not) happen in relation to policy implementation in health centres.

I build on existing work in development and democratisation studies to help account for what happened in the participation policy experience at both the macro (national policy adoption) and micro (implementation at the health centre and operational district) levels. The participation policy can be considered a development intervention as it was introduced in Cambodia by the international development community. Ferguson’s (1990) model of development as an anti-politics machine is applied to reveal the success of the participation policy. Although to date I have considered how the policy failed, examining in what ways it succeeded helps make clearer the broader political landscape. Ferguson’s model also
prompts an examination of the depoliticisation of the policy. Kapoor’s (2005) work on transference within development adds more depth to understanding the depoliticisation process. These explanations remain incomplete and to address these shortcomings I build on Orlandini’s (2003) preliminary research; she argues that the process of policy interpretation can be paralleled with consuming a commodity. I bring together the scholarship of these authors and others, and extend it to show how the Cambodian participation policy was consumed.

8.1 Development: The Anti-Politics Machine

Ferguson’s (1990) widely cited book on the nature of development has had a significant impact on development scholars (Chhotray 2007: 1038). This as well as that Ferguson’s arguments applied to the present study help to explain some of the key outcomes in Cambodia, and Ferguson’s focus on the hidden dimension of development projects, makes it a good starting point for the analysis of the third dimension of power. At the time of his study of a rural development project in Lesotho, almost all observers were agreed that Lesotho’s history of development was one of ‘almost unremitting failure [of development projects] to achieve their objectives’ (Murray cited in Ferguson 1990: 8). This situation seemed replicated throughout the developing world (Ferguson 1990: 9). The dominant question in development studies at that point was why development interventions failed.

Scholars and practitioners were rarely asking what development projects did do, what they succeeded at, a question Ferguson set out to investigate. He examined how institutionally produced ideas about Lesotho – shaped by the broader development discourse – affected the project and its outcomes (Ferguson 1990: xv). He followed Foucault to speak of ideas as a conceptual “apparatus”: ideas are not abstract, rather they are ‘an elaborate contraption that does something’ (Ferguson 1990: xv, emphasis in original). The discourse of development ‘identifies appropriate and legitimate ways of practicing development as well as speaking and thinking about it’ (Rossi 2004: 1).
The development discourse shaped the planning of the project, and these plans interacted with chance events and unacknowledged structures to produce unintended effects (Ferguson 1990: 20). Ferguson (1990: xv) demonstrated that in Lesotho ‘the “development” apparatus’ operated as an “anti-politics machine,” depoliticizing everything it touches, everywhere whisking political realities out of sight, all the while performing, almost unnoticed, its own pre-eminently political operation of expanding bureaucratic state power.

The expansion of state power was achieved through the establishment of government offices in the project area. Both the ideological effect of depoliticisation and the institutional effect of expanding state power were unintended yet had real impacts. Development interventions are not undertaken to achieve these side effects, and the resultant effects of development do ‘just happen to be the way things work out’ (Ferguson 1990: 256). It is that the unintended effects are also intelligible as part of another, authorless strategy about increasing state power and control that leads Ferguson to speak of the development apparatus as a machine, a system that acts beyond the intentions of the actors within it and the plans that they make (Ferguson 1990: 18 - 21). More recent studies building on Ferguson’s work further supports the relevance of the anti-politics machine to the present study. The anti-politics machine had the same effect of expanding state power when Bolivia’s Law of Popular Participation was implemented (Medeiros 2007: 413). Bryant (2002) has also found that NGOs have become attachments to the anti-politics machine and that they expand state power through extending governmentality.

In his influential book, Escobar (1995) takes a similar discourse-based approach to Ferguson. Both scholars have been critiqued for only giving a ‘partial understanding of the nature and effects of development intervention’ (Lewis et al 2003: 542). The lack of agency accorded to development actors has been one of the key critiques of the anti-politics machine (see for example Green 2003; Hickey and Mohan 2005; Chhotray 2007). It is the ‘anonymous automaticity of the machine’ that denies agency to development actors (Mosse 2004: 644). Scholars have argued the importance of agency, rather than assuming that
structure is the only determinant of outcomes in development (see for example Lister 2000; Newsham 2002: 12). The critical perspective of development that Ferguson puts forward and the instrumental view in which models of policy are seen as rational problem solving are both criticised by Mosse (2004: 644) for diverting attention from the complexity of policy as institutional practice. Agency is important within this practice.

*Contributions of the Anti-Politics Machine Model to the Cambodian Participation Policy*

Despite these criticisms, Ferguson’s book has two major contributions to this study. First, one question implied by his research is: although the policy fails to achieve participation, what does it achieve? As already mentioned, the policy resulted in an insisted political space (Carson 2008) for international NGOs. This was an unintended aim of the international NGOs who advocated for and developed the policy; they aimed to increase citizen participation. Nor was it the primary focus of DRAY in establishing HCMCs, as its focus was on getting women to give birth in health centres. Following Ferguson, this unintended effect of creating an insisted space is intelligible as a strategy to expand international NGO influence over bureaucratic state power. This expansion was clearly demonstrated in Chapter Seven, although there it was not framed in such language. This extension of influence happened at the macro level, with international NGOs exercising influence over domestic health and governance policy. At the micro level, DRAY exerted influence over the bureaucrats working in health centres and to a lesser degree they exerted influence over local leaders who were members of the committees. Unless DRAY decides to adopt the HCMC “component” of its work into other projects in the province it is working in, this expansion of international NGO influence is likely to last only for the life of the project, so this success must not be overstated. Prior to establishing the HCMCs, DRAY had little opportunity to meet regularly with health bureaucrats. This expansion of influence is the policy’s greatest success.

The second contribution of Ferguson to this study is highlighting the depoliticising nature of development. Public participation has also been widely criticised for being depoliticised (see for example White 1996; Hickey 2002; Cornwall and Brock 2005). The technocratic
approach to participation has ‘exacerbated the depoliticisation of development’ (Kothari 2005: 425). Political decisions are made in development yet they are portrayed as being technical and based on neutral expertise (Wilson 2006: 503). Bolivia’s Law of Popular Participation has been critiqued for recasting political issues ‘in terms of purely technical problems calling for technical solutions’, and for leaving politically sensitive issues such as land redistribution off the agenda (Medeiros 2007: 416). The participation policy in Cambodia was also depoliticised, being portrayed and understood as a technical intervention, part of a development project in the health field. Political issues such as poor pay of health workers or political reasons for having a poor public health system were not considered. Instead the focus was on an intervention that was far more politically and logistically feasible. Development interventions in part fail because they are depoliticised, as they are then unable to engage with the structural causes of poverty and other social issues (Bryld in Wilson 2006: 506).

It is possible that a depoliticising assumption in the Cambodian case was a belief that policy is a technical process, with policies implemented as written. The source of this assumption would be a belief in linear policy models, identified by Tordella (2003: 3) as a cause of depoliticisation in development projects in India. Given their experience in implementing a number of policies, the government would have been aware of the need to resource and institutionalise policies to ensure implementation and yet they failed to do so with the participation policy. The international development community advocated only for the adoption of the participation policy, but not its implementation. This may have been caused by one of the following: after adoption they no longer felt that the policy would work, they intended to use it in a way that did not require universal implementation or were unable to fund this, the policy had already achieved an ideological function, or they had a less detailed knowledge of policy processes and assumed a linear policy model. This latter reason is possible but unlikely as the international development community is comprised of professionals who are likely to be aware of how policy processes work.

A more certain depoliticising assumption in Cambodia was that “community” was constructed apolitically in the minds of policy makers and implementers, whereby power differentials were assumed not to exist or affect interactions between people. In an analysis
of the anti-politics machine in India, Chhotray (2007: 1041) notes that simplified ideas of community were assumed in the development project he analysed, where the community was conceptualised as a ‘self-sufficient, harmonious entity, unstratified by factors such as land ownership and caste’. Apolitical assumptions about “community” are dangerous (Williams 2004: 562). Amongst other effects, this idealisation of community leads to a tendency for development workers to assume community needs and expectations are homogenous (Quaghebeur et al 2004: 159).

Idealisation is a possible cause of assumptions about the apolitical nature of social relations in Cambodia. Kapoor’s (2005: 1208) writing on transference and idealisation in development gives an (incomplete) explanation of why this simplified understanding of power dynamics occurs. The idealisation idea has been considered by other scholars. Ferguson (1990: 10-11) himself cites Robertson, who makes reference to development as the attempt by society to re-make itself into an ideal world. But Kapoor considers this process when Western society is trying to re-make society in another location, i.e. transplanting their view of an ideal society in one culture into the lived experience of another. Kapoor (2005: 1208) calls this transference, arguing that Westerners are collectively unhappy with the democratic deficit in Western liberal democracies and there is a demand for more participatory democracy. Participation policies have partly been promoted abroad as a symbolic way that Western governments say to their own citizens that they are supportive of political participation in their own country as well, a motivation that was evident in the United States during the 1970s (Morgan 1990: 215). International NGOs are substantially funded by Western governments and therefore can be required to perform political functions such as this. Kapoor (2005: 1208) draws attention to the way participatory development has become ‘a vehicle… to try and resolve real or imagined liberal democratic deficiencies’ by attempting to make the perfect democratic society abroad.

Kapoor (2005: 1208) argues that a clear sign that participatory development is transference is that international development practitioners ask more of marginalised communities than is asked from Westerners in their own societies.
The implication is that we hold the ‘beneficiaries’ of [participatory development] to a higher standard or ideal. As a consequence, Third World communities may well be a dumping ground or test site for idealized forms of participation (Kapoor 2005: 1209).

International development agencies are the means for transferring these idealised forms of participation into idealised communities in developing countries. Cooke (2001) shows how social-psychological group processes that have been well understood in management studies for decades have been disregarded in the design and implementation of participation processes in international development. This is a possible sign of transference, as participation is expected to allow all to have a voice, even though no safeguards have been put in place to address group dynamics that are known to interfere with this outcome.

Kapoor (2002; 2005) and Cooke (2001) critique forms of participation such as Participatory Rural Appraisal that were developed specifically for application in international development and are widely used. These techniques do require more of beneficiaries than is required from most participation processes in Western contexts. They expect the involvement of all residents of an area to participate in activities such as determining the relative wealth of all community members, and they have simplistic views of power dynamics, seeking only to differentiate between the uppers and lowers, or those who are first and last (Chambers 1994).

Kapoor is close to the mark when he talks about idealisation. It is when he frames it as transference, applied to “the Other”, that his work loses relevance to committees. This is my point of departure from Kapoor. Participation is championed in both developing and developed nations (Mohan 2007: 779). It is introduced within Western countries as a means to address problems with representative democracy (Akkerman et al 2004: 82; Mohan 2007: 790). Although heavily critiqued, committees with similar process designs to the HCMCs continue to be implemented in Western contexts. There is only one aspect of the HCMCs where more is expected in Cambodia than in developed countries: the expectation that whole communities will turn out to elections for committee members. In Western contexts, positions on management committees are usually self-selected.
Committee designs in general assume that power plays no part in shaping group interactions, as demonstrated by the dominance in committees of both partisan participants and those from high socio-economic groups (see for example Irvin and Stansbury 2004; Marshall and Jones 2005). The discarding of knowledge about group processes (Cooke 2001) then is relevant to committees in all contexts. This type of depoliticisation is less a product of international development than something that applies to committees in general. Although Kapoor spoke of idealisation in relation to applying more demanding forms of participation to “Other” communities (Said 1978), I argue that it is also idealisation even when we apply depoliticised views of “community” and the associated simplistic participation processes to ourselves at the same time. Blaug (1999: 135) notes that there is a difference between the theory and practice of democracy (ideal vs. real democracy). Although the challenge for both academics and practitioners is to bring the real and ideal closer together (Blaug 1999: 135), frequently expectations of participation are set too high in both Western and developing countries. It is the ‘unrealistic assumptions about the possibilities and merits’ of participation (Kumar and Corbridge 2002: 73) that make it a case of idealisation and can also lead to the failure of participation (Kumar and Corbridge 2002: 76).

This idealisation was present in Cambodia and contributed to the failure of the participation policy. The process design, as discussed in Chapter Six, is evidence of apolitical assumptions about community dynamics being made in the official discourse by policy makers and implementers. The assumptions that power plays no, or a limited, part in dynamics within groups (be they communities or committees) in Cambodia is evidence of depoliticisation. The process design within the policy did not completely depoliticise the community, as there was mention of needing to have poor people and women on the HCMCs in recognition of existing hierarchies in Cambodian society. However, as previously stated, group dynamics were unaccounted for in the process design, with the policy assuming for example that ordinary villagers would speak in meetings with those with higher status present. Although DRAY actively chose known local leaders to be members of the committees, like the policy makers they were only concerned with who should be on the committees, not how they would interact. The idealising assumptions that social relations are unaffected by power are likely to lead to the failure of committees to
achieve participation when judged against the empirical frame presented in Chapter Five in a range of developed as well as developing countries.

The idealisation also contributed to the policy’s success, the expansion of the power of international NGOs. The depoliticisation of their role and the creation of the committees as part of a technical health intervention enabled DRAY an opportunity to expand their sphere of influence. Idealising and simplifying the role of the convenor, by removing any notion that they have power in shaping the process of participation, depoliticises participatory development (Williams 2004: 563; Kapoor 2005: 1207). As outlined in Chapter Seven, DRAY staff members’ positioning of themselves in a teaching role constructed the community as uneducated and created an illusion that DRAY was separate from the process of participation. This enabled DRAY staff to play a key role in shaping the participation, as they were doing it in the name of “capacity building”. Ferguson (1990: xv) demonstrated that the portrayal of development as a technical intervention masks its political functions. The denial of the agency of convenors of participation processes serves ‘to remove important aspects of the development process from public scrutiny’ (Williams 2004: 564).

8.2 Consumption of Participation

I have used Ferguson’s (1990) approach to deepen the analysis of the present study by identifying the policy’s success and analysing its depoliticisation. Yet agency is still unaccounted for, a criticism of Ferguson’s work that has already been discussed. The ‘machine’ fails to explain the exchanges and dynamics between the different actors, which are important for understanding the third dimension of power in the Cambodian participation policy experience. It is because of the inadequacy of the anti-politics machine to explain these exchanges in the present study, that I brought together the work of a range of scholars to extend understandings of the consumption of participation and participation policies.
In brief, the consumption of participation model presented here is as follows. International development actors produce, market, and “sell” participation policies and processes and in return offer an implicit promise of resources to the government. These policies and processes become products that are accepted and/or resisted by the government, and resistance can happen under the guise of acceptance. This exchange of participation in return for resources happens in the context of the game of international development. Participation becomes a product – an object – and thus its political purposes and functions are forgotten. The adoption of participation policies and processes becomes a commercial transaction and is reduced to a “tick in the box” exercise: either an agency “does” participation or they do not. No longer is the extent or quality of participation important.

Participation in international development has been accused of being neo-imperialist (Townsend et al 2002) as it involves the developing world being told how to live and govern themselves (Hickey and Mohan 2005: 244). Theorising the consumption of participation does not neglect such analyses. The neo-colonial project is revealed in the production, marketing and “selling” of participation, and in resistance to it.

In constructing a dichotomous relationship between government and the international development community I focus on the overall “official” position of both government and international development agencies. Although some variation in views within each of these two stakeholder groups is acknowledged, it is the official discourses that led to policy adoption, the “trade” in participation policies and programs in return for resources.

8.2.1 Consumption in the Development and Participation Literatures

Before discussing the literature relevant to the consumption of participation and the policy, there are literatures in two distinct areas in which consumption is related to citizenship that are irrelevant to this argument and need to be put to one side. The first is the notion of consumer participation. Those who use public services such as health services have in some instances come to be known as consumers or citizen-consumers, and were mentioned in Chapter Two (see for example Bickerton 1999; Khan 1999; O’Donnell and Entwistle 2004).
The second irrelevant area is the exercise of citizenship through consumption choices, examining historical and contemporary social movements that include consumer boycotts, fair trade, environmentally-focused consumption and anti-sweatshop movements (see for example Bryant and Goodman 2004; Jubas 2007; Trentmann 2007). In this second type of literature, consumption is meant literally, and attention is drawn to how power is exercised through patterns of consumption (Orlie 2002). These two literatures consider a different type of consumption, and with one exception will not be considered further.

Consumption is a term that has evolved from being used in a literal sense as eating, drinking or buying something to uses that are more figurative (Meletis and Campbell 2007). Consumption is an idea that has been applied to development policies through Orlandini’s (2003) examination of how governance policies introduced to Thailand as part of international development discourse and practice were responded to by Thais. Orlandini examined the ways that those who implemented “good governance” policy transformed it in its implementation to advance their own agendas, an active manipulation of policies introduced as part of international development. Paley (2001; see also 2002) demonstrated how the Chilean government marketed participation and democracy to motivate citizens to provide public services, for example collecting rubbish in public spaces. The export – another commercial term – of democracy and democratisation policies has also been examined, focusing on the way that Western models are transplanted in other locations (Nuscheler 1995). Carothers (1999) and Gaventa (2006: 17) critique the export of democracy – that is, the promotion of democracy through democracy aid programs, with a dual focus of creating democratic institutions and civil society – for promoting a specific idealised form of democracy that arises from one set of experiences. Henderson (2000: 7) found that attempts by American organisations to democratise Russia through exporting Western models of civil society failed dismally. Russian organisations funded by foreign donors lacked constituencies, compared with their locally funded or non-funded counterparts. The focus on exporting democratic forms draws attention to the possibility that the “trade” in participation policies is an imperial or neo-colonial activity, as these policies are exported to expand Western modes of governance and ideas of democracy.
Ideas related to consumption have been more directly applied to participation by Mosse (2003; 2004) and Kapoor (2005). They both consider the ways that participation has been marketed and branded – language and concepts associated with consumption. Mosse (2003; 2004) examines the ways that participation became a commodity in a development intervention in India. Kapoor (2005) discusses consumption in relation to participatory development more broadly. He considers how participation has been reduced into a set of toolkits and techniques and has thus become a package (Kapoor 2005: 1211). Participation is not only a trend but also an institutionally marketed brand, because one does not just take on participation when “doing” participatory development, but ‘[also] ‘community empowerment’, ‘good government’ or ‘democracy’ (presumably, a Western-style, wealthy democracy)” (Kapoor 2005: 1211). These scholars make a valuable contribution to understandings of the adoption of participatory policies and processes, but they each only examine a component or two of the exchange, for example participation’s production and marketing. I will draw further on the work of these scholars as I bring their work together and extend it to consider also the negotiations about the adoption of participatory policies, and forms of resistance to them.

8.2.2 Marketing the Product of Participation

The depoliticisation of participation is complicit in turning participation from a political process into a depoliticised technical product, something that can become a component in a development project or policy reform program. Although closely related, participation took on the form of two distinct products in the Cambodian experience reported here: the participation policy and DRAY’s participation program.

*The Marketing of Participation*

Cambodian health policy has long been driven by international NGOs as noted by Mr Thy Nem, the director of PEAKHEALTH, an umbrella agency for health NGOs in Cambodia:
From two or three decades ago, up to now, NGOs pilot implementation. This is best practice experience and contributes to policy change. Up to now there are a lot, participation policy, outreach guidelines etc. Even now we have reproductive health policy, child survival core strategy: all of these were formulated and based on pilot implementation of NGOs... So there is no question about NGO innovation and pilot implementation leading to policy development.

Health policies thus originate with NGOs, usually international ones, and are then marketed by the international development community to the Cambodian government as I show below. The dominance of foreign agencies in developing health policy mirrors experiences elsewhere (see for example Morgan 1990; Harcourt 2004: 2).

Foreigners and international agencies played a key role in the development of the participation policy, and of marketing it to the state. The main stakeholders with strong foreigner involvement were the United Nations Agency UNC and PEAKHEALTH. Mr Sam White, a non-Cambodian working with UNC, explained the policy development process:

*I gave a presentation to PEAKHEALTH on community participation. At this time... there were no policy documents. So then I went out and reviewed what the possibilities were. And then I came up with a formula and I said why don't we elect one man and one woman in the village and we called it a feedback committee at the time. And then at the commune level we elect one woman and one man for the health centre management committee, because at the time there were no non-health people involved [in health centre management].

At the time we started it up [did a pilot project] and did all these elections and things and we introduced them [the HCMC members in the pilot] in the role...*
At the time there was a raging debate about the structures for the community participation, and UNC held a workshop in Siem Reap, and the workshop decided unanimously to go with the structure of the feedback and the management committees. We had health advisors from UNC, NGOs, and provincial health department and operational district staff. This would have been in 1995 or 1996.

So then the Ministry got more involved. So let me see, what was done next? Yeah. We put this in place in all the Provinces where UNC was working, and also other NGOs who were at the workshop got involved, and then the Ministry of Health came on the bandwagon, and then PEAKHEALTH started a working group on community participation. They started working on what is community, what is community participation. Then they came with a final report to the Ministry of Health with policy recommendations. The chair of this working group was from [overseas].

This excerpt shows that the international development community, particularly UNC but also PEAKHEALTH, created the participation process of HCMCs as well as the product of a participation policy. The excerpt also highlights that the policy was a product marketed by Western development agencies to the Cambodian government by using pilot programs and workshops as sites to promote their idea. The Ministry of Health policy makers also acknowledged the importance of these pilot studies by UNC and international NGOs that adopted UNC’s model to the policy development process:

*It took about six months to write down [the participation policy] on paper. But the initial work had been done throughout the years... because we need to draw on the lessons learned from the field level. The community participation of the health centre management committee was already put in place before the policy* (Mr Serey Phiriak, Policy Maker, Ministry of Health, Interview).
The policy development process was significantly underway before the Ministry of Health became involved. It was only during the policy writing process itself that Ministry staff took a less passive role rather than merely attending workshops. The policy writing itself was more collaborative, involving staff from both the Ministry of Health and UNC as well as strong representation from PEAKHEALTH. This process will be returned to.

In the study area, pilot studies had also been used to market HCMCs; recall that KADARM had taken staff members from the provincial health department and operational district to UNC’s pilot project prior to establishing HCMCs. The largest evidence that the policy was marketed in some way by DRAY is that the government had not systematically implemented the policy prior to 2006, and yet it was implemented by DRAY with acquiescence from the health centres and operational district. HCMCs were marketed by DRAY as part of a whole program on child and maternal health. Participation has become professionalised through the production of paraphernalia such as training manuals and skills workshops (Kothari 2005: 440), processes that Mosse (2004: 650) found important to the ‘commoditization’ of participation in India. DRAY ran training workshops for participants and produced and used a training manual. Participation at both the micro and macro levels was marketed as an apolitical and technical intervention.

*Why Participation is Marketed*

Cambodia is not the only place where participation has become a product. Mosse (2004: 650) for example has shown that skilful marketing turned participation into a commodity that conferred a good reputation on the instituting agency in a rural development project in India.

There are many reasons why participation is marketed by the international development community in Cambodia and elsewhere. International development and public policy is homogenised as approaches representing a particular view of social change and development are strongly promoted by international institutions and NGOs that work in multiple countries (Apthorpe 1996: 31; Townsend et al 2002: 830; Kothari 2005: 437;
Carroll and Hameiri 2007: 413). Given this homogenisation, the country that is adopting the latest development interventions becomes ‘little more than an implementation partner’ (Carroll and Hameiri 2007: 414) for the same processes that are introduced around the world. Participation is now considered a central norm – even orthodoxy – of development practice (McNeish, 2006: 231; Mohan 2007: 781; Simon 2007: 213). Most of the development industry is an international advocacy coalition that promotes participation (see Sabatier and Jenkins-Smith on advocacy coalitions, cited in Princen 2007). Participation is promoted worldwide by a multitude of agencies including the World Bank, official government aid agencies and international NGOs.

Participation has an ambiguous definition and has multiple and varied meanings that enable it to gain support from a wide range of stakeholders (Mosse 2004: 650; Marsland 2006: 65), making it a widely marketable commodity. This means that it can be promoted in different ways according to the audience to whom it is to appeal. Participation’s commodification as a good, as good practice and as morally correct behaviour mirrors how decentralisation was produced as a commodity in Scotland (Paddison 1999: 107). As such, participation can be used to help those less fortunate, which is a key motivation in development interventions (Mercer et al 2003: 419). Referring to the idealism of participatory development and its relationship to democracy, Mr Sam White commented that ‘It’s quite romantic regarding democracy and the people who are the users, giving them a voice’ (Interview).

Democracy has come to be seen as a universal political form, an indicator of modernity and progress and a panacea for developing countries (Paley 2002; Michelutti 2007: 640). The democratic model arose in a particular context and is sustained ‘by beliefs local and specific to that context’; to suggest that it is universal is an ethnocentric assumption (Newsham 2002: 10; see also Nuscheler 1995). In Bolivia, NGOs responsible for helping implement the national participation policy ‘were quick to recognize that Western public administration and governance styles are embedded within cultural as well as technical systems’ (Kohl 2003a: 329). Participation has been introduced into some countries primarily to serve the ideological function of promoting ‘a Western democratic political ideology’, as Morgan (1990: 211) has shown in Costa Rica. Morgan (1990: 211) sought to explain why a participation policy in the health sector in Costa Rica had not been widely implemented.
The ideological function of promoting Western political systems was achieved when the policy was adopted. This combined with the policy failing to achieve its desired effects in practice led to participation being abandoned by the international agencies as well as the national government. Although participatory approaches should not be considered ideologically neutral, some practices can be transplanted without it becoming a neo-colonialist exercise (Newsham 2002: 34-35). Diamond (cited in Henderson 2000: 10) argues that there is a place for international actors in the promotion of democracy. Democracy is wanted by many in developing countries including national governments (Nuscheler 1995: 223, 231) so it is inappropriate to dismiss democracy as an imperialist imposition. However, the nature of its promotion abroad does demand examination.

Democracy is widely promoted by foreign donors in Cambodia (Van 2004: 9; Hughes 2005: 92), and the HCMCs were seen as a product that would advance democracy. In a discussion with one of the policy makers working for UNC, we discussed the low levels of participation in existing HCMCs in Cambodia. Mr Rem Suni commented that:

... in the long term I think things will change. In the Cambodian society, ordinary people will feel that they have more rights to speak, especially when they are the member of a committee like that [a Health Centre Management Committee]. [It will also change] because education will get higher, there will be more education in the future. But it will change with the Cambodian society. It will change not just because of the committee but because the society will change. But what we want is that the structure is already there, and those structures also play a role contributing to the change. You create committees to give people an opportunity to say something, but you also create committees to give capacity to the people.

In this way, the HCMCs are seen as part of the democracy building project, as a means to create democratic citizens in Cambodia. Those promoting the participation policy are trying to put in place a process of social change by exporting a political institution – a participatory structure. Participation then is a product that is expected to both develop and democratis Cambodia.
Participation fits with the logic of Western democratic and economic liberalisation approaches; in these the state is made more participatory and simultaneously rolled back (Zaidi 1994: 1386). The pluralisation of state decision making officially strengthened democratic citizens but it also created a space that international NGOs used to access the Cambodian state and influence their health programs. The desire for this type of influence is in part due to depictions of government, in Cambodia and elsewhere, of being inept and to blame for the failure of development (see for example Ferguson 1990; Zaidi 1999).

The heterogeneity of the development community accounts for the differences between the motivations of international NGOs involved in policy making compared to DRAY staff. Although DRAY staff members’ motivations were still shaped by the broader discourse, they pursued participation for its efficiency benefits rather than any political or ideological function. At the implementation level, DRAY used the participation program to create spaces for advocacy, community building, and community education.

8.2.3 The Exchange: Acceptance of and Resistance to Participation

Implicit Conditionality

There is an international context of formal conditionality in international development, whereby disbursement of aid funds is often provided on the condition that specified policies or practices are adopted by the recipient government (DFID 2005; Kapoor 2005: 1213). Increased citizen participation in government activities is often required as a formal condition of development assistance (Kapoor 2005: 1213). In recent years, there has been a shift from formal conditionality to another process whereby recipient countries are to be engaged in learning what policies to implement (Wilson 2006: 510), partly through participating in dialogues with actors in the international development community (Whitfield 2005: 643). As such they have become complicit in their own co-optation and an implicit conditionality is created. This is intended to result in greater country ownership of the policies they adopt, which is meant to increase the likelihood of them being implemented (Wilson 2006: 510). Although the participation policy was not required as a
formal condition for the disbursement of aid, nevertheless an implicit conditionality was in
operation as international agencies pressured and worked with the Cambodian state. The
government needed to acquiesce to the demands of international agencies to adopt more
participatory practices in order to access development resources.

As already discussed, existing models of government-NGO relations assume that
government is always the most powerful actor (Coston 1998), and the conceptions of
hierarchies of power within models of participation also assume that governments are at
the top of the hierarchy (see for example Arnstein 1969). These models do not fit the
context of countries such as Cambodia that are aid dependent. Resource dependency
theorists posit that governments adopt participation policies as a means to gain the
necessary resources from communities to fulfil their responsibilities, through inputs such as
labour (Zakus 1998). In Cambodia the government sought resources from the international
development community including NGOs.

The Ministry of Health is reliant on the international development community for
operational resources. As mentioned in Chapter Three, there are 98 NGOs working in the
health sector; 49 of them are international NGOs (Medicam 2005). They bring a significant
amount of financial and other resources to a range of health programs. Therefore, to ensure
that development assistance to the Ministry of Health continues, there would be great
pressure to accept policy positions put forth by international NGOs and agencies. Aid
dependency gives donors leverage to influence policy directions in recipient countries
(Osman 2005: 24). When a country adopts a participation policy, it ‘ipso facto gains respect
and legitimacy as a democratic power’ (Morgan 1990: 212). The creation of democracy was
the ideological function that the policy performed in Cambodia. Following the rhetoric of
international aid agencies (who in turn follow their donor governments’ political agendas) is
a strategic move to ensure that aid resources continue to flow into Cambodia, and more
specifically to the Ministry of Health. Governments and individuals thus “play the
development game” to access resources and funding in Cambodia.

In this research, the desire to attract funds from international NGOs was evident at both
the national and local levels, particularly the latter. Health centre staff often drew attention
to their lack of funds, and noted that they wanted to work with international NGOs as a
way to access necessary resources. The provincial, operational district and health centre staff in the study area supported the implementation of HCMCs only when an international NGO funded them. DRAY also provided funds for other interventions within the same health centres. Significant financial benefits were paid to health centre and operational district staff: they were paid to attend HCMC meetings, and the operational district vice-director had a car provided by DRAY.

The desire to attract funds is also evident in the following anecdote. When I met with the provincial health department director at the start of my fieldwork, his questions revolved around how much money I was able to bring into the health centres. When it was apparent that I was a student bringing no financial resources with me, our meeting quickly ended, albeit with his approval to conduct the study. Another PhD candidate, studying medical anthropology in the same province, was unsurprised by this response as he told me that the provincial health department and its director were keen to access additional financial resources from international sources.

The implicit conditionality operated at both the micro and macro scales, creating the conditions for Ministry of Health acquiescence to the adoption of a participation policy and the implementation of a participation program. The product being marketed, “participation”, came with an implicit promise that consuming it would lead to other benefits in the form of resources.

Because of the implicit conditionality associated with international NGO assistance, health centre staff members were keen to portray themselves as doing everything that they were meant to. My experience conducting interviews with HCMC members in Saomao Health Centre illustrates this well. Despite me stating clearly that I was not from an aid agency, I was still associated with the international development community, especially when people first met me. In Chapter Five I noted that the Saomao HCMC had members but no dedicated meetings, however, there is more to this story. Recall that according to the policy, it is members of the VHSG who are meant to be the community representatives on the HCMC. When I asked to interview the HCMC members, the health centre chief Mrs Oich Kimleng pulled volunteers out of their VHSG meeting. However, what surprised me was
that most of these respondents appeared a bit bewildered about being questioned about how they became members of the HCMC. I got the distinct impression that they had not known about the HCMC prior to being interviewed by me, although one or two respondents did speak confidently about being selected to join the HCMC but then were unable to support this with any details of HCMC – as distinct from VHSG – activities that they had undertaken. The official line put forward by Mrs Oich Kimleng was that Saomao had an active HCMC, however the evidence strongly suggests this was not the case. I was shown the official memo dated in 2001 that appointed members to both the HCMC and VHSG, demonstrating that a management committee existed. However, there were no dedicated HCMC meetings. Mrs Oich Kimleng’s interest in portraying an active management committee illustrates how she played the development game. She was trying to please me, as I was presumably part of the international development institution as I was foreign and asking about the details of their programs.

It is because of the implicit conditionality that Ministry of Health staff accepted the two participation products being marketed by the international development community: the policy at the national level and DRAY’s participation program at the health centre/operational district levels. The commodity that is officially exchanged is different from the implicit “products” that come with it: more resources for the government and ideological benefits for the international development community. The government’s acceptance of participation enabled them to please donor agencies and international NGOs that support the health sector. This phenomenon has been found elsewhere and results in the priorities of donor agencies predominating.

This happens because local bureaucracies perceive different approaches and priorities, and often find it necessary to appease the international agencies so as to gain access to funds and to make links with their international peer group (Zaidi 1994: 1389, who also draws on Justice’s work to make this point). Local bureaucracies are thus willing to suppress their own desires and views about a policy in order to benefit from the funds and resources that can be gained from international donors and NGOs. In the Cambodian case, priorities other than participation were
identified by interviewees from within the Ministry of Health. For example, the problem of inadequate health centre staff pay and its impact on health service quality was raised repeatedly with me. However, these issues were not considered in the policy-making arena, suggesting that they had been suppressed or were considered unviable. Instead the key issue as identified by the international development community – the need for greater participation – predominated.

Resistance through Consumption

There was not a complete rejection of Cambodian views, and Ministry of Health policy makers exercised their agency in a number of ways. The final form of the policy was not the product that was being marketed by the international development community but rather the result of their negotiations with the Ministry of Health. Through the consumption of participation, the bureaucracy became a site where power was negotiated between international development agencies and the state. Calista (1986: 282) notes that those making policy compromise as long as their intentions are not ‘fully lost’. Orlandini (2003) draws attention to consumption as an active rather than passive process. Although she analyses the ways that “good governance” policy was appropriated and re-interpreted by the Thai elite, I instead consider how a participation policy was surreptitiously resisted by the Cambodian administration under a veneer of acceptance. This resistance happened in two ways.

The first form of resistance was through Cambodian policy makers challenging some of the details of the process design put forward by the international development community. Differing views of representation and committee membership were evident between foreign and Cambodian policy makers. The foreign policy makers stressed the importance of the involvement of lay citizens in health centre management, as is shown in the excerpt from an interview with Mr Sam White below. The excerpt illuminates some of the negotiations and spaces of resistance:
Mr Sam White: I know that as soon as there is a village chief or a commune chief present in a meeting, the ordinary people would shut their mouths, and they would also always be checking their words. We thought it was so important to have only ordinary people as members of the committee.

Researcher: Why is that?

Mr Sam White: We thought it was very important to have mothers say what they think… they have a lot more knowledge about what are the situations of families. Nowadays the female from the village is the women’s association representative. On the commune council if a woman is elected she automatically becomes the gender focal person. If there is not they elect someone to be part of the commune council as the commune level gender focal point. So then I wouldn’t call that community participation because it is a local official or village-level semi-official, even though they have no pay at the village level. But the commune leaders are recognised as part of the government structure and are paid a small salary of 30-40 000 riels a month [US$7.50 - $10; note that the salaries in the study area were 70,000 riels/month in 2006]. I see Health Centre Management Committees now as the organisation of local officials to facilitate health services delivery. When there are no officials around, ordinary villagers talk. I’ve seen them change completely. I was really not happy with the final policy [where they required commune councillors to be on the committees]. It was political. Ordinary villagers, we want them there to open their mouths. The leaders already have their opportunity to say what they want.

Mr Sam White’s frustration at the lack of lay citizen involvement is apparent, both in terms of membership of committees as well as how active “ordinary villagers” are in meetings. However, despite this being a view strongly put by him and other foreign policy makers, in the final policy commune councillors (formal leaders) were included in the membership of HCMCs alongside ordinary villagers. The Ministry of Health policy makers were happy to have lay citizens on the committees, but they also wanted formal leaders there (Mr Serey
Phiriak, Interview). Mr Sam White described what happened regarding the naming and membership of the committees as a form of resistance:

Mr Serey Phiriak [the policy maker with the Ministry of Health], at the last moment he hijacked the whole thing. So that’s Cambodia. At the end they said the village chief is the male person in the Village Health Support Group. And because there was a Doctor who didn’t like the name Feed Back Committee they changed it to Village Health Support Group.

Although this change to the VHSG membership did not make it into the final policy document, this excerpt highlights the resistance of Cambodian policy makers to the product of participation as packaged by the international development community. Instead they adapted the model marketed to them to better suit Cambodian political culture, with its hierarchical forms of political involvement. By changing the detail of the participation policy to include commune councillors as well as lay citizens, the Cambodian policy makers actively consumed the participation policy in the manner described by Orlandini (2003) in the Thai context, changing its meaning and form in small ways as it was negotiated at the policy adoption level to suit local meanings and political culture. However, this consumption happened in negotiation with those marketing participation.

The second form of resistance, examined in Chapter Six, was the Ministry of Health failing to institutionalise the participation policy within its practice (at the national level) or implement it (at the local level). The non-implementation at the local level in Cambodia was more an effect of resistance at the national level rather than active resistance from local level bureaucrats themselves. In the formal conditionality process, although recipient countries sometimes agreed to conditions in areas of reform that they were unconvinced about, they have often ignored these conditions (DFID 2005). As the United Kingdom’s official aid agency puts it: ‘conditionality which attempts to ‘buy’ reform from an unwilling partner has rarely worked’ (DFID 2005: 6). This form of resistance draws on the notions of resistance examined in consumer culture, whereby ‘(non-)consumption’, through for example consumer boycotts, has been a way to protest political regimes or activities (Jubas 2007: 238). Although the boycotts of slave produced sugar in Britain in the late 18th and
early 19th centuries demonstrate how the non-consumption of one product was used to reject a related issue (Jubas 2007: 238), in the Cambodian case, non-consumption of the policy was a rejection of the product itself. However, the participation policy is not just a technical product but a politically and ideologically produced one.

Policy ownership is necessary in order that policy implementation is sustainable (Osman 2005: 19). There are three alternative relationships between policy writers and the policy that have been used to define ownership. First is that ownership can only reside with those who the vision originated with; second, that stakeholders who participate in policy development and take responsibility for implementing it have ownership; and third that those who can conceptualise the policy and see its value can have ownership (Osman 2005: 34). The marketing of the policy demonstrates the lack of ownership of the Cambodian government over the participation products that were introduced. The idea clearly originated with foreigners and the administration has not taken responsibility for implementing it and it was resisted at multiple levels.

8.2.4 The Effect of Consumption: A Tick in the Box

Clearly the actors in the present study exercised agency and hence the description of development as a machine is inappropriate. It is more apt to consider development as a game. Henderson (2000: 23) notes development’s funding game. In the development game ‘the government focuses on appearing to be doing what it is supposed to in order to access the money’ from donors, as has been found in Ghana (Whitfield 2005: 649). In order to acquire the implicitly promised resources, the Cambodian government exercised significant agency in maintaining a fine balance between meeting their own needs and appearing to meet the needs of the international development community. At the macro level, whatever the reasons for it were, the international development community failed to advocate for the implementation of the policy. This suggests that overall their only interest was that the policy was adopted and its impact was of no concern. This mentality is also evident in the way that the policy was implemented by DRAY, whose lack of interest in substantive levels of participation has been demonstrated in earlier chapters. DRAY was only concerned that
“participation” existed during the life of its program, so it is unsurprising that they used *per diems*. These purchased the participation of individuals and ensured that DRAY’s program appeared to include community participation as people attended the meetings.

The consumption of participation has thus created the conditions for participation to become a “tick in the box” exercise in the game of development. Participation in the form of the policy and program products has become a performance, of being *seen* to “do participation”. Yet beneath the surface what is being traded is ideological endorsement in return for resources. Doing participation is also important for another reason:

Packaging and branding are evidence of [participatory development’s] institutional complicities. When it is managerialised and marketed, then what matters is not so much whether participation works or is well done, but how it can help protect and advance institutional authority (cf Ferguson, 1990). Consequently, far from being taken up for people’s empowerment or democratic governance, [participatory development] is taken up, first and foremost, for institutional aggrandisement (Kapoor 2005: 1211-12).

Doing participation makes organisations look good, given the value of participation in the dominant development discourse. In the present study, it is the advocates for the participation policy, DRAY and the Ministry of Health at multiple levels that benefit from such aggrandisement.

Despite the direction I have taken with this argument, I consider that the committees could have achieved greater levels of participation. However, because the most important thing was achieving a “tick in the box”, the details of participation became insignificant. The result was that participation failed to achieve its stated objectives: the policy was not universally implemented or institutionalised, its implementation was not advocated for, and where HCMCs were established they did not achieve active citizen participation. This emphasis also enabled the expansion of international NGO influence as no-one was
focusing on what was happening in the name of participation. When governments primarily seek resources through participatory processes, this is not conducive to citizens having a voice and influence within the health care system (Zakus 1998). The characteristics of the resource dependency approach to participation are that there is no interest in intrinsic democratic values, the community is co-opted, there is only a minor effect of participatory process on institutional structure, and the institution maintains power (Zakus 1998: 491).

As participation was turned into a product that could be marketed, exchanged and exported, it became an object and was to be imposed on a depoliticised society. This does not account for the complex nature of social change that is required by participation processes, especially when these are intended as part of a broader shift to democracy. It is unrealistic to expect planned development interventions to alter local politics (Kumar and Corbridge 2002: 73). A democratic state cannot be exported through development interventions or imposed through aid conditionality, but rather the population has to agitate for democratic governance (Nuscheler 1995: 229; Fukuyama in Laird 2007: 466; see also Henderson 2000: 10).

It was this focus on the adoption of participation as a policy and a program that distracted the Cambodian government and international development community from the political empowerment of citizens in their relationships with the state. Both DRAY and the government became complacent, confident in the knowledge that they “did” participation. However, they have failed to see that citizens were not involved in government decision making in health centre management. Participants were also converted into objects of development rather than subjects (Escobar in Green 2003: 126; Newsham 2002: 35), as participation was done to them. The result in the present study was that citizens were sidelined in the participation process and their role became superfluous and incidental to the core exchange that happened in the development game in Cambodia; that is, the exchange between the government and the international development community. This breaches the social contract between citizen and state; this contract was confirmed by the government when they adopted the participation policy.
The consumption of participation model explains the policy adoption and implementation process and the actions of the international development community and the Cambodian government. My intent in using the model is not to remove power from the analysis of policy processes. Power is exercised through the production and consumption of and resistance to policies introduced in international development. Portraying development as a game rather than a machine rightly gives more emphasis to the agency that is missing from Ferguson’s (1990) anti-politics machine model. I have demonstrated how actors produced and consumed participation in the Cambodian case, and how participation became a product that was exchanged in the development market for an implicit promise of goods and resources to the government. The model also accounts for resistance, even when this happens under a veneer of “purchase” (policy acceptance). At the local level, the expansion of international NGO political space was made possible because the consumption of participation resulted in it being reduced to a “tick in the box”. The model of the consumption of participation describes the third dimension of power and explains the Cambodian participation policy experience.

These findings are likely to be relevant to the implementation of a range of policies in Cambodia as a number of health policies there came about through the active advocacy of international NGOs. The model presented here is also likely to be relevant in other aid dependent countries. This is because “developing” countries operate in the same “international development” environment, so these conditions in Cambodia are similar elsewhere. The key role of international NGOs and the adoption of participation policies in a range of countries as well as the homogenisation of international development discourse regarding the importance of participation all make this work relevant elsewhere. However, the application of this model to other contexts is beyond the scope of this thesis. Directions for future research are outlined in Chapter Nine.
CHAPTER NINE. CONCLUSIONS

I took a grounded theory approach to examining why, even with a national participation policy, the levels of participation varied in different Cambodian health centres. My initial guiding question had been to identify what the enabling factors for strong community participation were. Applying the empirical framework developed in Chapter Two to the seven health centres in a 12 kilometre radius of a regional capital in Cambodia, I found that the level of lay citizen and community participation was low. Although there were no examples of active community involvement in the management of health centres, I found that status was an important factor shaping individual participation in HCMCs and international NGO support was the key factor enabling operational management committees. I began to focus on the policy environment and examining why international NGOs were able to play such a key role in the experience of HCMCs.

9.1 KEY FINDINGS

The implementation of government participation policies has been relatively under-studied (see for example Clisby 2005; Stich and Eagle 2005), and there has been minimal work on the role of international NGOs implementing such policies. Although this present study is limited by its focus on seven health centres and its examination in detail of only one international NGO, I have contributed in-depth exploratory research about participation and international NGOs in Cambodia. More importantly, through addressing the research gap about the role and practice of international NGOs implementing government participation policies, I have made a novel contribution to the literature on participation.

Key Finding One. Low levels of participation can prevail when a national participation policy is in place.

The national participation policy was adopted in Cambodia requiring community representatives to play an active role in the management of public health centres. In only
four of the seven health centres did operational committees exist. In those four health centres that had committees, community representatives were largely excluded from the participation process. There were few lay citizen committee members, although the policy required them. Poor and young people were absent from the membership lists. Lay citizens and women rarely spoke in committee meetings. Those with high social status dominated meetings. This study has shown that despite the rhetoric of empowering the public and/or making health services more responsive and efficient, the HCMC committees were not influential in the management of the health centres and the lay citizens and other community representatives were side-lined by those people with more status, particularly the staff of the international NGO and the operational district office. Elite politics, evident in the HCMCs, casts citizens as passive and this is damaging to ordinary villagers and democracy in Cambodia (Hughes 2005).

Poor process design and a lack of institutionalisation have led to low levels of participation. These factors are problematic as the policy cannot be implemented nationally nor can it result in strong citizen participation. This environment has enabled international NGOs to play a key role in supporting the implementation of the policy and the establishment and management of HCMCs. This has a number of negative implications, including the lack of sustainability for such interventions and the portrayal of democracy as an external gift to Cambodians that originates outside existing decision makers and the governance structure. One of the key implications of this study’s findings for policy makers is the need to institutionalise policies. If international NGOs want a government to implement a participation policy, their advocacy should ensure that a suitable participation policy is designed, that adequate resources are available and allocated to implementing the policy, and that they continue to advocate for national implementation rather than advocacy stopping at the point of policy adoption.

Key Finding Two. International NGOs are interest organisations, and when they convene participation processes they can pursue their own program objectives at the cost of community participation.

There are significant tensions when an interest organisation – which seeks a particular substantive objective – convenes a participatory process. International NGOs created the
insisted spaces of HCMCs through advocating for the adoption of the participation policy in the Cambodian health sector and providing support to establish operational committees at the local level. Scholars have previously identified the possibilities for participation to result in manipulation and tokenistic approaches to involving the public in ‘participatory’ decision making (Arnstein 1972; Williamson and Fung 2004; Gideon 2005). This study exposed the ways in which and reasons why DRAY manipulated the participation process within HCMCs. Despite using the rhetoric of participation, DRAY used HCMCs to lobby, educate and mobilise formal and informal community leaders and health centre staff members as a strategy to reduce child and maternal mortality rates. The pursuit of substantive program objectives is not conducive to ensuring community participation. DRAY staff dominated committee meetings, and made design choices such as recruiting community leaders rather than lay citizens (“ordinary villagers”) to be members of the committees as this better suited their aims. As such, participatory forums can be co-opted and citizens side-lined when participation is part of a larger project.

Key Finding Three. Participation policies can be consumed in the game of international development.

By considering both implementation in provincial areas and the policy development process, I have shown how participation policies can be consumed in international development. In Cambodia, the participation policy and HCMCs were produced and marketed by international NGOs and the international development community. The Cambodian government supported the adoption of the policy as a means to access the substantial resources that international NGOs and the international development community have at their disposal, yet resisted the policy detail and implementation. For the international development community, participation operates as a shared value that agencies conform to (Rossi 2004: 13), and it can also perform ideological functions as demonstrated in Chapter Eight. As the focus shifted from active participation to achieving the “tick in the box” that said an agency had “done participation”, there was little impetus for policy implementation. Where HCMCs were established, participants became objects rather than subjects.
9.2 DIRECTIONS FOR FUTURE RESEARCH

The findings of this study were shaped by the particular policy, country, bureaucrats, international NGOs and citizens that were in the study area during the period that fieldwork was conducted. Very little research had previously been done on international NGOs implementing government participation policies. The qualitative in-depth methodology used in this study was justified by the lack of existing information about this theoretical and practical issue. However, there is now an empirical and theoretical basis for extending this work in a number of ways.

First, the consumption of policies in international development needs extensive examination. If this phenomenon is repeated with participatory policies globally – which mediate between citizens and the state – this should be understood and has important implications for the domestic development of participatory institutions, policies and practices. Research needs to be done into how governments receiving aid engage with donors and international NGOs in the exchange of adopting policies in return for funding. Examining whether the international development community finds the consumption process effective for bringing about changes in political culture or other outcomes, and whether it does contribute to such changes, has implications for the international development approaches they will adopt into the future. Further exploring how resistance is practised by national policy makers and governments will add further depth to understanding international development processes.

Second, the role of international NGOs in the implementation of government participation policies needs further exploration, including determining the extent to which international NGOs implement participation policies in other sectors and countries. The role of interest organisations in convening participatory processes and whether manipulation is widespread should be further examined. There is a need to further study the creation of ‘insisted spaces’ by international (non-national) NGOs, and examine how these spaces are used and the implications for governance and democracy as experienced by citizens.
A third option would be to re-visit the study area in the future to understand how the balance between the international NGO and both the lay citizens and other community representatives may shift over a significant period of time, in terms of actively controlling the agenda and outcomes of meetings. It would be instructive to return to the field to see if indeed the HCMCs stopped operating when DRAY left, as predicted by many respondents. This would deepen understandings of the dynamics between international NGOs and government and extend the findings of this study to give a fuller analysis across more of the development relationship cycle, and further investigate the issues of sustainability considered in Chapter Seven.

Fourth, it would be useful to examine how community members engaged with, succumbed to, resisted, and were affected by international NGO manipulation. This thesis, although drawing on the perspectives of participants, did not engage with how citizen participants felt about or if they were aware of the strong hand of the international NGO shaping their participation, as the manipulation was a theme that only emerged towards the end of fieldwork. It would be useful to understand the impacts of the manipulation on committee members’ understandings and expectations of democracy, and how it affected their engagement with democracy and democratic processes in other arenas. This would be instructive for those agencies seeking to bring about a shift to a more democratic culture.

Fifth, the role of trust in participation, and particularly in countries with legacies similar to Cambodia’s, needs further examination. Although trust is relevant to participation everywhere, the trust literature currently does not adequately consider the impact of a history of participation and government/citizen relationships within a country like Cambodia with a history of forced “participation”.

Participation policies and participatory processes continue to be adopted and implemented in aid dependent countries around the world. Although more research needs to be done, in this thesis I have highlighted the importance of examining the environment in which such policies are adopted, the relationship between policy development and implementation, and how power is exercised in participatory processes. Through my examination of national
participation policies in an international aid context, I have furthered our understandings not only of participation but also of international development processes.
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