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VOICE, CHOICE and DECISION:

A Study of Local Basic Service Delivery in Cambodia

The Asia Foundation

THE WORLD BANK

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ACRONYMS

ADB	Asian Development Bank
AOP	Annual Operational Plan
BTM	Battambang Province
CCWC	Commune Committee for Women and Children
CDB	Commune Database
CDD	Community-Driven Development
CDP	Commune Development Plan (five year plan)
CDPD	Commune Development Plan Database
CIP	Commune Investment Plan (Annual)
CMDGs	Cambodia Millennium Development Goals
COMFREL	Committee for Free and Fair Elections in Cambodia
CPP	Cambodian People's Party
CSF	Commune Sangkat Fund
D&D	Decentralization and Deconcentration
DFT	District Facilitation Team
DIW	District Integration Workshop
DOE	District Office of Education
DORD	District Office of Rural Development
EFA	Education For All
ESP	Education Strategic Plan
HCMC	Health Center Management Committees
HC	Health Center
HEF	Health Equity Fund
IP3	Three-year Implementation Plan
JICA	Japan International Cooperation Agency
KPC	Kampong Cham Province
KSP	Kampong Speu Province
M&E	Monitoring and Evaluation
MOEYS	Ministry of Education, Youth, and Sport
MOH	Ministry of Health
MOI	Ministry of Interior
MOP	Ministry of Planning
MRD	Ministry of Rural Development
NAR	Net Admission Rate
NER	Primary Net Enrolment Rate
NCDD	National Committee for Democratic Development
NGO	Non-Governmental Organization
NP-SNDD	National Program for Sub-National Democratic Development
OD	Operational Districts
O&M	Operations and Maintenance
PAP	Priority Action Program
PBB	Program Based Budget
PBC	Planning and Budgeting Committee
PC	Procurement Committee
PDRD	Provincial Departments of Rural Development
PHD	Provincial Health Departments
PIM	Project Implementation Manual
PMC	Project Management Committee
POE	Provincial Office of Education
RGC	Royal Government of Cambodia
RH	Referral hospital
RHAC	Reproductive Health Association of Cambodia
RILGP	Rural Investment and Local Governance Project
RWS	Rural Water Supply
SNA	Sub-National Authorities
SSC	School Support Committees

TAF	The Asia Foundation
TSO	Technical Support Officers
UNCDF	United Nations Capital Development Fund
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
VCD1	Voice, Choice and Decision: A Study on Local Governance Processes in Cambodia
VCD2	Voice, Choice and Decision 2: Local Basic Service Delivery
VDC	Village Development Committee
VHSG	Village Health Support Group
WatSan	Water and Sanitation
WFP	World Food Program
WSS	Water Supply and Sanitation
WSUG	Water and Sanitation User Groups

EXECUTIVE SUMMARY

The first study in this series, *Voice, Choice and Decision: A Study of Local Governance Processes in Cambodia* (VCD1), conducted in 2011, led to useful insights into the channels through which citizens engage in commune-level decision-making. It presented the formal and informal framework for citizen voice and downward accountability at the communes/sangkat level in Cambodia. This VCD1 study was, however, limited to the domain of the commune council, and focused mainly on Commune-Sangkat Fund (CSF) decision-making. Processes of voice, choice and decision are also crucial to effective service delivery, and, more broadly, to the development of consistent and predictable local governance. In discussion with the Human Development World Bank team and other development partners, it was agreed to extend the field research on Voice, Choice and Decision to encompass local basic services. This paper *Voice, Choice Decision: Local Basic Service Delivery* represents the next stage of this "voice" set of activities.

Voice, Choice and Decision: Local Basic Service Delivery: (VCD2) aims to generate better understanding of how citizens and users of services engage in the delivery of local basic services. The study focuses on developing an understanding of voice and accountability in three sectors – health, education and rural water supply. It sets out the relevant policy framework and compares this with the reality on the ground in each of the sectors, focusing particularly on the nature, scope and role of local agents established to implement formal sector policies for participation and the formal and informal processes which play out.

Background

The Royal Government of Cambodia (RGC) envisages an accountability framework that strives to establish increased citizen participation in local governance. The legal and policy framework for decentralization[1] articulates a transformation of accountability in governance through the process of sub-national democratic development.[2] It clearly defines vertical, horizontal and downward accountability relationships within the context of the directly-elected commune councils, and indirectly-elected district/khan, and provincial/municipal councils. It sets out the relationships between elected officials and the unified administrations responsible for public services, and defines the legal, administrative and fiscal instruments to ensure sub-national administrations (SNA) function as autonomous agents within a unitary state. Each of these aspects has contributed to the overall framework for accountability.

In practice, however, the boundaries of the accountability framework envisaged for sub-national government are quite narrow, and mainly apply to the structures of government under the control of the Ministry of Interior (MOI), as described in VCD1). In most respects, the health, education and rural water supply sectors do not operate within the same accountability framework. These basic services are the responsibility of line ministries in Cambodia. While they are theoretically deconcentrated with representative placed in provinces and districts, they still operate as highly centralized, vertical silos, with few decisions made at the local level. This paper considers how the primary participation vehicles – committees, groups, community-based organizations – established at the local level, function in this environment. It describes the membership and roles of these groups and their relationships with the service providers, commune councils, sub-national administrations, and citizens. In each sector it unpacks the processes through which these entities engage in decision-making (planning, monitoring, overseeing), the mechanisms for citizens to voice demands, and the means through which accountability is, or is not, established.

[1] Namely the Organic Law, the National Program and the three-year Implementation Plan. See footnote 6 for details.
[2] See Enhancing Voice Background report for further information

Voice and Accountability in Local Basic Services: Sector Findings

The forms of participation by citizens, their ability/willingness to articulate their voice, and the nature and scope of accountability by service providers in all three sectors are shaped by obscure and confused relations between actors, many with dual (state and non-state) identities.

Voice, Participation and Accountability in Health

The 2003 community participation policy for health envisages a Village Health Support Group (VHSG) and a Health Center Management Committee (HCMC). The VHSG and HCMC are defined in policy as the primary vehicles to engage local representatives in outreach and awareness building, and in the management of the primary health care facility, the health center. The policy prescribes the membership and roles of these groups/committees at village/commune level. A 2009 community participation policy develops this approach further but has not yet been approved or implemented.

'Community participation' to health practitioners and officials is synonymous with 'communities cooperating in outreach, campaigns and awareness building' i.e. getting villagers to join health campaigns which might, for instance, promote nutrition or maternal health care. The Village Health Support Group – through which the health sector gets down to the grass roots in villages in Cambodia – is a supply-side vehicle for this mobilization, providing an important outreach and awareness-raising role. Village health volunteers deliver messages to households, perform basic primary care services, and, through semi-structured monitoring, obtain information (including community feedback at times) to carry back to higher levels of government.

As a grassroots agent of change, the Village Health Support Group (VHSG) is, however, not performing a role that mobilizes voice and engagement for enhanced health service delivery. The VHSG is not mandated to mobilize voice, or to hold health service providers to account; nor is it, by nature of its current membership, the right organization to do so. Acting as an intermediary, the VHSG tends to establish a filter on community voice regarding health matters – the selected village volunteers are the bearers and custodians of information. This arrangement does not empower households or communities as service users with rights. Given that village volunteers channel feedback, and simultaneously provide outreach services, their dual role is ambiguous, spanning both intermediary and provider. There is currently no other direct mechanism for communities to provide feedback on health services generally, or on the services that outreach workers provide.

The Health Center Management Committee (HCMC) is a multi-stakeholder group of government actors and service providers that play neither a management role nor an oversight role – they currently function as a support committee. In practice, the chief of the health center plays a key role in the HCMC, chairing the meetings at times. Moreover, the intertwined membership of the committee (mixing service providers and community leaders) promotes a consensus-driven approach seen in other local level processes. The HCMC is not managing or overseeing, but generally supporting the HC chief. The HCMC, and the VHSG, are also constrained by low incentives and limited capacities – challenges that have only been overcome where external, typically NGO, support is present.

Although commune councilors chair HCMCs, they usually adopt a hands-off role. The HCMC policy envisages a key role for commune councilors - to contribute to the management of health centers (including planning, setting user fees, and managing budgets). In practice, however, commune councilors nominated to the HCMC tend to limit their involvement, due to a lack of time, capacity and an unclear mandate. Currently their mandate comes from the policy that they chair the management committee, but it is also established through their poverty reduction mandate. The overriding unwillingness to create discord locally curtails any actions that would hold to account health workers at any level, and commune councilors will step in only if complaints reach an unacceptable level.

There are functioning upward accountabilities for primary health care that keep services flowing and improving; problems are often resolved locally. Although there are currently few vehicles established for voice, the health sector has established internal accountabilities. Service providers are upwardly accountable to the next level – from the village/commune level facilities to the operational district, to the province, and to the national level. Villagers that are discontent with the performance of health staff do bring their concerns forward informally, and the concerns are filtered and then managed locally wherever possible. With few directives to improve, downward accountability is generally not a requirement or a priority for health workers.

In the absence of a clear mechanism for voice, and as incomes increase, households are often adopting a choice and exit strategy, rather than a voice and accountability strategy, to obtain better services. The reality is that the public health system only served 25 percent of those seeking treatment for illness or injury in 2010 (Martinez 2011). Rather than negotiating informal and mediated voice mechanisms, households who can afford it, opt out of the services provided by government, and seek primary health care from private and alternative providers. This has implications for the regulation of the private health sector (e.g. dual practices, unlicensed drug sellers) and the inclusion of these providers in governmental oversight arrangements, as well as opportunities for a shift to demand-side financing mechanisms (CCTs, scholarships, vouchers etc.).

Voice and accountability mechanisms in relation to primary health services have proven to be successful when stimulated through external agents, such as NGOs, who create space for voice. The fieldwork confirms that, where resources become available, NGOs are active, and make a difference in the levels of voice and accountability, through monitoring efforts and providing space and instruments for citizens to provide feedback). These initiatives not only stimulate the direct participation of users, but frequently mobilize the commune council as convener and driver of change.

Participation and Accountability in Education

The Education For All (EFA) and School Support Committee (SSC) are envisaged in policy as the primary mechanisms at the grassroots for community engagement in school decisions. Education policy envisages a role for the School Support Committee in the oversight and monitoring of budgets/expenditures and in the monitoring of inputs (curriculum) and outcomes (drop outs). The EFA was however not found in any of the communes studied; its role in monitoring performance and connecting to communes on outcomes is a gap that has not been addressed.

The School Support Committee (SSC) is the only functioning organization at grassroots level, and it does not currently provide an avenue for parents (users, citizens) to demand accountability for better quality education. Field research suggests that implementation of this sector policy is constrained – that the SSC performs a fund raising role (and is accountable for funds it raises), but that its function in oversight of services provided is minimal. This is due to the mixed membership of the committee, the role of the School Director in advising/convening the committee, the small and limited scope of budgets and decision-making, and the avoidance of confrontation between the Director and the SSC members. Policy formulation and implementation both promote consensus building and social harmony, rather than social accountability.

The School Support Committee represents another local level group acting as an intermediary. The SSC is a multi-stakeholder 'invited space' for the local elite and quasi-officials to communicate, and at times filter, the voice of ordinary citizens. The membership of the committee, of village elders and village chiefs representing ordinary citizens, not only determines the degree of accountability that can be achieved, but it filters the voice of users and citizens. Nevertheless, experience suggests that the messages passed on and up are often the right messages. SSC representatives are familiar with issues, should they choose to raise them, and the members tend to be individually accountable to a local constituency (the commune councilors and village chiefs) within a narrowly agreed mandate. The lack of space for ordinary parents to channel views, and follow up, provides little incentive or

opportunity for empowering them as active users of services. There is currently no alternative forum or institution to facilitate citizen/user voice or directly articulate demands unless facilitated by an external party or civil society representative.

Schools are generally accountable, upwards, to the District Office of Education. The provincial and district level offices of education are responsible for policy implementation, and they take or administer all major decisions related to budgets, staffing, school locations, and sanctions for misconduct. The individual schools are responsible for the actual service delivery, including staff management and minor financial decisions. The DOE monitors spending against approved budgets, but does not question the local implementation of the policy with regard to SSCs. Regular meetings with school management and monthly district meetings, which provide an opportunity for commune councils to engage in issues about schools in their jurisdiction, are mostly limited to statistical monthly reporting, and thus have little consequence for voice and accountability. Broader evaluations, although mandatory under the policy, are rarely carried out without the involvement of NGOs and external funding.

There is opportunity for the Commune Council to play an oversight role in the quality of local schooling, but this is often constrained by mandates and relationships. As seen in VCD1, commune councils are significantly more accountable for their actions (in relation to the Commune Sangkat Fund) than are local service providers. They understand accountability, and are willing to be held downwardly accountable. They are however constrained in their actions with respect to education, because of a lack of understanding of the causal linkages between education and poverty reduction[3], the widespread perceptions that councilors have no role in basic services, and a belief that teachers 'know best'. Commune Councilors do act if they see the importance, but, as the DOE is not downwardly accountable, these interventions can be difficult for councilors to work through.

As in health, NGO activity in education provides examples of how increased voice and accountability can work, if facilitated by outside actors. Working with the commune councils and the service providers, NGOs have introduced participatory practices to engage parents in feedback on schooling, and have encouraged citizens to demand accountability. While these monitoring and feedback activities have raised the quality of participation and accountability, such initiatives are random and usually limited to a defined period.

Participation and Accountability in Rural Water Supply

The Water and Sanitation User Group (WSUG) is the community level organization defined by national policy, but implementation is limited. Despite its potential, the WSUG, as defined by the RWS policy, has mostly been launched as an operating mechanism where donor-financed projects have been carried out. These user groups tend to be short-lived, ceasing to exist when funding is discontinued. Members have little training, formal obligation, or incentive to be pro-active thereafter. There is no elite capture as such, there is a strong commitment to provide water-for-all, but the approach has not been supported by the funds which might ensure its sustainability.

The participation of communities in rural water supply is typically found in the form of delegated local management (for ponds) and self-help groups (for wells). Since few rural water supply improvements are undertaken by the Ministry, communities mostly organize such improvements themselves. This local level organization is often initially facilitated by commune councils, although formal accountability processes are not established. In the case of community ponds, the leadership and management rely on traditional norms often associated with the pagoda. *Archas* – elders that are widely trusted by communities – take on a custodian role. Communities cooperate by adhering to rules and contributing to improvements. In the case of wells and associated hand-pumps, the arrangements made are more akin to a self-help group with broader membership of the community.

[3] The commune councils have a responsibility for poverty reduction in their respective jurisdictions.

Community engagement is most frequently stimulated through the local elite. In the water sector the *archas* are by far the most active and accountable local actor, especially in their management of community ponds, and their interactions with community members. The *archas* play this role out of a sense of responsibility for their communities. The actual service is uneven, depending on the capability and legitimacy of the *archas* and the local pagoda, and the levels of participation and accountability, but, in the main, *archas* play a critical role in ensuring villagers have access to water of a satisfactory quality.

Community level agents delivering water mostly work without payment or incentives and without policy guidance, formal training, or external financial resources. Without any funding of water supply, there is also only limited accountability provided to fellow villagers. As a result, some villagers exercise their right and ability to choose. Private and wealthier households increasingly opt out of communal water supply, dig their own wells, and allow a limited number of less fortunate households to use them. This practice runs a high risk of reinforcing the existing patronage relationships at the village level, and, although it fills gaps in service provision, it does not promote any improved service delivery or accountability from government.

These simple forms of community management occur largely without line ministry intervention, and there is virtually no downward accountability by the line ministry in this system. As a result of the dearth of line ministry supply in the communes visited, decision-making and the associated accountability between the line ministries and citizens/users is virtually non-existent, and participation in state-run service provision is limited to rare projects.[4] In the VCD2 sample communes, there was virtually no state provision or meaningful engagement with a state provider, and thus there was no detectable accountability system over rural water supply. NGOs were funding water projects, and were struggling to develop sustainable user groups after the projects ended.

Cross cutting issues and concerns

Participation in Basic Service Delivery

The sector policies for participation in health, education and water do not currently create space for, or empower, citizens/users to participate, or to empower them with information. Policies for community participation in each of the sectors are spelled out in some detail, defining organizational structures, membership and roles. Although they each function separately, and have particular factors that constrain the way they do function, the commonality is that they are highly captured spaces that do not envisage or provide space for citizens/users of services to voice feedback independently and safely. The policies are similar in spirit in so much as they set up roles for local leaders/elite/quasi-officials. Membership reinforces the balance of power and information with the elite, and processes do not empower the poor. There is almost no information flowing within the communities studied about services (standards, policies, budgets, targets, performance).

The nature of these groups/committees reinforces the consensus-driven approach adopted at the local level to all decision-making and conflict resolution. This not only reflects a culture of caution, but suggests that empowerment of citizens/users and social accountability processes have not yet been incorporated in policy development. In practice, a primary interest is that local relations are harmonious. Organizational structures are created, not for the purpose of enhancing voice or accountability, but for the purpose of doing what can be done to improve the services while building accord among all stakeholders through compromise. There are some fundamental gaps in knowledge and awareness of the role of citizens/users in a participatory process that is distinct from leaders, and service providers.

Sector policies for participation and engagement are not linked to each other or to commune processes. The sector policies for health, education and water have not been coordinated or linked,

[4] Cases were selected from the wider VCD1 sample and a pre-study indicated that the locations chosen had more activities in the water sector than in the other sectors.

and there are only weak linkages between the participatory processes for commune planning and annual decision-making for schools, health centers and water supply. The District Integration Workshop (DIW) provides the opportunity for the coordination of local level activities, but does not currently include coordination or discussion about the engagement of citizens in development processes.

In terms of implementation, a lack of demand for participation, even where opportunities exist, is common in Cambodia and relevant to the discussion on voice in basic services. Having the platform for voice is often not desired by citizens or users, and knowledge on how to generate this is not readily available. Moreover, both officials and citizens lack any belief that inclusive arrangements will make a difference. Villagers make rational decisions on where they should expend their efforts to improve their lives, and, for these reasons, it is unlikely that they would try to influence policy or the small budgets for deconcentrated services. These historically and culturally sustained social structures are nevertheless subject to change under specific circumstances. This lack of demand is generally exacerbated by a lack of access to information. Communities do not know what standards of service to expect, what the budgets are for services, or what performance is achieved.

At the local level in Cambodia, citizens/users are reluctant to articulate their voice, but if they do, they do so through intermediaries. These intermediary groups take two different forms.

(i) **Small, invited groups/committees** are comprised of a few active individuals, mostly elite members of the community, who usually serve in a multitude of similar bodies. Actors are benevolent and informed, but non-elected and non-representative, many in quasi-state roles. They hear about issues informally, and then carry, and filter, the voice of ordinary citizens to meetings.

(ii) Multi-stakeholder groups/committees with confused mandates include both service providers and community leaders/elite together, (e.g. village health volunteers, school directors sit beside village chiefs, elders (*archas*), commune councilors on these committees at village, commune and district levels) playing various service provider and supporting roles.

Participation in planning is constrained by the minor nature of decisions made at the local level, and there is almost no participation in monitoring. As noted in the VCD1 report, decision-making at the commune level can be extremely limited in scope; this is also the case for local basic services. As these sectors are deconcentrated, not decentralized, the decision-making that takes place by local groups is minor. Even if participatory mechanisms were well-designed, there is a limit to how much input citizens and users can provide at the planning stage. A critical gap for citizen/user engagement is the scope for engaging in other (non-planning) processes, e.g. monitoring of service provision that enable citizens to engage directly on matters that affect them.

The lack of funding affects the development of capacity and diminishes the importance of consequential participation of citizens/users. The lack of funds for the development of citizen engagement (e.g. through community facilitators), and the fact that existing funds are not used for this purpose (e.g. the Commune Sangkat Fund), illustrates the low priority given to citizen/user voice and engagement. Although village volunteers are paid an allowance for health outreach work, in the education and water sectors there is virtually no funding available.

Exceptions provide lessons for the development of voice and accountability processes. Users do articulate their voice occasionally in events with clearly defined rules and facilitation (e.g., formal workshops arranged by external parties). Although not all these situations could be called 'safe spaces', they do provide alternative vehicles for communication that have been endorsed by the normal players. Typically citizens are not aware of what to expect in relation to their rights and to agreed standards of service (e.g. number students per class). They make judgments as to what is acceptable/unacceptable (e.g. drunkenness of teachers), and voice their opinions only rarely, when

they perceive mismanagement to have gone too far. In these bottom-line cases, protests are clear and loud – caution is cast aside.

"Choice not voice": citizens are increasingly able to choose alternative service providers. Increasing incomes and levels of awareness are enabling households to decide to go to a different health center or an alternative provider, to build their own wells, or even to go a school in another village. As this could potentially change the structures of primary health, water and education services, there are significant implications for regulation, financing and voice. This 'opting out' can also have effects on those left in (normally the poorest households), weakening the collective voice, and potentially slowing the improvement of government services.

Accountability in Basic Service Delivery

Accountability and oversight systems for basic services have not been clearly established – existing structures and processes contain many internal conflicts. The oversight and monitoring of local basic services is not independent. The mixed membership of committees makes it impossible to identify clear accountability lines between users, service providers and elected officials. In policy, functions and actors are intertwined to a significant degree in all sectors. In practice, oversight and monitoring is either misunderstood, not performed (e.g. school budget/expenditure monitoring), or delegated back to the service provider/manager. Relationships between these elite committees and the service providers are close, and consequently there is virtually no accountability in the arrangement.

The consensus-oriented socio-political culture is deeply embedded in the implementation arrangements for local basic services, and heavily constrains local oversight processes. Local actors are very cautious about being perceived as 'meddling' in the affairs of others, they make every effort to avert conflicts and prefer to 'help-out' the service provider than hold them to account, particularly with the management of schools and health centers. Because of the confused accountabilities of the actors involved, there is no functioning local oversight system involving commune councilors or civil society for the basic services (health, education and water). The necessity for internal social harmony in the community comes at the cost of not establishing and implementing arrangements that foster accountability to citizens and users.

Without strong direct engagement from local citizens through citizen groups, with no pressure from organized civil society, and no directives from above, service providers have not yet embraced the concept of downward accountability. Notwithstanding efforts in the health sector to get down to the grassroots levels, and the peculiarities of the water sector, downward accountability generally is very weak, even when compared with the downward accountability of the commune council. Although council processes are formal and not yet effective, commune councils, as local institutions, have broadly grasped their responsibility for mobilizing citizen participation, engagement and accepted that they are accountable to the citizens that elect them. This is not the case for the deconcentrated service delivery units.

In Cambodia, the health and education systems for service delivery are driven by upward accountability within the line ministry, and there are few decisions at the local level; whereas rural water supply is a local concern. Decisions on health and education services are passed down from higher levels of government; accountability is planned to be mainly upward as service delivery units report back on progress. This dynamic is exacerbated in practice by a lack of capacity and the norms of government – service delivery units look "upwards" for guidance and take instructions as a norm – and this is accompanied by a lack of willingness to accept responsibility at the service delivery unit level. The system of accountability is therefore constrained by the lack of authority at the local level as well as the organizational problems described above.

Commune councils could act to promote both voice and demand greater accountability in local basic services, but their mandate to do so is not always clear, and they lack confidence in their

interactions with line ministry officials. Notwithstanding the social harmony imperative described above, some commune councilors understand the importance of local basic services in poverty reduction, and are aware of their poverty reduction mandate. They are not always aware of how best they can engage with line ministries. They lack confidence, are not sufficiently skilled to dialogue, and do not always get traction with line ministry officials when they attempt to do so. The Commune Committee for Women and Children (CCWC), with its limited budget, plays a limited role in some cases, but does not have the authority to make the difference needed.

As is the case with efforts to foster participation, a severe lack of capacity at the local level constrains the development of accountability. The dynamics observed in the communes studied suggest a severe lack of capacity with regards to voice and accountability among the actors engaged in basic services. At the local level, with just basic training, there are villagers serving as health volunteers, contract teachers, or caretakers of community ponds, who understand dimensions of accountability; while at the commune level, there is a growing competence building from the work in the councils. However, the research found that, while district and provincial level staff have good knowledge of their upward accountability in the ministry, they do not have an openness towards, or capacity for downward accountability without support and capacity building by NGOs.

Recommendations

The specific and general findings presented in the study highlight a number of potential areas of policy change (some of which are already being discussed), as well as opportunities for future research. Policy recommendations include:

- **Processes for voice and engagement need clarification in sector policies, and, as they are revised, policies should be coordinated to the extent possible.** Sector participation policies should make a clear distinction between community participation for the purposes of outreach campaigns (as for health) and self-help groups (as for water) on the one hand, and on the other the forms of citizen engagement that promote voice and accountability. The operationalization of the SNDD social accountability framework provides a potential platform to develop this clarity and to ensure local level mechanisms are aligned and reinforce each other.
- **Membership of groups/committees at the local level is currently limiting the space for voice and blurring the lines of accountability.** At the grassroots level, the separation between those that provide an outreach service and the users of the service is critical. Clarity and distinction between management and oversight functions is urgently needed. Local level committees (SSC, HCMC and VHSG) require review and clarification of their roles, responsibilities and functions, especially with a view to enhancing empowerment and engagement of ordinary citizens and establishing local accountabilities.
- **Participatory spaces that encourage voice and engagement must be pro-actively developed and sensitively implemented.** Given that citizens generally avoid engaging with the state, and that the benevolent attitudes of the elite members of the community dominate local dynamics, it is essential that safe spaces for voice and engagement are found – at village level – either within the relevant sector or the local governance framework. Mechanisms for sensitive and independent facilitation will be critical.
- **The mandate of the Commune Council in supporting, monitoring and overseeing local basic services needs to be clearly and consistently defined in both council and sector procedures.** In practice, commune councilors are playing vastly different roles, some holding service providers to account, and others rubber-stamping decisions by the managers of service delivery units – and so removing local accountability for local basic services. Policy dialogue is needed to clarify relationships between line ministry staff and elected commune councilors (given their poverty reduction mandate).
- **Service providers require significant attitudinal change and capacity development to improve downward accountability and follow in the footsteps of commune councilors .** Service providers (teachers, school principals, health workers, health center chiefs) need to develop, as a core

competence, conceptual understanding and practical knowledge of downward accountability. The experience of commune council capacity development can be followed.

- **Functional assignment offers an opportunity to change accountabilities in service delivery.** The proposed delegation of functions to communes and districts offers an opportunity to develop demand-side processes involving citizens/users and elected councilors, as well as lowering the level of decision-making around appropriate aspects of service delivery.
- **Monitoring and evaluation (M&E) should include the governance principles of voice and accountability.** M&E systems should include simple indicators on the degree of meaningful engagement of citizens/users. These can be measured through perception surveys, community scorecards or through third party monitoring.
- **The role of non-state actors as outside facilitators of voice and accountability is emerging, and needs to be worked out to scale the practice up.** The role of external facilitators is key to ensuring that the processes are inclusive (of e.g. women, youth, vulnerable groups) and empowering for ordinary citizens and users. Policies need to be updated to take into account these processes, and impact evaluations carried out to see what works, when, where and why. Moving forward, sustainable funding approaches are needed to facilitate participation and empowerment processes.
- **Policy needs to respond to the growing trend for users of health, education and water supply to exercise choice and obtain services from alternative and private providers.** While users can vote with their feet – not returning to pay for services they are not satisfied with – the burgeoning market of private providers needs appropriate regulation (e.g. dual providers).

Like VCD1, the findings presented in VCD2 have been drawn from a limited sample, and validated by experts and stakeholders. A random, quantitative research initiative that broadens and further validates these findings may be useful if policy change is constrained. At the same time, there is a need to improve our understanding of specific blockages and opportunities. Key areas on follow-on research are:

- What is the trade-off between social harmony and social accountability and what are the long term effects on empowerment of women and youth specifically? Does this trade-off affect the quality of service delivery?
- The question of intermediaries: what opportunities and challenges will arise when moving forward with the decentralization reform processes?
- How can line department – local (commune and district) council relations be enhanced to improve accountability arrangements?
- Understanding how NGOs enhance voce and empowerment – the role of NGOs in voice, choice and decision.

CHAPTER 1
INTRODUCTION

The *Voice, Choice and Decision: A Study of Local Governance Processes in Cambodia* (VCD1) study, conducted in 2011, led to a set of useful insights into the channels through which citizens are heard in commune level decision-making. It presented the formal and informal framework for, and constraints to, citizens' voicing issues, and the overall downward accountability framework of commune/sangkats [5] in Cambodia. The findings of this exploration provide policy makers, development partners and other stakeholders significantly more detail and in-depth understanding of commune decision-making processes and the engagement of citizens – informing both quantitative studies and the very extensive literature on decentralization reform.

This first "Voice" (VCD1) initiative was, however, limited to the somewhat narrow domain of the commune council and focused mainly on Commune-Sangkat Fund decision-making. Processes of voice, choice and decision are also crucial to effective service delivery and more broadly, to the development of consistent and predictable local governance. In discussion with the HD team and other development partners, it was agreed with management to extend the field research on Voice, Choice and Decision study to encompass local basic services.[6] This paper *Voice, Choice Decision: Local Basic Service Delivery* (VCD2) represents the next stage of this extended endeavor.

Voice, Choice and Decision: Local Basic Service Delivery: (VCD2) aims to generate better understanding of the platform for citizen/user voice in basic service delivery by considering, in detail, the nature, scope and role of local agents (committees, institutions, individuals) established to implement sector policies, and to identify any other informal channels for the voice of citizens and users of services. In its final form, the study focuses on developing an understanding of voice and accountability in three sectors – health, education and rural water supply. The research and documentation adopted a common framework to the extent possible, considering, in the first instance, what was intended by policy (the arena, organizations, roles and relationships), and comparing this with the reality on the ground in each of the sectors. This final paper then considers the cross cutting themes – identifying the commonalities and differences between these sectors.

1.1 Background

Through the policy and legislative framework articulating the decentralization reform, the Royal Government of Cambodia (RGC) envisages an accountability framework that strives to establish increased citizen participation in local governance. The Organic Law, the National Program and the three-year Implementation Plan[7] articulate the transformation of accountability in governance through the process of decentralization and deconcentration, defining vertical, horizontal and downward accountability relationships. Directly-elected councils in communes with accountbaility to their constituents are now well established. Moving forward, (i) the indirect elections of councils at province/municipality and district/khan levels; (ii) the unified administrations at these levels to coordinate public service activities; and (iii) the development of the legal, administrative and fiscal instruments in which sub-national administrations (SNA) are autonomous agencies within a unitary state; together provide the RGC roadmap for increased accountability.

[5] Commune refers to a rural setting, while Sangkat refers to this jurisdiction in urban areas. The paper will use the term communes to apply to both communes and sangkats.
[6] Building on the research undertaken in the first phase of this initiative, the research teams returned to six of the 12 communes studied to examine the form, scope, and dynamics of participation and accountability in local basic services.
[7] The Law on Administrative Management of the Capital, Provinces, Municipalities, Districts and Khans (the Organic Law); National Program for Sub-National Democratic Development 2010-2019 (NP-SNDD) ; The First Three Years Implementation Plan (2011-2013) of NP-SNDD (IP3).

In practice, however, the boundaries of the accountability framework envisaged for sub-national government are quite narrow, and mainly apply to the structures of government under the control of the Ministry of Interior (MOI) (as described in VCD1). In most respects, the health, education and rural water supply sectors do not operate within the same accountability framework. These basic services are the responsibility of line ministries in Cambodia. While they are deconcentrated, they still operate as highly centralized, vertical silos, with few decisions made at the local level. This paper considers how the primary vehicles of participation – committees, groups, community-based organizations – established at the local level for participation, function in this environment. It describes the membership and roles of these groups and their relationships with the service providers, commune councils, sub-national administrations, and citizens. In each sector it unpacks the processes through which these entities engage in decision-making (planning, monitoring, overseeing), the mechanisms for citizens to voice demands, and the means through which accountability is, or is not, established.

The key concepts of this report include *participation*, which is understood as the "process through which stakeholders influence and share control over priority setting[s],"[8] and *accountability,* which is seen as the obligation for the decision-makers to "answer to citizens for the decisions taken."[9] These terms will be further elaborated in the conceptual review below.

This paper considers the links between the community level groups in each sector and the relevant service providers, commune councils, other sub-national levels of government, and additional actors, such as non-governmental organizations (NGOs). It also considers participatory processes, of a formal and informal character, through which these groups could engage in decision-making. In particular, the report examines the nature of participation, decision-making, and accountability within and among these groups, and between the groups and the governing institutions primarily responsible for service delivery in the three sectors. To that end, the study employs a sector-by-sector analysis to explore the policy framework for voice, accountability and local service delivery; underlying factors shaping participation; existing participation practices; and the resulting accountability arrangements. Further, the study employs a comparative framework to assess the differences across sectors and to illuminate progressive practices, as well as weaknesses, in existing policies and practices regarding participation and accountability. Finally, the study provides conclusions to inform the ongoing development of commune and district processes aimed at supporting the delivery of social services.

1.2 Methodology – Approach, Case Studies and Data Collection

While VCD1 was organized around a case study approach (Yin 2003), this paper is structured thematically, with each sector analysis addressing the nature of participation, decision-making, and accountability. Like VCD1, VCD2 aims to develop understanding of voice and accountability dynamics by analyzing the structures, processes and practices that are in place; and the degree to which they enable or constrain participation and engagement of communities in development. The structures put in place to enhance community engagement in local basic services include the formation of community groups and user committees for each sector.

The findings are informed by interviews conducted at the national, provincial, district, and village levels. The team interviewed various actors involved in the respective sectors, regarding existing practices of participation and accountability, and how they shape service delivery. A broad analysis of policy development at the central level, especially respective central ministries' plans and ambitions for participatory localized strategies, frames the interviews with different stakeholders. These formal strategies, and other more locally invented approaches, are triangulated with findings gleaned from interviews at the provincial and district levels. At the sub-district levels, user committees are the focus, including how they inform existing accountability mechanisms (both upward and downward

[8] World Bank, "Participation at Project, Program & Policy Level," http://go.worldbank.org/HKL3IU1T21, accessed June 9, 2011.
[9] See Agrawal and Ribot 1999; Ribot 2012; Moncrieff 2001.

accountabilities). The views of the committee are also triangulated with those of the commune councils, locally active NGOs, and with a selection of household interviews.

The research team visited two communes in each of the three provinces that were the focus of VCD1 – Battambang, Kampong Speu, and Kampong Cham. The six cases were chosen from among the 12 VCD1 communes to illuminate a wide variety of contexts for service delivery, as well as varied underlying conditions that are common to many communities in Cambodia. These factors required the selection of both semi-urban and rural communes, central and remote communes, and politically homogenous and heterogeneous communes. Selection criteria also considered the level of engagement and activity of various user committees, and the presence of donor support, including NGOs.

The study draws heavily on the concepts used in the first phase of VCD1 research. The quality of participation is analyzed along a ladder of increasing depth, ranging from manipulation to promotion of information and more substantive inclusion. This ladder framework will be further extrapolated in Chapter 2.1 (cf. VCD1). Decision-making is less salient in this study, as the key agents in service delivery (community groups and user committees) do not carry decision-making power on a par with the commune councils (as in VCD1). It should also be acknowledged that, in these sectors, institutions for participation are not solidly built, and participation needs to be detected in unorthodox forms. The most obvious form (which was also noted in VCD1) is through *intermediaries* between citizens and decision-makers, where participation is indirect and often informal. Another form is participation by a limited few who are a part of the upper strata in local communities (see below for further explanation). The various committees have potential to force (or inspire) accountability from decision-makers, which is analyzed across three dimensions — upward, horizontal, and downward (further explanation is provided in the conceptual review).

By design, this is a qualitative study with a limited sample; therefore, the findings are not representative of the entire country. However, the team has made extensive efforts to triangulate the findings by comparing them to: (i) VCD1 and the commune case studies; (ii) previous research; and iii) the extensive and comparative experience of the field researchers and the team leaders, as both fieldwork and analysis are marked by in-depth knowledge of culture and historical circumstances. As such, the hard evidence stays within the six case studies, but the credibility of the claims and hypothesis may extend beyond the six cases.

1.3 Outline of the Report

Following this introduction, Chapter 2 presents a brief conceptual discussion on theories of participation and accountability (and comments on decision-making and choice), reviews previous findings on these themes in the three sectors in Cambodia, and ends with an explanation of the report structure. Chapters 3 to 5 comprise the bulk of the report, analyze in turn the health, education and water supply sectors with regards to voice and accountability. The analysis begins with a review of relevant policies, and then analyzes the *de facto* forms of voice and accountability in each sector based on the field research. These sector analyses consider the actors involved in local decision-making on each service, the dynamics of participatory process if they exist, and the accountability arrangements found in each sector. Chapter 6 then provides a comparative analysis of these findings. Overall conclusions and policy recommendations follow in Chapter 7.

CHAPTER 2
BACKGROUND AND APPROACH

This section discusses the main concepts that underpin the research, and examines the critical aspects of the analytical framework. In particular, how participation and accountability connect to choice and decision-making; how these concepts have been applied in these sectors in Cambodia and what has been learned to date; and how the conceptual approach responds to the particular experience and context in Cambodia and the Terms of Reference for the study.

The conceptual framework of the report discussed below responds to the context of service delivery in Cambodia. First, health, education, and water services are the responsibility of line ministries implementing centrally defined policies. The presence of these line ministries at the local level is limited, as is their capacity. Key decisions are generally made at the national level. . Second, community participation is limited. There is a significant gap between citizens and the state, even where efforts have been made to establish engagement processes. This is exacerbated by the technical and deconcentrated[10] nature of the sectors examined —health, education and water. Third, given the systems of patronage that have dominated Cambodia and have been subsumed into post-conflict institutions, the concept of accountability is new, and systems of accountability are in their infancy. Upward accountability to political patrons and central institutions is the norm, while downward accountabilities to citizens and users are only emerging.

2.1 Review of Concepts

Since the 1970s, community participation has become a central tenet of many development efforts. In the review undertaken by the research team, two aspects – the implications of the decentralization reform and the creation of user committees – were considered. In theory, by transferring authority and resources to local and sub-national administration, decentralization is expected to facilitate demands articulated from citizens. In practice, however, the result has been mixed (World Bank 2004; Shah 2006; Öjendal & Dellnäs 2013; World Bank 2012 (Website)). While the benefits of decentralization have been achieved in some countries, in others, decentralization has not had tangible impact on poverty alleviation, or enhanced inclusion, mobilization and participation of communities. Although criticized for bypassing the state (Ribot 2012; Manor 2004; Barron 2010), user committees and community-driven development have become increasingly common models/mechanisms to enable collective action by the poor to influence and enhance the delivery of basic services.

The overall challenge for user committees is to achieve a meaningful dialogue with the decision makers and/or the service provider. Literature suggests that, to understand the efficiency of these committees and how they promote voice, three related aspects should be examined: (i) the institutional structure of the committees, including their origin and modes of selection, remits, funding, and lifespan; (ii) their interaction with other actors (e.g., local councils, line ministries, villagers); and (iii) underlying factors, such as political culture, local governance and decentralization, relevant sector policies, and institutional arrangements (Manor 2004).

Ensuring access to, and quality of basic public services to citizens, especially the poor, is both a priority and a challenge in many developing countries (World Bank 2004). Participation is expected to

[10]This report largely follows the terminology in the established literature where *decentralization* refers generally to the transfer of powers and resources from the central government to lower levels in the state hierarchy, where local authorities are given distinct powers and discretionary resources, are democratically elected, and are primarily accountable downwards to their constituencies. *Deconcentration* refers to an assignment of functions to the local government/agencies by the central government, making the local government primarily accountable upwards (Turner & Hulme1997; cf. Smith 1985; Crook and Manor 1998; Manor 1999; Agrawal and Ribot 1999; Larson & Ribot 2004; cf. Öjendal & Dellnäs 2013).

raise the quality and legitimacy of the decisions, as well as the capacity of local governments to respond effectively to community needs (Plummer and Taylor 2004; cf. Chambers 1983). Further, accountability arrangements assure that the decisionmakers answer to citizens for the decisions taken (Agrawal and Ribot 1999; Ribot 2012; cf. Moncrieff 2001). Both are vital for the delivery of high-quality social services. Although the importance of participation and accountability is solidly established in policy debates, developing such mechanisms is complex – there is no guarantee that it will be done as prescribed or deliver expected results. Moreover in practice, the demands on community members to participate place a burden on an already strained poor population. Increasingly, it may be more rational for individual villagers to choose other options, rather than engaging in slow policy processes (cf. Cooke & Kothari 2001; cf. World Bank 2012).

As mentioned earlier, for the purposes of this study, participation is defined as "the process through which stakeholders influence and share control over priority setting, policy-making, resource allocations, and access to public goods and services."[11] It may appear in *formal* or *informal* procedures, and in *direct* and *indirect* forms. To assess the quality of these participatory processes, an analytical framework known as the "ladder of participation"[12] provides an indication of the level and quality of stakeholder engagement. The concept was initially suggested by Arnstein (1969), and has since been used in a variety of ways (e.g., Plummer 2000; 2003; Connors 2007; Fung 2006). Set in the context of free-standing development projects, Arnstein focuses on eight rungs, which are then sorted in three categories as "degree of citizen power," "degree of tokenism," and various forms of "non-participation." Plummer (2000) modified this approach to consider the links to local government. As applied in VCD1, the ladder framework includes: (i) manipulation, (ii) information-sharing, (iii) consultation, (iv) cooperation, and (v) mobilization.

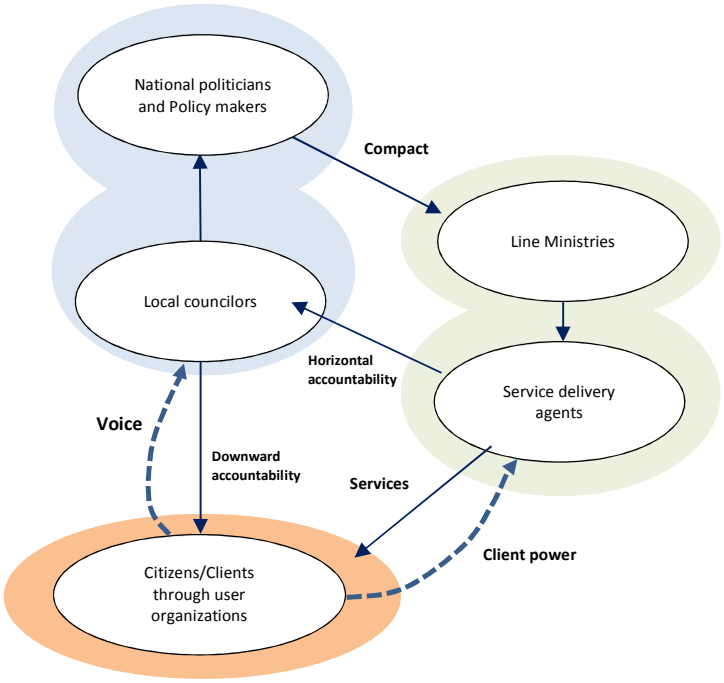
The difference in outcomes can, according to the literature, be explained by a combination of factors: the "medium" and "intermediaries" by and through which participation takes place (Plummer 2000; World Bank 2004); the "distinguished characteristics" of service being provided (World Bank 2004; UNICEF 2011); and the "broader cultural, political and economic context" in which participation occurs (World Bank 2004; UNICEF 2011). The latter two may be self-evident – services are different and context matters – but the former requires a comment.

Recent research emphasizes *who* participates (Fung 2006), and through *which means* (Connor 2007) they participate. In particular, Fung's comment that "some participatory processes are completely open to all who wish to engage while others invite only elite stakeholders such as representatives of peak associations" (2006:6), speaks to the Cambodian context, where citizens' views are commonly communicated through the "local elite". This, as well as the definition of participation above that emphasizes the "stakeholder" dimension, distinguishes between various stakeholders that are divided between *citizens, users,* and *local elite*.[13] Hence, the analysis following the empirical review below will consider the ladder framework, but also *who* is party to the act of climbing the ladder.[14]

[11] World Bank, "Participation at Project, Program & Policy Level," http://go.worldbank.org/HKL3IU1T21, accessed June 9, 2011.
[12] This concept was used for the VCD1 study, adapted from Plummer 2000.
[13] The "local elite" is both specific for Cambodia and important for this study. The local elite is a minor grouping in basically every village setting, with porous boundaries and undefined inclusion. It is not solely based on class, wealth, education, political position, skills, age, nor religious sanctity, but rather on a pragmatic combination of these factors (cf. Vimelea 2011). The strength of this social structure may go back to the early days of the post-Khmer Rouge reconstruction efforts in the rural areas where everybody that could contribute was called upon. Although generally pursuing the common good, members of this elite are self-appointed representatives, with the village chief in the center. They tend to be men above 50 years of age, and with a historically built reputation for trustworthiness. Interestingly, individuals from this "elite" are commonly called upon when something needs be done – from health issues to small-scale irrigation plans – and therefore, also maintain their status as the local elite. They do not act as a unified group, nor necessarily share values or political views, but throughout this study, it is evident that individuals from this grouping occur in virtually all local bodies and positions. Their tendency to occupy available positions harbors real significance for this study as it becomes next to impossible to hold each other accountable. Participation, to the extent it occurs, often goes through the elite who act as intermediaries.
[14] Goodson & Phillimore (2010:5) supports this and takes it a step further in distinguishing between "vertical," "horizontal" and "everyday" participation, broadening from the view that participation is a one-way street between state and citizens. For a general overview of the existing literature on participation, see Brodie et al. (2009). Overall, recent literature has expanded the ways in which participation is understood and investigated.

The 2004 World Development Report (2004) offers an accountability framework highlighting three important relationships: between citizens and providers; between citizens and politicians/policymakers; and between providers and politicians/policymakers. Under this framework, these accountability relationships need to be strengthened to improve service provision. Among these three relationships, the first two (between citizens and providers and between citizens and politicians/policymakers) are especially relevant to the assessment of voice and participation in the sectors selected. To more accurately describe the Cambodian sector context, this accountability framework can be disaggregated as in Figure 1:

Figure 2.1
Three distinct sets of stakeholders in an accountability framework



Recent academic work has focused on improving understanding of the problem of effective public service delivery by drawing on new literature on political economy and on the economics of organizations and incentives. For an overview see Besley and Ghatak 2006; and for illustration see Devarajan, Khemani, and Walton, 2011). This political economy literature provides a better understanding of how the government works in practice and directly relevant to this research endeavor. The economics of organization focuses on understanding incentive issues in public organizations, including bureaucracies and service delivery agencies. An emerging body of literature also examines the effect of efforts to enhance accountability by increasing performance measurement (Besley and Ghatak, 2003; Doran et al., 2008; Campbell et al., 2007).

2.2 Review of Sector Research on Voice and Accountability

In contrast to VCD1, where the focus was on commune councils (functioning within a decentralized framework, with downward accountability and electoral mechanisms), VCD2 considers deconcentrated sectors, with limited delegation of power and with the key institutions having primary upward accountability. This difference has far-reaching consequences for the ability to generate citizen participation and establish downward accountability (Manor 2013; cf. Ribot 2013). In such a setting, user committees and community groups, which have emerged in Cambodia over the last

decade (cf. Kim & Öjendal 2006), are potentially important vehicles for voice and participation in the processes of service delivery.

The commune council is locally elected, generating a certain degree of citizen participation, and displays a distinct sense of downward accountability (cf. VCD1 2011). It also has a general mandate to alleviate poverty and improve living conditions locally (cf. Rusten et al. 2004), which – given the importance of services for poverty alleviation – includes improving the quality of service delivery. However, the commune councilors typically complain that they have no access to the line ministry decision-making, policy-making and resource allocation in the sectors. Interestingly, they do have access to Health Center Management Committees (HCMC) and School Support Committee (SSC) groupings, which oversee Health Centers (HCs) and schools, respectively. The councils also increasingly engage in local water provision, albeit facing structural impediments that limit their ability to make a real impact. The role of the commune council is inevitably explored as a key dimension of this study.

The existing research on this topic notes that these committees (the commune councils and the community groups where they exist) may serve as intermediary institutions and provide the only functional mechanism for channeling citizens' opinions to decision-makers.[15] In line with this, the 2009 World Bank assessment of citizens' participation states:

> *Ordinary citizens have very low expectations that authorities would consider their requests, let alone entertain their "claims" or attempts to influence decisions or seek accountability. If the gravity of the matter leaves no choice but to contact authorities [they will make] a "plea", if possible through an intermediary, rather than to make a "claim" on the basis of evidence and institutionalized rights.*[16]

Such intermediaries include, for instance, village chiefs and user committees, such as the SSC, HCMC, and Water and Sanitation User Groups (WSUGs), which then represent key structures for tracing participatory mechanisms and accountability processes.

Education. In the education sector, the bulk of the existing literature suggests that, to date, local communities have engaged in school affairs through in-cash and in-kind contributions, while their role in internal decision-making processes remains limited (Pellini 2005; Nguon 2011). For example, the SSC, the most common local organization involved in education issues, is historically referred to as the "parent association", and is considered by the communities to be a traditional local institution, or one that is mainly involved with school construction. Membership is often unclear, but generally includes the *archas*, or respected village elders, who are active in the pagoda committee. In some cases, it might also include parent representatives (Norak 2000; Sovann 2000; Kim and Ojendal 2007). According to a 2002 Ministry of Education, Youth, and Sport (MOEYS) policy, the SSC is meant to help manage the school budget (called the program-based budget, formerly the Priority Action Program). (MOEYS & UNICEF 2005; World Bank 2005; Nguon 2011). It is unclear from the existing literature, however, how active the SSCs have been in other school affairs (e.g., planning, student attendance, and teacher quality monitoring).

Some reports suggest, without real elaboration, that higher levels of parent involvement exist as well (NGO-Education Partnership 2011). Overall, since the existing literature largely questions both the involvement of villagers in the SSC, and the activities of the SSC in school management, it provides few insights into the extent to which participation has actually shaped accountability, and enhanced the quality of education service delivery.

Health. Existing research on participation in the health sector focuses on the Village Health Support Group (VHSG) and the HCMC, but provides limited insights into the extent to which VHSGs are

[15] Chandler (1991) views this as a historical core structure of governance in Khmer society.
[16] World Bank (2009): 52f..

involved in promoting community voice, or how such local bodies shape accountability mechanisms. According to the literature, since the late 1990s, VHSGs were considered important links between communities and the public health system, especially in promoting health awareness and conducting outreach activities (Ministry of Health et al. 2006; Bacaron 2011). More recently, VHSGs, together with local authorities, have also been engaged in other health-related work, including the implementation of the Health Equity Fund (HEF), by assisting with the identification of poor households led by the Ministry of Planning (MOP) (Noirhomme et al. 2007). Furthermore, the research indicates that the VHSGs have faced a number of challenges, including limited capacity and inadequate incentives.

A 2003 Ministry of Health (MOH) policy established the HCMC, which is chaired by the commune/sangkat chief, as another local mechanism to promote community participation. Based on fieldwork in six Health Center (HC) areas, Rushton (2006) noted that there was still a significant gap in what the HCMC meant to achieve according to the 2003 MOH policy and what it had actually accomplished. Rushton drew three conclusions from his observations. First, the direct participation from ordinary citizens through the HCMC is limited. Second, status plays a key role in shaping interaction between different people within the committee. Third, the committee's existence and functioning is very dependent on support from NGOs.

In terms of accountability, Men et al. (2005) suggest that, in the current context, community participation cannot be expected to lead to more accountable service delivery. Instead, better incentives for health workers are needed, accompanied by stronger monitoring systems, and more engagement from sub-national authorities (SNAs). Ozawa and Walker (2011) introduce a more market-oriented dimension of accountability, arguing that people will exercise their choice of going to the private rather than the public health service providers, if they feel that the public ones are not trustworthy, and consume too much time and resources.

Water. Although no systematic studies discuss the quality of participation through the water and sanitation user groups (WSUGs), anecdotal evidence strongly suggests that the WSUGs have existed only on paper; possibly with the exception of some cases where there has been explicit support from NGOs and donor projects (cf. UNICEF 2010). The so-called village development committee (VDC), created by the Ministry of Rural Development (MRD) in the 1990s, is also largely obsolete. In addition, researchers argue that the presence of the MRD at the local level has been too limited to contribute to any meaningful delivery of services to rural Cambodia. Instead, most of the funding related to rural water supply has been provided through donors and NGOs (UNICEF 2010). However, many of the WSUGs funded by donors were found to be inactive after the projects end, as in the case of the Asian Development Bank's Tonle Sap Rural Water Supply and Sanitation Project (ADB 2011).

One lesson that can be drawn from this finding is the significant potential impact from NGO projects (cf. Öjendal 2013; Ou & Kim 2013; The Asia Foundation 2012). For instance, a report from the National Committee for Sub-National Democratic Development (NCDD) indicates that education, and WatSan projects have commonly been funded by NGOs, complementing line departments' engagement (NCDD 2010; World Bank 2012). In addition to financing projects, these NGOs have also initiated processes aimed at specifically promoting participation and accountability at the local level. These interventions include engaging village volunteers, promoting public forums between citizens and local authorities, undertaking citizen report cards, and evaluating processes (NCDD 2010; World Bank 2012).

2.3 The Emerging Framework

The comparative sectoral nature of this study presents particular policy-related analytical challenges, as the approaches to participation and accountability in the three sectors differ considerably. As discussed above, the patterns of participatory and accountability mechanisms vary by sector, and are seemingly not always designed to be fully participatory. There are a number of challenges for the

overall framework of the study.[17] First, VCD2 is a study of deconcentrated sectors, with limited space for local decision-making. Budgets are already set, management manuals compiled, staff recruited from above, and policies written centrally. Second, there is no obvious local arena where decisions are made. In water and education, key decisions are made at the district level and above, to which there is no local access. In health, it is the Operational District (OD), which is the key agency, but they are only indirectly available to influence from below. The third challenge is the limited existence of active communities. As a result, there is a lack of precedence for a collective body that represents citizens.

The following chapters present empirical findings (Chapters 3-5) and are each structured with the following sub-sections:

- *sector overview,* including the respective policies on participation and accountability;
- *key actors* in each sector, and the roles and relationships between actors in each sector;
- *participation and choice*, which is thematically structured around the extent to which villagers use "voice" or "exit" (cf. Hirschman 1970) as a way to exercise choice;
- *participation, decision-making, and accountability*, in which the role of participation in the nature of decisions is discussed, and how the decision-makers are held accountable; and,
- *conclusions* on the key patterns of each sector.

[17] These challenges are based on the experiences from VCD1, the literature review, the sector policy reviews, and phone interviews carried out during the first phase of this study. These are not empirical findings from the study's fieldwork, but they are included to provide context for the empirical findings presented in Chapters 3-5.

CHAPTER 3
VOICE AND ACCOUNTABILITY IN PRIMARY HEALTH CARE

Among the three sectors included in this study, the health sector has the longest track record of deconcentrating service delivery in Cambodia. Efforts to enhance community participation in the health sector were introduced in the late 1990s. As a sector, it is one of the most heavily reliant on donor and NGO funding and operations. This creates both overlaps and opportunities for systems of accountability and participation. The chapter begins with a brief sector overview of the policy context, and introduces the key actors, agents and vehicles for community participation – the Village Health Support Groups (VSHGs), and the Health Center Management Committees (HCMCs). This is followed by an analysis of how this works in practice. .

Issues to be addressed and indicative indicators of enhanced health services in Cambodia

Despite significant improvements in health outcomes and use of health services in Cambodia during the past decade, a number of challenges remain. First, despite progress in access and quality of public health services, most Cambodians, including the poor, primarily seek care in the unregulated private sector, including unlicensed drug shops. Second, although quality and access of services and the public sector are improving, difficulties include: shortages of key inputs (drugs and equipment); absenteeism of staff; impolite staff behavior, particularly toward the poor; long waiting times; inadequate cleanliness and hygiene of the health facility. Perceptions of quality and trust are key determinants of decisions to seek care. Third, out-of-pocket health expenditures remain a burden, particularly for the poor. The establishment of transparent user fees has reduced "unofficial" payments, and Health Equity Funds (HEFs) – which pay user fees on behalf of the poor, usually through a local NGO – have helped reduce the burden of out-of-pocket payments. But unofficial payments persist, particularly at hospitals, and only about half of the eligible poor are currently covered by HEFs. Fourth, the clinical quality of services in the public and private sectors need to be significantly improved. This is complicated by the fact that most clients demand clinically inappropriate services (e.g., injections, IVs, antibiotics) even when they are not medically necessary. Finally, Cambodians living in remote or vulnerable communities have lower use of health services and worse health outcomes, but outreach services to these communities remains uneven.

The health sector has begun piloting community scorecards and other social accountability instruments (although not in the villages included in this VCD2 study) that provide illustrations of the indicators that can be used to measure health improvements. This initial experience suggests several indicators might improve as a result of enhanced social accountability:

- Reduced staff absenteeism, improved staff politeness, and reduced waiting times;
- Improved hygiene, cleanliness, and maintenance of facilities
- Improved understanding by clients on their entitlements for public service, and improved understanding of clinically appropriate care (e.g., reduced demand for injections)
- Increased use of public services, and reduced use of unlicensed drug sellers
- Increased coverage of key preventive services (e.g., vaccination, vitamin A), particularly in remote communities
- Increased percentage of poor with HEF cards
- Reduced unofficial payments, and possibly net reductions in out-of-pocket expenditures for the poor and near-poor
- Finally, if combined with supply side measures and monitoring to improve the clinical quality of care, measurable improvements might be attained in 2-3 years in health or nutrition outcomes (e.g. child mortality, malnutrition).

Input provided by Timothy Johnston, Senior Health Specialist, World Bank

3.1 Sector Overview and Policy on Participation

3.1.1 Sector Overview

Since 1994, responsibility for implementing health programs has been placed under the officials of the Provincial Health Departments (PHDs) and Operational Health Districts (ODs)[18] rather than the centrally managed programs of the Ministry of Health (MOH). This arrangement carries significance for the accountability of the service provider, as described below. The health service delivery system has reached down to the commune level through its 24 PHDs, 77 ODs, 75 referral hospitals (RHs), 967 Health Centers (HCs), and 108 health posts (MOH 2008).

An Operational District (OD) has a catchment population of approximately 100,000 individuals, and under each OD, there is a referral hospital and a network of HCs. According to the Health Coverage Plan adopted in 1996, each HC is responsible for providing the "Minimum Package of Activities" to a population of 10,000 citizens (MOH 2002). This package, a 2007 MOH guideline, includes: providing general health consultations; offering maternal, child, and reproductive healthcare; delivering preventive care; curing selected communicable and non-communicable diseases; and performing general health awareness-raising (MOH 2007). Despite the fact that the system's infrastructure technically covers the entire country, and has a clear and broad mandate, the reality is that the public health system only served 25 percent of those seeking treatment for illness or injury in 2010 (Martinez 2011). This may suggest that a large part of the population still relies on private health care (licensed and unlicensed), or does not seek health care at all.

In terms of institutional development, the health sector has made considerable progress toward locally defined, output-based planning and management, based on the Annual Operational Plan (AOP) and the Three-Year Rolling Plan. As part of the annual planning process, each HC is expected to prepare a document which details the program activities that the HC will target and implement in the upcoming year, together with performance indicators. Each activity is linked to different sources of funding, including the government, NGOs, and user fees. The AOP from each HC is considered at the OD level, before being consolidated and forwarded to the provincial and national levels. Once the AOP is approved, quarterly and monthly plans are also required, along with monthly reports on work progress and budgetary status. Monthly meetings between HCs and ODs are also held on a routine basis (MOH 2007).

Box 3.1
AOP Preparation and Output-Based Focus

The AOP is a key document for every HC. It is an output-based plan that applies last year's performance as a basis for planning. It could serve as an accountability framework for the HC, as its funding is related to its outputs. Typically, the OD facilitates an annual planning process that includes a detailed discussion with the HC to develop a feasible annual plan, internal discussions with the Health Center Management Committees (HCMC), and then approval by the OD. The commune chief debriefs the council regarding the activity of the HCMC. Establishing the user fees for various health services is also a part of the AOP preparation process and often takes place in a workshop context, either at the OD or provincial level. The HC in KPC2,[19] for instance, has a target for revenue generation from user fees. In order to attain their monthly outreach activity targets, the HC deploys

[18] A health *Operational District* typically comprises of 2-3 administrative districts. ODs were established to comprise a catchment population of approximately 100,000, which is appropriate size for a district/provincial hospital and a series of health centers (usually 10-15 per OD). In some cases the ODs cut across an administrative district, but MOH is working to revise boundaries so that these are aligned. An administrative district typically has too small a population to justify building a hospital with inpatient services.

[19] The referencing system for the communes studied in VCD2 conceals the name of the commune (which seems necessary given the sensitive nature of some of the findings and issues discussed) and also provides an indication of which province each commune is in. BTM references Battambang, KPC indicates Kampong Cham, and KSP refers to Kampong Speu.

its staff to provide general consultations and medicine to villagers. This supports their outreach activities. HC chiefs that were interviewed clearly understood the mechanisms of this output-based performance requirement. As the HC chief in BTM1 stated, "My HC is accountable for meeting the targets in terms of number of patients treated and clients reached, as set out in the AOP."

The health sector is heavily reliant on donor and NGO funding and operations, which could create overlapping systems of accountability. Despite annual increases in the allocated national health budget, donor and NGO funding still account for about half of total public spending on health (World Bank 2011). Approximately 115 international and national NGOs are working in the health sector (MEDICAM 2008), with more than 20 donors supporting the Health Sector Support Program, and various health sector projects. NGOs operating in the sector focus both on the supply (i.e., improving service delivery and building institutional capacity of health delivery agencies) and demand sides (i.e., provision of social protection). One particularly noteworthy program is the Health Equity Funds (HEFs), which reimburses RHs and HCs for the services they provide to the poor. The implementation of HEFs is expanding rapidly, and will most likely cover all public facilities before 2015 (Martinez et al. 2011).

3.1.2 Policy for Community Participation in the Health Sector

Efforts to enhance community participation in the health sector were introduced to Cambodia by donor agencies in the late 1990s, and were consolidated into MOH Community Participation Policy in 2003. According to the 2003 Policy, participation in the health sector is encouraged through the establishment of the Village Health Support Groups (VSHGs) at the village level, and the Health Center Management Committees (HCMCs) at the commune level.

Village Health Support Groups. The MOH 2003 policy indicates that each village is supposed to have two VHSG members, one male and one female, elected from all members of a village (who meet certain criteria). It also stipulates that VHSG members must:

- ensure a regular flow of information between the community and the HC;
- distribute and post health education materials to villagers;
- assist the HC team in outreach activities and health campaigns to inform communities on health related awareness;
- help detect cases of tuberculosis and follow Directly Observed Therapy Short course or DOTs;
- identify poor households in their villages (to be exempt from payment for health services); and
- organize transport for referred patients to the HC or referral hospitals.

Membership is drawn from communities, with members as volunteers and not government staff. The role of the VHSG is to provide outreach services, and connect the HC to the community through the provision of information and preventative services. It was not envisaged as a community-based organization (CBO) that represents communities, or provides a mechanism for villagers to voice collective concerns or demand accountability.

Health Center Management Committee. According to the same 2003 policy, the HCMC should have 8 to 12 members, including a representative of the commune council who acts as the chair, the HC chief, vice chief, midwife, and selected VHSG members. The HCMC members are responsible for:

- preparation of the AOP of the HC;
- monitoring and evaluation of the implementation of the AOP;
- management and use of the HC budget, including user fees and fee exemptions[20];
- maintaining buildings, vehicles, and other equipment; and

[20] The MoH Health Financing Charter (1996) also emphasizes the need for community participation when establishing user fees. It states that the HCMC has the responsibility to set the user fee at a level affordable for the community, which varies depending on the local context.

- referring 'victims' (patients) to HC or referral hospitals.

As envisaged in the policy, the HCMC is also not a CBO representing the interests of the community/users of health services. It is a "provider committee", with responsibilities for delivering services. Provisions regarding the VHSG and HCMC were re-emphasized in the MOH 2007 Guideline on the Minimum Package Activities for the Development of Health Centers.

The 2008 Community Participation Policy. In 2008, a new Community Participation Policy was drafted. The intention of the 2008 draft was to further develop the VHSG and HCMC, and enable them to become more effective mechanisms of community participation. By doing so, it hoped to inspire HCs to become more accountable, and encourage the users/clients to be more aware of preventive health measures, and seek appropriate health care. The 2008 Draft Policy also provides details in terms of the structures, roles and responsibilities, financial support, and incentive mechanisms for the VHSG and HCMC, including the following.

- The membership of each VHSG is expected to increase (one member per 10-50 households). Membership is to be determined by the community, the chief of the OD, and the HCMC.
- A VHSG leader is to be appointed, and provide information about HC services and fees to the community, report on user satisfaction to the HCMC, and promote client/user rights.
- VHSG members are to receive various kinds of support (i.e. in-kind from various actors, including the community, HC, OD, and HCMC), which is meant to motivate them in their voluntary efforts.
- To generate financial support for the VHSG, the HCMC is expected to advocate for:
  - appropriate financial resources in the HC's AOP to cover the annual costs of the VHSG;
  - the development of community financing mechanisms *"community participation funds*";
  - earmarking of a budget in the Commune Sangkat Fund (CSF) for social services, including VHSG management and capacity building.

The 2008 Policy remained in draft, however, and was never widely disseminated. In 2012, MOH initiated a consultation process to update the policy, which will be undertaken in coordination with the National Committee for Sub-National Democratic Development Secretariat (NCDD-S), and the process for functional review for decentralization and deconcentration. Although the draft policy revision would strengthen the existing structure, and enhance awareness of clients/users, it would not address the inherent difficulty (and potential conflict of interest) of utilizing a multi-stakeholder community group of service providers, councilors, and service users as a mechanism for community participation, while holding the same service providers to account.

3.2 Key Actors in the Local Health Sector

3.2.1 Village Health Support Group (VHSG)

Membership and selection. The VHSGs in the six communes studied each includes two to three citizens, at least one of whom is a woman. Two of them are officially selected by the HC chief. Only one of the VHSGs interviewed (KPC2) had provided members with a formal identification card to verify their VHSG membership. In most villages, members have their names registered at the HC and are simply recognized by the villagers because of their outreach activities.

In some cases, a third member had been appointed to the VHSG to support NGOs working with HCs. For instance, in KPC1, an additional VHSG member was recruited specifically to help the work of the Reproductive Health Association of Cambodia (RHAC), an NGO that provides family planning and sexual and reproductive health services in Cambodia.

Most VHSG members identified in the communes visited were already nominated in quasi-state roles as members of the village authority – the village chief, deputy village chief, and other elite village member. Key informants at the local level indicate that villagers generally prefer such individuals to serve on the VHSG, as they are well-informed about the health needs of households and village statistics, can maintain strong local relationships, and can facilitate health events and visits conducted by HCs and NGOs.

Selection of new VHSG members is necessary only when existing VHSG members resign. While the policy sets down an election process for this position, in practice, in the communes visited, the HC chief initiates the process of selecting VHSG members, and asks village chiefs to propose appropriate candidates for consideration. However, there were also cases in which the HC chief identified candidates, and then sought the approval of the village chiefs. The HCMC is typically informed after the selection process. As an HC chief claimed:

> *When the HC or NGOs need volunteers, we, the HC, ask the village authority to recommend a few citizens from their village, and then the HC decides on the selection, or sometimes we already select a few citizens . . . and ask the village authority for comments instead* (HC Chief in BTM1, Interview).

A number of criteria were followed regarding the VHSG membership in the communes visited. Being active in the community, as well as literate and able to share information with villagers, is prioritized. It is also necessary for VHSG members to be available to join regular meetings and able to perform the tasks assigned from the HC. Women tend to be preferred in the selection, as they are regarded as suitable candidates for tasks related to awareness-raising and sharing information, performing household visits to check on health status, and providing basic health advice and care for issues such as reproductive health. In the research sample, roughly 70 percent of VHSG members were found to be women. A female VHSG member describes her selection:

> *I am not sure why I was selected as a VHV[21]. Maybe because I know how to read and write. Or maybe they [HC & NGO] need women rather than men to educate women about health issues. And I have free time to join meetings at HC* (VHSG member in KPC1, Interview).

Roles and functions. In practice, in the communes visited, VHSGs are expected to: (i) help educate citizens in the village about health; (ii) encourage villagers to go to the HC; (iii) refer pregnant women to deliver at the HC; (iv) collect specimens for TB tests; (v) observe villagers health; (vi) keep statistics of newborn children; and (vii) ensure regular flows of information between the community and the HC. Some are also asked to assist with identification of the poor, which determines eligibility for free health services at the HC.[22]

To enable VHSG members to perform these tasks, they are provided with training (1-5 days). According to one VHSG member:

> *I have received primary healthcare training from World Vision. After that, I could teach citizens about health, join awareness raising with the HC and the NGO, record the number of children under two years old, and accompany the HC staff during vitamin A provision and vaccination injection* (VHSG member in BTM2, Interview).

VHSG members who work on malaria are trained to conduct malaria tests and provide medicine for mild symptoms, as noted in the cases in KPC2 and BTM2. VHSG members who work on reproductive health are allowed to sell birth control products to villagers.

A key task of VHSG members is to collect health statistics and report to HCs and HCMCs using standard data reporting formats. Qualitative information, such as citizen complaints regarding HC staff attitudes, for example, is not recorded and is less common, but depends on VHSG members' verbal feedback to the HC and/or HCMC. All VHSGs are required to attend the monthly meeting at the HC and support NGO visits. However, only selected VHSGs are appointed to join the HCMC meeting. As one HC chief put it:

[21] VHSG members were previously named Village Health Volunteers (VHV).
[22] The "ID poor" process is led by the Ministry of Planning.

> *All VHSGs from different villages under HC's catchment area join a meeting every month, but only a few of them are selected as representatives to join the HCMC meeting* (Deputy HC Chief in KPC1, Interview).

Incentives. Fieldwork suggests that, although VHSG members do not receive a regular salary, a set of minor incentives keep the VHSG members going. Although these incentives are very small, they seem to be enough to keep the volunteers motivated, establish some mutual accountability, and, despite turnover of volunteers, make the overall system work. These incentives include: free health care from HCs for themselves and immediate family members; opportunities to receive health-related and other capacity building or financial support from either the HC or NGO. In addition, they are allowed to make small profits from some roles, as explained by various VHSG members interviewed for VCD2. Overall, they receive few benefits, but local status and the opportunity to be recognized by other community members was found to be a critical aspect of their motivation.

> *While providing health education on birth spacing, I am also allowed to sell Ok [birth control] at a standard price [500 riel per pack] to villagers. I get 200 riels per pack as my profit* (VHSG member in BTM2, Interview).

Another volunteer added:

> *If I help refer a pregnant woman to deliver at the HC, I will be offered a travel allowance [10,000 riels], and when I get sick I can get medicine from the HC for free* (VHSG member in KPC1, Interview).

Challenges. Despite the training they have received, many VHSG members who were interviewed raised the need for more capacity building regarding the health issues for which they are required to disseminate information and provide guidance. The interviewed HC chiefs acknowledged this capacity shortfall, and claimed to have developed plans to provide additional and regular training for VHSGs. In practice, however, the training has been infrequent and heavily dependent on NGO initiatives and financial allowances.

The VHSGs also face several logistical challenges regarding their work. For example, based on the interviews, mobilizing villagers to attend meetings and outreach events organized by HCs and NGOs is difficult, and often they turn to village chiefs, or other older citizens, to promote attendance through their social influence. In addition, VHSG members all face difficulties in conducting household level outreach. As a VHSG member in Battambang commented:

> *I have no transportation, so I have to walk from house to house to spread information that the HC asked me to ... And it was really hard for me to gather mothers in the village to join short training sessions on how to make nutritious porridge. At that time, I asked for help from the village chief, but he himself is busy with many other things* (VHSG member in BTM1, Interview).

In a few cases, villagers expressed concern about the performance of some VHSG members. For instance, some VHSGs were perceived by villagers to be biased toward particular persons or groups in distributing medicine and vitamins. Some were said to use their roles to sell un-prescribed medicines. HC chiefs and NGOs recognize these problems, but did not see what they could do, given the large number of VHSG members, the low incentives they receive, and weak oversight over VHSG performance. However, selected household interviews suggest that these VHSG practices are not widespread, and have not led to citizen/user discontent with this outreach system.

3.2.2 Health Center Management Committee (HCMC)

Membership. The commune chief serves as the chair of the HCMC, the HC chief is the deputy chair, and other participating stakeholders include the Focal Point for Commune Committee for Women and

Children (CCWC), selected health staff, VHSG leaders, and supporting NGOs. When two communes share one HC (as in KPC1), the chief of the commune where the HC is located is the head of the HCMC, while the other chief acts as deputy head, alongside the director of the HC. In all of the communes visited under VCD2, there were no 'ordinary' villagers serving on the HCMC. Interviews with HC chiefs indicate that village chiefs (who are also VHSG members) are the ones frequently attending the HCMC meetings – although in everyday work, they are less active.

Roles and Responsibilities. The HCMC conducts meetings to discuss a wide range of topics, including updates from the NGOs and the OD regarding new policies, guidelines, as well as the OD supervision visits. Meetings might also review the HC's AOP implementation, user fee setting and exemption, planned outreach activities, complaints from villagers through the VHSG members, and/or complaint box (see next section), and any other health problems on the ground, such as disease outbreaks. The HC usually prepares a list of user fees and exemption rates, and proposes it to the HCMC for a decision. The HC chief then brings the HCMC decision to the OD for discussion.

Interviews with HC chiefs indicate that the OD prefers to have similar user fee levels across all HCs in its catchment area. However, there are also cases where the HCs make a strong case, and manage to maintain their own fee structure. In BTM1, for instance, the HCMC made a proposal to reduce the fee to help the poor. The proposal was discussed at the OD level and finally was approved. According to the HC chief in this case, the approval was possible because of the strong leadership of the commune chief. This example suggests that, on occasion, the commune/sangkat authority is able to promote some measure of downward accountability. However, the role of the commune authority as a member of the HCMC is usually limited and mostly symbolic. For example, the main role of the chief, as seen in the fieldwork, is to open and close the HCMC meeting, while the HC chief and representatives of the NGOs have the most say as to which specific issues should be included in the agenda.

Field interviews indicated that it would be considered active enough if the HCMC managed to meet once every two months. The HC chief and other HC staff are usually present at each meeting. However, the commune chief does not usually attend every HCMC meeting, as s/he is usually involved in other matters, and therefore tends to delegate responsibilities to other councilors. When the commune chiefs are absent, the HC chief will act as the chairperson of the meeting. In communes visited, various NGOs are also present in the HCMC meetings. Neither the HCs nor the commune councils have allocated budgets to cover the small expenses incurred by the HCMC meetings (e.g., snacks, transportation cost for commune councilors, etc.) in the communes visited. These expenses have usually been covered by the partner NGOs.

The voice of the commune councilors (including the chief) and the VHSG within the HCMC meeting varies, depending on the topics or issues being discussed. These actors tend to have less voice on the more managerial matters of the HC. The following quote illustrates this point.

> *The HCMC meets every two months ... to discuss problems and review the progress and plans of the HC. The commune chief usually just symbolically endorses the plans and expenditures of the HC without trying to question or alter the proposed plans in any way. At the meeting, we also discuss the budget of the HC, but the chief has little understanding of this issue and does not want to step in as everyone knows that it is the OD who has most say in approving the budget and undertaking the monitoring of the HC* (HC Chief in KSP2, Interview).

The VHSG and the commune councilors, however, tend to have more of a role regarding reports or complaints from the community made either through the VHSG or the complaint box which is placed at the HC (see below). At the HCMC meeting, the commune chief is given the authority to open the complaint box. One HC deputy chief observed:

> *Mostly, when the discussion at the meeting concerns plans and budget and diseases, the VHSG and the commune councilors just listen. However, when the*

> *meeting turns to complaints from the community, VHSG [members] jump in. The commune chief and CCWC focal points tend to also join the discussion around such complaints* (HC Deputy Director in KPC1, Interview).

The commune chief's reluctance to engage in sectoral issues and tendency to defer to the technical staff/officials is a common pattern in rural Cambodia. Commune councils are still learning about the implications of their mandate for poverty reduction, and many do not always see the links to local basic services, or feel they can intervene in this regard. This is not always the case, but it can be a key factor affecting levels of participation in, or meaningful demand for accountability through, the HCMC. Consequently, HCMC meetings become more of a mechanism to share information between the commune authorities and health officials, and less of a forum to discuss implementation issues and devise concrete responses to address citizen complaints.

In the six communes researched for this study, the HC chiefs see the commune councilors and commune chiefs more as figureheads, whose local knowledge and opinions are valuable, but not as being in a position to hold the HC accountable. The following illustrates the perception of one HC chief interviewed:

> *. . . but the commune chief or commune councils are like our parents. They have clear information from the citizen in the community. They have stronger authority and we need to let them know most of our activities… when we do the campaign, awareness raising, and other outreach activities, we need to inform them. We let them provide some guidance for us.* (HC Chief in KSP2, Interview).

Challenges. The research suggests a number of challenges for HCMCs. First, the commune authority in the HCMC tends to be rather inactive in some aspects of HC management. This is partly because of the limited capacity of community members, and their reluctance to exert their voice outside of what they see as clearly defined formal mandates. Further, some commune chiefs explained their unwillingness to raise their voices in the HCMC as a reflection of their desire to avoid conflict and disagreement. For example, one commune chief in KPC1 commented that even though the commune council is technically the head of the HCMC, they are reluctant to challenge the HCs, as they were seen to possess superior technical knowledge. An OD Director confirmed this point by commenting:

> *Some commune chiefs and councilors dare not to provide constructive criticism to the HC during the HCMC meeting as some of them are new to the position and, somehow, they try to avoid conflict in the meeting* (OD Director in BTM1, Interview).

This reluctance on the part of the commune councilors is an indication of their still widespread perception that their mandate lies mainly in managing the CSF (currently expended largely on local infrastructure projects), community mobilization, and security; whereas tasks such as health and education belong to the respective line agencies. The reluctance is also reinforced by the common attitudes of health practitioners, who tend to think that they, and not lay-persons, including commune councilors, know their work best. For instance, the HC chiefs interviewed seemed to downplay the role of commune chiefs in health management and the development of the AOP. One HC Chief commented:

> *The AOP is technically complex. In order to prepare the AOP, the HC needs to put much effort on reporting, budgeting and planning. In practice, however, we . . . [hardly] get any comment from non-HC staff on the AOP during HCMC meeting* (HC Chief in KPC2, Interview).

Second, the HCMC role in raising common complaints regarding service issues has also been limited. In the communes visited, it is not uncommon to find users of health services to be discontented with the services provided, particularly the unfriendly attitudes of health staff, the extensive waiting time,

medicine that is perceived to be sub-standard, and limited health care advice.[23] However, users are not likely to raise their concerns through the VHSG. First, while citizens will share their concerns informally in the village, they prefer not to confront others, especially those in positions of authority, including the HC chief. Second, according to the interviews, citizens with improved economic circumstances are likely to go to an alternative HC or private providers if they are not content with the service provided by the HC in their commune, rather than providing feedback to improve services (the question of choice will be discussed further below). Third, those VHSGs, who bring voices and complaints from the community and report them to the HCMC, are more likely to be perceived as a part of the HC (and thus dependent on their goodwill), and do not feel that it is the best channel for raising complaints about the HC. Commune councilors and the HC chiefs are also aware of what villagers think about the HC at large. They are, however, less informed of the specific cases unless the information is brought to them through the VHSGs or other informal means, such as through word of mouth or at informal village gatherings. Even when complaints are raised from the citizen to the VHSG, the latter might not carry it to the HC and HCMC forum unless there is support from NGOs.

The research suggests that NGOs play an important role in addressing this challenge, by creating an enabling environment to address villager concerns, and facilitating HCMC meetings. The HC chiefs and OD staff reiterated this observation, adding further that NGOs have been important in ensuring active and engaged HCMCs and VHSGs. NGOs such as RHAC, for instance, have provided small travel allowances to commune councilors, VHSGs, and other stakeholders as incentives for them to attend the HCMC meetings. The presence of NGOs at HCMC meetings can also incentivize VHSGs to bring concerns forward because they expect that the NGOs, which provide financial support to the HC, will have more leverage in pressuring the HC to address the problems. A VHSG member claimed:

> *As a village volunteer, receiving incentive from an NGO, I am encouraged to speak out and bring unusual cases in the village to discuss in the monthly meeting with HC and NGO staff. But I sometimes prefer to keep silent if there is no NGO present … without an NGO, my voice is useless* (VHSG member in KPC1, Interview).

[23] It should be noted that many villagers do not have a good understanding of the causes and cures of disease, and are not always correct in their judegement of health services – they often equate good heath care with more medicine.

Figure 3.1
Voice and accountability relationships in local health services

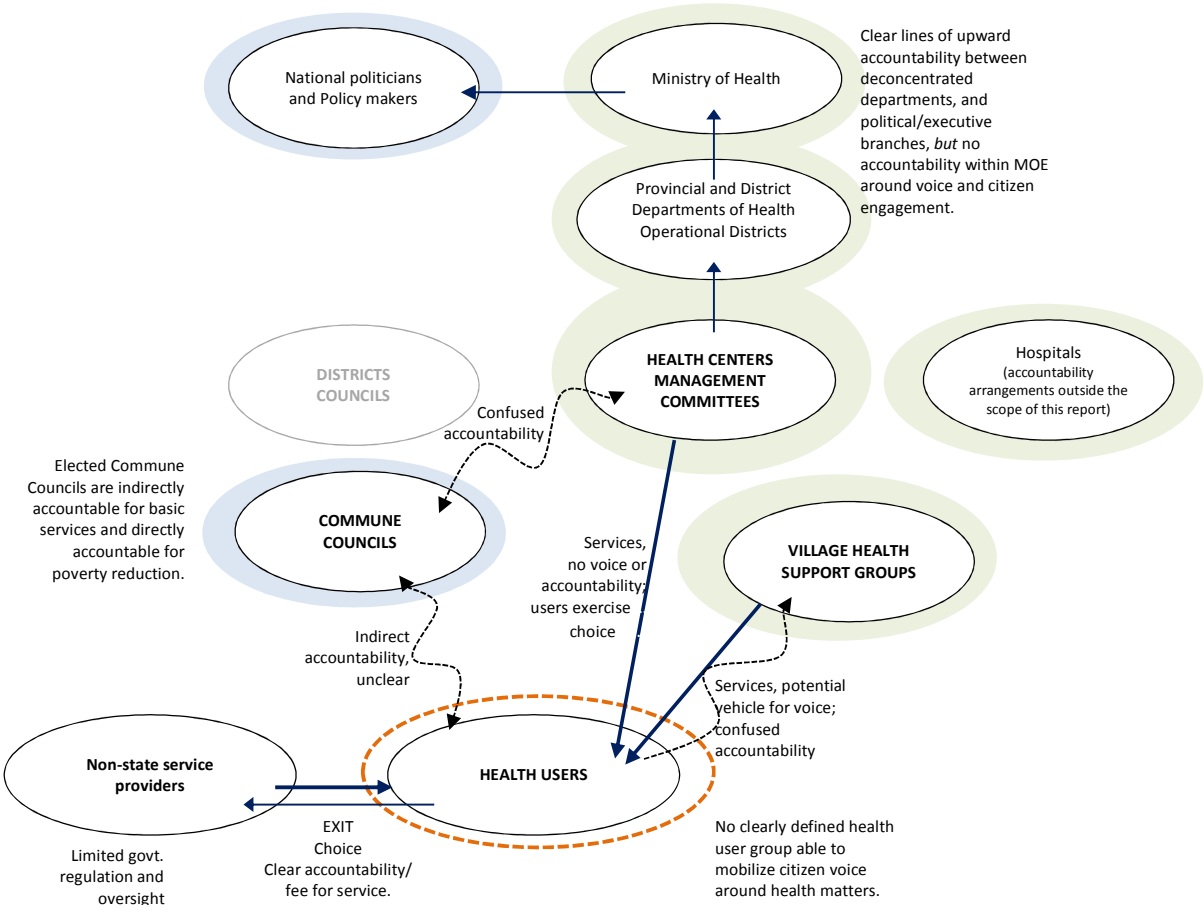


Table 3.1: Policy and implementation – Health

	Policy Guidelines	Implementation – Findings
Policy statement	The VHSG and HCMC are the primary vehicles to encourage participation of communities.	Community participation is conceived as community engagement in campaigns, awareness building and other outreach.
Vehicles VHSG	The establishment of the VHSG will encourage community participation.	In policy and implementation, no responsibility is given to the VHSG to enhance the voice of communities
• role and responsibilities	i. Ensure a regular flow of information between the community and the HC;	Carried out
	ii. Distribute and post health education materials to villagers;	Carried out
	iii. Assist the HC team in outreach activities and health campaigns to inform communities on health related awareness;	Carried out
	iv. Help detect cases of tuberculosis and follow Directly Observed Therapy Short course or DOTs;	Carried out
	v. Identify poor households in their villages (to be exempt from payment for health services); and	Carried out
	vi. Organize transport for referred patients to the HC or referral hospitals.	Carried out
• Membership	(from 2008 draft policy) One member per 10-50 HHs To be determined at local level VHSG leader appointed. Drawn from communities, with members as volunteers, not government staff. VHSG should receive various kinds of financial in kind support.	Normally 2-3 citizens (one woman); in sample 70% women. Members are typically village chiefs and selected women, literate, and active on other committees, mostly already in quasi state roles. Membership not contested. The HC chief and village chief collaborate in the selection of members. Minor financial incentives are provided – enough to keep them in these positions. Includes free health care for HH, opportunities for capacity building that may bring per diems, small profits from selling birth control, travel allowances. .
HCMC • role and responsibilities	The HCMC is a "provider committee" with responsibilities for delivering services.	In policy and implementation, no responsibility is given to the VHSG to enhance the voice of communities
	i. Preparation of AOP of the HC	Mostly left up to the HC chief
	ii. Monitoring and evaluation of the implementation of the AOP	Not carried out, unless NGO support available.
	iii. Management and use of the HC budget, including user fees and fee exemptions	Mostly left up to the HC chief, but the HCMC does play an active role in setting user fees.
	iv. Maintaining buildings, vehicles, and other equipment	Currently maintenance of health centers and equipment should be a central MOH responsibility, but it is generally not adequately financed or done by MOH. Facilities might use their user fee revenue and HEF revenue (if they get) to do small repairs and upgrades.
	v. Referring victims to HC or referral hospitals.	Mostly left up to the HC chief
• membership	8 to 12 members, including: • a representative of the commune council who acts as the chair, • the HC chief, vice chief, • midwife, • selected VHSG members.	Generally as required. Commune chief as chair, HC chief as deputy chair, CCWC, CHSG leaders, selected health staff and supporting NGOs. Role of commune is limited and usually symbolic. CC members do not always attend meetings, delegation to the HC chief is common. Membership is a mix of the service providers themselves and the commune council.

3.3 Participation and Choice – Voice or Exit?

Voice. Citizen participation in the formal mechanisms of the VHSG and the HCMC is neither organized nor common in relation to local health services. These forums act more as delivery agents with a communication role, rather than vehicles for citizen engagement in decision-making (i.e., planning, budgeting, and reporting). Based on the study's findings, these entities do, however, play a monitoring role, though this is "internal" to the system rather than one which provides oversight and accountability.

Given the particular nature of the VHSG and HCMC – as outreach and management of a service agency, respectively – the participation that has emerged has occurred through other channels.

- *Users can raise their voices through a complaint handling mechanism.* A complaint box is located in every HC compound. VHSGs provide forms to any users/clients who wish to make a complaint. They can either fill in the forms themselves or ask the VHSG member to do it on their behalf. Introduced in mid-2011, the complaint boxes were expected to encourage villagers to provide feedback and complaints about HC services or give suggestions or ideas for improvement. The interviews in the visited communes revealed, however, that very few written complaints or suggestions have been received through this venue. A number of reasons were suggested by key local informants, including: lack of awareness among villagers about the intention of the complaints box, illiteracy, and fear among villagers that the process will not be anonymous and they will be identified if they submit complaints in a box located in or near the HC.

- *Direct participation also takes place through public forums where NGOs have funds to provide support (e.g. MediCam and Amara in BTM1).* The purpose of these ad hoc forums is to increase communication between the service providers and clients/service users. Such forums illustrate the collective involvement of the community, local authority, and service providers regarding service delivery. Further, such forums allow community members to express their needs and concerns, and the service provider an opportunity to respond directly. Based on the interviews, the villagers consider the interventions by NGOs to be useful. However, because these events are sporadic, it is doubtful that they will have a significant impact on decision-making or foster a wider culture of participation.

Choice. The research found, however, that "choice" was far more likely to be exerted by citizens/users than "voice." Evidence suggests that even the poor in remote areas are willing to seek alternatives to obtain primary health care services. In addition to the HCs in their communes, citizen can opt to go to private providers, a nearby HC in another commune, or referral hospitals in district towns. Increasingly, citizens choose to shift service providers rather than make formal complaints or assert themselves by engaging in participatory processes. As a villager in KPC1 said:

> *A year ago I went to the HC nearby. I felt the same as other villagers that the physician in the HC had a bad attitude toward poor citizens. From there, I went to another HC, which, although farther away, has more friendly staff… I did not report my issue to any authorities but I did tell the story to my neighbors and relatives. I think it is easier to just change to other places rather than making complaints.* (Villager in KPC1, Interview)

Taking into account costs and benefits, local residents make rational decisions as to whether they go to the HC in their commune, or to an alternative health care provider (private physicians included). For instance, a few local citizens in KPC2 indicated that they do not waste their time waiting at the HC. In this case, especially for common illnesses, such as colds and flu, they opt to buy medicine from a nearby medicine stand instead. According to the interviewed villagers, this reduces the opportunity cost of waiting in line, and instead they can spend that time on income-earning activities. Although, from a service provider's point of view, this behavior may not be optimal for improving health, it is nevertheless a distinct local pattern.

Villager preference for private providers also seems to be increasing, and includes medicine stands attended by owners/employees with limited medical training. The preference for this kind of provider is historical to some degree but also reflects a lack of understanding of what constitutes good health care. Many villagers judge health care by the amount of medicine and shots they take, and their perception of what enables them to recover fastest. Some HC chiefs interviewed, however, also indicate that clients might be turning to private physicians because the HC does not meet their needs, due to a lack of facilities and diagnostic equipment for blood tests, etc.

Household interviews in the six communes indicate that, in general, villagers do not know the scope of the HC roles in providing services to people. They are not aware of the strategic focus of the HCs (and know even less about the role of the HCMC). The limitations, both perceived and real, of HCs in meeting specific health needs shape the expectations of villagers. For instance, although HCs are expected to provide a range of services, in practice, villagers only expect a few services. These include: vaccination and provision of nutrition pills; reproductive and pregnancy related services; diagnosis of specific diseases, including tuberculosis and malaria; and general consultation and advice. Users rarely rely on the HC for more difficult complaints (e.g. diabetes, mental health, or sexually transmitted diseases).

There is some indication from the research that demand for health care declines further in more remote areas, where villagers are less educated, have little trust in state institutions, have even less knowledge about their health, and thus are less likely to seek professional healthcare. This lack of demand seems to persist, in spite of the variety of local awareness-raising and information-sharing events, and the increasing availability of health services within the village/commune. The research revealed a number of cases where a lack of awareness and lack of demand resulted in health problems being exacerbated.. In this context, the HCs face not only the dilemma of providing services, but also of clearly communicating what it is, what constitutes good health care and what it can do for the citizens.

3.4 Participation, Decision-Making, and Accountability

3.4.1 Downward Accountability

With the exception of the public forums supported by NGOs, which allow citizens to directly express their concerns to health service providers, there is no effective channel for citizens to hold service providers accountable for local health services.

Complaints box. As noted above, the complaint box is an accountability mechanism that has been established with the intention of strengthening the links between the clients, the VHSG, and the HCMC; but is neither well understood nor used by local citizens to voice their concerns to the HC. Several factors help to explain this, including a lack of demand on the part of the citizens themselves, lack of trust that their demands will lead to changes, and, in many cases, their ability to complain by exiting – when they have a choice to opt for another primary health service.

User fees. While it may be that user fees can generate more client power in the user-service provider relationship (because users can choose whether they return to the same clinic to pay the fee again), the research in the communes studied found that service provider accountability did not increase with a user fee and it the reasons for this was not ascertained. E.g. was the user fee was too small to prompt better performance and accountability by HC workers (either individual transaction costs or as a percentage of the HC's total revenue), did HC workers receive better incentives elsewhere.

HCMC and VHSG. Some level of downward accountability has been made possible through the HCMC, with help from VHSGs. The institutionalization and integration of the HCMC and VHSG into the supply chain of health service delivery has formalized the roles of community actors, other than HC staff, in key decision-making areas affecting the performance of health centers (see Section 3.1 above). In the

context of the commune, HCMC meetings are arranged separately from the monthly commune meetings, which also help to bring health issues and services more into focus, and make these issues more apparent and inviting for engagement from commune councils (creating a measure of horizontal accountability). Such a separate forum does not exist for other sectors, including education (discussed in the next chapter).

While the HCMC meetings are not ideal mechanisms to enhance citizen participation, they provide a forum that promotes accountability and addresses HC performance. Interviews indicate that HCMCs discuss the complaints that are raised by the VHSGs (almost all of whom are also members of village authorities), or received through the complaint boxes. In some cases, this has led to actions being taken by the HC. For example, in KPC1, there were cases where HC officials followed up with, and issued warnings to "bad-mouth" mid-wives, who were accused in complaints of insulting and ridiculing villagers. In KPC2, even the commune chief had intervened in one such case. Selected households and local authorities interviewed also indicated improvements in health staff friendliness as a result of the HCMC meetings.

In spite of the institutionalized space created for VHSGs and HCMCs to provide feedback to the HCs, the potential of the VHSG and the HCMC to enhance accountability depends on their ability to collect, carry, and use citizens' concerns to influence the decision-making process. However, as discussed in section 3.2.2 above, local citizens have been reluctant and/or unable to bring their concerns to the VHSG to be presented at HCMC meetings, partly because they see the VHSGs as mainly just working on outreach activities on behalf of the HC. This is not to say that VHSG members are not aware of the dissatisfaction of villagers toward the HC. The challenge, however, is that VHSGs tend to be reluctant about raising those concerns at HC and HCMC meetings. This may be due to the fact that the VHSGs and commune councilors, including the chiefs, who are members of the HCMCs, usually have low expectations as to whether their voices in the HCMC can actually lead to significant changes.

The ability of the VHSG and commune councilors in acting as agents to demand accountability on behalf of villagers is limited also by other factors – the most frequently mentioned being low incentives and lack of available time for them to perform their tasks. Leadership is another factor. Strong and active VHSGs and commune councilors show more interest in getting information regarding HC performance, and raise more issues at HCMC meetings. The weaker ones indicate that they possess little knowledge about HC operations and activities, let alone financial management and monitoring, which then are left to the HC chief and OD, respectively (See Section 3.1.2).

Moreover, perceived mandates and sector compartmentalization also make commune councilors, including the strong ones, reluctant to actively engage in HCMCs and hold the HCs to account, indicating low horizontal accountability. The reluctance stems from their perception that the HCMC is more of a sectoral mechanism, and, if they make too much noise in that forum, they are afraid they might be seen as overstepping boundaries. The reluctance is even greater in the case of two communes sharing one HC. The chief of the commune which does not host the HC is perceived to have less ownership, and thus displays less assertiveness in public forums.

Commune chiefs, however, are more confident in representing citizens' concerns over health issues at district-level inter-sectoral meetings, presided over by district governors. This is because the commune considers such meetings as within their own line of hierarchy (i.e., of the Ministry of Interior). However, according to commune chiefs interviewed, the district meetings have often proved to be ineffective for two primary reasons. First, the multi-sectoral agenda of the meeting makes the discussion much less focused, and as a result, it serves as more of a reporting forum as opposed to one that considers issues of accountability. Second, the district governor (and now the council) has no clear authority over sectoral issues, which significantly limits his/her ability to respond and, in turn, indirectly undermines the representative roles of the commune.

Commune Council. The commune councils, like the district councils, are not given a clear mandate on health issues (although they are made responsible for the broader poverty reduction mandate).

Besides chairing the HCMC, the only role that the commune council has that is related to health is through its Commune Committee for Women and Children (CCWC). Yet the CCWC's jurisdiction, and limited access to available funds to address health issues remain too small to hold the HCs accountable. As Box 3.2 below indicates, the CCWCs are struggling to make themselves active, and have yet to learn how to influence other actors.

Box 3.2
CCWC's Role as Health Providers

According to the Ministry of Interior's Guideline dated 2010, the CCWC has a role in promoting maternal health, including promoting maternal health awareness, and safe delivery through provision of transportation for poor pregnant women to an HC or referral hospitals. The CCWC is supposed to work with and through the VHSG at the village level. There are two relevant cases of CCWC engagement in this study: one demonstrates the success of a CCWC in improving participation and the other reveals some implementation issues.

In BTM2, the commune council's second deputy is the CCWC focal point. She has frequent interactions with the CCWC at the district level, and has discretionary authority on the use of the commune council budget for health activities. In 2011, a portion of the CCWC's $800 budget was spent on health activities such as referring pregnant women to the HC for giving birth (30,000 riels was given to each case), conducting awareness raising, and providing a travel allowance to other CCWC members who join awareness activities. The CCWC, in this case, was active partly because they received strong administrative support from the clerk in preparing documentation to meet the demands of the treasury. This is consistent with a key observation from VCD1—spending CSF money on social services more complex than roads.

In another case, in KPC2, a contracted CCWC focal point is assigned to implement health activities, since there is no female commune council member. The focal point had not managed to spend much of the CCWC's $800 allocated fund for health or other social activities. In 2011, only $90 was spent, and only two awareness-raising meetings were conducted. The funds were largely spent on buying snacks for the villagers during the meeting. However, the inactivity of the CCWC cannot be linked to the focal point alone. The CCWC focal point acts on the command of the commune chief, and in most cases, she needs clerical and administrative support from the clerk to prepare necessary paperwork to perform her job. In this case, the commune chief and clerk were not particularly supportive.

3.4.2 Upward Accountability

The more structured monitoring system, linked to specific outputs and performance indicators, and tied to financial support for both HC and health staff (as indicated in Box 3.3 below), makes upward accountability in the health sector stronger than downward. All the HCs visited by the research team submit regular reports and receive regular inspections from their ODs. [24]

Performance based monitoring is driven in part by NGO funding. Interviews with a PHD director also indicated that about 30 to 40 percent of HC revenue comes from NGOs. This funding is linked to performance scores that are produced as a part of the annual monitoring exercises. The proportion of output-based pay for health staff is also high. According to an estimation of the PHD director, a mid-wife, for instance, can receive up to $150 to $200 per month[25] with less than 60 percent of her income coming from her government salary. The performance-based mechanisms promoting strong upward accountability indirectly help to promote downward accountability i.e. as financial incentives promote upward accountability and higher levels emphasize the importance of the welfare and perceptions of the user.

[24]The NCDD-S also incorporates results for social services within the IP3 results framework, e.g. number of women supported by CCs to go to HC for ANC/safe deliveries.
[25] A portion of this income is midwifery incentives that are financed by the budget ($15 per delivery at HC, though usually shared with staff and sometimes community workers).

Box 3.3
Incentive and Monitoring Systems in the Health Sector

In BTM1, the HC is subject to regular monitoring by the OD and NGOs. In addition to submitting monthly reports (called HC1) to the OD on its activities, the HC also receives regular supervision visits from the OD on a quarterly basis to make sure that it operates in accordance with various guidelines issued by the MOH and the planned activities as indicated in its AOP. The HC is also regularly monitored by an NGO (the University Research Company (URC) that assesses service provision and the quality of care at the HC. The findings are then used as a basis for determining the funding level of the HEF. The regular monitoring, and the fact that it is tied to future funding, is a strong incentive for HCs to deliver quality services. The findings are then presented and discussed at the HCMC meeting.

The HC in KSP2 presents another model of monitoring. The HC has been subject to joint monitoring by an NGO (RHAC) and OD staff through a satisfaction survey, which is done as a part of its project implementation, with randomly sampled HC clients. The spot checks covered 20 percent of the total number of villages served by the HC. The findings from the survey are checked against the monthly reports submitted by the HC. The findings of the survey are then presented and discussed at the HCMC. According to the interviewed RHAC officials, should the concerned HC disagree with the findings, more discussion can be undertaken at the OD level. If the survey reveals serious irregularities, such as informal fee charges for a delivery, RHAC might choose to freeze its support for the HC.

3.5 Summary

The VHSG plays the roles of a grassroots service provider and an intermediary for local health services; it is not a CBO that promotes active citizen engagement in health service delivery. The health sector has extended experience in reaching villagers through the establishment of de-concentrated service providers at the HC level, and by developing a cadre of outreach and prevention teams (i.e. the VHSGs) that communicate with citizens and users of health services, and feed information back to HCs. However, the current system, in which VHSGs act as grassroots providers, does not promote citizen engagement in primary health care decision-making (i.e. planning, budgeting, and reporting). The research also found that it cannot, by its nature and composition, promote mechanisms for users to hold government to account for health service provision. The VHSG does, however, link communities to providers and, at times, acts as an intermediary. While it is often assumed that the VHSG is a CBO, the research confirmed that it does not display the characteristics of a CBO that is able to convene villagers in a safe participatory space. The implication is that, at present, there is no system for the organization and mobilization of communities around health matters.

The HCMC is a supply-side vehicle to include other key, mostly government, actors and service providers in the management of local health centers. The HCMC facilitates roles for non-HC staff, especially commune councilors, to contribute to the management of the HC. The roles include planning, setting user fees, and managing budgets. In practice, however, depending on the leadership, the commune council role has been limited to agreeing on user fees, and referring clients with special needs to hospitals (and utilizing the commune budgets for this purpose). Both the VHSG and HCMC are impaired by low incentives and limited capacity of workers, resulting in high turnover; challenges that have only been overcome where NGO support is present.

Citizens do not engage in local health service delivery other than as users, and there are currently few vehicles established for participation, besides one-way flows of information. It is not uncommon for villagers to be discontented with the performance of HC staff; but few villagers, including those in leadership roles, take action, or bring their concerns directly to the HC or to the VHSG (even on a confidential basis through the complaint box). It is also rare that citizens communicate their concerns to commune councilors, partly because they do not see health as being a responsibility of councils. Citizen participation is limited to their receiving information through awareness-raising and outreach activities conducted by the VHSG and the HC.

At the same time, there is little demand by citizens for this opportunity to participate. This is partly driven by the lack of interest or opportunity to use their voice to improve the HC, and partly because citizens can opt out to obtain a higher quality service elsewhere. The research noted that citizens did not seem eager to demand accountability through voice and participation. While this attitude is unsurprising in the Cambodian context (and consistent with the findings of VCD1), increasingly, it reflects the fact that citizens have become more able and willing to seek services from nearby HCs and/or private providers (possibly as a result of higher incomes) and, possibly, the lack of understanding of what constitutes good health care.

NGOs have attempted to provide space for citizen participation in health service delivery mostly through their roles as service providers, but NGOs are also starting to mobilize health social accountability processes. In an *ad hoc* manner, and linked to the localities where NGOs are already working, the research also came across initiatives where communities were more effectively consulted to inform improvements in health services. These efforts pave the way for the formation of community groups, equipped with information on what to expect in terms of functions and performance standards, and thus more able to advocate for improvements in their local health services.

In their quasi-official and intermediary roles, village authorities and trusted community members engage in decision-making forums in a more substantial way - to some extent carrying citizen/user views. Village leadership (i.e. chief and deputy chief, literate and active villagers) fill the positions of the VHSGs, and participate in health decision-making forums (HCMCs, commune councils, and at times, OD/District meetings). They are reasonably well informed about policy and practice, and are consulted at meetings. However, a distinction must be made. It is this group of quasi-officials that are mostly paid for their state role – not ordinary citizens/users. As intermediaries, the extent to which these members effectively represent their communities varies by individual and village circumstance, but the research does illustrate that these individuals have a fairly good understanding of ordinary citizens' views (e.g., on user fees, health staff performance and attitudes) and, to an extent, represents these views. This can be constrained both by the individual style and by the lack of citizen voice or demand for accountability.

The HCMC has overall responsibility for health services, but is a multi-stakeholder committee comprised of commune leaders and health service providers. As management committees, HCMCs contribute to particular aspects of management and are aware of/manage complaints, but generally stay away from key decisions. In some situations, they have mobilized citizen participation, but do so from a position of authority. With regards to their oversight role, HCMC members who are not health professionals consider their lack of technical knowledge as a reason for not engaging in key decisions; they prefer to maintain harmonious relationships rather than actively engage, or simply do not have the time or incentive to play the role intended by the policy.

Upward accountability arrangements are established and functioning effectively. The institutional arrangements for the delivery of health services are largely focused on upward accountabilities to higher levels within the MOH. The monitoring systems established over the last decade function effectively, and are enhanced by NGO assistance. Incentives and systems that require staff to follow rules seem to ensure the required degrees of accountability to higher levels of government. It would also appear that this accountability relationship is prioritized over others.

Horizontal accountabilities are constrained by unclear mandates and roles. While there is a certain degree of horizontal accountability (mostly seen as accountability to commune councils), a primary impediment is the perception and understanding of the commune council mandate. This does not always fully recognize that the poverty reduction mandate of a council is linked to primary health care services, and that the councilors' elected role provides them with the mandate to hold local service providers to account. This lack of clarity is exacerbated by confusion regarding the role and function of the HCMC, with the inherent conflicts of interest in management and oversight – such as the opportunity for the chief of the HC to choose members of the committee. Horizontal accountability is

also constrained by the technical nature of the services being provided, and the long-standing view that health is for professionals, that laypersons are not qualified to comment. Moreover, village elders, are engaged in decision-making processes, often as members of committees, blurring the lines of accountability.

Downward accountability, the accountability of service providers to citizens, is limited. A number of reasons were identified for this. First, although the policy requires the engagement of citizens, it is in practice limited to the engagement of the village elders, who play dual roles. Accountability to citizens is diminished by the lack of direct opportunity. Occasionally, downward accountability has been achieved through NGO activities that promote appropriate vehicles, clarity in roles, and forums for dialogue. Second, the systems and structures (i.e. the HCMC and the VHSG) established include staff/service providers themselves, making it difficult for lines of accountability to be established. Third, the number of decisions made locally is limited. Providers cannot be held accountable for things they cannot change (e.g., the availability of medicines in health centers). This problem is not only a result of the systems established in the sector, however. The research also revealed a fundamental lack of demand for accountability, along with the lack of demand to participate. The case studies revealed that citizens are increasingly opting out of their local health services, rather than holding local service providers to account.

CHAPTER 4
VOICE AND ACCOUNTABILITY IN EDUCATION

Cambodia has made remarkable progress in improving access to education in the past decade. The Royal Government of Cambodia (RGC) is on track to achieve the 2015 CMDG targets of improving the Net Admission Rate (NAR) and the Primary Net Enrolment Rate (NER), with reduced regional disparities. The expansion of school infrastructure, training and deployment of teachers, and a reduction in cost barriers for parents have contributed to these advances.

The sector still faces significant challenges however, especially in terms of improving service delivery at the sub-national level. This chapter begins with a brief policy overview, including the participation and accountability envisaged in the education sector. The key actors are introduced, as well as the proposed role of the School Support Committees (SSCs), the main platform through which community voice and participation is anticipated. This is followed by a presentation of the empirical findings of the participation and accountability structures found, in relation to schools in the communes studied. The chapter concludes with a summary of the constraints to voice and accountability, and what steps are needed to bring implementation in line with policy.

Issues to be addressed and indicators of enhanced education services in Cambodia

Most schools in rural areas lack key inputs to improve the quality of education (e.g. qualified teachers teaching a minimum number of hours, textbooks, reading materials, laboratories for science and qualified school principals) and even urban schools lack some of those inputs. Not all teachers perform their assigned tasks as stated in Teacher Professional Standards. As a result, classroom tests are not conducted regularly and the results from classroom tests are not universally used by teachers to help slow learners. Student books, intended to record student results and inform parents, are not completed and teacher-parent discussions are rarely held. School support committees do not have the capacity to produce the school development plan which is the instrument intended to address the problems of individual schools. The MOEYS has strengthened the quality of sector plans to address these issues, however linkage between the central and sub-national plans are not yet in place.

Government introduced school operational budgets in 2000 to improve the quality of education provided in schools. The effectiveness of teaching depends on how the school operational budget (SOB) is spent. The rules applied to school budgeting require certain percentages to be spent of the five expenditure categories (with 4 disbursements annually), the rules do not allow school support committees to spend the school budget on specific needs (the right things) or at the right price. For example, SSCs are not permitted to exceed a certain budgetary proportion on teaching and learning materials. Moreover many schools in rural and remote areas do not have electricity and piped water to pay for, but are not permitted to use that allocation to fund other needs. Delegation of the responsibility for SOB to the School Support Committee to ensure expenditures are relevant to individual school needs has not been possible to date.

Over the last 4 years, through the pilot of school improvement grant under Education For All Fast Track Initiative project, 650 schools have improved education outcome indicators. The education outcome indicators include and will be rolled out within the Education Strategic Plan 2014-2018.

- the enhanced role of the school support committee in overseeing the school budget
- drop-out rates
- increased enrolment of poor students
- a measure of the improvement of overall student performance.

Input provided by Simeth Beng, World Bank

4.1. Sector Overview and Policy on Participation

4.1.1 A Brief Sector Overview

The main policy governing the education sector is the Education Strategic Plan (ESP 2009-2013), which aims at promoting access to, and quality of education, and institutional and capacity development for decentralization in the education sector. Currently, the focus of the Ministry of Education, Youth and Sport (MOEYS) is basic education, within the context of its ESP, using budgetary resources from both the government and development partners. The pattern of funding indicates that the education sector is almost as donor-dependent as the health sector. Historically, although the national education budget has risen from US$123.5 million in 2007 to US$229 million in 2011, foreign aid and NGO support remain critical. Moreover, the trends in the allocation of total government recurrent spending on education are concerning, decreasing from 19 percent in 2007 to 16 percent in 2012. Meanwhile aid disbursement to the sector has increased from US$80 million in 2006 to about US$125 million in 2011, while NGO support allocated for the sector has increased from US$28.7 million in 2009 to US$35 million in 2011 (RGC 2011).

Administratively, the education sector is divided into national, provincial, and district levels, as well as clusters of schools, and individual schools, all of which have defined functions and responsibilities. The national level is responsible for strategic direction, policy development, national budgeting and meeting ambitious education targets. The Provincial Office of Education (POE) is responsible for leading and managing the sector in the provinces. The District Office of Education (DOE) interacts with schools in the district through regular reporting and meetings. The interaction is mainly to provide instructions to schools on how to perform their roles, which include implementation of educational programs, enrolment of students, compiling statistics on students, managing the school budget, conducting evaluations of staff for promotion, managing and delegating responsibilities to each staff person within the school, preparing teaching material, and developing other educational activities (MOEYS, 2010). To ensure good compliance with these instructions, DOEs are expected to conduct regular school monitoring through the District Training and Monitoring Teams but this is not tied to any school incentive scheme.

At the school level, a School Development Plan is prepared and approved by the DOE every year (see Box 4.1 below). In addition to teacher salaries, each school receives an operational budget called the Program Based Budget (PBB), which was introduced in 2007 following the Priority Action Program (PAP). The PBB, which is channeled to schools via the provincial treasury, the POE and the DOE, is a formula-based budget amounting to about US$1,200 for a primary school of 500 students.[26] The schools need to follow a specific guideline when spending the PBB. Despite some execution challenges (such as rigidity in quarterly budget disbursement), the PBB has proved to be a very helpful operational support for schools, although inadequate to cover all recurrent expenditure. In addition to the PBB, schools might also receive direct support from NGOs and aid agencies, as well as non-educational support, e.g. the World Food Program (WFP) support for food for children.

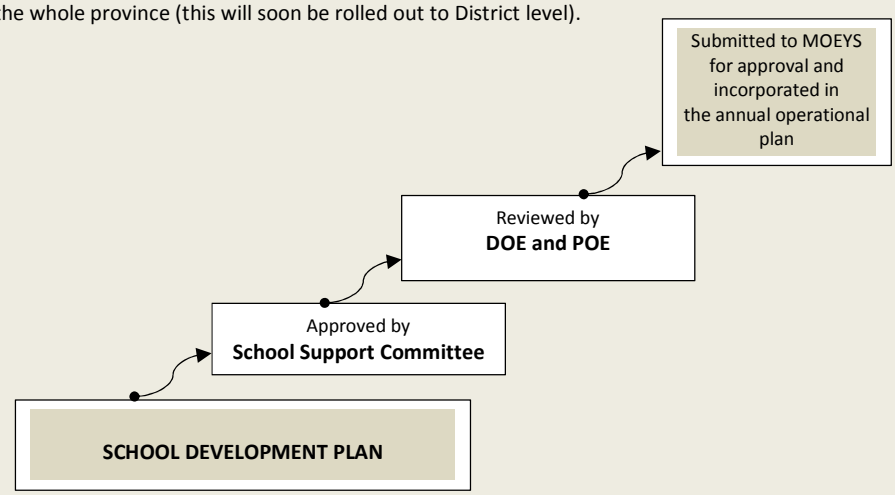
Box 4.1
Proposed Approval of School Development Plans

Every year, a School Development Plan is prepared prior to the new academic year. The plan includes key performance and outcome information, including:

- status of the students in the previous year;
- planned school construction activities (such as new or repaired classrooms);
- scheduled repair and maintenance for gardens and gates;
- the need for teacher capacity building;
- study materials needed;
- the annual program based budget .

[26]According to Prakas No. 191: For a pre-school, it is R200,000-300,000 per school, plus R6,000 for each student; for primary education, it is R500,000-700,000 for a school, plus R7,000-8,000 for each student; and for secondary school, it is R1.0-1.5 million for a school, plus R15,000-18,000 for each student.

Under the guidelines, the plan should be reviewed and approved by the school director, followed by approval from the School Support Committee (SSC), after which it is sent to the DOE for further approval. AOPs from all districts are sent to the provincial level to be compiled, and become the education AOP for the whole province (this will soon be rolled out to District level).



4.1.2 Community Participation in Education Policy

Key policies in the education sector emphasize the need for community participation, especially of the commune councils, to help ensure equitable access to, and quality of basic education. The ESP (2009-2013) expresses the need for "enhanced/community involvement in all stages of schooling, especially by commune councils." The Child Friendly School Policy also stresses the importance of community engagement "to enhance the dynamic relationship and two way participation between schools and communities so that schools become community-supported resource centers, where children, families and communities become resources for school improvement and play an active role in management."

In 2009, (approved 2012) the MOEYS issued a guidebook on the relationship between schools and communities. According to this guidebook, to promote community participation, the school needs to arrange various activities to interact with parents, including the annual school opening events, occasional community meetings on certain issues related to schools, and visiting student families in trouble. In addition, various committees need to be established at the initiative of school directors, including the Education for All (EFA) Committee at the commune level, the SSC for each school, as well as various study clubs.

Education for All Committees. According to Sub-decree No. 84 (2001) on the Creation of National Education for All (EFA) Committees, the committee is made up of the Commune Chief as Chairman, an Education Officer as Vice Chairman, and School Directors and Village Chiefs as Members. The roles of Commune EFA committees include:

- developing EFA implementation plans to achieve EFA targets;
- engaging local stakeholders in implementing activities set out in EFA plans;
- making financial decisions with respect to the allocation of resources to achieve EFA targets;
- coordinating activities with those of other relevant stakeholders in respective local institutions;
- regular monitoring of progress towards EFA targets.

School Support Committees. Based on the official guideline of the MOEYS issued in 2002,[27] the SSC is supposed to have various roles and responsibilities ranging from school budget management to helping ensure education quality. More specifically, they include:

- raising community contributions and assessing the needs for new schools;
- strengthening engagement on curriculum and making school plans pertinent to children's basic learning needs (including becoming a "friendly school environment");
- developing plans for purchasing school materials and making decisions on school expenditures;
- monitoring the quality of teaching and learning; and
- understanding pupil drop-out.

The SSC consists of approximately 10 members selected from the community. The committee members are typically commune chiefs, village heads, other elders in the community, and school principals. Other teachers and villagers, including pupils and their parents, can, according to policy, also be members (MOEYS 2002).

4.2 School Support Committees[28]

4.2.1 Structure and Membership

In the visited communes, the primary mechanism for school interactions with communities is through the School Support Committee (SSC) and one SSC was attached to each major school.[29]

Membership. The SSC consists of five to ten (sometimes more) "respected citizens'" that are nominated by the village chief and/or commune chief, agreed upon by the school director, and approved by the DOE. Two or three members of the SSC are *archas*,[30] as they are widely trusted in the local community because of their age, reputation, networks, and connections to the pagoda. Most of the other members were commune councilors, village chiefs or deputies from the villages the schools serve. Although the SSC is meant to provide oversight and approvals (e.g. of the School Development Plan) in practice, the school director was found to be an advisor in some cases. These appointments rarely cause any controversy, since the SSC does not control any major financial flows. To serve on the committee is generally seen as voluntary work with few rewards, and no cases of serious internal conflicts or complaints of manipulation were found in the communes studied.

The SSC is, by nature of this membership, not a user-group. The members are quasi-officials and/or selected through a top-down process from the local administration (the commune chief). Moreover, the members are either appointed or endorsed by the service provider itself (the school principal). As such, it functions differently from a community-based group that provides opportunity for users to provide feedback on the performance of teachers, staff and school management. It is a multi-stakeholder group that mixes up the stakeholders , not a user or community group that could act as a vehicle for citizen voice or hold the school to account. The intention of the appointments of these groups seems rather to be aimed at finding community members that "represent" the community. The groups do not provide "safe spaces" for the community to voice their concerns, but they are established as intermediaries between the schools and the local authorities.

[27] The Minister of Education endorsed a formal Guideline on primary SSCs in September 2012, which includes details on the role of parents and community members in relation to the school. The research reflects the operational environment before that guideline, though little change would have been made in recent months.

[28] In the communes visited, only SSCs were functioning. Therefore there are no empirical references to the EFAs in this section.

[29] In cases where there were minor or very remote schools (as in some villages in BTM2) and the community has been unable to gather enough volunteers to fill a full SSC, there is often an ad hoc body led by the village chief with similar, albeit with less formalized tasks.

[30] Traditionally the *archa* is a trusted and respected figure, close to the monks, who has had the opportunity to show virtue. They typically have good relationships with villagers.

In all six communes studied, the SSC had been established, but the commitment, depth, and degree of power exercised by each SSC varied widely, as did its identity as a "committee." While the committee members in these communes usually include individuals who are trusted by the local community, and are perceived to have relatively reliable opinions on the activities of the school, the research found that there is no direct citizen or parent participation in the SSC – villagers do not have the ability to change the committee's composition or express their views through the committee.

Even though the committee does not promote participatory processes, it is however integrated in the community and is more likely to be effective in interpreting villagers' sentiments than a limited number of open village meetings. Often, key persons in the committee maintain dialogue with villagers, consulting them to learn about issues and preferences. This does engender a level of accountability. As seen in Box 4.2 below, the *archas* maintain a sense of accountability vis-à-vis the community and exert leverage through the respect they gain. Here, as in many other processes, a form of indirect participation is at work.

Box 4.2
SSC and its Interaction with the Community

In KSP1, there are eight primary schools, each with their own SSC. In addition to the School Director, who serves as the advisor/convenor, each SSC is composed of about five community representatives formally recognized by the DOE. *Archas* play active roles in the SSCs in KSP1. In 2010, for example, these *archas,* together with the village and commune chiefs, mobilized villagers to contribute cash to help a school. Many people claimed to contribute, citing the perceived trustworthiness of these *archas* based on previous successful fundraising efforts. Interviews with village and community authorities also indicated that they have been working with these *archas* on various matters, especially those related to community events and construction of school buildings. In addition, the research showed that the *archas* had been living in their villages for decades, they know almost all villagers, and were well informed about village issues and needs.

Village elders or *archas*. To a large extent, the *archas* and active villagers see SSC membership as an extension of other community work they have been engaged in, such as the pagoda committee. The main incentive for some *archas* to be willing to participate within the SSC, as well as other local committees (especially the pagoda), is to build a better image and enhance respect and trust from other villagers. However, the research also indicates that this reputation can also lead to indirect financial incentives. For instance, a respected *archa* in rural Cambodia, especially one who is seen to be active in society, is often invited to lead a religious activity of a household, which results in a small cash payment to the *archa* (US$1.5-5). Although this is a small amount, it can be very helpful for some senior villagers who can no longer farm and do not receive regular support from their children.

Another expected reward from serving on the school committee is a chance to be seen as associated with government affairs and with external elites, such as NGOs, politicians, or wealthy philanthropists, who seek to engage the community through the *archa*. That is, association with these external actors improves and consolidates the *archa's* position within the community. One SSC member explains:

> *Now, I am 60 years old and I need to go to find 'thoi' (religion) in the pagoda, and help the monk in his construction. In 2008, because people trusted me, I was chosen by the commune chief to help raise money to buy land for building a secondary school… Besides the pagoda and school work, I sometimes get invited to help lead ceremonies that people hold. Sometimes, they offered me R5,000 and R10,000 or some food or tea just to appreciate my help… I am old now, living with my married daughter and can only help look after an ox which I would sell sometime soon…* (SSC member in KPC1, Interview).

School Director. The role of the School Director is very important in setting up the SSC, and keeping it active. The School Directors in the communes researched were found to be the key actor, selecting appropriate members of the SSC. As a school director in KSP2 stated:

> *We have to be smart to choose someone to be a member of the SSC. We have to choose a person who is popular, active, has networks so that s/he can contribute much to the school* (School Director in KSP2, Interview).

The School Director, in this case, managed to form an SSC with 13 members, many of whom are influential people (e.g., two commune councilors, village chiefs, and *archas*) and all of whom have been able to help with the funds for constructing buildings and developing the school environment.
The nature of the link between the SSC and the Commune Council varied in the cases studied. In some cases, this is established by the appointment of a Commune Councilor to the SSC, whereas in others, the link to the Council is indirect – through the appointment of the village chiefs and their deputies. There was some suggestion that the village level appointment is more appropriate for primary schools, and the commune appointment for secondary, but there were variations to this.

4.2.2 Roles and Responsibilities of the School Support Committee

Fundraising. Evidence from the research suggests that the primary role carried out by the SSC is the collection of financial contributions for the construction, extension, and renovation of schools; and that this is consistent with the broader role traditionally played by *archas* and village chiefs. This is not unexpected from pagodas – raising money locally for school improvements is generally accepted and undisputed. The SSC plays an active role in raising local contributions, making links with other potential donors (e.g. CPP Party Working Group members, Cambodians expatriates, NGOs, etc.), and with the DOE, which might help make that connection. Although fundraising for school construction was a common SSC role in all the schools visited, there did not appear to be much accountability demanded by the households making these contributions. The contributions are not entirely voluntary but they do not always come with any potential influence over how and where a school will be built.

Archas and village chiefs often request contributions based on the economic position of the household (the contributions requested from poor households are minimal). Although it is possible for an individual household to refuse to contribute, in practice, the social pressure exerted on these households makes this unlikely. Typically, during religious ceremonies, the names of people who contributed to the school project are publicized over loudspeakers. It is a source of pride to be named on these occasions, and conversely, a source of shame to not have one's name called. As one villager stated:

> *I do not have much money to contribute, but [….] I have to since it is hard to say no. And, I even feel embarrassed if I don't, as I heard and saw [that] other people contributed in the religious ceremony* (Villager in KPC1, Interview).

School budget management. Evidence from the research also suggests that, although mandated by policy, the role of the SSC in school budget and expenditure management has been largely limited to rubber-stamping expenditures and the decisions made by the School Director. The SSC does not hold the School Director accountable in any way for financial matters. As this is the only oversight mechanism in place at the local level, this means there is no oversight mechanism for school budgeting and expenditure. The SSCs rarely alter or scrutinize the budgets presented to them annually. The reason appears to be twofold: (i) there is limited discretion in the formulation of the budget (the SSC is really only ensuring that the budget includes the required budget lines); and (ii) any inquiry by the SSC would be seen as a declaration of mistrust vis-à-vis the school leadership. In order to protect social harmony, this is usually avoided. According to one SSC member:

> *I never check or ask what the school money is used for. I just sign the document to acknowledge it as required. If I do, it seems I do not trust the School Director and we would then feel uncomfortable working together or meeting each other…* (SSC member in KSP2, Interview).

Engagement on the curriculum and quality of teaching. Similarly, the SSCs rarely intervene in matters regarding the curriculum, teaching techniques, staff, or quality control. This is explained by the common *perception* (of both villagers and the SSC members) that the SSC's oversight role is limited to construction-related work, while teaching is a technical and management issue that should be under the authority of the School Director and the DOE. According to the research, the oversight role envisaged in the policy is neither known nor put in practice. As one SSC head in KSP1 described:

> *I can raise lot of money from local people and especially from people abroad to build and repair the school. This is what I can do, but I do not have much time to get involved more in school management and the quality of teachers. Let the School Director do it because he knows more about the school* (SSC head in KSP1, Interview).

Making the school a friendly environment. The research found that SSCs engage in those roles associated with making a friendly environment. This might include arranging a "first day at school event" (*pakvesanakal),* or soliciting rice contributions for breakfast/lunch for poor children, and draws the community into the education of the children.

Monitoring drop-outs. The research also noted that the SSC only rarely performs its role in relation to understanding and monitoring school drop-outs. In those cases that were identified, the SSC made home calls with the village chiefs and encouraged children that have dropped out to return to school. Although the evidence of this role was limited, it was noted that this monitoring was also carried out by teachers or by "friend-groups" of students looking out for each other (as in KPC2).

Beyond these activities over the past three years, SSCs in the visited communes did not hold any other open village meetings, or organize other processes for facilitating participation and engagement from villagers in the development of the schools. Typically citizen participation was warranted and sought only when there was pressure for, or agreement on, the need for a new, extended, or renovated school (indirectly demanded from citizens). The SSC often responded to this and started fundraising through the *archas,* who would take on the task of collecting funds from the local households. In this situation, the SSCs hold meetings with the local authority and school management, so that they can help ensure that the proposals are in line with parents' expectations. While this process further explains the intermediary role of the SSC, and the adoption of informal and indirect participatory mechanisms, it also underscores that a measure of public trust exists between the *archas* and the parents, and that the parents are consulted in the process.

4.3 Participation and Choice – Voice or Exit?

Although community participation is encouraged in the policy, direct parental and community engagement in school matters is – as seen through the explanation of the roles of the SSC – limited to being informed about key school events and activities and making financial contributions for school improvements.

The research noted, however, that more direct parental and student participation occurs in a few annual events. This includes "the first day at school event" (*pakvesanakal*), as well as other outreach activities carried out by SSC members to encourage parents to send their children to school (often at the cost of the income the children would earn for labor). The research noted that such events usually provide a formal one-way communication channel and do not offer a wider problem-solving forum where the community has the opportunity to question the school management. Conversely, school management does not share any managerial concerns with the community at this forum (except for

some statistics on enrolment and drop-outs) and does not solicit community feedback. As above, frequently the "first day at school event" is used to appeal to parents to contribute cash, labor, or materials for school construction work. To this extent, the outreach activities consist of fund raising and awareness-raising activities rather than opportunities for communities to voice their concerns about schools.

According to interviews with SSC members and commune councilors, parents are not well informed about school management, including school budget management. The primary interaction with parents comes through the "study record books," which must be signed by parents every month, and the messages on free school registrations posted in school compounds. Although parents are able to provide feedback in practice, most parents just sign and return the forms. This passivity is very common in rural areas (such as KPC1, KPC2, and KSP2), where the literacy rate among parents is low and/or livelihood concerns often take priority over education. In urban areas (such as BTM1), anecdotal evidence suggests that parents tend to be more aware of school management-related problems such as teachers asking for informal fees.

The lack of active participation and engagement from parents in rural areas does not imply that they are content with the schools. On the contrary, evidence from the research shows that parents have several concerns, especially in relation to teacher absenteeism, poor performance, and misconduct. When confronted with such problems, the research revealed a number of choices made by parents; and decisions made by school directors and local leaders to improve school performance. The range of solutions initiated by school directors and community leaders, with some involvement from the community, include: hiring locally-based contract teachers with less formal education; allowing permanent teachers (who do not want to stay in remote areas) to sub-contract their positions to contract teachers; and allowing older children to teach younger children. The research did not find any discontent among parents regarding these kinds of solutions, or concerns that they would result in a lower quality of education.

Situations were also found where communities were directly involved in addressing problems. In BTM2, for instance, which is located far from the nearest town, the commune has had difficulty maintaining formal education institutions. Few schools have been built and it has been challenging to recruit people to teach there. As a result, state presence in education and support in the areas has lagged far behind other districts in the province. To address these shortcomings, and to keep up with the increasing need for schools, the community, under the leadership of the village chief, undertook to recruit local teachers, raise funds for salaries, "head-hunt" possible teachers based elsewhere, and provide certain benefits (e.g., sleeping quarters, extra rice, etc.).

While the BTM2 case is unique in this study, it emphasizes the importance of local leadership (in this case, the village chief). As a former Khmer Rouge-controlled zone, the local authority in BTM2 has experience in managing the needs of the community, rather than waiting for support from the higher level. In this case, the absence of central government support triggered the village and commune chief to take the initiative locally to improve schools rather than waiting for external or higher level assistance. The result was a better school than they had before (although without comments on how to further enhance the quality of teaching without support from DOE/POE).

Parents also exercise choice (rather than voice) when they have the economic capacity and the infrastructure and facilities are available (e.g., paved roads, constructed school buildings). In other cases where similar teaching problems persisted, parents chose to send their children to another school. The examples include KPC2 and KSP1, where improvement in road conditions and the construction of new schools have allowed parents to opt out of the nearest school, and send children to schools in nearby villages. In such situations, improved livelihoods and physical access has a tangible impact on the quality of education and Increasingly, households have the option to seek better quality education for their children, even if it comes at a cost. This also has an impact on the poor, who have less choice and less voice to make the existing schools better. In this regard, the commune council's widespread construction of roads (cf. VCD1) has facilitated greater choice in

service delivery. Again, this example emphasizes that exercising choice is a more common approach than exercising voice.

Box 4.3
Better Rural Roads, Improved Living Standards and Choice

In all the communes visited, rural roads and living have tangibly improved in recent years. In KPC2, four years ago this remote commune was disconnected from the closest towns due to the bad quality of the road that linked the village to the main road. Utilizing the Commune Sangkat Fund and with contributions from Plan International and political party sources, the commune now has roads that allow people to travel from one village to another, and more importantly, to schools and health centers. The road has made it easier to transport pregnant women to health centers and for children to ride bikes to school. Better roads, together with the small improvement in living standards (in this case, resulting mainly from planting and trading cassava), have not only improved access to public health services, but also expanded the range of choices available to citizens, by enabling them to seek alternative state service providers (e.g., a nearby health center) or private physicians, or to move children to better schools.

Finally, NGOs have developed a range of mechanisms to galvanize state-citizen dialogue. In BTM1, AMARA (Cambodian Women's Network for Development) provides a platform for villagers/parents and local authorities to discuss school matters and identify problems. In 2010, for instance, villagers were invited by the NGO to raise their concerns with the school and teachers. To make sure that the problems raised by villagers could be properly addressed, the *sangkat* played the role as facilitator, while the School Director was present to receive feedback from participating villagers. This meeting was found to be useful because the school weaknesses became transparent, helping the parents to apply pressure more effectively on the School Director. However, while the event coordinated by the NGO was helpful, like other NGO projects, it was not sustainable and did not continue when the NGO support ended.

4.4 Participation, Decision-Making, and Accountability

Unlike the health sector, which has generated some amount of upward accountability, education has not established a results-oriented monitoring system that enhances school performance.

Looking downward, the accountability of the school management and teachers to the community is also limited, perhaps with the exception of school construction, where local contributions had been solicited. This finding confirms the finding in the earlier Voice Choice Decision research, (VCD1) that local contributions do generate more interest from the community in watching over the local authority – communities feel more able and willing if their own money is a part of the effort, but as was stated above, there is little interest in close monitoring of events. Rather, it is vigilance against the possibility that their money being misused. This study also highlighted that key local leaders (i.e., local authority, school director, and *archa*) have a strong interest in maintaining their own image and popular trust. This motivates them to be transparent and accountable around the use of citizen contributions.

Community trust can be undermined when the people perceive that the SSC and local authorities have not kept their word (as described in Box 4.4 below). This point is consistent with a key finding in VCD1, which suggests that people will react when promises are broken. While this form of public trust does not point to the introduction of different or more meaningful forms of participation, it does suggest that relationships between villagers and the elite may be shaped by a certain variation of a social contract.[31]

[31] According to Scott (1976), this form of public responsiveness resonates with James Scott's concept of the "moral economy," which identifies a range of strategies that clients employ against their patrons in the absence of traditional accountability mechanisms. Since his seminal work, much analysis of the peasant dynamics in Mainland Southeast Asia has followed this logic.

Box 4.4
Villagers React to Mismanagement in Money Collection

This example provides insights into the quality of community participation and oversight of local service delivery. The KPC1 primary school was constructed in 2009. An external donor promised to build one school building with five classrooms. However, the donor required the School Director to provide land for the school building and the community members to contribute their labor in building the school. The School Director cooperated with the Commune Chief to invite the head monk, commune councilors, village chiefs, and *archas* to discuss this issue; however, regular villagers were not present, arguably due to the fact that the meeting took place during harvest season. The small group who attended the meeting decided that the whole community would need to help purchase private land, and each family would need to contribute 40,000 riels.

Once this decision was reached, a meeting with about 60 villagers was held to inform them of the contribution required. Some villagers felt that the contribution was burdensome, but agreed to contribute, because no one really objected, and the request from the school and commune chief was perceived to be reasonable. An agreement was reached at the meeting that the contribution would be collected starting from the time of the meeting until a few months after the harvest season.

Somewhat later, the school director called for another meeting to discuss the land refill that was necessary to construct the school. The committee decided to ask each family to contribute an additional 40,000 riels. While most people had agreed to pay 40,000 riels initially, they were later unhappy and confused. Some people thought that the *archas*, school directors, village chiefs, and others broke their promise by asking for the additional contributions. To mitigate this issue, the SSC members made a public announcement through the village speakers regarding the necessity of contributing the additional funds.

With respect to school management and teacher performance, community mechanisms to hold schools accountable are even weaker.

- The *SSCs*, despite their formal roles in ensuring proper school budget management and overall school performance, are generally reluctant to exercise such authority, fearing that it might imply a lack of trust in the School Directors, and cause discord in local relations.
- The *Commune Council* plays an even weaker role. First, the fact that there is no explicit role for the commune authority (as there is with the HCMC) makes commune chiefs and councilors very reluctant to step into what they consider to be the domain of the Ministry. Second, the only formal interaction between the commune councils and school directors is the monthly commune meeting, in which many issues (not just education) are discussed. The monthly meeting is also driven largely by reporting, without real debate on issues. Interviews with commune councilors indicated that at these meetings, the school director only reports on student statistics and makes requests for the commune and village authority to assist in encouraging drop outs to go back to school. They do not report on the school budget, teacher performance, or parental complaints.
- Although *parents* are generally poorly informed, show little interest in school management matters, and have few opportunities to hold school management and teachers to account, the study found that parents might take action with respect to teacher performance in response to serious and obvious breaches of proper teacher behavior. In such cases, parents might approach the school director to complain, or they go to trusted authorities, such as village chiefs and *archas,* and ask them to take action on their behalf. Interestingly, even in such cases, parents do not see the SSC as playing an institutional role, but rather as a group of individuals that can be approached, and who they can, or should use to channel their voice or demand accountability. In other words, the SSC, for all the reasons set out above, and particularly its mixed membership, has not managed to establish itself as a local institution with an accountability role.

Box 4.5
Weak Leadership, Public Trust and Choice – A School in KSP2

In 2008, a school in KSP2 had a long history of mismanagement: some teachers came late or were frequently absent. According to the interviews, two teachers showed little interest in teaching, even when they were present. In spite of several notices from the school, there was no improvement and the school director reported them to the DOE. As a result, the teachers were removed from their positions in that school (it is not clear if they were transferred to other schools or not). At the request of the School Director, three new teachers were sent to replace the two in the following year. This example suggests that there is some precedent for internal checks and balances.

However, the most significant issue at this school was the behavior of one teacher, who was frequently drunk during school hours, and when teaching. Parents found this behavior unacceptable. Some decided to send their children to other schools, even though they would need to pay for transportation. Other parents complained to the village chief, who was also, in this case, the head of the SSC. He brought this issue to the school director for discussion. The school director warned the teacher on several occasions, but there was no change in his behavior. The village chief also raised this issue at appropriate meetings—for instance, at a workshop in KSP province. Despite his efforts, the department did not take any serious action, but the school director was pressured to take action. In late 2011, the school director called a meeting of all teachers, and also made an agreement with the misbehaving teacher to be compliant with the teachers' code of conduct. The director also told him that he would be transferred to another school if he did not conduct himself appropriately. The teacher is still employed – although it is questionable if his performance has improved.

Upward accountability mechanisms are embedded within the school management system and in the reporting and inspection mechanisms that exist between the school and the DOE. However, the study found that, compared to the health sector, these mechanisms have been less effective in producing the right incentives for schools and teachers to perform better. In each school, for instance, there are three committees that deal with personnel issues that are meant to help improve teacher performance: the Staff Evaluation Committee, the Disciplinary Council (which solves teacher problems and can impose administrative sanctions on educational staff), and the Competition Committee. In practice, these bodies (especially the Disciplinary Council), have had limited influence over teachers who are underperforming or committing wrongful acts, largely because they have no decision-making power. They can only refer cases to the DOE and POE. Moreover, the DOE and POE do not have authority to sanction teachers, but refer these matters to MOEYS for final approval under a process which is very time consuming and thus rarely used.

Under these circumstances, accountability relationships are confused and/or limited. Figure 4.1 provides an illustration of the local roles and relationships that need to be addressed, if actors engaged in the provision of education services are to be held accountable.

Figure 4.1:
Voice and accountability relationships in education

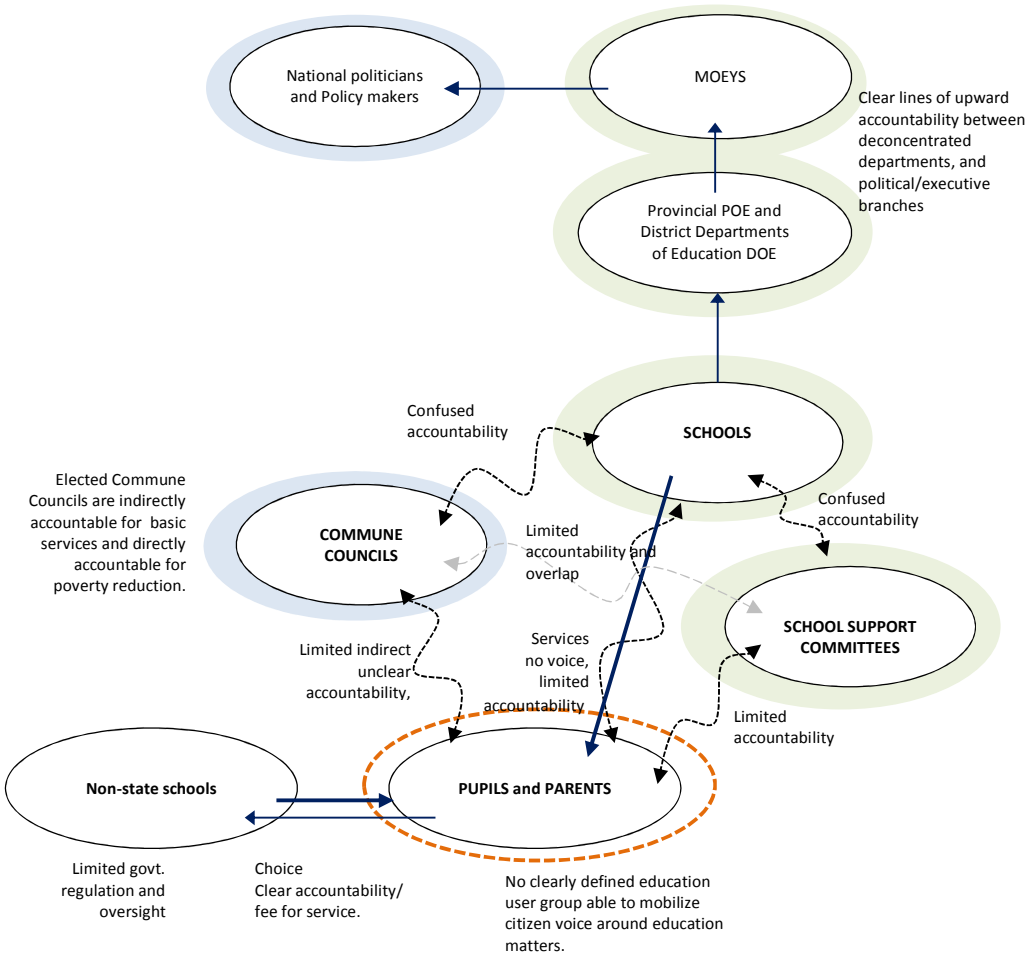


Table 4.1: Policy and Implementation – Education

	Policy /Education Guidelines	Implementation – Findings
Target (2009-10)	Primary Net Enrolment Rate 96%, (96% female) ECE enrolment of 5 year olds 50%	94.8%, (94.6% female) 39.8%
Services (2009-10)	Pupil teacher ratio primary: 45% Survival rate (Grade 1 to Grade 6): 75% Textbooks pupil ratio in primary: 4.0% % of schools audited annually: 5%	49.2% 61.7% 3.3% 1.1%%
Policy for voice and participation	Community members are to play an active role in school management.	In practice, community role limited to activities that are "helping out" not those holding school management to account.
Organization at community level • Membership	School Support Committees (SSC) Mixed stakeholder organization comprising "respected citizens" drawn from local communities (Village Chiefs and *archas*). School director serves as an advisor.	Mostly executed according to the guidelines. 5-10 members nominated by the village chief /commune chief, always includes a few *archas*, and is agreed upon by the school director. Membership is not contested as it is unpaid work and it does not control significant financial flows. The school director acts as an advisor in most cases. The policy calls for a mixed stakeholder group. The result is a group that has little distance from the school management and mediates between school directors and the community for specific purposes.
• Roles	School support committees established to: – Generate community contributions – Engage on curriculum – Create a child friendly environment – Review purchasing and expenditure plans – Monitor teacher quality – Address pupil drop out	Yes, effective. Role in management is limited to construction and fund raising. No. Yes. Events planned to support schools. No. Limited, rare. Limited. Although key individuals (village chiefs) follow up
Institutional responsibility • MOEYS	Policy development and oversight Sets budgets Monitors??? Sanctions for non-performing teachers	Policy development carried out but with little oversight or corrective action. Sanctions on non-performing teachers difficult to realize.
• POE/DOE	Accountable to MOEYS Compiles school development plans Monitors	Upward accountability from school to DOR, school development plans compiled. Almost no monitoring unless supported by NGOs.
• Commune Councils	The Commune Council role in education is mandated through its role to reduce poverty in the commune. There is no specific provision for Commune Councilors to be appointed to the SSC.	In practice, Commune Councils are sometimes hesitant to get involved in matters they perceive to be Line Ministry. Some do however, providing the precedent for the Commune Councils to hold school directors accountable for the quality of education being provided in a community.
• International NGOs / Local NGOs	Alternative service providers.	NGO service providers offer households a choice of schools. NGOs supporting social accountability activities enhance the Council and parents voice to demand better services.

According to the MOEYS 2009 Guidebook, the DOE should communicate with the community to get their feedback about the performance of the schools in their localities. In practice, however, such communication has been almost non-existent. Instead, what this study found was the occasional school inspections conducted by the DOE. Interviews with selected schools and the DOE indicate that the inspection, which is supposed to occur twice a year, has been generally ineffective. Interviews with key informants at selected provincial offices of education and MOEYS indicate that, in practice, the inspection has not been regular, has not followed any established standard procedures, has been poorly funded, and in some cases, even created opportunities for corruption. Unlike in the health sector, inspection in education has not been tied to the incentive scheme (e.g. the PBB) that a school receives. Also, during each inspection, the inspectors mainly talk only to the school directors and conduct perfunctory checks on education facilities such as toilets and wells within the school compound. They do not engage with any community actors, including the SSC or commune councilors.

4.5 Summary

Active mechanisms to promote voice and participation in education matters are limited. Although various education policies have required the establishment of committees to promote community participation in education service delivery, such as the SSC, these committees do not include everyday citizens or users, they are limited to the elite members of the community.

The School Support Committee does not act as a group that promotes voice; instead, it is primarily focused on providing financial support. Despite policy to institutionalize the SSC to perform functions that: (i) help raise community contributions, (ii) engage in school planning, and (iii) oversee school budget management and school performance, in practice, the SSC has been active mainly in fundraising for school-related construction projects. This would appear to be attributable to three reasons. First, many SSC members are *archas,* who are familiar with community construction and fund-raising, but tend to limit their involvement to this task. Second, the SSC members do not perceive themselves as being competent in advising or controlling school management. Thirdly, SSC members are reluctant to monitor school performance and budget so as not to undermine the relationships they have with school directors, or cause disharmony in the community.

Examples of community and parental "participation" beyond financial contribution are rare, but exist in areas that demonstrate strong local leadership. Low literacy levels and/or other livelihood commitments, as well as the current membership requirements of the SSCs, prevent important community inputs to the school management, especially in rural areas. As a result, interaction tends to be limited to mere information-sharing in these areas. In urban areas, parents are more informed and attentive. Exceptions to this limited community participation were found in several remote areas where state support for education has been limited. In these situations, communities pro-actively identified ways to make their schools function. Yet even in this case, it should be noted that citizen participation from villagers is largely still limited to making financial contributions. Strong local leadership is imperative to realize change to this social pattern that is characteristically Cambodian and has been noted in other studies.

NGOs have occasionally and successfully provided space for greater citizen participation, but efforts are not sustainable. NGOs have developed a range of mechanisms to galvanize state-citizen dialogue, such as facilitated community meetings where villagers, parents, and local authorities discuss their concerns regarding education services. On these occasions, state-citizen consultation or even cooperation takes place. While the meetings have largely been successful in providing a safe space for dialogue and a venue to apply pressure on school management, the meetings end once the NGOs complete their work in a particular project or community.

There are effectively no forums or attempts to engage parents in consultations over education services. Cooperation with the community is generally not achieved or sought, aside from

interventions by NGOs and the self-help arrangements that could be found in very remote areas where the communities are accustomed to caring for themselves.

Village elders – locally influential individuals – have access to the SSC and are able to represent parents, but do so only as a last course of action. Local elites intervene on behalf of communities in rare circumstances. They make up the SSC and are equipped to be fully informed, and to establish high-quality information-sharing with the school management. Despite this, they tend not to intervene with "everyday" issues – they feel neither empowered to, nor capable of doing so. Neither are the parents, as they typically have very little (and low-quality) education themselves.

School management is left to school directors and there is no real oversight at the community level. Although the SSC is not prevented from engaging in more depth in the management of schools, it rarely does so. When the SSC is mobilized to support school affairs, it focuses mostly on fundraising. The low capacity and education of parents in the community, the widespread tendency to avoid situations that create disharmony, the lack of time and/or incentives, and the assumption that schools are functioning well, mean that complaints are infrequent, engagement is minimal, and the SSC does not provide community level oversight.

In terms of downward accountability, villagers tend to be unable to demand accountability for the quality of education. The area where regular citizens are able to demand limited accountability is primarily for school construction, in which they make individual financial contributions. SSC members and school directors are more careful in managing community contributions and delivering on promised improvements. They are aware that if they mismanage community money, they will lose the trust of their communities and thus discourage future contributions. Parents are also seen to demand accountability in situations where the poor performance by staff has become too obvious and extreme. In such cases, citizens engaged the local elite (mostly village chiefs) as intermediaries, rather than deal directly with the SSC.

The upward accountability to the MOEYS representatives at the district level remains weak. Mainly due to the weak monitoring mechanisms, and the absence of explicit links between incentive schemes and performance evaluations of the school or individual staff members, schools are not being held accountable to the DOE and the DOE is not particularly accountable to the national level. Moreover, the sheer weight of monitoring school performance in a vast number of schools in each district overburdens the capacity of the DOE.

The mechanisms and policies for accountability from the school to the SSC, and from SSC to the commune council, are in place but remain undeveloped and inactive. The study observed a few cases – such as with inappropriate teacher conduct – where these mechanisms were useful, but these were exceptions. In general, the SSC is reluctant to exercise its formal role in ensuring proper school oversight. Commune councils do not always exercise their mandate for poverty reduction, or fail to perceive the linkages between education and poverty reduction, and thus consider an accountability role to be outside their domain.

These conclusions suggest that voice in relation to education matters is heard only indirectly through intermediaries, and often via informal discussions with individuals in the SSC. Along the "ladder of participation," it is only on rare occasions that community participation becomes anything more than information sharing or consultation. Accountability is weak in each direction: upward (e.g., inadequate monitoring and incentive systems), and downward (e.g., no direct avenues for citizens to articulate demands). The accountability arrangements at the local level are confused, both in policy terms, through the mixed (provider-official) and elite membership of committees established to promote community participation, and in implementation. The opportunities for participation and voice that are presented are not executed to any significant degree.

CHAPTER 5
VOICE AND ACCOUNTABILITY IN RURAL WATER SUPPLY

Although Cambodia is richly endowed in fresh water resources, levels of access to clean water are still low. Forty percent of Cambodia's rural population had access to clean water supply in 2008. As a CMDG, the RGC has committed to increase this coverage to 50 percent in 2015 and 100 percent in 2025. With such low coverage, policy makers and service providers will both need to exhibit high levels of accountability and responsiveness to the needs of rural communities, if these high targets are to be met. Documenting the research undertaken in the same six communes, this chapter considers the voice and accountability mechanisms that are at play around rural water supply in villages in Cambodia. As in the health and education chapters, it considers the policy context for rural water supply, with respect to the roles and responsibilities of national and sub-national actors, and community participation. It then disaggregates the de facto situation in relation to two primary sources of rural water supply, and sets out the dynamics of villagers' access to water supply.

Issues to be addressed and indicative indicators of enhanced rural water supply in Cambodia

Despite the increase in rural access to improved water sources from 29% in 1990 to 58% in 2010, persistent challenges in rural water service delivery remain. Overall, service provision in rural areas is at quite basic levels with only five percent of rural households accessing piped water supply through local private operators, and the majority of rural households relying on communal facilities of some sort, such as ponds, boreholes, protected dug wells, complemented with the seasonal use of rainwater. Service delivery for rural water supply through the mandated Ministry of Rural Development is very thin on the ground and mainly follows projects of development partners and NGOs, installing communal facilities. In areas, without such "project-support", rural water is simply a matter of self-supply, with better-off households investing in their own wells, or through local self-help groups, occasionally supported by commune councils.

The safeguarding of adequate water quality is also problematic, as no routine water quality monitoring system is in place executed by MRD, other than the initial testing of water quality in externally supported water supply projects. This means that those communities relying on self-supply could be at risk, especially in arsenic-contaminated areas of Cambodia. Moreover, there is no system in place to monitor the provision of rural water supply services and the functionality of existing facilities. MRD recently approved the Rural Water Supply and Sanitation Strategy, which outlines the expected roles of District Offices, Commune Councils and Village-level Water and Sanitation User groups.

The primary indicators that might be relevant in efforts to measure performance and strengthen accountability of such service delivery at commune level:

- Percentage of functioning water facilities in the commune as of total number of water facilities
- Percentage of water facilities routinely tested for water quality by the District Office
- Percentage of WSUGs meeting with their constituency monthly (evidenced by minutes of meeting)

Although rural water supply has not been assigned at commune level, there permissive mandate allows them to support rural water supply service delivery and hence the percentage of commune budget spend on rural water supply could be added to the commune level performance indicators.

Input provided by Susanna Smets, Senior Water and Sanitation Specialist, WSP

5.1 Sector Overview and Policy on Participation

5.1.1 Brief Sector Overview

The Ministry of Rural Development (MRD) has primary responsibility for rural water supply in Cambodia, and plays an important role in implementing, facilitating, and collaborating with national and international NGOs, and the private sector, in the provision of rural water supply and sanitation. The 2011 National Strategy for Rural Water Supply, Sanitation and Hygiene (2011-2025) determines the principles, strategic objectives components, and relevant operational approaches.

The primary constraint to water supply in rural Cambodia is the lack of national budgetary support to the sector. Funding available at sub-national level for rural water supply is limited.[32] The budget for RWS was approximately US$ 800,000 in 2011, 73 percent higher than in 2008. This amounts to about $US40,000 per district. Since 2008, roughly 60 percent of the annual budgets were spent on construction and repair of pump wells. Despite the increase, however, various reports (e.g. UNICEF, 2010) and the 2011 National Strategy suggest that the current national budget is far too low to meet the policy targets; the sector is also highly dependent on donor funding for all new RWS investment (including ADB, JICA, UNICEF).[33]

Currently, the state budget for rural water supply is located with the Department of Rural Water Supply in the MRD. This department carries out projects with central budgets, including construction of pumps and wells, repair of existing wells and pumps, rehabilitation of community ponds, and provision of water containers; and allocates annual resources to the Provincial Departments of Rural Development (PDRD) on the basis of the project location. In these cases, the PDRD and the District Office of Rural Development (DORD) officials play coordinating/implementing roles. As a result, the RGC budgets, over which one might expect to see citizen voice and government accountability play out, are not only low, but they are centralized, and the decision-making criteria around the allocation of projects is not transparent.

5.1.2 Community Participation Policy

The MRD is de-concentrated to provincial and district levels of government, and has mechanisms to work at the commune and village levels. This structure, however, does not assign functions or budgets – it is an arrangement whereby the sub-national levels of government have representatives at the lower levels of government, not one which passes down powers and budgets.[34] As mentioned above, the 2011 National Strategy for Rural Water Supply, Sanitation and Hygiene (2011-2025) determines the principles, strategic objectives components and operational approaches. The following roles and responsibilities aim to focus on voice and accountability relationships.[35].

- **MRD, central level.** It is the responsibility of MRD to facilitate and coordinate all NGOs, agencies who are working for the sector, PDRD, and water supply and sanitation providers, to promote the creation of Water and Sanitation User Groups (WSUG) for any new or rehabilitated Water Supply and Sanitation (WSS) system. MRD coordinate between sector stakeholders in order to make the

[32] PDRD and ODRD officials noted that budgets have declined considerably following the completion of the Seila initiative (an UNDP aid program in support of decentralisation and deconcentration).

[33] Typically, investment and activities relating to rural water supply include construction, repair, and operations and maintenance of wells and ponds, the provision of water storage facilities such as jars and water filters, and awareness raising activities, especially related to sanitation and hygiene practices. The needs for these different types of services, and the actual types of services provided, differ from place to place, depending on the accessibility, quantity, and quality of water sources – either from freshwater streams or underground sources.

[34] A functional mapping exercise is currently being carried out as a first stage in functional assignment for decentralized service delivery.

[35] A complete analysis of the roles and responsibilities of Cambodian institutions is provided in various documents including UNICEF 2011

best use of resources, to avoid the overlapping of responsibilities, and to provide support and information where needed. MRD disseminate the guidelines to all concerned with WSS.

- **PDRD, provincial level**. **DORD, district level**. The responsibility for rural water supply at the provincial level lies with the Provincial Rural Development Committee, assisted by the PDRD and the DORD, to implement MRD activities at the provincial level, including the coordination of people, contractors, and NGOs within its area. The PDRD is in charge of conducting regular testing (every 6 months) of all water points.

- **Commune Councils.** The development and construction of water infrastructure in rural areas is the responsibility of commune councils, and communes have ownership of systems created within their territories. Commune councils are mainly expected to: (i) attract investment for the development of rural water supply and sanitation; (ii) identify, plan, formulate, and if necessary set up the WSS; (iii) transfer the management of WSS infrastructure to WSUGs, and endorse their statutes; and (iv) analyze and validate the contracts entered into between WSUGs and private entrepreneurs. The Commune Planning and Budgeting Committee is expected to facilitate meetings for villagers to voice their needs related to water and sanitation, and exchange information with the council. The deputy chief in charge of social issues serves as the reporting focal point for the WSUGs chairs. When necessary, the commune is expected to create a commune water committee, that includes the chairs of the WSUGs and commune councilors, to coordinate water and sanitation activities at the commune-wide level.

- **Village chiefs.** The village chief should be involved in the identification and implementation of WSS as well as in the process of formation of WSUG. The village chief is expected to encourage people to attend meetings related to WSS identification, planning and implementation; bring forward needs at commune level; facilitate the establishment of WSUGs; follow up the implementation at village level; and report to the commune council about the possible problems occurring.

- **Villagers**. All villagers, whether or not they are users of the rural water supply infrastructure, are expected to participate in water needs assessments, identification, selection and implementation of projects; and in construction of rural water supply and sanitation facilities, especially by contributing to the project cost through provision of labor, materials or other means.

- **NGOs**. It is anticipated that NGOs will facilitate the establishment of a WSUG for any new or rehabilitated community WSS system within their working areas. They are expected to provide financial and technical assistance for the formation of WSUGs, vocational training for WSUGs on water point operations, maintenance and repairs, and other skills training based on community demands.

- **Private Sector.** The guidelines also envisage private entrepreneurs working with WSUGs on: (i) manufacturing equipment (e.g., jars, rings); (ii) supplying equipment such as spare parts; (iii) civil works, including drilling and construction of WSS systems; and (iv) assistance with the management of WSS systems (especially piped water systems). If WSUG boards want to contract private sector entities for one of these tasks, they are expected to contact the commune council to enter into an agreement with the private sector, and obtain support of the PDRD on technical issues.

A number of policy and strategy documents and guidelines for rural water supply set out the intended arrangements for the participation of the community, and the accountability of the government. These documents seem to increasingly include reference to these issues – while the documents are all broadly consistent, the details have been deepened as the RGC vision has been clarified.

A. The 2003 *National Policy on Water Supply and Sanitation* establishes the requirements for community participation. It requires communities to take responsibility for:
    - the establishment of the user group;

- the planning process, so that they (the community members) can receive a service that they are willing to consume and pay for;
- the financial management process, including the spending of available funds and the requirement for additional local contributions;
- the implementation of rural water supply investment projects, and making local contributions into the projects, including labor and in-kind contributions; and
- monitoring and evaluation of the water supply service provided, based on its actual outputs and impacts on health and well-being of the community.

The policy states that the role is to prepare plans, oversee the operation, maintenance and repair, and promote ownership over the provision of water and sanitation services, to ensure transparency and sustainability. In so doing, the policy establishes the good governance sustainability practices anticipated from the user groups.

B. In 2011, a new National Strategy for Rural Water Supply, Sanitation and Hygiene was adopted for 2011- 2025. MRD developed the Rural Water and Sanitation Supply (RWSS) strategy in a highly consultative process over the period 2008-2010 with development partner and consultant support. The 2011 Strategy outlines a number of key principles for rural water supply. A central principle of the strategy is **community-based management.** This includes:

- *Participation* – the participation of all members of the community in the development and management process
- *Responsibility* – the community owns and is responsible for maintaining the systems
- *Authority* – the community has the legitimate right to make decisions on behalf of the users
- *Control* – the community is able to carry out and determine the outcome of its decisions
- *Accountability* – the community must accept the consequences of its decisions and understand that it is accountable for its actions.

Another principle includes a **demand responsive approach** as the foundation for community management. This includes the principle that communities initiate requests for developing services, and that decisions are based on willingness to pay, cost sharing and 100% community responsibility for O&M. The principles establish the role of the "local authorities" to determine the exact contributions to capital cost; and note that operation and maintenance responsibility lies with user committees, through the WSUG, supported by a district level O&M support service. The strategy further states that the provision of rural water supply should conform to the D&D reform agenda. The formation and training of the WSUG is considered critical to ensure community participation, especially in managing the operation and maintenance of water supply systems.

5.1.3 Water and Sanitation User Groups (WSUGs)

In line with the 2003 National Policy, the Guidelines for the Establishment of Water and Sanitation User Groups (2005) sets out the objectives, composition, and roles of WSUGs, as the organizing structure for community participation in the water supply and sanitation sector.

- **Objectives.** The Objectives of the WSUG are to ensure that rural people have: (i) sustained access to safe water supply and sanitation facilities; (ii) sustained operation and maintenance procedures; and (iii) hygiene education for the benefit of all users in the area. The objectives also set out responsibilities of rural communities in relation to water, sanitation and hygiene.
- **Membership.** WSUG members are the head of each user's household who wish to access, and contribute to the capital and maintenance costs of, a water supply and sanitation community infrastructure (e.g., well, tube well, pond, piped water system or other). In the case of many wells within a village, one WSUG is required for each system.
- **Responsibilities.** WSUG members are expected to help identify and select the type and location of water supply; participate in the selection of systems they are willing to pay for; and contribute

cash, labor, or materials and land to support the construction, as well as operation and maintenance of the system. A number of special conditions protect how "very poor" households engage in the WSUG. All WSUG members of a community water system are required to sign statutes that set out the rights and duties of users, the conditions of access, the management system, and the expected contributions to the WSS infrastructure. The commune chief and PDRD validate the statutes.

- **Management**. Management of the WSUG is by an elected WSUG board consisting of five villagers, including at least two women. The WSUG Board has the overall responsibility for operation and maintenance of the water system. If the system is built on or near private land, the land-owner is also a member of the board. The board: (i) oversees contributions from WSUG members for operation and maintenance of water sources, and participates in determining the contribution; (ii) manages, maintains, and monitors the sources in a sustainable way; (iii) promotes, implements, and disseminates water use and hygiene education to users within the community; and (iv) communicates and collaborates with other rural water supply actors, including reporting to the PDRD if the water supply is seriously damaged, and the communities cannot effect the repair. The board is also responsible for a number of governance principles that have an influence on voice and accountability, including: (i) ensuring that the provision of water supply and sanitation services is transparent and equitable; (ii) participating in the preparation of village development plans relevant to water supply and sanitation services; (iii) engaging in solving water supply and sanitation related issues; and (iv) meeting with villagers to share results and discuss problems.
- **Capacity development.** MRD is in charge of coordinating the training operations for WSUGs, including: technical training (for the repair of hand-pump wells and information on spare parts and costs); water use and health education (e.g. maintaining and cleaning the campus of a water source and storing equipment, awareness building on the use of safe water supply, benefits of use of sanitary latrine); and management training to WSUG Boards (roles and responsibilities, leadership and organizational management, budget management, and monitoring and evaluation to WSUG..
- **Monitoring and Evaluation.** The performance of WSUG, and utility of the water supply system, is to be monitored under a number of conditions. Evaluation should apply during and after the construction, with regular check up every 6 months. The WSUG board and the commune council are in charge of supervising the construction or rehabilitation, with the support of PDRD. The WSUG Board and the commune council are in charge of regularly checking the functioning of the WSS systems (provision of water supply, hygiene around the WSS system), and report to PDRD in case of a problem. The PDRD is in charge of conducting regular water testing (every 6 months) of all water points.
- **Mandate.** The WSUG is meant to be recognized by commune councils and the PDRD, and that the PDRD will maintain and display the list of WSUGs and the level of operation of each related WSS system.

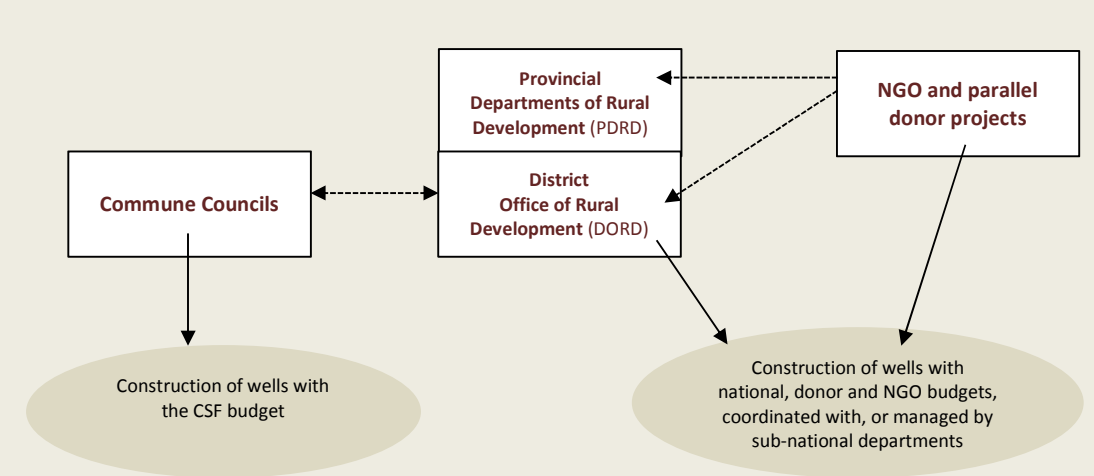
With regards to accountabilities, the strategies note that organizations have multiple accountabilities: downwards to electorates, beneficiaries, partners and staff; and upwards to higher levels of government and donors.

5.2 Key Actors in Rural Water Supply

In the communes researched, with the exception of KPC2, households use two sources for different purposes: (i) water from ponds and natural streams for drinking and cooking; and (ii) well water (of poorer quality) for bathing and washing clothes. In all communities, water storage is also a common practice, either in traditional jars (*peang)* or in trough storage facilities for rain water.[36]

[36] Household water storage is an important dimension of community water use but does not require participatory practices and is thus not the focus of this study.

Figure 5.1
Institutional relationships in rural water construction projects



New water supply and rehabilitation is financed through three different types of organizations and stakeholders:

- **MRD.** In two of the six communes (KPC2 and KSP2), PDRD were reported to have implemented two projects, involving the digging of five wells, and awareness raising activities on sanitation. The other four communes had no water supply projects directly supported by the MRD, and thus no opportunity to reflect on the voice of communities, and the way decisions were made. In the six communes visited, researchers found limited MRD presence through the PDRD or DORD in the villages. With this limited presence, it did not function as an investor nor as a capacity-builder, which was consistent with the budget data noted earlier.

- **The Commune Council**. The decision to invest in water supply, be it ponds or wells, and the location, is included in the CIP, a process that allows some measure of public voice to be expressed through village-level meetings (cf. VCD1). The research noted that, although water supply is the second priority (after rural roads) for CSF investment, given the limited resources in the communes visited, the responsibility for water supply has been passed down to villages over the last three to five years – often without financial or management support.

- **NGOs, political parties, and other village actors**. For ponds or wells funded by NGOs and political parties, the funders and the district administration/commune council come to a decision through a genuine consultation with a small group of local leaders, in an "invited space" similar to the decision-making in commune councils. While the local elites/elders largely make the decisions, this narrow form of participation, or elite capture of the investments, did not occur in the communities studied. (see Box 5.1 below).

Box 5.1
NGOs Support for Dug Wells

In BTB2, many villagers rely on ponds for their water consumption and cooking. Some people access water from the nearby natural stream, but wells are not common. In recent years, a new well was financed by the NGO *Action North Sud* in 2000. The well is located near a primary school, and the villagers report there was a genuine discussion when the decision was made regarding the location of the well. The NGO and village chief suggested that the well should be dug on the premises of one villager, who was willing to contribute his land. However, the director of the primary school requested that the well be placed near the school building, to avoid any traffic accidents when kids had to cross the road to fetch water. Everyone, including the supporting NGO, saw the logic of the director's proposal and agreed. The well is still in operation and maintained by the school.

5.3 The Dynamics of Voice and Accountability in Rural Water Supply

As reviewed above in examining the policy and key actors in the sector, investments and activities relating to rural water supply include: construction, repair, and operations; maintenance of wells, ponds, and less frequently, the provision of water storage facilities such as jars and water filters; and awareness raising activities, especially related to sanitation and good hygiene..

5.3.1 Community Ponds Management

Ponds are the primary source of water for drinking and cooking in the communes researched. They are highly valued and communities have a strong incentive to participate in their upkeep and maintenance. This stronger sense of ownership of ponds than wells appears to be because: (i) households are more likely to consider ponds public goods (i.e. resources for the collective benefit of communities/villages); (ii) they are usually located in public places rather than private premises and thus provide more constant freedom of access; and (iii) many of the ponds have existed for generations, and there is a strong sense of attachment by villagers.

In practice, the commune council, in its role as focal point for water supply prescribed by the guidelines, delegates the task of maintaining the ponds to appropriate village level actors. In the cases studied, this delegation was to two or three *archas* working closely with village chiefs. These *archas* are not elected, but rather are appointed to take responsibility for the village water supply, at the recommendation of village chiefs and with the approval of commune chiefs. The *archas* voluntarily maintain the ponds as a part of their traditional role; indeed, there were cases found where the responsibility passed down from *archa* to *archa*. They often try to delegate specific tasks e.g., construction of stairs and protective walls, guard duties to prevent animal pollution, opening water gates and filling the pond, and reserving the water for use in dry season.

To perform these tasks, *archas* raise contributions, both in cash and kind, from the water users in the community. The research indicates that a majority of the households make contributions when asked, although some do ignore requests repeatedly. As indicated in Box 5.2 below, two factors are critical when it comes to encouraging contributions. First, the *archas* are usually well-respected and trusted, which raises expectations that they will handle contributions wisely. This reputation does not, however, relieve them from being held accountable for delivering tangible results. The second important factor is cultural. Interviews reveal that, if the appeal is made from the pagoda, especially from the head monks, local households are willing to contribute to improve their standing in the community. This is, of course, made more difficult in villages that are small and/or remote, and therefore do not have their own pagoda or a cadre of *archas*.

Box 5.2
Archas Raising Local Contribution for Ponds

In KPC1, an old pond is the primary source of water for the village. The pond was rehabilitated with financing from the annual Commune Sangkat Fund in 2007. In 2009, the maintenance of the pond was delegated to two *archas*, and announced in a village ceremony by the village and commune chiefs. Prior to this, some older *archas* were looking after the pond, but, as they were too old to perform their duties, their tasks were passed down to the new *archas.*

In 2010, the newly appointed *archas* proposed that a fence be built to prevent animals from entering the pond area, and requested financial contributions from the villagers. Some contributed immediately after hearing the announcement, but others postponed their payments. To push the work forward and show people that the fence would definitely be built, the *archas* made a credit-arrangement with a contractor to start building the fence. As the collection process went on, the *archas* placed a speaker at the site and asked people to contribute. The *archas* explained that villagers often need to see things before they are willing to contribute, and it is better when *archas* take a risk and contractors commence the work without full funding. This is possible because of the moral authority of the *archas*, and because the commune chief supports the approach. If households do not pay, the *archas* will announce their names on the speaker or ask the head monk to intervene.

Collaboration between the *archas* and village chiefs/deputies is vital in managing community ponds. While *archas* are more effective in raising local contributions, village chiefs have the responsibility to resolve conflicts, and bring them to the councils' attention. They also carry more weight in enforcing rules with water users. More specifically, when there is conflict over water sharing, non-payment for bulk water supply[37] or pond pollution, *archas* seek to educate the villagers responsible. If the offenses continue, *archas* have no mandate to punish the offenders and they lean on the role of the village chief to apply sanctions.

The *archas* and village/commune officials are not only active in looking after existing ponds, but in some cases (as in KSP1), they also take the initiative to dig new ponds.[38] This might require significant investment and, in some cases, the leadership organizes to offset the cost by selling the excavated soil, or agreeing for a contractor to dig the pond from an agreed site in exchange for the soil removed. These decisions are made by the *archas* and village leaders.

The findings of the research, however, highlight that in those communes reliant on community ponds, WSUG Boards had not been formed, and it was thus not possible to analyze whether or not it functioned according to the policy, or whether it was an effective vehicle for citizens/users to communicate their needs and concerns about the access to water.

5.3.2 Wells and hand pumps

Drilled wells are the major alternative source of drinking water and serve about 25-30 households each. The village wells in the communes visited are built by NGOs and/or the MRD through the PDRD.

Under the Rural Water Supply policy, in areas where livelihoods have improved (even in the remote areas of BTM2 and KPC2), donors such as NGOs (as in BTM2) have introduced cost-sharing arrangements for the capital development costs of enhancing water supply. The cost-sharing requires beneficiary villagers (i.e., the 25-30 households obtaining water from wells) to provide matching contributions for proposed projects. In most cases, local people are willing to contribute, although there are also cases where this approach has not been accepted. This might occur due to a combination of factors: (i) inability of *archas* or the village authorities to coordinate and collect the needed matching contribution; (ii) a dependency mind-set among some villagers (see Box 5.3 below); and (iii) unresolved disputes with councilors, which resulted in a loss of trust in commune leaders.

Box 5.3
Community Collective Action Failures

In BTB2, where NGO support has been provided for over ten years, a village did not provide the matching contributions for a well for about 20 households. The village chief explained: "*When I went around asking for contributions, some people said the angkar (or NGO) might have already decided, so even if we do not make a contribution, they will still give us the wells."* As a result, the village chief dropped the matter, and the opportunity for NGO support was missed. A commune councilor from KPC2 complained that *"the Excellency, while helping people in his commune, has created a wrong expectation from the people in my commune. Now, my villagers expect that things will be given to them freely, and there is no need for any contribution from them."* However, interviews with citizens also found that, in the last five years, the commune has had disputes with the district and outsiders regarding community-land and forest. This has led to a loss of trust, and villagers were not willing to contribute to any activities initiated by the commune council or village authority.

[37] In one village *archas* decided to charge some fees for individuals who were drawing water in bulk for use during special ceremonies, such as a wedding. There were a few cases in the past where those people did not pay, and *archas* were not able to enforce payment. What they could do was to ask the village chief to intervene, but without certainty as to whether there would be action taken on the issue.

[38] This is similar to the SSC in the education sector which takes responsibility for constructing new schools.

Despite the policy regarding cost-sharing and community engagement, implementation encounters a number of political and attitudinal constraints. The intent of the policy is often hampered by local conditions as was found in BTB2 (see Box 5.3)

Role of the WSUG. In accordance with the 2003 National Policy, the 2005 Guidelines, and the 2011 National Strategy, WSUGs are usually formed when an NGO, MRD, or the commune council decides to build a well. In the communes visited, according to interviews with village chiefs and members of WSUGs, the five member WSUG boards were normally headed by the household where the well was located, with other villagers and/or *archas* serving as members. Village chiefs play key roles in suggesting, and in some cases appointing, the members of the WSUG board.

To help the board members perform their roles (and as required by policy), some NGOs provide training on maintenance and repair and also provide key spare parts. However, the research noted that these WSUGs have incurred serious problems in being sustained, partly because of a lack of capacity and regular support from the funding organization (NGOs, PDRD/DORD), and partly because members have not played the roles ascribed. Quality of drinking water also affects the formation and sustainability of WSUGs. In three of the communes visited (KPC1, KSP1, and KPC2), the quality of the well water is regarded as poor, its use is limited to bathing and washing clothes, and there is little interest in participating in the WSUG.

Without external support and the training envisaged in the policy – and frequently without follow-up – monitoring and maintenance efforts of wells decline rapidly. The WSUG Boards explained that it was difficult to maintain a well properly, and to motivate water-users without outside support – the committees had mostly ceased to operate within a year: "*Since this well was constructed, nobody [came] to ask us about it or follow up on the committee we formed."* The policy/strategy does not set out any financial or other incentive for WSUG Board Members (unlike the incentives available to VHSG Volunteers), and this affects commitment and performance of these volunteer committees. As a result, after that short period, the maintenance of the well usually falls on the household where the well is located. It then becomes a one-household decision whether they either abandon the well altogether, because they cannot afford to continue taking care of it (as in KPC1), or treat the well as their own. They also decide whether they will allow other households to use it. A WSUG Board member notes:

> *Usually, I look after the well alone. Previously, when I needed to repair the well, I used spare parts given by the NGO and asked other people to help with labor and cash. At first, more people contributed, but the well broke down frequently because of misuse of the hand-pump. After a while, some of my neighbors stopped contributing, and chose to either dig their own wells or go to fetch water from another neighbor. Now, I look after the well myself and will warn anyone who uses it without hygiene.* (WSUG Board Member, In KSP2, Interview)

In all cases, the primary point of dialogue is the location of the well. This has become a sensitive issue over recent years, and a decision that now triggers a consultative process, involving the financing donors (PDRD/NGOs), the commune and village chiefs, and the villagers. During the 2000s (the Seila period), wells were built on the premises of the village chief on the assumption that they would be better maintained. However, the research noted that villagers increasingly saw this decision as one that provided preferential water supply to the village chief, possibly a form of elite capture, and there is now a trend in communes to avoid the conflict that would affect the village chief's political popularity. As a result, NGOs are now more likely to consult with the local communities (including the village chiefs and *archas)*, to decide on the location, and the wells are now more likely to be drilled in the middle of the village. Predictably, there seems to be a trade-off between wells being close to the village chief/local authority and being well-maintained. The more "public" or "neutral" the space where the well is located, the more vulnerable it becomes to collapse from misuse and/or inadequate maintenance and this is compounded by the absence of technical support.

In the communities visited for this study, there were no examples of WSUGs functioning as envisaged by the policy. There are a few cases where the outcome is in line with what the policy envisages, but in all cases, there are either wealthy individuals providing what is necessary, and building their individual status in the village; already existing institutions (schools or pagodas) taking the lead; or village chiefs who are acting from a sense of administrative responsibility.

A possible exception would be in KPC2, where the quality of the well water is suitable for drinking and cooking and where there are fewer private wells – a community well is properly maintained by a WSUG Board. The board member responsible for hygiene maintenance (in this case the village chief's wife, a VHSG member), builds awareness of hygiene and how to properly use the well and hand pump. The water users contribute cash and labor for its upkeep and maintenance, and are careful in ensuring hygienic practices (see Box 5.4 below). Although this example reflects policy, it is the village chief and his wife, in their quasi-state roles, that have stepped in to establish and maintain the WSUG policy.

Box 5.3
A WSUG Board led by the village chief

In a village in KPC2, two wells have been provided — one was financed by Seila in 2004 and the other by Plan International in 2012. A new WSUG was established — under supervision of Plan International — comprised of the village chief, a teacher, and one external advisor. The shortage of water sources in the village encouraged villagers, and people living near the newly dug well, to actively contribute labor and materials to maintain this well, and to protect it from animals encroaching on the well and from unhygienic use. The Chairman of the WSUG Board, the village chief, assisted in this process. One villager mentioned that she is happy they constructed the well, and she is pleased to contribute cash and labor. Other users also take responsibility for taking care of the fence and the well.

The wife of the village chief, who is a member of the WSUG Board and also serves as a village health volunteer, provides local trainings on health and hygiene, and attempts to raise awareness about hygienic use of the well. She encourages villagers to build their awareness through meetings.

However, the overall trend observed in the communes visited by the research team suggests that households are frequently opting out of the national policy requiring participation, and instead, pay to establish their own household supply. In areas where wells are used as the primary source of drinking water (as in KPC2), and where they can afford it, more households now dig their own wells (for instance, in KPC2, the cost of digging a well is approximately $100). These household-level private wells tend to be used by the households themselves, but also, with conditions, to neighboring (poorer) households. In many cases, however, this reinforces more of a patronage system than it does a sense of "community".

5.4 Participation, Decision-Making, and Accountability

As envisaged by the national policy for rural water supply (and frequently in the absence of any activity by the government in provision and maintenance of village water supplies), the communities, the commune council, and village leaders find local ways of establishing a reliable supply of water. While this is what is broadly expected from the policy, poor implementation has undermined efforts to develop communal management of construction and operation of rural water supply projects. Furthermore, the informal transfer of authority, combined with the lack of MRD presence locally, has contributed to the relative lack of accountability.[39]

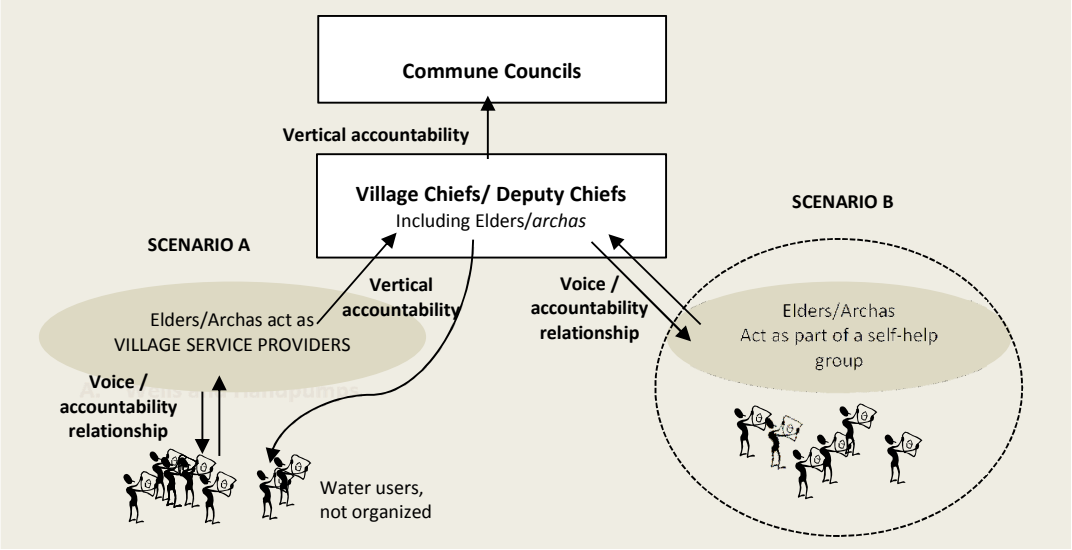
[39] Reinforcing this dynamic, donors and NGOs continue to be key providers of new investments for water supply, but they usually operate through stand-alone projects. Integration of these projects with state structures, including the MRD's vertical line and sub-national administrations, is irregular, which also undermines accountability.

Community Participation through WSUGs. Strong community participation in processes of locating, constructing, and managing rural water supply infrastructure is crucial to the national policy, but the findings of this study raise concerns regarding the effectiveness of the policy, and the 2011 Strategy on strengthening community participation and accountability through WSUGs. If the presence of the MRD continues to be limited, and support from NGOs continues to be *ad hoc*, it is not clear how this policy will ensure sustainable community participation through the user groups. It is also not clear which part of government is formally accountable for water service delivery. Unless the lack of institutional support is addressed, the committee itself is not likely to be sustainable, as has been the case of well committees discussed in the previous section. On the contrary, it seems clear that there will be no dramatic improvements in water access as a result of this policy.

While the fieldwork for this study suggests there are sustainability concerns regarding the WSUGs, this does not mean that community participation and accountability around water supply are absent in rural Cambodia. Instead, the researchers observed that rather than being shaped by central policy, participation and accountability are influenced by the available water resources and relational dynamics among key community actors, including commune councils, village chiefs, *archas,* and users. If the demand for ponds and wells is reflected in the CIP, commune councils assume accountability for meeting villagers' needs. However, the extent of commune support will depend on priorities and available CSF, as well as their ability to raise funds from other sources, such as NGOs and political parties. At present, financial limitations will prevent commune councils from assuming any major responsibility for the water sector, and the level of communication and division of labor between commune councils and the MRD is also limiting.

Community Ponds. For water provided through community ponds, the researchers found that unofficial local arrangements between villagers and a few *archas* and, in some cases, village chiefs, have increasingly been established, in which these leaders assume responsibility and, if household contributions are made, accountability. These relationships depend on the trustworthiness of the local leaders and their ability to show tangible results. Should the *archas* fail to perform, people lose respect and cease participating in, or contributing to future collective endeavors.

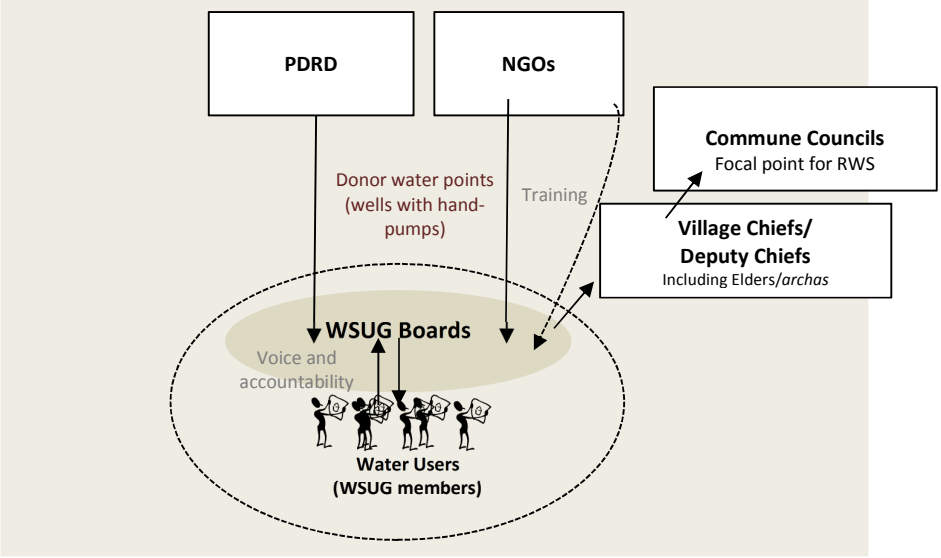
Figure 5.2
Participation and accountability relationships - Ponds



These relationships are described in figure 5.2. In some cases (Scenario A), the *archas* are appointed and act as service providers. They tend to be accountable to those that appointed them, and engage community members in a more limited way. In other cases (Scenario B), the elders are leading a self-help group arrangement, and act more as a member of the community. In this case, the line of accountability (as weak as it is) removes the service provider as a unit of accountability under the commune.

Wells. Village chiefs are jointly accountable, with supporting NGOs, for locating wells in a way that will not cause resentment. The location of where to build a well has become less controversial in recent years, as more and more people can afford their own wells. Thus, public pressure regarding the locations of publicly funded wells has declined considerably. While conflict around the location of wells seems to have reduced, other participation and accountability concerns remain. Most importantly, the sustainability and accountability of the WSUG for the maintenance of community wells has been weak, and as a result, the operation of wells has been highly unsustainable.

Figure 5.3
Participation and accountability relationships - Wells



The established WSUG is expected to be responsible and accountable for taking care of the well. However, the committee typically becomes defunct shortly after being established, leaving the household that hosts the well to be responsible for operation and maintenance. At least two factors help explain this dynamic. First, community wells, which are often located on the premises of an individual household, tend to be viewed more as private rather than communal property. This attitude, in turn, makes the committee's role in representing community interest over a public good (the wells) rather weak. Second, as more private wells are available, people, including the poor, have more choice in accessing well water, and thus see participation as a less urgent need. Private patronage structures may become more dominant as a result, since the poor need to have good relations with the more established villagers, who have the means to drill wells.

How the relationships work in practice? The levels of participation and voice, and the roles and accountabilities envisaged in the policy, are a far-cry from that found in the research. The lack of MRD presence and the lack of funds in the communes mean that the activity at the local level dominates the provision. This activity is generally not through a well-functioning user committee, but through a home-grown locally developed model of key village representatives, working in collaboration with the village chief to ensure safe water supply in villages. In some cases, there are

links to the commune chief, and in all cases, the ruling party structures ensure that a reasonable water supply is available.

Figure 5.4
Relationships and lines of accountability: policy versus practice

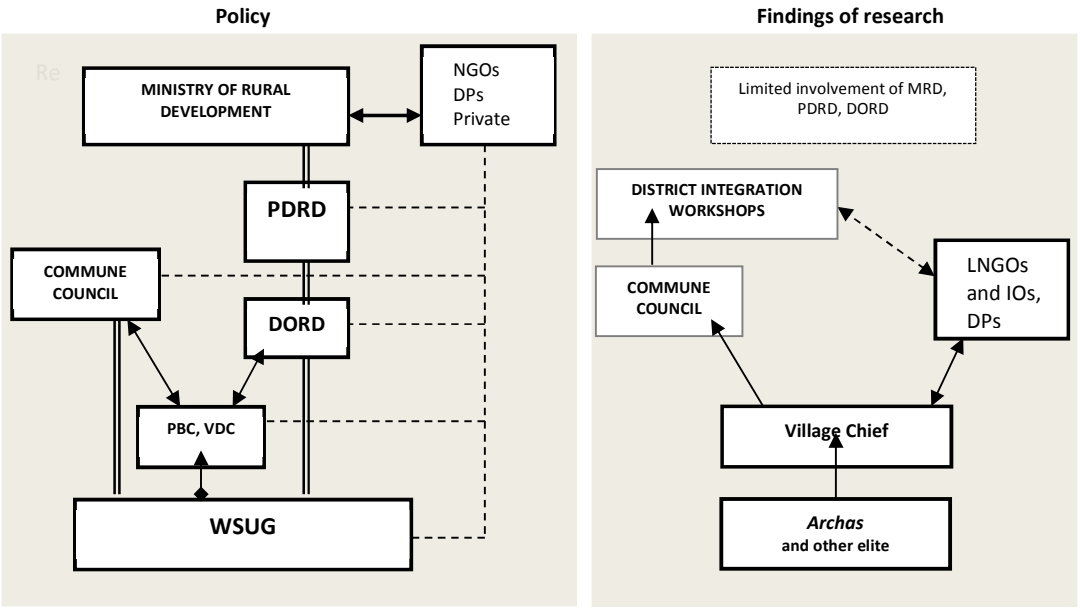


Table 5.1: Policy and implementation - Rural Water Supply

	Policy /WSUG Guidelines	Implementation – Findings
Target	50% in 2012 100% in 2025	40% (2008) UNICEF
Principles • Community based management	Communities should manage RWS and have decision-making power. (participation, responsibility, authority, control and accountability defined)	A lack of understanding that the policy for RWS is community-based management. Perceptions that MRD should supply services, suggest that there is still an understanding that water supply is governments responsibility. Perception of communities being left on their own.
• Demand responsive	Foundation of community based management.	Budgets are lacking, but local level decisions are made.
• D&D	Consistent with SNDD reform. Decentralization of service provision and management.	Budgets have not followed functions. The role of the commune is not well understood.
• Cost sharing	Cost-sharing for capital development costs determined by commune councils. 100% costs paid by communities for O&M	The principle of cost-sharing is adopted but not always understood as a government policy. Cost-sharing for capital development costs determined by commune councils has been done in consultation with users.
• Accountability	Downwards to electorates and beneficiaries; upwards to higher levels of government.	There is little accountability in any direction due to blurry lines, a lack of clarity on the role of the commune and the lack of a regular link to line agencies
• O&M	O&M through user committees supported by a district level support service.	User committees tend to take care of maintenance – the O&M of ponds is more sustainable and trusted than that for wells.
Institutional responsibility • MRD	Sector leadership and coordination	No visible presence and limited understanding of facilitation role.
• PRD/DORD	Ministry representative at provincial and district level; responsible for implementation if funds available.	Has been limited to project initiatives.
• Commune Councils	Commune councils are the focal point for the development and construction of water structure in rural areas. Commune signs contracts if Commune funds involved.	The role of the commune council is significant, but communities seem to lack knowledge of the communes' formal role. Commune water committees not found. Communes sign contracts for CSF water supply projects.
• International NGOs	Provide financial and technical assistance for the formation of the WSUG. Provide vocational training on O&M, WSUGs. Coordinate through DI workshop.	International NGOs have provided water points, mobilized WSUGs and provided trainings on hygiene and maintenance. A lack of follow up affects the sustainability of the WSUGs and the supply itself. Coordinated through the DI workshop.
• Local NGOs	Service delivery agents, no role ascribed for the facilitation of voice or accountability	Local NGOs have not been engaged in supporting communities either with supply or social accountability around water.
• Private Sector	Contracts to be signed by communes.	Contractors for the digging of wells.
Community based Organizations	The formation of WUSGs for all new and rehabilitated water points. No reference to the role of archas.	Archas can play a critical role in managing traditional sources such as community ponds, and mobilizing new water sources. Three conditions re the WSUGs were found: 1. WSUG formed, did not continue after one year 2. WSUG formed and continues to function 3. Quasi WSUGs – local ad hoc user committees working effectively.
• Leadership	WUSG Board with clearly defined roles and responsibilities	Some WSUGs loosely follow guidelines. Quasi 'board' structures also evident – called committees – in place and carrying out the roles envisaged but without the formality envisaged for functions and mandates.
• Membership	WUSG members are the water users of a water point	Little understanding that all citizens that use and access a water point are thus members of the WSUG.

5.5 Summary

The current approach to the local development of rural water supply, and the participation and decision-making processes, vary according to the water source. The national policy for rural water supply, which places the onus on communities, is implemented without technical or financial support. The policy also assumes that actors outside the MRD will do the majority of the work, and, in the process, take overall responsibility for its implementation. Given the very limited presence by the line ministry with respect to rural water supply, villagers mostly rely on their elite/leaders/village chiefs to organize better access. In some cases, this involves engagement with the commune councils and allocation of commune resources.

5.5.1 Voice and Participation

The research found that a number of forms of participation had emerged in water supply in the communes studied, with varying depth and quality depending on several factors, including water sources (i.e., community ponds or dug wells), the key actors, and economic circumstances. While there are instances of local action, and community self-help groups being formed and taking responsibility for water supply, instances of voice and participation not existing were more common. There are neither state agents present to hold accountable, nor an active process through which citizens can participate. This raises concerns regarding the effectiveness of the current policy framework, given the *ad hoc* nature of the support provided to the WSUGs and the lack of capacity development and sustainability of these vehicles.

The participation of the community takes various forms, and is vital, or in many cases, there would be no water supply. Like the other sectors, participation of users in rural water supply is informal and indirect, often demonstrated through a self-appointed or commune council-appointed local elite, that the community considers to be reliable. They often assume a quasi-state accountability and rely on local authorities to provide support for enforcement.

More specifically the research identified:

(i) self-help groups made up of “invited leaders” mobilized to provide water for villages, requiring contributions on occasion and held accountable by users for the continued supply;
(ii) dysfunctional, non-operational WSUG/user groups unable to be sustained due to lack of incentives, training and support;
and less frequently –
(iii) a functioning WSUG working effectively as a self-help community-based organization well-coordinated with the health VHSG; and
(iv) formal participation through commune council structures in those cases where the participatory processes of the commune council are followed, but are not necessarily consequential (cf. VCD1).

In some cases, self-help groups made up of “invited leaders” mobilized to provide water for villages, requiring contributions on occasion, and were held accountable by users for the continued supply. Community ponds, for example, are traditionally maintained by the village *archas*, and sustainable arrangements are generally maintained though their traditional leverage over communities. Local people were also found to be keen to contribute both cash and labor to their local leaders to ensure the maintenance of ponds, suggesting a form of participation is at work. In such cases, local leaders feel the need to be accountable for the villagers and try to be transparent and keep their promises.

Dysfunctional, non-operational WSUG/user groups have proven unsustainable due to lack of incentives, training, and support. In the case of dug wells, the formal structures of participation through WSUGs, anticipated by the national policy, rarely work. In the communes visited, some wells were constructed by NGOs, and in those cases, a WSUG was required to be formed after the well was completed. However, the WSUGs have proved to be unsustainable because of low participation from

other beneficiaries (beside WSUG members), limited capacity of the members, and inadequate technical support from the DORD and NGOs. In better-off areas, where more people are able and willing to pay to have their own wells dug, households are increasingly opting out of communal supplies, preferring instead to finance and maintain household wells. The water from these private wells is also shared, which benefits the poorer neighbors, re-introducing private and individual features in the water service delivery at the local level.

Field research identified formal participation through commune council structures in those cases where the participatory processes of the commune council are followed, but are not necessarily consequential (cf. VCD1). With MRD effectively absent from the local level, local communities are urged to participate and assume responsibility, in spite of their obvious lack of technical capacity, financial resources, and organizational skills. The result is a manipulative form of participation, where engagement is effectively a façade. That said, the engagement of the local state (i.e. the village chief and commune councils) and the semi-official engagement of the local elite, provide an avenue for citizen input all the way to consultation and mobilization, albeit without the authority or the budget for delivering expected rural water supply services. In this context, it is also worth noting that villagers do complain to traditional village elders and sometimes, commune councilors, about low quality water or inadequate supply. However, this does not lead to a quick solution for the most part, and households are left on their own to find solutions.

5.5.2 Choice

While there are few aspects of rural water supply where decisions are required, and the scope tends to be narrow, the process is collaborative and aimed at consensus. Most poor villagers have little choice and few options for their access to water, and there are few decisions put before them which create an opportunity to choose. Better off households are opting out of communal supplies, preferring instead to finance and maintain their own household wells. Similarly, commune councils make few decisions that might engage communities; they solve problems through obvious opportunities. In those cases where decisions are made (i.e. location of wells and cost-sharing levels), village leaders are mobilized by NGOs or commune councils to consult with the water-users and develop a negotiated agreement.

5.5.3 Accountability

The lines of accountability for rural water supply are clear in policy terms, but unclear to water users. As envisaged by the national policy for rural water supply, the research highlights that communities, communes, and village leaders together find local ways of establishing a reliable supply of water, but most of these approaches have blurred lines of accountability. First, there is a lack of understanding of accountabilities around a strategy that is defined as community-based management. Second, there is a lack of demand for accountability that would appear to be due to a lack of understanding of standards. Third, there is a lack of transparency and awareness around the roles and responsibilities of local authorities and MRD/PDRD/DORD. There is some evidence that villagers hold local 'politicians' accountable (village chiefs and commune councilors), but also believe, or are led to believe, that this is not a council mandate, and that councils do not have recurrent budgets and/or the capacity to solve water supply problems.

Accountability is shaped by the available water resources and relational dynamics among key community actors, including commune councils, village chiefs, *archas,* and the water users, and to some extent DORD line ministry officials. Indeed, this adaptation to context is envisaged by the policy framework.

Accountability in its various forms – downward, horizontal, and upward – is difficult to locate and assess when reviewing rural water supply through community ponds and dug wells. As there is no

identifiable "provider" that offers any tangible accountability locally, it is difficult to define who is accountable for rural water supply in most of Cambodia's villages. MRD (at the provincial and district level) assert that lack of funds and the presence of a centrally controlled system are the key reasons for this absence. In practice, villagers hold the local "politicians" (e.g., village chiefs and commune councilors) accountable, with the caveat that (i) water is not perceived as their primary mandate; (ii) they do not have a recurrent budget; and (iii) their capacity to solve problems is circumscribed.

The accountabilities that develop at the local level tend to be between users and non-state service providers. The commune council's engagement tends to be channeled through informal but endorsed mechanisms, such as unpaid *archas*, who operate in an environment of trust associated with their traditional role in the community (but with no formal training or accountability). Should the *archas* fail to perform, people lose respect and cease participating in, or contributing to, future collective events (i.e. they opt out or exercise choice on subsequent occasions). More clarity is needed as to the future role of archas.

Limited state funding and over-reliance on NGO funding raises the concern of whether MRD staff will be able to provide needed support to WSUGs, as expected in the 2011 Strategy. The limited budgetary deconcentration of the sector helps explain the limited presence of MRD provincial and district staff. In those cases where NGOs have worked with the line ministry officials to provide new water sources, users have held both NGOs and the MRD/PDRD/DORD accountable for delivering promised improvements. But this support is short-lived, and the participatory approaches to operations and maintenance envisaged with the investment are unsustainable.

There is greater clarity of accountability when the commune council is directly involved. If the demand for ponds and wells is reflected in the CIP, commune councils assume accountability for meeting villagers' needs. However, the extent of commune support will depend on priorities and available CSF, as well as their ability to raise other sources of funding from NGOs and political parties. In order to establish a higher degree of participation and accountability, the only option in the short- to medium-term seems to be to vest the commune councils with a stronger mandate, and financial resources, to make a dent in the weaknesses in the local aspects of water delivery.

CHAPTER 6
SYNTHESIS OF FINDINGS AND CONCLUSIONS

In recognition of the differentiated nature of the sectors, and to give clarity to the specific circumstances around voice and accountability, this report has disaggregated the presentation of the findings of the research by sector. Following a summary of this information, this synthesis chapter will attempt to compare, contrast and identify the commonalities between these sector situations, and include, where informative, comparisons with the findings of commune processes discussed in Voice, Choice and Decision 1. To this end, the chapter will first consider the core relations between key actors in the three basic services, and assess the mechanisms for participation and accountability. Second, the chapter will provide a comparative analysis across sectors, synthesizing key issues that have emerged in the course of the research. Finally, the chapter will present concrete recommendations for policy, implementation and research.

6.1 Voice and Accountability in Local Basic Services

Voice and accountability are relational concepts. The forms of participation by citizens, their ability/willingness to articulate their voice, and the nature and scope of accountability by service providers in all three sectors, are shaped by obscure and confused relations between actors, many with dual identities as state and non-state figures. These characteristics are summarized below.

6.1.1 Participation and Accountability in Health

Primary health care processes in Cambodia have developed a somewhat different scope and meaning of community participation. "Participation", to health practitioners and officials, is synonymous with "cooperation in outreach, campaigns and awareness building", i.e. getting villagers to join health campaigns (which might promote nutrition, maternal health care for instance). The Village Health Support Group – the way in which the health sector gets down to the grassroots in villages in Cambodia – is an important vehicle for this mobilization, providing an important outreach and awareness raising role. Village health volunteers deliver messages to households, provide them with simple services, and, through semi-structured monitoring, carry information (including community feedback at times) back to higher levels of government. The VHSGs, comprised of community volunteers, village chiefs and the elite, play an important supply side role, and report within the Ministry of Health to district level officials. In communes implementing donor funded programs they are themselves, or together with others, grassroots workers with specific roles (e.g. malaria, TB).

As a grassroots agent of change, the Village Health Support Group (VHSG) is not performing a role that mobilizes voice and engagement for enhanced health service delivery. The VHSG is not mandated to mobilize voice or hold health service providers to account, nor is it, by nature of its current membership, the right organization to do so. Acting as an intermediary, the VHSG tends to establish a filter on community voice regarding health matters (similar to the Village Chief in relation to the Commune Sangkat Fund). "Village volunteers", selected, not competitively recruited, are the bearers and custodians of information. This arrangement does not empower households or communities as service users with rights. Given that the village volunteer channels feedback, and simultaneously provides outreach services, their role is dual and ambiguous, both intermediary and provider. There is currently no direct mechanism for communities to provide feedback on health services, or on the services that outreach workers provide.

The Health Center Management Committee (HCMC) is a multi-stakeholder group of government actors and service providers that play neither a management role nor an oversight role – they currently function as a support committee. In practice, the chief of the health center plays a key role

in the HCMC (chairing the meetings at times, and always present). Moreover the intertwined membership of the committee (mixing service providers and community leaders) promotes a consensus-driven approach seen in other local level processes, and, as a result, the HCMC is not managing, or overseeing, but playing a supportive role. The HCMC (and the VHSG) is also impaired by low incentives and limited capacities – challenges that have only been overcome where direct external, typically NGO, support is present.

Despite the chairing and membership of the HCMC by commune councilors, they usually adopt a hands-off role. The HCMC policy enables a key role for commune councilors to contribute to the management of health centers (including planning, setting user fees, and managing budgets). In practice, however, commune councilors nominated to the HCMC tend to limit their involvement, due to a lack of time, capacity and an unclear mandate. Findings show they play a low-profile role, often delegating, not attending meetings, and avoiding, where possible, situations where they may need to hold the HC chief to account. Although the commune councils are aware of the importance of downward accountability, understanding of their mandate in relation to primary health care is weak, or at best indirect – through their poverty reduction mandate. This curtails their willingness to hold health workers to account, and they step in only if complaints reach an unacceptable level. Councils also engage in health issues through the CCWCs, and are able to pay for small services (e.g. emergency transportation) within the Commune Sangkat Fund budget.

There are functioning upward accountabilities for primary health care that keep services flowing and improving, and problems are often resolved locally. Although there are currently few vehicles established for voice, the health sector has established internal accountabilities. Service providers are accountable upwards to the next level – the village/commune level facilities to the operational district, to the province, and to the national level. Villagers that are discontent with the performance of health staff do bring their concerns informally to the HC chief, the VHSG or the commune council. These concerns are filtered and then managed locally wherever possible. With few directives to improve, downward accountability is generally not a requirement or priority for health workers.

In the absence of clear mechanism for voice, and as incomes increase, households are often adopting a choice and exit strategy, rather than a voice and accountability strategy, to obtain better services. Rather than negotiating informal and invited voice mechanisms, households who can afford it, opt out of the services provided by government, and seek primary health care from private and alternative providers. This has implications for the regulation of the private health sector (e.g. dual practices) and the inclusion of these providers in oversight arrangements.

Voice and accountability mechanisms in relation to primary health services have proven to be successful when stimulated through external agents, such as NGOs, who create space for voice. The fieldwork confirms that, where resources become available, NGOs are active, and make a difference, in the levels of voice and accountability, through monitoring efforts (e.g. participation in HCMC, introducing health community scorecards). These initiatives not only stimulate the direct participation of users, but frequently mobilize the commune council as convener and driver of change.

6.1.2 Participation and Accountability in Education

The School Support Committee, the primary mechanism at the grassroots level for community engagement in school management and oversight, does not currently provide an avenue for parents (users, citizens) to demand accountability for better quality education. Education policy envisages a role for the SSC in the oversight and monitoring of budgets/expenditures and in the monitoring of inputs (curriculum), and outcomes (drop outs). Field research suggests that implementation of this policy is constrained – that the SSC performs a fund raising role (and is accountable for funds it raises), but that its function in oversight of services provided is minimal. This is due to the mixed membership of the committee, the role of the school director in

advising/convening the committee, the small and limited scope of budgets and decision-making, and the fear of confrontation between the director and the SSC members. Policy formulation and implementation both promote consensus building and social harmony, not social accountability.

The School Support Committee represents another intermediary, multi-stakeholder 'invited space' for the local elite and quasi-officials to communicate, and at times filter, the views of ordinary citizens. The membership of the committee, of village elders and village chiefs representing ordinary citizens, not only determines the degree of accountability that can be achieved, but it filters the voice of users and citizens. Nevertheless, experience suggests that the messages passed on and up are often the right messages. SSC representatives are familiar with issues, should they choose to raise them, and the members tend to be individually accountable to a local constituency (the commune councilors and village chiefs), within a narrowly agreed mandate. The lack of space for ordinary parents to channel views, and follow up, provides little incentive or opportunity for empowering them as active users of services. There is currently no alternative forum or institution to facilitate citizen/user voice, or directly articulate demands, unless facilitated by an external party or civil society representative.

Schools are strictly upwardly accountable to the District Department of Education. The provincial and district level departments of education are responsible for policy implementation, and they take or administer all major decisions related to budgets, staffing, school locations, and sanctions for misconduct. The individual schools are responsible for the actual service delivery, including staff management and minor financial decisions. The DOE monitors spending against approved budgets, but does not question the local interpretation of the policy with regard to SSCs. Regular meetings with school management, and monthly district meetings which provide an opportunity for commune councils to engage in issues about schools in their jurisdiction, are mostly limited to statistical monthly reporting, and thus have little consequence. Broader evaluations, although mandatory under the policy, are rarely carried out without the involvement of NGOs and external funding.

There is opportunity for the Commune Council to play an oversight role in the quality of local schooling, but this is often constrained by mandates and relationships. As seen in VCD1, commune councils are significantly more accountable for their actions (in relation to the Commune Sangkat Fund) than local service providers are. They understand accountability, and are willing to be held downwardly accountable. They are however constrained in their actions with respect to education, because of a lack of understanding of the causal linkages between education and poverty reduction[40]; the widespread perceptions that councilors have no role in basic services; and a belief that teachers "know best". Commune councilors do act if they see the importance, but, as the DOE is not downwardly accountable, the SSC does not provide oversight as envisaged and there is a less receptive environment than in health, these interventions can be difficult for councilors to work through.

As in health, NGO activity has provided examples of how increased voice and accountability can work, if facilitated by outside actors. Working with the commune councils and the service providers, NGOs have introduced participatory practices to engage parents in feedback on schooling, and encouraged citizens to demand accountability. While these monitoring and feedback activities have raised the quality of participation and accountability, such initiatives are random and usually limited to a defined period.

6.1.3 Participation and Accountability in Rural Water Supply

The participation of communities in rural water supply is typically found in the form of delegated local management (for ponds) and self-help groups (for wells). Since rural water supply improvements undertaken by the Ministry of Rural Development are still limited in number,

[40] The councils have a responsibility for poverty reduction of which access to improved education is a critical part.

communities mostly organize themselves.[41] This local level organization is often initially facilitated by commune councils, although formal accountability processes are not established. In the case of community ponds, the leadership and management is culturally-driven and associated with the pagoda. *Archas,* widely trusted by communities, take on a custodian role and communities cooperate by adhering to rules and contributing to improvements. In the case of wells and associated hand-pumps, other arrangements are made that are more akin to a self-help group.

The Water Sanitation User Group (WSUG) is the community level organization defined by national policy, but implementation is limited. Despite its potential, the WSUG, as defined by the RWS policy, has mostly been launched as an operating mechanism, where donor-financed projects have been carried out. These user groups tend to be short-lived, ceasing to exist when funding is discontinued. Members have little training, formal obligation, or incentives to be pro-active thereafter. There is no elite capture as such, there is a strong commitment to provide water-for-all, but the approach has not been supported by the funds which might ensure its sustainability.

Community engagement is most frequently stimulated through the local elite. In the water sector the *archas* are, by far, the most active and accountable local actor, especially in their management of community ponds, and in their interactions with community members. The *archas* play this role largely out of a sense of responsibility for their communities. The actual service is uneven, depending on the capability and legitimacy of the *archas* and the local pagoda, and the levels of participation and accountability, but, in the main, *archas* play a critical role in ensuring villagers have access to water of a satisfactory quality.

Community level agents delivering water mostly work without payment or incentives and without policy guidance, formal training, or external financial resources. Without any funding of water supply, there is also only limited accountability provided to fellow villagers. As a result, some villagers exercise their right and ability to choose. Private and wealthier households increasingly opt out of communal water supply, dig their own wells, and allow a limited number of less fortunate households to use them. This practice runs a high risk of reinforcing the existing patronage relationships on the village level, and, although it fills gaps in service provision, it does not promote any improved service delivery/accountability from government.

These simple forms of community management occur largely without line ministry intervention: there is little or no downward accountability by the line ministry in this system. As a result of the dearth of line ministry supply in the communes visited, decision-making and the associated accountability between the line ministries and citizens/users is virtually non-existent, and participation in state-run service provision is limited to rare projects.[42] In the VCD2 sample communes, there was virtually no state provision or meaningful engagement with a state provider, and thus there was no detectable accountability system over rural water supply. NGOs were funding water projects, and were struggling to develop sustainable user groups after the project ended.

6.2 Participation and Accountability across Sectors

6.2.1 Participation in Basic Service Delivery

Compilation of these research findings provides more clarity in the nature and scope of voice and participation, the ways communities are organized – group formation, membership and leadership, the relationships within the framework of service delivery, and the factors constraining effective voice among citizens and the users of basic services.

[41] MRD investments were not found in communes studied. One case, using donor funds was recalled by interviewees.
[42] Cases were selected from the wider VCD1 sample and a pre-study indicated that the locations chosen had *more* activities in the water sector than the others.

At the local level in Cambodia, citizens/users are reluctant to articulate their voice, but if they do, they do so through intermediaries. In the case of health and education services, where formal and direct participation is largely absent, the established vehicle for voice (if there are issues to be communicated) is through the elders and elite in the village (quasi-state representatives such as village chiefs, deputies). Grassroots and other local organizations, established in respect of local basic services in Cambodia, function as intermediaries for community voice. They take two different forms.

(i) **Small, invited groups/committees** comprised of a few active individuals, mostly elite members of the community, who usually serve in a multitude of similar bodies. Actors are benevolent and informed, but non-elected and non-representative, with many in quasi-state roles. They hear about issues informally, and then carry, and filter, the voice of ordinary citizens to meetings.

(ii) **Multi-stakeholder groups/committees with confused mandates** that include both service providers and community leaders/elite together, (i.e. village health volunteers and school directors sit beside village chiefs, elders (*archas*), and commune councilors on these committees at village, commune and district levels). Many actors play more than one role.

The sector policies for participation in health, education and water do not currently create space for, or empower citizens/users to participate. Policies for community participation in each of the sectors are spelled out in some detail, defining organizational structures, membership and roles. Although they each function separately, and have particular factors that constrain the way in which they function, the commonality is that they are highly captured spaces that do not envisage or provide space for citizens/users of services to voice feedback independently and safely. The policies are similar in spirit, in so much as they set up the roles of local leaders/quasi-officials. Membership reinforces the imbalance of power and information with respect to basic services. The policies are not empowerment-focused – they have not, through information, instruments or processes, developed an increasing role for villagers, women or youth. Instead, they rely on citizens/users being represented effectively by quasi-state leaders and/or the elite. However, in a context where voice is perceived to be high-risk, utilizing these intermediaries (i.e., village chiefs, *archas*, commune chiefs, etc.) to channel complaints may be the next best thing. Often, villagers prefer it this way - the individual villager does not have to take any risk, but there is a reasonable chance that his/her complaint will be channeled upwards.

The nature of these groups/committees reinforces the consensus-driven approach adopted at the local level for all decision-making and conflict resolution, as well as the domination of a small group of local elite. This not only reflects the culture of caution, a widespread lack of trust, and general reluctance by citizens to engage in public matters, but suggests that in policy-making, social accountability is not what is being sought. The primary interest is in social harmony. Organizational structures are created, not for the purpose of enhancing voice or accountability, but for the purpose of doing what can be done to improve the services, while building accord among all stakeholders through compromise. There are some fundamental gaps in knowledge and awareness of the role of citizens/users in a participatory process that is distinct from leaders, and service providers.

Sector policies for participation and engagement are not linked to each other or to commune processes. The sector policies for health, education and water have not been coordinated or linked, and there are only weak linkages between the participatory processes for commune planning and annual decision-making for schools, health centers and water supply. The District Integration Workshop (DIW) provides the opportunity for the coordination of local level activities, but does not include coordination or discussion about the engagement of citizens in development processes.

In terms of implementation, a lack of demand for participation, even where opportunities exist, is common in Cambodia and relevant to the discussion on voice in basic services. Having the platform for a voice is often not desired by citizens or users, and knowledge on how to generate this is not present in government. Moreover, both officials and citizens lack any belief that inclusive

arrangements will make a difference. Villagers make rational decisions on where they should spend their efforts to improve their lives, and for these reasons, it is unlikely that they would try to influence policy or the small budgets for deconcentrated services. These historically and culturally sustained social structures are nevertheless subject to change under specific circumstances. This lack of demand is generally exacerbated by a lack of access to information. Communities do not know what standards of service to expect, what the budgets are for services, or what performance is achieved.

Participation in planning is constrained by the minor nature of decisions made at the local level, and there is almost no participation in monitoring. As noted in the VCD1 report, decision-making at the commune level can be extremely limited in scope; this is also the case for local basic services. As these sectors are deconcentrated, rather than decentralized, the decision-making that takes place by local groups is minor, and accountability is upwards. Even if participatory mechanisms were well-designed, there is a limit to how much input citizens and users can provide at the planning stage. A critical gap for citizen/user engagement is in other (non-planning) processes, e.g. monitoring of service provision, that enable citizens to engage directly on matters that affect them.

The lack of funding affects the development of capacity, and diminishes the importance of consequential participation of citizens/users. The lack of funds for the development of citizen engagement (e.g. through community facilitators), and the fact that existing funds are not used for this purpose (e.g. the commune Sangkat fund), illustrate the low priority given to citizen/user voice and engagement. Although village volunteers in health are paid an allowance, in education there is no funding for engagement, and there are no funds available at all for the water and sanitation user groups.[43]

Exceptions provide lessons for the development of voice and accountability processes. Users do articulate their voice occasionally, in events with clearly defined rules and facilitation e.g. formal workshops arranged by external parties. Although not all of these situations could be called "safe spaces", they do provide alternative vehicles for communication that have been endorsed by the normal players. Typically, citizens are not aware of what to expect regarding their rights and agreed standards of service (e.g. number of students per class). They make judgments as to what is acceptable/unacceptable (e.g. drunkenness of teachers), and voice their opinions only rarely, when they perceive mismanagement to have gone too far. In these bottom-line cases, protests are clear and loud – caution is cast aside.

"Choice not voice": citizens are increasingly able to choose alternative service providers. Increasing incomes, and levels of awareness, are enabling households to decide to go to a different health center or an alternative provider, to build their own wells to obtain household level water supply, or even to go a school in another village. As this could potentially change the structures of primary health, education and water sector services, there are significant implications for regulation, financing and voice. This "opting out" can also have effects on those left in (normally the poorest households), weakening the collective voice, and potentially slowing the improvement of government services.

6.2.2 Accountability in Basic Service Delivery

Accountability and oversight systems for basic services have not been clearly established – existing structures and processes consist of many internal conflicts. The oversight and monitoring of local basic services is not independent. The mixed membership of key committees makes it impossible to identify clear accountability lines between users, service providers and elected officials. In policy, functions and actors are intertwined to a significant degree in all sectors. In practice, oversight and monitoring is either misunderstood, not performed (e.g. school budget/expenditure monitoring, or delegated back to the service provider/manager. Relationships between these elite committees and

[43] Limited funds to the Commune Committee for Women and Children (CCWC) may be made available , and this is a potential channel for financing.

the service providers are close, and consequently there is virtually no accountability in the arrangement. The research noted however, that there did not seem to be much scope for the misuse of funds, despite the significant discretion given to service providers.[44]

The consensus-oriented socio-political culture is deeply embedded in the implementation arrangements for local basic services, and heavily constrains local oversight processes. Local actors are very cautious about being perceived as "meddling" in the affairs of others, they make every effort to avert conflicts and prefer to 'help-out' the service providers rather than hold them to account, particularly with the management of schools and health centers. Because of the confused accountabilities of the actors involved, there is no functioning local oversight system, involving commune councilors or civil society, for the basic services (health, education and water). The necessity for internal social harmony in the community comes at the cost of establishing and implementing arrangements that foster accountability to citizens and users.

Without strong direct engagement from local citizens through citizen groups, with no pressure from community-based organizations, and no directives from above, service providers have not yet embraced the concept of downward accountability. Notwithstanding efforts in health and education to get down to the grassroots levels, and the peculiarities of the water sector, downward accountability is very weak, even when compared with the downward accountability of the commune council. Although council processes are formal and not yet effective, commune councils, as a local institution, have broadly grasped that they are responsible for mobilizing citizen participation and engagement; and that they are accountable to the citizens that elect them. This is not the case for the deconcentrated service delivery units.

In Cambodia, the health and education systems for service delivery are driven by upward accountability within the line ministry and there are few decisions at the local level. Decisions on health and education services are passed down from higher levels of government; accountability is planned to be mainly upwards, as service delivery units report back on progress. This dynamic is exacerbated in practice by a lack of capacity and the norms of government – service delivery units look "upwards" for guidance and take instructions as a norm – and this is accompanied by a lack of willingness to accept responsibility at the service delivery unit level. The system of accountability is therefore constrained by the lack of authority at the local level, as well as the organizational problems described above.

Commune councils could promote both voice and accountability in local basic services, but their mandate to do so is not always clear to them, and they lack confidence in their interactions with line ministry officials. Notwithstanding the social harmony imperative described above, some commune councilors understand the importance of local basic services in poverty reduction, and are aware of the poverty reduction mandate. They are not always aware as to how they can engage on the poverty reduction mandate, and are rarely sufficiently confident or skilled to dialogue with line ministry officials. The CCWC, with its limited budget, plays a limited role in some cases, but does not have the authority to make a difference.

A widespread lack of capacity at the local level constrains the development of accountability. The dynamics observed in the communes studied suggest a severe lack of capacity with regards to voice, and accountability, and this is most acute at the district and province levels. At the village level, with just basic training, there are villagers serving as health volunteers, contract teachers, or caretakers of community ponds, that understand dimensions of accountability. At the commune level, there is a growing competence, building from the work in the councils. However, the research found that, while district and provincial level staff have good knowledge of their upward accountability within the ministry, they do not have an openness or capacity for downward accountability, without the support of, and capacity building by NGOs.

[44] The study was not able to draw conclusions on corruption, but notes the lack of transparency and accountability in the systems.

6.4 Recommendations

The general and specific conclusions presented above suggest a range of specific policy recommendations and opportunities for future research. Some of these recommendations are already being discussed, and the research further validates or emphasizes the urgency of these initiatives.

6.4.1 Recommendations – Policy and Implementation

The processes for voice and engagement need clarification in sector policies; as they are revised, policies should be coordinated to the extent possible. Sector participation policies should make a clear distinction between community participation for the purposes of outreach campaigns (as for health) and self-help groups (as for water); and the forms of citizen engagement that promote voice and accountability. The operationalization of the NP-SNDD social accountability framework provides a potential platform to develop this clarity, and to ensure local level mechanisms (commune, health, and education) are aligned and built upon, and reinforce each other. Multi-sector platforms open up the space to broader dialogue and prioritization.

Participatory spaces that encourage voice and engagement must be pro-actively developed and sensitively implemented. Given that citizens generally avoid engaging with the state, and the benevolent attitudes of the elite members in the various local organizations, it is essential that safe spaces are found – at village level – either within the current sectors or the local governance framework. Developing mechanisms for sensitive and independent facilitation will be key.

Membership of groups/committees at the local level is currently reducing the space for voice and blurring the lines of accountability. Two changes are needed.

- **At the grassroots level, the differentiation between those that provide an outreach service and the users of the service is also critical.** It is important to clarify that the VHSG is an outreach mechanism for health centers – it is not a health user-group advocating for health interests or accountability. As dialogue centers on the development of instruments and vehicles for voice, this distinction between service provider and user needs to be kept clear. Linkages should be made with the institutional structures established for the social accountability framework.
- **Clarity and distinction between management (the executive of an organization) and oversight (actors nominated to make sure management is doing its job), is urgently needed.** While the oversight role of committees at the local level needs to be more clearly spelled out and implemented, the functions of these organizations, established for oversight, should not be confused with helping out the service providers. In practical terms this means, for instance, that the SSC function of fund-raising and making the school user-friendly, should be separated from the function of budget and performance monitoring.

The mandate of the Commune Council in supporting, monitoring and overseeing local basic services needs to be clearly and consistently defined in both council and sector procedures. In relation to health and education services, where centralized line ministries dominate policy and decision-making, commune councilors need to have a more clearly defined role in the committees to which they are nominated. In practice, commune councilors are playing vastly different roles, with some being willing to hold service providers to account, and others standing back and rubber stamping decisions by the managers of service delivery units (health chiefs and school principals), and so removing an opportunity for a line of accountability for local basic services. Policy dialogue is needed around the role of elected councilors (given their poverty reduction mandate), and the capacity needed to perform this role; and the relationships between line ministry staff and commune councilors, together with; the lines of accountability.

Service providers require significant attitudinal change and capacity development to improve downward accountability – they should follow in the footsteps of commune councilors. Service providers (teachers, school principals, health workers, health center chiefs) need to develop, as a core skill, a conceptual understanding and practical knowledge of downward accountability. While this is happening to some extent in health centers, where the friendliness of staff is monitored, in general the idea of accountability to citizens and users runs counter to the patronage systems of the past. Significant attitudinal change will also be required. The commune councils have started this transformation - it takes time, targeted effort and monitoring.

Functional assignment offers an opportunity to change accountabilities in service delivery. The delegation of functions to communes and districts offers an opportunity to develop demand-side processes involving citizens/users and elected councilors, as well as lowering the level of decision-making around appropriate aspects of service delivery.

Monitoring and evaluation should include the monitoring of voice and accountability. Whereas the health and education sectors have developed methods to collect information on health and education services outputs and outcomes, there is only limited experience in measuring (and correlating with outcomes) participation and accountability. Monitoring and evaluation systems in the sectors should include simple indicators on the degree of meaningful engagement of citizens/users. These can be measured through perception surveys, community scorecards or through third party monitoring. The lack of any follow-up on policy in this area means that they are not implemented, and problems in the policy framework are not highlighted and corrected.

The role of non-state actors as outside facilitators of voice and accountability is emerging, and needs to be systematized. Efforts to introduce social accountability mechanisms have been launched at the local level in Cambodia, both in respect of basic services and commune investments. The role of external facilitators is key to ensuring that the processes are inclusive (of women, youth, vulnerable groups), and empowering for ordinary citizens and users. Policies need to be updated to take into account these processes, and impact evaluations carried out to see what works, when and why.

Moving forward, funding for the facilitation of participation, voice and empowerment is vital. The lack of funds to implement policy has hampered the development of the WSUG and other community-based organizations. Ideally this funding would flow through independent channels, and through commune councils, but sectors need to take responsibility for enhancing the voice of citizens and users with respect to specific services. Options will need to be considered and debated, keeping in mind short, medium and long term outcomes. The role of local NGOs will be important, as facilitators that empower citizens and users to articulate their voice and demand accountability from service providers.

Policy needs to respond to the growing trend for users of health, education and water supply to exercise choice and opt out of government provision and obtain services from alternative and private providers. While users can vote with their feet – not returning to pay for services they are not satisfied with – the burgeoning market of private providers needs appropriate regulation in certain areas (e.g. dual providers, unlicensed drug sellers), and demand-side financing mechanisms (CCTs, scholarships, vouchers etc.) to encourage use of better quality services.

6.4.2 Recommendations – Research

Like VCD1, the findings presented in this VCD2 report have been drawn from a limited sample, with the findings validated by experts and stakeholders. A useful next step may be to develop and execute a random, quantitative research initiative to broaden and further validate these findings. At the same time, there is a need to improve our understanding of specific blockages and opportunities. A number of these are outlined below, and a number overlap with the in-depth research recommended in VCD1.

Enhance understanding of the trade-off between social harmony and social accountability. The findings drew attention, in almost all situations, to the desire for concord between actors at the local level: citizens prefer not to raise issues unless they have to, community leaders prefer not to hold other members of the community, who are providing a service, to account for their actions, unless the situation becomes uncomfortable. In almost all cases, the findings highlighted that, when issues need to be addressed, a consensus approach, and compromise is taken as the best way to resolution. Research is needed to better understand this overriding desire for harmonious relations at the community level. Under what circumstances does it occur/not occur? Does it affect the quality of service delivery? In what way? Who is affected? Is it achieved at the cost of accountability? How can accountability processes play out in this context, and alongside this socio-political characteristic?

Enhance understanding of the role of intermediaries with a view to their effective positioning in reform processes. As in VCD1, the village chief plays a dual role as citizen and state official – articulating voice of the villagers, and sitting on committees making decisions around local basic services. This intermediary role of the village chief is one which channels, filters and shapes the views of communities. The messages are generally formed through local 'invited' conversations. These may be exclusive of women, youth and the poor, they may be formed within a limited political space, but nevertheless may often send the "right messages". In-depth research that drills down into the local dynamics around the village chief would provide better understanding of the constraints and opportunities associated with this position. The research could be linked to the "social harmony" research described above.

Enhance understanding of line ministry – local council (commune and district) relations. There is widespread evidence that commune councils are reluctant to engage in deconcentrated sectors/line ministry matters despite their poverty reduction mandate. It would be useful to carry out a broader assessment of this issue as it plays out at the local level, and formulate some clear recommendations as to the ways line ministries can cooperate with commune/district councils in order to improve the accountability for the services delivered. A key aspect of this would be the mechanisms that line ministries currently adopt to monitor and evaluate their performance, and the role that (skilled-up) commune councilors should take as social accountability develops in Cambodia.

Enhance understanding of the role of NGOs in enhancing voice. The findings of the research noted that space for voice is possible when external actors (such as NGOs) become engaged. This is not currently elaborated in any detail. While we have documentation from the DFGG project as to how specific social accountability activities and instruments create this space, broader documentation that captures the diversity of how NGOs have empowered citizens and facilitated voice through other activity, including service delivery activities, would be useful.

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