

NGOs, International Aid, and Mental Health in Cambodia

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A thesis

submitted in partial fulfillment of the
requirements for the degree of

Master of Arts in International Studies

University of Washington

2016

Committee:

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Program Authorized to Offer Degree:

Jackson School of International Studies

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Abstract

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Research shows that there are enduringly high rates of trauma in Cambodia from the Khmer Rouge genocide and current daily stressors including poverty and a corrupt government. Additionally, Cambodia is a highly aid dependent country. There is strong international involvement not only in providing aid to the government, but also in giving grants to local NGOs. Despite this heavy international aid, mental health services in Cambodia are insufficient to address the need. Cambodia is party to the International Convention on Economic, Social, and Cultural Rights, meaning that Cambodia is legally obligated to ensure the right to the highest attainable standard of health which includes mental health. Because Cambodia faces resource and infrastructure limitations, the international community is legally obligated to assist Cambodia's efforts in ensuring the right to health, under the same convention. The fact that these

services are not being provided shows that both parties are failing in their obligation to the right to health. The purpose of this thesis is to examine why this mental health gap is not being addressed by international or local actors.

To gather data, interviews of local NGOs were conducted in Cambodia, along with observations of meetings with international and local actors, and on-the-ground volunteering experience with a local Cambodian NGO. Some document analysis was also conducted to gather data about how these entities present their programs and goals. The findings from these different sources of data were recorded and triangulated to find common themes and conclusions. This research revealed five main conclusions about why mental health is not being addressed.

First, there is poor collaboration between international donors and local NGOs, as well as poor participation with the recipient communities. Second, there is a tension between high government corruption and a need for better regulation of the NGO sector. Third, local NGOs have little autonomy in their programmatic priority setting. The international community has more money and power to set the health agenda in Cambodia. Fourth, there is a disconnect between the Western dominated international understanding of trauma and healing and the culturally embedded Cambodian understanding of trauma and healing. Finally, there are significant funding and infrastructure shortcomings that limit the ability of local NGOs to function effectively. All of these conclusions negatively affect aspects of the right to the highest attainable standard of health and have important implications for research and policy.

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Introduction

The purpose of this study is to create better understandings of how international and local nongovernmental organizations address issues of mental health services in Cambodia. My research question is: why, despite the long-term presence of many international NGOs working on health and rights issues in Cambodia, is there an enduring service gap as mental health service provision and usage remains low and trauma rates remain high? I want to find out to what extent NGO policy contributes to why this gap exists in order to help better understand how to improve collaboration and participation that respects local culture and aligns services with population needs. This in turn will reveal how NGOs can adjust policies to narrow the gap between services and needs.

This study focuses on availability, accessibility, acceptability, and quality (AAAQ) of health services as well as the levels and mechanisms of participation these international organizations use. From a human rights perspective, these elements of health services comprise the legal obligation of Cambodia and its duties to assure standards of donors in the provision of health services (International Covenant on Economic, Social and Cultural Rights, 1966). For comparison, I also address mechanisms and approaches that Cambodian NGOs working on similar issues use. More concisely, my objective is to investigate the interrelated topics of the prioritization and implementation processes of the international community and local NGOs working on mental health in Cambodia. Additionally, I want to provide a better understanding of this issue to facilitate an appreciation and understanding of other cultures in development efforts. One goal of this research is to encourage best ways to support and provide health development assistance and the right to the highest attainable standard of health not only in Cambodia but in other contexts as well. Development professionals, international aid organizations, and creators

of health policy for diverse populations, specifically in Cambodia, should be interested in this puzzle in order to identify ways to improve mental health services and thus support the right to health.

This research project describes the paradox between international efforts and high trauma rates in Cambodia. The background section begins with a brief overview of Cambodia's history, the effects of the Khmer Rouge genocide, and cultural experiences of trauma to set the context for this project. I then provide an overview of the international response, aid policies, and health priorities in Cambodia. Then I discuss important concepts related to international development and the human rights approach to health. Some of these include international legal conventions, the right to the highest attainable standard of health, and participatory development strategies. Then I will provide a description of remaining knowledge gaps and the conceptual elaborations that I am seeking to identify. I then describe my methodology for my research and discuss my findings and their implications for research and policy.

Background

A brief overview of the history of conflict in Cambodia

Cambodia has experienced multiple phases of violence, from its time as a French colony to the rise of the Khmer Rouge, the ensuing genocide, and the following waves of political and social violence. Cambodia was colonized by the French in 1863 until 1954, then was bombed heavily during Vietnam War in the 1970s. The Khmer Rouge genocide led by Pol Pot began in 1975 and for the most part ended in 1979, although the Khmer Rouge maintained some power and remained a source of conflict until 1989. It wasn't until 1996 that the regime was completely dissolved (Miles & Thomas, 2007). The Khmer Rouge genocide stopped when the Vietnamese invaded in 1979. Cambodia remained under the power of Vietnamese occupation until 1993

(Miles & Thomas, 2007). In 1993, the United Nations facilitated Cambodia's independence from Vietnam and established a new governance infrastructure. Socio-cultural factors and experiences that led to the genocide and that continue to be relevant to health and trauma in today's constitutional monarchy include high rates of poverty, government corruption, and low education rates. These are underlying determinants of health, which under the obligation of ICESCR, Cambodia is legally required to address.

Establishing the Khmer Rouge conflict as a genocide through literature and case comparisons

The Khmer Rouge genocide shares many characteristics with genocides in other countries, which confirms its categorization as genocide. Genocide broadly refers to the intentional killing of a specific group of people, most often by a government, and is a major human rights violation. More specifically, genocide has three defining elements that distinguishes it from more general war: actions legally defined as genocide according to the 1948 Convention on the Prevention and Punishment of Genocide, victim identification as targeted groups, and the intent of the perpetrators to destroy that group (Komar, 2008).

In her study of genocide, Komar identifies components of victimization in the Rwanda and Yugoslavia genocides (Komar, 2008). These include victim differentiation, segregation in refugee camps or concentration camps, recruitment and incitement tools such as radio broadcasts and active recruitment, and victim targeting based on social data, among other identifiers (Komar, 2008). The experience of Cambodia and the Khmer Rouge has been classified as a genocide and shares many of the qualities of genocide that Komar finds in the Rwandan and Yugoslavian genocides. For example, the Khmer Rouge conducted broadcasts to construct belonging and exclusion between the Khmer Rouge and to construct difference to target specific groups of victims (Hinton A. L., 2004). The Khmer Rouge identified, discriminated, segregated,

and targeted victims using processes similar to those in Nazi Germany, Bosnia, and Rwanda (Hinton A. L., 2004).

Other commonalities between the Khmer Rouge genocide and others, specifically the genocide in Rwanda, include an appeal to peasantry, strong value of rural life, and economic development discourse all rolled into a political agenda (Verwimp, 2006). Perpetration similarities also exist. In both the Rwandan and Cambodian genocides, the perpetrators fostered a culture of fear and obedience (Mironko, 2006). In both, intellectuals were the first to be killed, and the conflicts were importantly placed within the context of surrounding geographic political environments (Verwimp, 2006). Also in Cambodia and East Timor, small civil wars led to a catastrophe (war and genocide) which led to major international intervention including extended foreign occupancy and UN intervention (Kiernan, *Genocide and Resistance in Southeast Asia*, 2008).

These similarities and parallels in process between the Cambodian genocide and other documented genocides indicates the comparability and potential for expanding knowledge gained from this case to other cases of genocide. The context of genocide, along with its initial impact on society, are necessary starting points from which to build an understanding of the long-term effects of genocide on health and rights, and the local and international intervention strategies in response. Much of the trauma, poor underlying determinants of health, and limited access to AAAQ health care were significantly exacerbated by the Khmer Rouge genocide.

Describing the problem: the effects of the Khmer Rouge genocide on health

This sequence of violence, especially the genocide by the Khmer Rouge, has had significant long-lasting consequences across multiple generations in Cambodia (Field, Muong, & Sochanvimean, 2013). The initial impacts of the genocide were plenty. The Khmer Rouge

regime demolished the education system in Cambodia, which has limited the educational opportunities for children not only immediately following the conflict but also still today. Recent research has shown that in the Siem Reap province of Cambodia the average years of education is 2.5 years (Mollica, Brooks, Tor, Lopes-Cardozo, & Silove, 2014). Additionally, the Khmer Rouge targeted the educated members of society for execution, thus eliminating Cambodia's educated citizens and limiting rebuilding capacity (Miles & Thomas, 2007).

The Khmer Rouge genocide was also devastating for Cambodians in the areas of health and rights. The Khmer Rouge destroyed many underlying determinants of health, including refusing education and medical care, starving the Cambodian people, and bringing people into poverty, not to mention direct fear, violence, and killing. The effects of the genocide radically affected the population and created high rates of trauma among adults and children through violence exposure. The Khmer Rouge regime killed roughly 25% of the population in Cambodia (Diaz Pedregal, Destremau, & Criel, 2015). Over 1.5 million Cambodians were killed either from starvation, forced slave labor, physical abuse and beating, illness, or direct execution during the genocide, and many children were taken from their families. The Khmer Rouge wanted to reduce family loyalty and emotional attachments (Mam, 2006). This separation was another source of trauma and it intensified opportunities for negative mental health outcomes for these children. The Khmer Rouge also traumatically targeted attachments by attacking religion, which was a crucial part of Khmer culture (Mam, 2006). The Khmer used indoctrination in an attempt to 'build adults' with no emotional expression or attachments (Ebihara, 1993). This had, and continues to have, important implications for enduring trauma and mental health concerns in Cambodia, as well as mental health and human rights policies.

In addition to devastating the underlying determinants of health, the Khmer Rouge

regime destroyed Cambodia's health system, resulting in both immediate and long-term poor availability, accessibility, acceptability, and quality of health services (Diaz Pedregal, Destremau, & Criel, 2015). Under the Khmer Rouge, health care was not available, accessible, acceptable, or of high quality. The right to health did not exist in Cambodia. Nearly all doctors and medical professionals were killed. After the genocide, there was no psychological support system, only medicines and traditional healers (Thion, 1993). Cambodia's health care system is still poorly managed and inefficiently regulates the health care sector (Grundy, Khut, Oum, Annear, & Ky, 2009), leading to inadequate health care provision by the AAAQ standard and poor realization of the right to health, as above evidence has shown. Additionally, corruption within the government, including the Ministry of Health, has severely limited any progress toward the right to health and kept Cambodia in violation of its legal obligations. Still today, health care in Cambodia falls short of the AAAQ standard. Given the clearly identified evidence of high levels of mental illness and poor healthcare resulting from the Khmer Rouge genocide, this insufficiency is especially significant for mental health care in Cambodia.

Mental health and trauma: understanding the conceptual disconnect

According to the American Psychological Association and for the purposes of this research project, trauma refers to a distressing experience, or an emotional response to a terrible event (American Psychological Association, 2015). This research paper focuses primarily on trauma related to experiences of violence from the Khmer Rouge genocide. Also important are the ways in which trauma is expressed. Western approaches define trauma primarily with Post-Traumatic Stress Disorder (PTSD). In Cambodia however, other culturally embedded psychosomatic symptoms are more important and are a greater cause for concern (Hinton,

Hinton, Eng, & Choung, 2012). This has the strong potential to affect the acceptability and quality of mental health services to Cambodians.

Cultural experiences of trauma

In Cambodia, an important limiting factor for the ability of international aid and development efforts to address mental health concerns is the cultural differences and relativity on how trauma and other mental health concerns are experienced. Development professionals' definitions of trauma and effective services don't account for cultural manifestations of trauma or understandings of how the body works. Dominant Western ideas of mental health, trauma, and healing tend to dominate approaches in other countries, including Cambodia (Watters, 2010). In Cambodia, many studies measure PTSD. PTSD is a commonly applied diagnosis to any group of people who have experience war or other disaster- it is the "lingua franca of human suffering" (Watters, 2010). Many Western understandings of mental health are being imported around the world and overriding local traditional understandings of these issues (Watters, 2010). The Cambodian experience, however, shows that these Western categorizations and diagnoses are not universally applicable. Ethan Watters sums it up this way, "...the experience of mental health cannot be separated from culture...we invariably rely on cultural beliefs and stories to understand what is happening" (Watters, 2010). This speaks to the importance of culture to the acceptability of mental health care.

A further example of the importance of cultural context is that many studies have documented evidence that Cambodians experience trauma in the form of psychosomatic cultural syndromes that are more relevant trauma indicators than the Western construction of PTSD (Hinton, Hinton, Eng, & Choung, 2012). Some examples include Khyâl attacks, "heart weakness", and "ghost pushing you down" (Hinton, Hinton, Eng, & Choung, 2012). Khyâl is a

substance Cambodians believe flows alongside blood, and which causes serious health consequences if it is disturbed, often through trauma (Hinton, Hinton, Eng, & Choung, 2012). Studies have found Cambodians are much more concerned about these psychosomatic symptoms than they are about PTSD symptoms (Hinton, Hinton, Eng, & Choung, 2012). The disagreement in the literature and on the ground about the definition of trauma and mental health need is illustrative of important challenges of international development and aid. This culturally embedded trauma expression adds challenge to intervention effectiveness, especially when most interventions and studies come from Western perspectives with Western solutions.

Persistence of trauma over time

Another aspect of trauma theory which is important to define is the intergenerational transmission of trauma. This refers to the passing of trauma symptoms from one generation to another through a variety of mechanisms including genetics, parenting style, emotional responses, and others. There is significant evidence that intergenerational transmission of trauma is a prevalent process in Cambodia (Field, Muong, & Sochanvimean, 2013).

Some studies have examined what Cambodian parents and children think about their mental health needs resulting from these outcomes. One such study by Mollica et al examined how parents and youth perceived the mental health impacts of trauma after the genocide (Mollica, Poole, Son, Murray, & Tor, 1997). This study found that youth's perceptions of their traumatic experiences indicated high levels of mental health need. This study also found evidence that one quarter of the children experienced trauma symptoms within the clinical range of need (Mollica, Poole, Son, Murray, & Tor, 1997). The children in this study associated their anxiety, depression, and attention problems to their trauma experiences (Mollica, Poole, Son, Murray, & Tor, 1997). The perceptions of these children's parents differed slightly in terms of

identification of mental health symptoms displayed by the children. Over half of the parents reported emotional and behavioral symptoms in their children that were within the clinical range. They were similar in that they also associated these symptoms of anxiety and depression (with the addition of aggression) to their children's trauma experiences (Mollica, Poole, Son, Murray, & Tor, 1997). Another study found that children's perceptions of their parents' mental health status contributes to the intergenerational transmission of trauma. Children of those who exhibit trauma symptoms also exhibit higher levels of mental health problems, including trauma symptoms (Field, Muong, & Sochanvimean, 2013). This study also found that these children attribute their trauma to anxiety over their parents' trauma symptoms (Field, Muong, & Sochanvimean, 2013). All of this is evidence that local perceptions of both adults and children align with the plethora of study findings describing significant youth mental health need in Cambodia and the persistence of trauma for generations after the genocide.

Mediating and moderating trauma outcomes

This strong correlation between genocide experiences, trauma, and mental health consequences in Cambodia, including among youth, does have moderating and mediating variables that affect the extent of this association. Studies have found evidence of both risk and protective factors for psychosocial consequences and health among children (Mollica, Brooks, Tor, Lopes-Cardozo, & Silove, 2014). Risk factors for poor mental health outcomes include parental trauma, personal exposure to trauma, and individual characteristics (Mollica, Brooks, Tor, Lopes-Cardozo, & Silove, 2014). Studies on the intergenerational transmission of trauma have found that youth with parents who experience trauma symptoms also have higher trauma-related mental health needs (Field, Muong, & Sochanvimean, 2013); (Munyas, 2008). Similarly, there is evidence that children in Cambodia who experience trauma and violence, as still occurs

today, also experience higher rates of cultural trauma symptoms and have higher rates of needing mental health care (Field, Muong, & Sochanvimean, 2013). Finally, individual characteristics including higher poverty and less stable family structures mediate increased manifestations of trauma symptoms (Mollica, Brooks, Tor, Lopes-Cardozo, & Silove, 2014).

Protective moderating factors to the association between trauma and mental health also exist. One significant moderating factor is social support, which has been shown to improve psychosocial adjustment among children with parents who experienced trauma from the Khmer Rouge genocide (Field, Muong, & Sochanvimean, 2013). Another moderating factor for trauma and child mental health is an agreed-upon sense of justice and closure in a community regarding past traumas from the genocide (Sonis, et al., 2009). These risk and protective factors relate to underlying determinants of health, and can be potential points of intervention and focus for services to reduce trauma and mental illness and improve realization of the right to health.

Implications for international efforts

Additionally, there is evidence that there are still important gaps in mental health service, despite heavy and long-term international involvement and governmental development on health issues in Cambodia. Strong evidence has been gathered that the Cambodian youth population experienced severe mental health needs post-genocide (Mollica, Poole, Son, Murray, & Tor, 1997), and more evidence is gathering that current youth also have important mental health impacts from the trauma their parents experienced during the genocide (Mollica, Brooks, Tor, Lopes-Cardozo, & Silove, 2014); (Field, Muong, & Sochanvimean, 2013). There is also evidence for other ways in which local need and the right to health are missed by international interventions which inadequately address the right to health and AAAQ. One example is that research and trauma studies focus too much on PTSD symptoms. Many studies use measures

tested in Cambodia, but are still primarily measuring Western understandings of trauma how it manifests in terms of symptoms and effects, which may miss some important aspects of the way Cambodians experience trauma. Examples of this include Sonis et al, Mollica et al, and Field et al. These studies make important policy recommendations for health issues to address some of the trauma and mental health concerns in Cambodia, but because of the gap in relevance, these are not fully addressing local manifestations of trauma and local concerns and fears and thus perpetuate the service gap. This focus on PTSD has the potential to result in policy recommendations that do not meet the acceptability standard of the highest attainable standard of health. This is further evidence for the need for effective interventions and services to address this mental health concern and limited right to health experienced by multiple generations of Cambodians. International entities working in Cambodia have a legal obligation to assist, which in order to do well would require interventions which are culturally relevant and acceptable to the recipient communities.

Describing international aid, development, and health priorities in Cambodia

International aid has played a major role in Cambodia's development since the Khmer Rouge genocide. International aid refers to financial or other support provided from one government (unilateral) or groups of governments (multilateral) to another to assist in development goals often identified by the donor country. Aid can be tied, in which the receiving country must meet a set of stipulations of the donor country, or un-tied, in which donors give aid with no strings attached (Radelet, 2006). The International Covenant on Economic, Social, and Cultural Rights (ICESCR) is one international mechanism that was a condition of initial aid to Cambodia. Because Cambodia ratified the ICESCR, Cambodia is bound under international law to provide for the highest attainable standard of health for its people, and this includes available,

accessible, acceptable, and high quality health care (Committee on Economic, Social and Cultural Rights, 2000). The ICESCR also holds the international community accountable for ensuring the right to health in countries that are obligated under international law to fulfill the right to health but are resource limited (Committee on Economic, Social and Cultural Rights, 2000), as is the case in Cambodia. The international community has a legal obligation to assist Cambodia in fulfilling the right to health. In Cambodia, where the government is not respecting its legally binding right-to-health obligation, the international community's assistance can strengthen a restricted civil society and use tied aid to encourage the protection of rights. Historically, international entities have not fully complied with this obligation nor actively prioritized their legal obligation to assist.

The history international aid in Cambodia

Despite the state of the health system in Cambodia, the international community was slow to intervene. The Vietnamese presence deterred major world powers from providing aid, although Cambodians did not have a negative view of the Vietnamese occupancy. In 1979 right after the end of the genocide, MSF said that aid was necessary, but the organization only received aid support from UNICEF, Red Cross, Med. Aid, Vietnam, and the USSR (Kiernan, *Genocide and Resistance in Southeast Asia*, 2008). Later on, as aid increased, UN aid went mostly to Khmer Rouge camps in Thailand, the UK sent military aid to train in destroying civilian targets, and the US implemented a Trading with the Enemy Act, which also benefitted the Khmer Rouge and its allies (Kiernan, *Introduction*, 1993). US policy was to veto aid to Cambodia, support the Khmer Rouge role in Cambodia, and provide military support for Khmer Rouge allies because the US wanted an anti-Vietnamese government in Cambodia (Kiernan, *Introduction*, 1993). This is another example of the international community's historic failure to

act on their obligation to assist other nations in attaining and protecting human rights, including the right to health.

After Cambodia's externally facilitated and monitored independence, other international entities including the UN, the World Health Organization, and many international NGOs began work in Cambodia and exerted significant influence in forming Cambodia's government and health system (Diaz Pedregal, Destremau, & Criel, 2015). Western dominance has important implications for Cambodia's overall development as well as the availability, accessibility, acceptability, and quality of mental health services. For example, the WHO along with other large international NGOs regularly partner with the Ministry of Health in Cambodia to recommend improvements to its national health strategies and plans (Diaz Pedregal, Destremau, & Criel, 2015). Health funding is also a dominantly international system. The WHO, for example, not only helped develop Cambodia's health sector but also assisted with increasing funding for its development (Diaz Pedregal, Destremau, & Criel, 2015). Currently, international aid accounts for over twice as much health spending as the government of Cambodia (Diaz Pedregal, Destremau, & Criel, 2015). The government pays for 10% of overall health spending, international aid pays for 20%, and the remaining two thirds of health costs are paid for by users, many of whom can't afford to pay these costs (Diaz Pedregal, Destremau, & Criel, 2015), making health care inaccessible for most Cambodians. The international entities which are involved in health funding and policy in Cambodia are legally bound to help fulfill the right to health, including AAAQ.

International human rights mechanisms and health

International law is in support of building the health sector, and names health as a basic human right. The right to the highest attainable standard of health is identified by many

international conventions which Cambodia is party to, including the International Covenant on Economic, Social, and Cultural Rights (ICESCR), the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), and the Convention on the Rights of the Child (CRC). The ICESCR broadly defines the right to health, CEDAW articulates the right to health for women, and the CRC articulates the right to health for children. These rights include the right to affordable, appropriate, accessible, acceptable, and high-quality health care (Committee on Economic, Social and Cultural Rights, 2000). In this context, accessibility refers not only to physical access but the ability to receive care without discrimination, information access, and economic access for all, including the poor (Riedel, 2009). Acceptability includes cultural relevance of services to needs. There is significant evidence about the fact that the Cambodian government and the international community have made steps toward improving the health system since Cambodia's independence from Vietnam, however health, specifically the human rights aspects of health, have not been prioritized in the larger development project. The establishment of the international human rights conventions in Cambodia, many of which address the right to health create a framework by which the government and international partners are held accountable for ensuring the highest attainable standard of health, but this realization of the right to health is still lacking along with the AAAQ of health services, especially for mental health. The international law accountability mechanisms which could hold Cambodia and the international community accountable for not fulfilling the right to health have been gaining momentum globally (Sikkink, 2011). This has important implications for the potential of local and international communities to engage in effective advocacy for the right to health, and important legal implications if the right to health continues to be ignored.

Participatory mechanisms and health

An important piece of fulfilling the right to health in Cambodia would be local and international communities truly engaging with one another to promote the right to health and provide AAAQ services. This collaborative approach, which shapes international health and development frameworks is broadly labeled participation. Participation is a growing methodology in international development that refers to various levels of local community inclusion in program development, implementation, and evaluation. Participation refers to actual involvement of local people in development projects. Although this sounds like an ideal approach, participatory methods have challenges and shortcomings as well and will be discussed in greater detail. Participation is recognized to be a very vague and ambiguous construction but one that is invoked by many different projects and actors (Cornwall, 2008).

One way in which the participation construct is vague is related to how these organizations create and combine participatory methods, legal tools, and other approaches to build their programs and policies. A major criticism of development efforts is that development can be a very top-down process (Chambers, 1983). This Western expertise being implemented in less powerful communities is clearly visible in Cambodia. Many of the legal provisions, governance structures, and social services, including health, were externally pressured by global governance entities and international donors who provided much-needed aid to Cambodia's government. The United Nations not only facilitated the conditions of Cambodia's independence, but also required that UN-mandated human rights laws be implemented in Cambodia's new "independent" society. The UN ensured the government formally took on these covenants, including the ICESCR (Whalan, 2012). This involvement is further evidence that these external values were imposed on Cambodia and its new government by external, more powerful entities with very limited participation. Where voluntary implementation would have

improved the health and human rights and development environment in Cambodia, external non-participatory pressure has not yielded sustainable realization of these rights. Today the status of these rights is still far behind what is written in Cambodia's documents and development has been slow (Whalan, 2012).

International organizations have some level of collaboration with Cambodia's government and health ministry; however, there is low involvement of health care recipients. Participation is a core human rights principle. The ICESCR requires participation, stating that "A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels" (Committee on Economic, Social and Cultural Rights, 2000).

Current participatory strategies have fallen short of this standard. Inadequate institutionalization and poor process design on the part of key players has led to low collaboration rates in the health sector (Gilfillan, 2010). Lack of participation is prominent in health services in Cambodia by all providers. In Cambodia, services provided by international NGOs experience higher usage rates because they tend to be more affordable, of higher quality, and easier to access than government services (Cornwall, 2008). Still, however, international services focus on strategies set by Western powers who do not understand Cambodian culture, are of poor quality, and are physically and financially inaccessible for many Cambodians. International organizations have some level of collaboration with Cambodia's government and health ministry; however participation with health care workers and recipients on decision making for programs is low.

Although collaboration and participation are important components of development and the right to health, there are some who point to important shortcomings of common participatory

approaches, especially when they don't include the recipient community. Development researcher Andrea Cornwall identifies issues in defining and deciding who participates. She discusses how approaches that attempt to identify specific target groups for interventions often ignore social dynamics and power structures within those groups and communities (Cornwall, 2008). Additionally, she reminds us that “being involved in a process is not equivalent to having a voice” (Cornwall, 2008). Overall, participation is much more complex and difficult to achieve than simply involving community members in a process. Similarly, in a paper about the paradoxes of participation in development, Frances Cleaver concludes evidence is lacking in support of the effectiveness of participation strategies (Cleaver, 1999). Cleaver also identifies how many participatory projects attempt to implement external ideas of institutionalism, bureaucracy, and functionalism, which ignore local social and historical contexts (Cleaver, 1999). Additionally, in development and participation efforts there are conflicting ideas about culture, what it is, and how it affects development (Cleaver, 1999). These are important to be aware of in addressing health and rights issues.

Stemming from this issue of culture, it is clear that international aid has played an important role in policy, rights, and program development in post-conflict Cambodia, yet there is debate as to the cultural relevance of these efforts and their alignment with local perceptions. Research shows that the international community, especially NGOs, have established health services in Cambodia. Existing research and policy, however, tends to neglect the important cultural elements of trauma and mental health in the provision of these services as well as the state of the right to the highest attainable standard of health. Not much is known about how international actors incorporate the voice of service recipients and local health workers to make sure their services are addressing local need, rights, and beliefs as they relate to mental health

and health services (Hunt & Backman, 2009). International organizations working with local NGOs in a truly participatory relationship may generate more mental health services that align with the requirements for the right to health and AAAQ.

In this sense, international interventions do not always satisfy the acceptability qualifier for realizing the right to health, and not enough is known about why or how this gap exists and is maintained. Similarly, Gilfillan identifies gaps in research and knowledge related to international NGO involvement in the health sector in Cambodia. She identifies a lack of knowledge about how these organizations implement participation strategies and how they include local voices in their operations (Gilfillan, 2010). This reveals a shortfall from the accessibility and availability requirements as well, where the people have a right to participate in all health-policy decisions. Another important aspect of this topic which is unknown but to which this research topic seeks to contribute is what the differences are between international NGOs and local Cambodian NGOs working on this issue in Cambodia. Most of the research focuses on approaches to trauma and how it is researched rather than how organizations are or are not addressing it in the field. Examples of this include Hinton et al. 2012 and Mollica et al. 2014. We need more information on how organizations approach mental health and the right to health.

The supremacy of measurability

On a larger scale, dominant international development priorities are generally defined and influenced by a very economic, measurement-driven agenda rather than a population health or human rights driven agenda. The most dominant conception of development is economic development. John Roemer defines economic development as “the degree to which an economy has implemented an efficient and just distribution of economic resources” (Roemer, 2014). Stemming from this generally agreed-upon priority, most development projects focus on some

form of poverty or inequality reduction, or issues associated with these specific indicators. Although these are important issues in development, this narrow focus misses other important aspects of development and community need. An example of this is the old Millennium Development Goals (MDGs) and the new Sustainable Development Goals (SDGs). The intent of the MDGs was to unify a global agenda for development and to improve important indicators (Adams & Tobin, 2014). These goals, however, were created primarily by powerful developed countries and global governance entities that may not understand the various cultures in developing countries. There was little collaboration with these developing countries which were the primary targets of the development goals (Adams & Tobin, 2014). The Sustainable Development Goals are the product of a more collaborative process, and are more inclusive. This offers hope for more comprehensive aid and development efforts in the next fifteen years.

Mental health was not a consideration of the MDGs, nor is it a priority in the new SDGs. The overall lack of priority and data on existing mental health needs and service quality are problematic factors that limit the provision of mental health services in Cambodia (WHO, 2011). The Sustainable Development Goals only address mental health in one of the targets, but in terms of substance abuse (United Nations, 2015). Mental health is generally mentioned in the document describing the agenda of the goals, but only specifically refers to substance abuse (United Nations, 2015). Additionally, health surveys do not account for mental health, creating a shortage of mental health data. Reflective of the previously identified international priorities, the only child indicators included in these data are child and infant mortality, nutrition, and vaccination rates for infectious disease (National Institute of Statistics, Directorate General for Health, and ICF Macro, 2011). Given these challenges and shortcomings, Cambodia's health care services and systems inadequately address the health needs of the Cambodian population,

especially for mental health and trauma care (Hinton, Hinton, Eng, & Choung, 2012) (Grundy, Khut, Oum, Annear, & Ky, 2009). International organizations and donors focus much more readily on easily measurable health indicators which align with global priorities, such as maternal mortality and infectious disease immunization, so there is inadequate support and resources for sufficient trauma care, especially for children. This focus on measurability negatively impacts the availability and acceptability of the full right to the highest attainable standard of health. The Cambodian government also focuses on easily measurable data, as exemplified by the key findings of the National Institute of Statistics (National Institute of Statistics, Directorate General for Health, and ICF Macro, 2011). Mental health services in Cambodia are lacking and should receive more attention for improving the availability and relevance of these services in a post-conflict society.

This lack of focus on mental health is especially concerning given the data which show that mental and behavioral disorders are the number two cause of disability globally and regionally (Institute for Health Metrics and Evaluation, Human Development Network, The World Bank, 2013). The number one cause of years lived with disability is lower back pain (Institute for Health Metrics and Evaluation, Human Development Network, The World Bank, 2013), which in Cambodia would be associated with trauma just as much as, if not more than, symptoms such as depression. This is evidence that mental health and trauma care is an important aspect of the highest attainable standard of health in Cambodia.

This contributes to the debates as to whether dominant measurement approaches, or approaches focused on economic standards, truly measure development and wellbeing. These measurements include various poverty line measures, inequality measures, and indexes measuring broader concepts such as human development (Poddar, Chotia, & Rao, 2014)

(Morduch, 2009) (Birdsall, 2007). Although these measures provide statistical information, an important question is whether these really measure what is going on. These measurements may or may not be relevant to specific communities, especially after a project is finished and the development professionals move on. Mosse touches on this concept when he writes “development success is not merely a question of measures and meters of performance; it is also about how particular interpretations are made and sustained socially” (Mosse, 2004). This idea of social sustainability is an important tie between development priorities and implementation mechanisms.

The need for more research

There are several significant reasons why we need a better explanation about how NGOs operate in Cambodia in terms of availability, accessibility, acceptability, and quality of mental health programs. One reason is that there is a lack of information on how local and international NGOs invoke different strategies in their efforts to provide aid and promote mental health care in Cambodia. Another reason is that other researchers have identified the need for more research and information about international NGO participation policies and methodologies in the health sector in order to identify areas in which these services and methods can be improved (Gilfillan, 2010). Additionally, some research has found that international development aid is not always viewed positively among Cambodians (Diaz Pedregal, Destremau, & Criel, 2015). This may be related to the lack of understanding of local customs and beliefs and lack of participatory methods. More information is needed about local NGO attitudes and experiences. Improved explanations for how NGOs develop, implement, and evaluate their programs and how they include local input are important because participatory processes are increasingly prevalent in aid dependent countries like Cambodia. These policies are informed by research on this topic. Thus,

improved research and explanation on these methods will help inform improved policies and approaches to improve AAAQ and the right to health. Finally, other research has clearly shown the importance of including local beliefs and practices in mental health care in order for it to be accessible, acceptable, used by the community, and implemented by local health practitioners (Henderson, et al., 2005). This further reveals the importance of understanding to what extent existing approaches follow these recommendations and improve service AAAQ.

There is a clear gap between the frameworks and approaches used by international organizations to address mental health and the needs of the local communities, as evidenced by enduringly high rates of trauma. Issues of cultural differences in problem definition and solutions, lack of participation with Cambodians, and dependence on Western development priorities are some reasons why I expected this gap to exist. To conduct research to answer my question and investigate this paradox, I traveled to Cambodia to conduct interviews and field observations with several international and local NGOs. I describe my methodology in more detail in the Methods section below.

Methods

I approached my research using a bricolage approach. I used interviews, observations, volunteering, visiting monuments and attending events to gather data related to my question. This multi-faceted approach gave me a more in-depth understanding of how NGOs operate in Cambodia, and how they approach health policy and right to health issues. My experiences visiting monuments, attending events, and volunteering helped provide perspective when I systematically analyzed my interviews and observations. I conducted a total of nine interviews. I visited the Killing Fields to see how the Khmer Rouge genocide has been memorialized. I also attended five meetings between organizations working on health and/or human rights issues and

attended one special event put on by a Cambodian NGO. Finally, I spent four to five days per week for four weeks volunteering with and observing a local NGO focused on health issues.

The evidence I gathered for this research took the form of interviews of professionals working in local NGOs as well as international funding organizations in Cambodia. I conducted interviews with staff from some of the most prominent local NGOs working on health and human rights issues in Cambodia. Interviews were conducted in Cambodia during the summer of 2015. I started with a list of local NGOs and international donors, then proceeded with a snowball approach to finding more NGOs to include in the study. I contacted these organizations by email to request interviews. During the interviews, I asked for referrals to other community-based health services that I could observe or interview regarding on-the-ground practice. I conducted a total of nine interviews. These organizations asked for anonymity due to concerns of releasing not yet publicized information and concerns about political consequences. As a result, I have created coded names to replace the actual organizational names. I designated local organizations as Cambodian NGOs, or CNGOs, and I randomly assigned numbers to each organization to differentiate them. I coded interviewees within the same organization with a letter after the organization number, for example CNGO2a.

One organization in which I conducted interviews was an organization that focuses on women's health and rights (CNGO1). Another organization works on community mental health and human rights (CNGO2). The organization I named CNGO3 works on indigenous health and rights. I conducted many observations, volunteered for, and had discussions with members of CNGO4, which works on health and community education. I also interviewed an international donor agency (IO1), which has also been highly involved in health projects in Cambodia.

Although I reached out to three other international agencies, none of them responded to my request.

For my interviews, I asked interviewees to describe their health-related projects, their main donors and partners, their priorities, and their process for addressing these priorities. I asked questions about processes related to priority and goal setting, program design, implementation, funding, and evaluation. I also asked questions about how these processes have changed over time, how the organization decides who will be involved, and to what extent local communities are involved in any of these processes. I also asked questions related to how the organization frames and discusses the main issues they are working on and how these issues and frameworks have changed over the course of the organization's work in Cambodia. Additionally I asked questions about staffing, funding sources, and connections with Cambodia's Ministry of Health to determine collaborative efforts on a policy scale. The purpose of asking these questions was to provide a range of evidence about the processes by which international and local NGOs in Cambodia operate and advocate or intervene on mental health issues. I asked 'how' or 'why' follow up questions to obtain greater depth of information in responses and to gain a more detailed explanation from each respondent. Additionally, I asked questions about the challenges of operating in Cambodia, what the biggest frustrations have been, and what ideas respondents have for improving services and usage. See Appendix A for a full list of interview questions. My interviews were conducted in English. This was acceptable to the interviewees, as much business is conducted in English, especially for NGOs who receive most of their funding from international sources. I took notes during the interviews, then refined and further reflected on what I had heard by memoing at the end of the day.

The meetings I attended were primarily between international donors and Cambodian implementation partners. I observed several meetings held by various UN entities, including UN Women, UN Human Rights Commission, and WHO, and attended by local implementation partners. Observing these donor-recipient meetings helped me gather information about what qualities and types of organizations or projects are preferred by the international donor community. Two of the meetings I attended and observed were between Cambodian NGOs who were discussing a partnership to receive a grant or implement a program. Some of these meetings were in English and some were in Khmer. For the meetings conducted in Khmer, I had a translator fluent in both Khmer and English translating the proceedings for me during the meetings and I took notes on her translations. Similar to the interviews, I took notes during the meetings and used memoing to fill in my thoughts and observations at the end of the day. During this time I also memoed my initial impressions about how my findings and impressions from meetings, observations, and interviews fit together.

One Cambodian NGO does mental health direct service as well as health care worker trainings so I accompanied service providers on one of their direct service events. I followed a similar process for this special event and for my other observations. For these experiences, I went and observed, and I took notes after the experience was over. In this way I obtained valuable information about how mental health approaches are implemented on the ground.

Finally, I volunteered for and observed the operations of a Cambodian health education and human rights NGO (CNGO4) for four to five days a week for four weeks. This experience showed me how local NGOs typically approach and receive funding, how decisions are made and priorities are set, and how day-to-day operations look. This experience afforded me ample opportunities to observe the operations, priorities, and challenges of a local NGO working in this

field. Working with this organization also gave me valuable on-the-ground observation opportunities to enhance my understanding of how the organization operates in service provision and program implementation at the ground level. I wrote down my experiences, observations, and impressions at the end of each day of volunteering. During all my interviews, observations, meetings, and events I kept all the materials I received and used these to analyze how organizations are framing and discussing health issues.

The logic for choosing the initial organizations for interviews is that these are the largest and most well-known international and local NGOs operating in Cambodia that work on health, human rights, and policy issues, and that responded to my requests for interviews. The international organizations I contacted are identified in the literature as being heavily involved in developing Cambodia's health policies as well as providing services since Cambodia's independence, and thus were good sources of historical knowledge for health priorities, challenges, and strategies. The local NGOs I contacted work specifically with mental health issues by providing direct service and by training health professionals to deal with mental health concerns of their patients, human rights and health issues, or health education issues. Including these organizations gave me greater insight into how mental health and health rights programs operate on the ground, how they are used, the challenges they face, and the approaches they take to reach the community. Interviewing and observing donor entities helped me examine the issues from the other side of the policy and implementation spectrum, and identify donor priorities in choosing which specific issues and projects to support.

I sampled from within these organizations by establishing contacts with most of these NGOs in Cambodia before traveling there to conduct interviews in person, then emailing the organizations for which I received referrals from the NGOs I initially contacted. I interviewed at

least one representative from each organization as decided by the organization. I contacted most organizations through their main contact email provided on their respective websites, unless I had a specific contact in the organization. I established contacts with other local NGOs upon arrival in Cambodia through snowball sampling of personal connections between my interviewees and staff of other local NGOs.

Overall, interviewing and observing these organizations was best for answering my research question because I gained information from the most closely involved organizations working on health and human rights issues in a range of capacities from international donors and policy advisers to local service providers and NGO leadership. Additionally, these are the actors with the most potential for affecting the mental health service and policy environment in Cambodia, and thus the most potential to improve AAAQ and the realization of the right to the highest attainable standard of health. The evidence from these interviews provided information about how these NGOs operate, how they prioritize health issues, and what participatory methods they use to engage with the local community or other actors in needs assessments, program design, and implementation. This approach also helped identify why mental health service gaps exist, where they come from, and what frameworks dominate the health development environment in Cambodia.

In addition to the interviews and observations while shadowing employees, I examined any available organizational reports and publications that I received during my field experience and that I could find online to identify frameworks, discourses, and language choices that each organization uses to describe concepts, problems, and approaches related to mental health in Cambodia, specifically for children. I conducted a thematic analysis of the materials from each organization to compare and identify any emergent themes between or across organizations. I

analyzed any documents and materials I obtained in Cambodia as well as documents from the websites of each organization, and triangulated my findings with those from the interviews and observations.

I used Excel to systematically analyze the data from the interviews and meetings. I organized the data into an Excel table by organization and by interview question for interviews. Each organization had its own sheet in the workbook, and I transcribed all my interviews and observations into the sheet. I organized notes from meetings and my volunteering by my observations, I organized documents by topic, and interviews by interview questions. I then used a color coding system to discover and identify similar themes based on common words in the discourse of each data source. I starting by highlighting pieces of data that expressed similar ideas both within and across sheets in my workbook. I then did some initial coding by writing down the main finding or theme from these responses and observations in the cell to the right of each data cell. I then analyzed the main conclusion from each piece of data and conducted a second round of coding by compiling these finding into overarching common themes. I then assigned each theme a color, and colored the data cells that corresponded best to each theme. For cells that were relevant to multiple themes, I made a note next to the cell. I then compiled a list of data for each theme, including cells with more than one theme in each relevant list. I used a similar method to code my field observations and document analyses. I entered all of my observations into Excel and highlighted observations, with colors grouped by similar key words and themes. I then listed the main themes and trends that came out of my observations with organizations. For the document analyses, I searched specifically for problem definitions, which data were included in reports, funding information, and strategic approach information to reflect

the types of questions I asked in the interviews. I then compiled the data from each organization to compare and analyze on these data points.

Using this method, I identified several themes across the data in response to my research questions and related to the NGO experience with mental health and human rights. During this process, I made sure to refer back to my notes and my reflections to make sure the themes I was identifying were true to the context of the responses and observations. After this process of highlighting similar cells, the themes identified in the results section stood out very clearly from the data.

For my analysis, I used an ethnographic grounded theory approach. I looked at the compiled results from my data and extrapolated major emergent themes across all my interviews, document analysis, and field observations. The themes I identify in my results are grounded in the Cambodian social context and political environment. I did not go into my research and analysis with a preconceived theory about my data. Instead, I developed my conclusions from my experience in Cambodia, working closely with these organizations. As an active participant, I gathered deeper understanding than I would have using only interviews. I used the experience and perspective I gained from my on-the-ground experienced immersed in the culture of Cambodian NGOs to inform how I looked at my data and how to interpret the themes that arose from my research.

Results

From my research, I found that there are broader operational concerns for local NGOs that preclude mental health care beyond cultural differences and direct service issues. At some points I felt like I was asking the wrong questions based on what I was hearing about the local

NGO experience. Mental health and trauma are issues, but there are so many issues and barriers before them that prevent them from being forefront issues. Government corruption, funding issues, and international priorities and power were the main issues that prevented mental health and therefore the highest attainable standard of health from even being on the agenda. I noticed an interesting mix of organizations ‘adapting’ Western concepts or program models to fit the local context because the Western models are not culturally relevant and do not address what the culture views as the core problem or need.

There are overarching barriers that limit the feasibility of such a specific concern as mental health care. One underlying cultural context which it is important to mention before addressing other concerns is the memorialization of trauma. I visited Khmer Rouge genocide memorial sites and I observed that the memory and trauma is very much still a relevant part of life in Cambodia. In my volunteering and observations, I noticed that even small, day-to-day things can trigger traumatic memories of life under the Khmer Rouge regime. One day I was casually speaking to a staff member of CNGO4 about seafood and crab. All of a sudden she was telling me about when she was a child and her family got evacuated from Phnom Penh, at which point she was placed in a labor camp. She told me there was so little food that she would sneak out of the camp at night to try to catch crabs from the river. She would risk getting caught and punished or killed in hope of something to eat. She also told me there were five things that were like gold during the Khmer Rouge genocide: rice, salt, sugar, tobacco, alcohol. It was amazing to me how a casual conversation could so easily be turned to memories of the Khmer Rouge era. This is when I more deeply understood that still there must be so many triggers of Khmer Rouge trauma in daily life. Everything can be connected to a memory.

The memorial sites were very difficult to visit and absorb, but I noticed that although the memorialization was to honor victims and remember as a culture, most of the visitors were tourists. I saw very few Khmer visitors during my visits. Listening to the information tapes showed me how the site was constructed to preserve the proof, to educate the next generation, and to provide evidence for the Khmer Rouge trials. The exhumed and clearly displayed remains were shocking, and very clear evidence, but also went against Khmer Buddhist culture, which calls for immediate cremation after a violent death so the spirit does not stay and cause sickness or misfortune (Hughes, 2006). As a result, many Cambodians believe Choeung Ek (The Killing Fields) to be very dangerous and offensive (Hughes, 2006). This aligns with my findings and observations at Choeung Ek. At the same time, however, this site provided undeniable evidence of genocide and torture and includes traditional Cambodian symbolism in the architecture and layout of the memorial site. Many human rights events take place at Choeung Ek as well, one of which I visited. In this way, this and other sites are sometimes used a place of recognizing the human rights violations and encouraging healing.

The Killing Fields for me were heartbreaking to visit, and this is where I truly faced the reality of the genocide, beyond research and to its actual impact on the people of Cambodia. I was almost sick partway through the self-guided tour and had to take a break. I thought “who am I to be here researching? What do I know? I wish there was something I could actually do but there isn’t. All I can do is cry”. It was the signs all over the walkways saying ‘please do not step on bones’ that really got to me. It is not all buried. Even if parts of the horror seem in the past, buried with time, remnants continually surface. Constant physical reminders surfacing and resurfacing with the seasons. This struck me as a powerful parallel of what the survivors and their descendants experience. Slowly trying to move forward from the past, but memories and

other remnants from that time constantly arising to scream that there is no moving on. I had already learned through research that the trauma is still affecting multiple generations of Cambodians. It was almost entirely tourists at the killing fields.

Not surprising given this endurance of trauma, many of my interviewees addressed Khmer Rouge trauma, or placed current political and social traumas within the historical context of the Khmer Rouge and present context of a government that is not for the people and does not respect human rights. This underlying observation that trauma and its memorialization is still a very relevant aspect of life and NGO focus in Cambodia justified and informed my more specific findings about this topic. Across different interview questions and interviewees, major trends emerged that came back to specific aspects of health policy and NGO operations in Cambodia. My document analysis reflected these findings from my interviews and field observations. My experience working in the field four to five days a week provided a conceptual and experiential foundation which guided my perspective on the health and rights issues I was curious about. This complemented the perspectives voiced by the Cambodian NGO staff I interviewed. My on-the-ground experiences also helped me to identify what I should pay attention to during the special events and meetings I attended and observed. The complementary findings from my bricolage approach can be grouped into five major themes or categories which emerged from my research with NGOs in Cambodia:

- 1) Communication, collaboration, and participation are overall inadequate for successfully joining efforts to address mental health in Cambodia
- 2) Government corruption limits freedom and service delivery, yet there is a need for better regulation and coordination of services.

- 3) Local NGOs have a lack of autonomy to set their own priorities or programming goals. Their activities are primarily reactive to donor requests and calls for proposals, which are primarily guided by international priorities.
- 4) Local and international communities have misaligned conceptions and understandings of mental health, trauma, and best treatments.
- 5) Capacity limitations are a primary concern for local NGOs trying to address issues of health and human rights in Cambodia. Most commonly, these concerns relate to funding and infrastructure needs.

Theme One: Poor Collaboration and Participation

An important aspect of human rights and health policy in Cambodia that emerged from my research is the poor state of collaboration and participation. Between international and local organizations, collaboration is very top-down and limited. Between organizations and the community, participation is almost entirely lacking. Every organization I interviewed discussed the importance and effects of these relations with other local NGOs, international organizations, government agencies, and recipient communities, but also expressed difficulty in successfully developing and maintaining these relationships. A WHO document said there are “over 100 health-related national & international NGOs working in Cambodia” (World Health Organization, 2009). One interviewee also estimated somewhere over 100 health NGOs, but did not know the exact number and expressed that the sector is not very unified (IO1). These partnerships were very short-term and in the name of benefitting both organizations rather than joining forces to benefit the community.

One major component of this theme is lack of alignment within organizations and sectors regarding standards and process of providing mental health services. In response to a question

about the challenges of working on mental health in Cambodia, a member of CNGO2 said, “other organizations need to know how psychotherapy can be misused. There is no legal action for misusing this treatment. There is a radio show that abuses idea of counseling and does more harm than good” (CNGO2a). Organizations do not have a centralized entity which establishes best practice and coordinates efforts. As one respondent stated, “A network in mental health does not exist” (CNGO2b). My observations also confirmed this finding. In my observations during my volunteer experience, I found that the organization was not a part of any group of organizations working on health issues in Cambodia. Additionally, local organizations did not gather together to share findings, program ideas, or challenges. A specific example is one organization which was trying to do LGBTQ health and rights programming. There was no standard of information, and those working on the program had no education or experience with the LGBTQ community or LGBTQ issues. One common trend in program communication I observed during my interviews and volunteer work is that many local NGOs use radio for advocacy and raising awareness. Although they may not communicate or collaborate strongly with each other, radio education programs on health issues are very common. Still, there is no standard for what information should be shared, or how accurate that information needs to be. I did observe some organizations collaborating in the sense that one organization would use another’s radio program to advertise the first organization’s program, or contract an organization to put together the first organization’s annual report. Still in these cases there was a financial cost associated.

Despite the lack of coordination and centralization, some organizations do try to reach out and collaborate, but with little sustained success. A respondent from the same local NGO said “our organization attends conferences and trains staff in orphanages for how to deal with

behavior problems and how children learn their behavior from their parents” and “we invite the government to listen in to our conferences and trainings about mental health” (CNGO2a).

Another respondent said "we work with the district level and province social workers, the Ministries of Women's Affairs, Youth and Veterans, and Social Welfare staff. We invite them to learn about communication skills, how to talk and listen to people with mental health needs" (CNGO2b). In this way, some organizations are attempting to close this coordination gap in providing mental health services for children, but as described by members of this organization, service provision is still scattered and disorganized among sectors. Other respondents described challenges in working with other entities, but did not describe the same level of effort in coordinating knowledge and practices. A report from CNGO3 stated partnerships and networking as one of the organization’s intervention approaches, but the rest of the document contained no information about how these partnerships and networks are formed or used. This fragmented approach and lack of common standards negatively affects the accessibility and quality of mental health services.

In my field work, my most prominent observation related to participation and collaboration was the preeminence of international authority in defining problems and prescribing solutions. The collaboration and communication between international entities and local NGOs was primarily top down. Local NGOs tended to collaborate with each other mainly to get grants or provide training and information, but not to collaborate on actual program implementation or priorities. I observed several meetings where local NGOs contracted some temporary services, but I did not observe true collaboration or partnership. International to local collaboration primarily took the form of donor to recipient and expert to less-informed. It was only in these settings where I saw multiple local NGOs gathered together, but it was more of a

lecture or facilitated meeting set up rather than a meeting among equals to define best practices and share findings and resources. I observed this in each of the UN implementation partner meetings I attended as well as in my field observation with the local NGO (CNGO4). In my observations, I only saw partnerships or contracts based on one temporary project rather than continuing collaboration. I observed that these were less of a partnership and more of service contract arrangement, where one entity provided funds for another to carry out a project sponsored by the funding organization.

Another piece of evidence showing this top-down approach is the language of the meetings. Only one of the implementation partner meetings I attended actually took place in Khmer and was facilitated by a local staff member. All the others were conducted in English with foreign facilitators. One meeting I attended was a UN Women meeting. UN Women holds regular meetings with implementation partners, which are local NGOs. At the meetings, they discuss results, project plans and implementation, achievements, lessons learned, and challenges or solutions with each partner every quarter. In this meeting, the UN Women meeting facilitator discussed how in their sponsored projects, a multi-sectoral support has been successful, and UN Women promoted this for applicants to their new project request for proposal. In this way, international entities to some extent promote collaboration between sectors, but in practice it is limited to a donor-recipient relationship where the international organization holds the power. This limits the ability of local NGOs to express their ideas and concerns. In my observations with local NGOs, successfully implementing projects with cross-sector collaboration proved more difficult than was expressed in these meetings. Additionally, one interviewee said “NGOs don’t talk to each other, big [international] NGOs don’t talk to little [local] NGOs” (CNGO3b).

This same interviewee also stated that “internationally trained NGOs also don’t ask the community what they need or want” (CNGO3b). This is evidence that participation is low as well. None of my interviews, observations, or field experience showed me any cases of the local recipient communities being involved in program design or priority setting. These observations are what initially showed me that there was a significant lack of collaboration and participation in the health and human rights field in Cambodia. Organizations don’t engage with the local communities to conduct needs assessments or ask community members about their experiences with programs. I saw this trend also in my observation of the development of the LGBTQ health and rights program. During the program development process, there was no inclusion of the LGBTQ community. They were not represented in the creation of a program that was intended to help them. In my time in Cambodia, I did not come across any cases in which the recipient community was included in program or policy discussions. Participation is required by ICESCR, but it is not happening in Cambodia’s health and human rights work. The international dominance and lack of participation limits the acceptability and quality of mental health services that should be tailored to fit the needs and beliefs of the intended recipients.

Another common trend I observed within this collaboration theme is engagement with the government. A prominent international organization reported that they focus on collaborations with the government and reporting the health policies that exist. One representative from a large international organization said “many NGOs are trying to help the government, both bilateral and multilateral organizations, which are primarily international” (IO1). Another local organization said their organization “holds trainings at the MoH, mostly about domestic violence” (CNGO1) which is closely related to mental health and trauma in Cambodia. The largest local NGO I interviewed listed a large variety of government groups with whom they try to work: “We train

local key people, start self-help groups, home-based counseling, train people how to identify mental health, counsel people about trauma and do conflict mediation. We train police and lawyers how to interview without causing more damage. We work with the district level and province social workers, the Ministry of Women's Affairs, youth, and veteran social welfare staff. We invite them to learn about communication skills, how to talk and listen to them" (CNGO2a). One international organization interviewee described the large number of international and local organizations trying to work on health, and the disjointed nature of the sector. This same interviewee discussed the difficulty of transferring aid, priorities, and plans between this international organization and the government. One problem is "transferring reliance from external to internal sources" (IO1). The government accepts international funding aid, but is slow to produce results or implement programs sponsored by the international community. The government doesn't share its funding or support with local NGOs. One interviewee stated that as a result of this, that organization in Cambodia is starting to work more with NGOs instead of working exclusively with the government (IO1). Businesses focus on economic development, not the community, leaving NGOs to find their own way to sustain themselves (CNGO4). The lack of priority and willingness to assist and collaborate by the government limits the availability, accessibility, and quality of any attempts at mental health services. This leads me into the second theme- the tension between the need for regulation and government corruption.

Theme Two: Regulation-corruption legal tension

"NGOs are the ones doing something because the gov't is not" (CNGO1). A significant number of interviewees directly addressed government corruption or interference as a prohibitive factor to mental health service efficacy. At the same time, many respondents identified the need

for stronger regulations and higher standards of care. In many ways, these act as competing needs that create tension for policy priorities and effective mental health service delivery. One interviewee said, “There is no oversight in psychotherapy or a mental health ethics committee” (CNGO2a) This respondent also said, “We try to involve the government in whatever possible service but it is not going very smoothly because of politics.” (CNGO2a).

One respondent said this about attempts to work with the government: “government likes to show they are the ones to authorize and announce everything. We try to invite and inform the government from the beginning. They sent 2 staff for 2 days but the training was 5 days” (CNGO2a). Another program in which this organization faces this challenge is mental health first aid. "Everyone can help with the mental health problem. We are a member who was approved to be trained to be trainers for Mental Health First Aid Cambodia. In the government, some sectors did not agree to this even though we were accepted in the international community" (CNGO2a). The same respondent described challenges the government places on the organization's programming: "In Cambodia, if we say the prison tortures prisoners, we will get shut down. So we try to say something similar, like we are studying the mental health of something, but we can't say we are doing assessments for prison, even if it is in the name of a convention Cambodia signed" (CNGO2a). Politics and corruption in Cambodia makes it difficult for NGOs to provide quality, acceptable care.

Additionally the UN entities often pointed to the Ministry of Health as a partner, but I observed local NGOs to have little trust or influence with the MoH. The UN Women country coordinating office reports that they will support constituents to participate in policies and laws and gender equality as well as support the government. Another local organization, while describing what it is like to address health policy said that “there is corruption in the MoH as

well” (CNGO3b). Some international organizations also have jaded views of the government. USAID for example lists a major challenge being the fact that “political constraints limit human rights” in Cambodia. Civil society in Cambodia is extremely restricted. One local organization’s staff member put it bluntly and said, “If international aid goes to the government it doesn't get to the people” (CNGO3a). This has also been a challenge for community members trying to organize for health and human rights. "There were 1000 families in a community and two people studied to lead the community in advocacy. The community wouldn't follow because they were scared of the government (CNGO3a).

In contrast to the distrust of the government due to high levels of corruption, in my observations I did see some attempts, at least on paper, for the government to improve its regulation and standards of service provision. For example, the Government Health Development’s mission is “to lead and manage the entire health sector to ensure that quality health services are geographically and financially accessible and socio-culturally accepted to all people in Cambodia”. Still, WHO reports in its Country Cooperation Strategy document that Cambodia has no mental health policy, though there is a draft somewhere, but it is not formally recognized (World Health Organization, 2009). Additionally, I discovered in my volunteering experience that the Royal Government produced a policy document called “I4C Packs” which is a form of a community-scorecard accountability mechanism for various government sectors including health and education. Its goals, according to the document, are to provide "information for citizens" including the “rights of service users, budgets and expenditures, and sector performance against set standards” (NCDD, 2014). Despite the existence of this accountability mechanism on paper, I did not see any evidence of the level of infrastructure necessary for this to be successful. Actual implementation of this process is extremely limited, if it exists at all.

Government-sponsored health care is also corrupt and in violation of the right to health. CNGO3b told me about a clinic that infected 700 people in one community with HIV. Public clinics are supposed to be free, but they are often too corrupt and therefore too expensive, forcing people to unlicensed and untrained private doctors, such as the ones in the above-mentioned clinic. Additionally, CNGO3b talked about how a government ID is required from a specific region to get health services in that region, but because most people are migrants from different regions, they cannot get government health services and must go to unsafe private clinics (CNGO3b). This severely limits access to health care.

Another observation related to theme two about government corruption or interference is the NGO law. While in Cambodia, the government was pushing a new law to tighten control over or regulation of NGOs, depending on who you talked to. In my interviews, observations, and field volunteering experience, I noted a universal opposition to the law among local NGOs. The proposed law was a huge object of debate while I was there. There were many protests, but the organizers did not plan or announce the locations until right before so they wouldn't get shut down. Technically there is a process for legal protests, but there was so little trust of the government that the protests were planned in secret. They would appear and disappear just as quickly. Some colleagues went looking for the protest but could not find it. All they knew was the general area. All the organizations I talked to expressed extreme concern over this law. It would give the government complete control over NGO service delivery, funding, programming, and issue engagement. I found this NGO law debate to be interesting, because I observed a strong distrust of the government, and fear of retribution for any critical statements or activities. At the same time, however, these NGOs and other community members participated in protests and made stickers opposing the law.

There were multiple protests and the local NGOs I was in contact with strongly opposed the new law, but did not have much hope of having enough influence to stop it. The local NGOs focused on one small part of the law, which would require all NGOs to re-register and allow the government to control sources of funding and programming priorities. "When the law passes, the government will control NGO sources of funding, control grants. The government's new NGO law is rumored to be strictly controlled by the government. We are concerned if everything is monitored we won't be able to do the human rights approach or really address mental health concerns. Opportunities for funding will be less. International NGOs hope local NGOs can advocate for human rights, but we won't be able to" (CNGO2a). Although most of these NGOs would agree that there is a need for greater regulation, this government control outweighed any regulatory benefits the law might offer in the eyes of these NGOs. Until government corruption decreases, local NGOs will likely be resistant to government efforts to regulate the nonprofit sector in Cambodia.

I noticed similar restrictions created by government corruption in the actual programming of local NGOs. Even though Cambodia is technically bound by many of the international human rights conventions, I saw very little evidence that the government actually upholds these agreements. Many NGOs I interviewed or observed were trying to address human rights issues created by the government's actions, including land grabbing and prison torture. One member of CNGO3 (interviewee B) stated that for the most part, organizations can do the work, they just can't be open about it. No Facebook posting, no reports or written documentation, no government criticism, because people who are too noisy about this work have been threatened, killed, or have disappeared (CNGO3b). Respondent A from CNGO 3 said that the government does not provide for public health, they only care about business and development. The

interviewee cited economic land grabbing as an example, where the government is seizing and developing land under whole communities, evacuating poor families in order to sell the land to large companies (CNGO3a). This same interviewee discussed with me about how the government is now getting more aid from China, which also cares more for economic gain than the people and communities whom these actions affect. This interviewee then suggested technical aid to the government rather than financial aid in order to help the government provide services instead of just having the money line the government officials' pockets. Tight government control and heavy prioritization of economic gain strongly illustrates the government's lack of health prioritization and neglect of its obligation to ensure that care is AAAQ, in accordance with the right to health.

Theme Three: Lack of autonomy in priority setting

A third prominent theme in my research which extends from and goes beyond government control is the lack of local autonomy in setting health and program priorities. Multiple respondents discussed priority setting either on an organizational or international scale, and existing differences in perception of issues and needs when creating these priorities. For the most part, local entities have little ability to design programs for new or unique issue areas because donor priorities are well established. Calls for proposals have specific programs and impacts in mind. Thus local NGOs tend to be reactive to these calls for proposals and focused on donor priorities and requests more than their own needs assessments and community priorities. This in turn limits the acceptability and availability of mental health programs that are responsive to need. One local NGO staff member stated clearly that "aid differs from the need." (CNGO3a). Another respondent said "our priority is to try to see how the service exists in the system. We also try to respond to other needs like Khmer Rouge survivors and mental health treatment. We

try to address our priority based on the Cambodian situation and international trends in mental health” (CNGO2a).

Another manifestation of this lack of autonomy is the areas of focus that large organization choose for local implementation partner programming. In meetings between international organizations and local NGOs, I observed that international organizations presented about how to prioritize and approach certain problems, but in many cases these were not the problems prioritized by the organizations in attendance, and they did not address needs that these local organizations deemed more urgent. One interviewee said, "there is no sole support for our work. Sometimes we have to change the work to fit a call for proposal. We change our practice and strategy to fit. We always try to make our programs ethical, clinical, with good supervision, and a monitoring system to report. We use these main concepts in dealing with crisis, in whatever proposal even if we can't focus on our preferred priorities. Once we were told to advocate for our approach instead of changing it. But if we do this they won't fund us because international organizations have their own agendas” (CNGO2a). These constraints make it extremely difficult for NGOs to provide AAAQ services.

Additionally, the overall “development” concept clashed on multiple levels. Health and human rights issues were created by things done in the name of development. Economic development was prioritized more than health and human rights by the government, leaving many people homeless and without health resources. The economic development agenda trumps community health and rights. One NGO representative I interviewed discussed the problem of economic land grabbing. As previously mentioned, the government is flooding and filling in land inhabited by poor communities, forcing them out so the government can sell the land to big businesses for economic gain, but also the government is doing this in the name of development

(CNGO3a). The local people are too afraid of the government and unaware of their rights to do any advocacy, so they give up and many become depressed. (CNGO3a). I also observed this prioritization of economic gain over community wellbeing, which is a violation of the right to health, in my general experience of living, researching, and volunteering in Cambodia for a short time.

The international organizations I interacted with, which were primarily donors, had clearly stated priorities. Many WHO documents focused on WHO priorities for health development in Cambodia. They were all measurable aspects of health. WHO foci include maternal health, newborn health, child health, communicable diseases, non-communicable diseases, environmental health, and health system development (World Health Organization, 2009); (Western Pacific Region Health Databank, 2011). The WHO non-communicable diseases fact sheet was full of data, but mental health was not included (World Health Organization, 2014). If mental health was to appear in any category, it would be non-communicable diseases. This exclusion illustrates the lack of international focus on trauma and mental health, and therefore the lack of available services.

Similarly, USAID's stated priorities focus on nutrition, democracy, elections, supporting organizations that advocate democracy, fair elections, and protecting rights of vulnerable people (USAID, 2015). All of these align closely with Western values and priorities. Within the health focus is maternal and child health, infectious disease control through improving service delivery and community outreach, consistent with the Sustainable Development Goals. One NGO who has been a recipient of USAID aid said "USAID have supported us for four-year projects. They saw need and asked us what we wanted to do to address it. At the same time, we have to adjust to

fit their priorities and frameworks" (CNGO2a). In this case, USAID did ask for some local NGO input, but still within a Western framework.

This lack of autonomy limited the effectiveness of local organization. One annual report from a local NGO reported that clients were concerned that the organization was too donor oriented, not focused enough, and too reactive (CNGO2 annual report). All this aligns with consequences of being dependent on international donor priorities. Many organizations cited very broad priorities in their reports such as "health, advocacy, and participation in governance" (CNGO3 annual report) and "education through the use of effective media, communication, and advocacy activities" (CNGO4 annual report). This is too broad to be effective in all areas, but in the Cambodian context, it is broad enough to cover many international priorities and therefore funding sources.

One local NGO staff member reported that they "try to address what is really the mental health need from grassroots and professional levels" (CNGO2b). At the same time this same staff member said there is "no sole support for our work. Sometimes we have to change our work to fit the calls for proposals. Practice and strategy has to change to fit" (CNGO2b).

I went to one special event put on by an organization that adapted a Western human rights approach to trauma recovery to better fit Cambodian culture. The organization got funding from international sources to promote a human rights approach, so the local organization creatively adapted the program framework to make it work for what they knew their constituents needed. The event was on World Torture Day, and was intended to remember the Khmer Rouge genocide and provide healing for survivors. The Western approach called for victims to write their testimony of the human rights violation they experienced, then read it aloud in a public

place near the location of the offending party. Instead of taking this approach, which would not fit the acceptability or quality standards, the organization asked the Khmer Rouge survivors to write their stories and read them in front of monks at the Choeung Ek Killing Fields. The event was open to the public, but not widely advertised. After the survivors read their testimonies in front of the monks, the monks performed a blessing, and planted a tree together with the survivors. In this case, there was some room for creative flexibility, but overall international frameworks and priorities dominated the programming choices of local NGOs.

Theme Four: Misaligned knowledge and understandings

A fourth significant theme that emerged was the existence of a disconnect between international and local conceptualizations of mental health and trauma. In the interviews, many respondents discussed direct cultural differences in understandings of trauma, recovery services, and the effects of trauma on individuals and communities. The lack of international prioritization has translated to lack of information in Cambodia. One local NGO staff member said, “people don't know about mental health. They are familiar with medicine, pregnant women, and malaria” (CNGO3a). In one meeting I observed with a UN entity and local implementation partners, the presenters (none of whom were Cambodian), presented on the economic constraints of women’s confinement to the shadow economy. Although this was interesting information, very little of it was specific Cambodian data. Additionally, there was little follow-up on what this meant for the local NGOs and their widely varied areas of focus, thus limiting the availability of appropriate services.

In terms of trauma, I observed that trauma was not necessarily viewed as something that can be healed or cured, contrary to Western beliefs about trauma and mental health. This aligns

with other findings about the significance of culture in how trauma is experienced, how mental health is understood, and the negative outcomes of imposing other definitions on that culture (Watters, 2010). International approaches focus on the brain and psychology, which doesn't align with the Cambodian understanding of trauma. "It is a part of you and spiritual interventions are what people prefer, what is culturally believed to help" (CNGO2c). Differing need perceptions and priority setting were also apparent in my field observations. An example of this is the Khmer Rouge survivors who found more healing through more acceptable spiritual ceremonial approaches than through trying to "fix" their trauma and its effects.

I observed a healing ceremony for Khmer Rouge survivors. In order to get funding, the organization had to take a human rights approach, but elements of this approach clashed with their cultural values. To minimize this disconnect, the local organization adapted the desired international approach to fit local practice. "We do testimonial therapy-a human rights approach to torture. It is advocating, fighting for justice and awareness with Khmer Rouge survivors. We are not aiming for a human rights approach, we are aiming for healing. In the Human Rights approach, a person writes a testimony then reads it aloud in front of the authority figure (like protesting torture at the police station). It is in public. In our healing approach, people write a testimony, read it out loud in front of a pagoda in front of monks. The aim is to make connection to loved ones who died in that period, to move on, get a blessing, and not be stuck in the trauma. The monk keeps the document. We receive very good feedback, it is the first time they feel different in their bodies" (CNGO2a). The organization adapted the human rights approach to fit their beliefs about what their clients need and what would be most helpful.

A member of another local organization that works on mental health issues stated that "community recognition not large, there is still stigma, people are ashamed and do not seek help"

(CNGO1). This respondent said this is because "mental illness is related to a spirit ghost, magic, so people seek help unseen spiritually" (CNGO1). This shows that Cambodians do have a concept of mental health, if it is different than Western understandings and less professionalized. Stigma is high and if people have trouble coping or experience the expressions of trauma previously mentioned, many do not seek help right away. Another organization works with some of the ramifications of this stigma: "we treat mentally ill people who have been locked up because their family cannot bear it, so they lock up, sometimes for 10 years" (CNGO2b). A staff member from another local organization explained Khmer mental health responses the following way: "From the rural Khmer perspective, people first try their own ritual remedy at home, then if that doesn't work they go to monks, fortune tellers, spiritual healers, seek advice from the elderly, or go to a medium and their last resort is to seek professional help" (CNGO3a). A representative from another local NGO said that especially rural Cambodians use "traditional prayers to pray for illness. Indigenous communities pray to the forest, mountains." (CNGO1). Mental health efforts should focus more on the community level to make it relevant to the people. This could be an extension of the efforts of one of the local organizations that does trainings with community leaders and other people with understanding of and influence in local communities: "In the community setting we try to be more sustainable, we train local key people, do self-help groups, home based counseling, and train how to identify mental health, console a person about trauma, and do conflict mediation. We train police and lawyers how to interview without doing more damage. We do radio broadcasting, theater, and self-help groups to respond to not-complainant survivors to make the message reach people that mental health affects every aspect of life" (CNGO2b). This is an example of using locally relevant approaches to making acceptable services more available and accessible.

International research does not sufficiently address the influences of day-to-day stressors that create trauma and mental illness. International efforts also do not recognize the local expressions of trauma. One local staff member said, “it is hard to say the effect of trauma. Many people we work with feel depressed” (CNGO3a). A local psychologist said that the “first symptom usually sleep problems, headaches, thinking too much” (CNGO2c). This is consistent with existing research about the mental health effects of trauma in Cambodia, and preliminarily links these effects between Khmer Rouge trauma and current traumas the Khmer people face.

From the perspective of a local organization, the most common mental health needs are depression from poverty, domestic violence, alcohol abuse, family issues, and injustice in society like land grabbing” (CNGO2b). Another staff member from the same organization said, “domestic violence and alcohol were most common when we started. It is still true now due to the war, anxious situations, ongoing internal conflict, and changing political scenes all cause mental health problems. Clearly domestic violence and alcohol abuse covers up all these mental health aspects” (CNGO2a). Another respondent said, "when people seek professional help, they switch to depend on medications, not talking and working through trauma. Many people don't believe talking or psychotherapy will help" (CNGO2c). This shows that interventions should use more culturally acceptable approaches to meeting mental health need.

Theme Five: Capacity

One of the most prominent themes in interview responses was capacity, primarily infrastructure and funding. Many interviewees directly identified funding issues as challenges or limiting factors to accomplishing more comprehensive health and human rights services in Cambodia. Funding issues were not only limiting what they can do financially, but also limited

them by what big international donors would give money to support. For example, one local NGO representative said, “some [international donors] do have calls for proposals for mental health, but there are very few overall. There are one or two per year that fit with our work.” (CNGO2a). This same interviewee also stated outright that there is “not enough international funding support for mental health” (CNGO2a). One WHO document that outlined its operations and country cooperation strategy in Cambodia reveals that most external funding goes to reproductive health and communicable diseases. This is further evidence of the lack of availability of mental health care.

Funding was a prominent theme in my field observations as well. I observed that often projects were too short and funding too little, making it difficult for local NGOs to make a concrete plan to address health, specifically mental health, issues in Cambodia. Donor priorities determined the priorities and programming of local NGOs. One international organization staff member said, “The US, Gates Foundation, and small countries designate their donations for their priorities” (IO1). I observed that projects were created based on international call for proposals. I observed that local health and human rights NGOs could rarely afford to have core competencies or ongoing projects in their issue area of choice. Maintaining funding would be too difficult. In one UN entity meeting, the facilitator said the NGOs had to implement their projects according to the UN plan as stated, or they would take their money back. Impact was important, evidence based, that was what funders look for. But few NGOs had the resources to collect valid and reliable evidence, especially since most projects were so short and essentially outlined by larger international donor entities.

In my volunteer experience is where I really saw the effect limited, controlled funding has on local NGOs trying to focus on mental health and rights issues, and how it affects AAAQ.

I came into the experience with ideas about how NGOs should be managed, with diverse income sources, core programming foci, and very limited mission creep. When I started observing and volunteering with the organization, I was shocked by how many different and unrelated programs and projects CNGO4 had in progress or in the planning phase. I kept wanting to say the organization should stick to its core competencies instead of creating new projects in response to a specific request for proposal in order to get that money. I thought that would spread the NGO's resources and staff too thin and limit its effectiveness at any of its programs. But I quickly learned that that was my own Western training and understanding of how nonprofits become successful and sustainable. NGOs in Cambodia survive by reacting to donor priorities and requests for proposals. There is not enough funding to allow NGOs to pick an issue and focus solely on addressing that need in the community. Funding and requests for proposals were nearly always asking for a specific program to address a specific issue, most often aligned with measurable, international priorities as I discussed in theme three. There are too few grants specific to the Cambodian context, especially mental health, to allow organizations to solely focus on their programming and still acquire enough funds to be sustainable. Additionally, I observed a high level of stress about the proposed NGO law, which would give the government the power to approve or deny all international grants. From the perspective of the NGOs I talked with, this would further limit the availability of funding and threaten their continued existence and ability to provide services that promote the right to the highest attainable standard of health.

Many interviewee statements also discussed issues of poor infrastructure and service delivery systems. This theme is closely related to corruption and funding, however it represents a specific aspect of these themes that emerged often enough in my research to warrant its own recognition. According to one local interviewee, "the biggest mental health need is mental health

services because after the Khmer Rouge there were none. How should the need be addressed now, because there were mental health asylums before the Khmer Rouge but now twenty years after there are no mental health services” (CNGO2a).

In my observations, service delivery was outlined specifically by international donors. They provided lectures on best practices but often gave no practical steps for how local NGOs were supposed to accomplish these, especially with limited resources. The government has adopted some adaptation of community scorecards and accountability plans, which are Western development concepts, but implementation was lacking and I observed local NGOs write this into grant proposals without a plan for how to accomplish it, because they knew it would fit the international donors’ mental models of ideal service delivery and effectiveness. Ultimately, the infrastructure was not in place to support these and other activities the NGOs were encouraged to implement.

Health insurance infrastructure to make health care affordable is also lacking. A WHO document reported that 40-50% of the population uses traditional medicine, which is not covered by health insurance. Additionally, there is no service delivery model for non-communicable diseases at the primary health care level, according to WHO.

Documentation by both local and international organizations identified poor service delivery structure, and therefore poor accessibility, as a significant barrier to their work. A USAID document reported that “health and education systems are underfunded” showing the unsupported nature of service delivery systems in Cambodia. A report from a local organization discussed the need to improve their management and delivery structure. Limited capacity and limited funding were listed as two of their greatest challenges. Multiple consecutive years of

documents from another local organization focused primarily on issues of funding and operating with certain constraints in discussions of their challenges. According to a WHO document, Cambodia relies on donor funding for over half of health financing. This means more constraints due to donor priorities and ineffective systems for filtering donor contributions.

Discussion

For this research project, I set out to answer the question of why mental health is not a development priority in Cambodia, despite high rates of documented trauma and mental health need, and low realization of the right to health. In order to answer this question, I traveled to Cambodia and interviewed local NGO staff, observed some meetings, programs, and events, and volunteered with one organization. I asked questions about priority setting, funding, and programming to try to discover how local NGOs determine their policies and programming related to health and human rights. This bricolage approach provided a well-rounded exposure to the local health and rights NGO experience in Cambodia. I was able to triangulate my findings from my interviews with my observations, volunteer experience, and document research to arrive at an explanation for my question.

Through my research I found that local health and rights focused NGOs do see a need for mental health support although it is not reflected in their programming. I also confirmed that nobody is addressing this need, which is a major legal violation for Cambodia, which is legally bound to its obligation to its people under the ICESCR. It is also a legal violation for the international community, which is also bound to its obligation to assist. Availability, accessibility, acceptability, and quality are all lacking in Cambodia's current health environment, as is any concerted attempt to address this. From this research, I found five main themes in my

data that speak to why mental health and the highest attainable standard of health are not priorities. I found that there is too little collaboration and partnership between sectors, specifically international donors and local NGOs, to systematically address mental health concerns. International and local NGOs also engage in very little participation with the community. Organizations working on similar issues typically don't join together or do needs assessments, making any efforts to address mental health services and the right to health too fragmented to be effective or sustainable. This limits the accessibility and quality of mental health care because the community does not have information on where to go, and programs are not based on shared knowledge or resources.

Additionally, I found there are competing political and legal needs that preclude work on mental health and rights in Cambodia. Government corruption restricts NGO freedoms, yet there is no regulation to monitor and support the NGO sector. Fear of government retribution and lack of sectoral legitimacy are prohibitive conditions for NGOs who would like to address human rights violations and mental health needs. This limits the availability and quality of mental health care because the government severely limits what NGOs can do, and at the same time does not effectively regulate health care services.

Thirdly, I found local NGOs do not have sufficient autonomy from international agendas and donors to create their own priorities or programming goals, which limits Availability and Acceptability of services. Local NGOs do not focus primarily on mental health issues because in order to financially survive as organizations, they must align their programming with donor requests, which do not prioritize mental health, the right to health, or availability, accessibility, availability, and quality. A fourth and related finding is that the international community has a different understanding of mental health, how trauma is experienced, and the best ways to

address these concerns. As a result, local NGOs struggle to simultaneously satisfy their donors and their constituents. This lack of international prioritization has translated to a lack of information, resources, and support to develop mental health programs in Cambodia that abide by the AAAQ qualifiers mandated by international law in the ICESCR. These shortcomings limit the acceptability and availability of mental health care because international NGOs do not provide enough support to mental health issues, creating a shortage of mental health services. Additionally, existing services must align with international understandings and priorities, meaning they are often not culturally acceptable to Cambodian recipients.

Finally, I found that local NGOs trying to address issues of health and human rights face severe capacity limitations in the form of infrastructure and funding. The health sector in Cambodia is still underdeveloped, and there is significant corruption in the Ministry of Health. Local NGOs identified poor infrastructure as a limitation to effective NGO programming and mental health care. This, combined with extremely limited funding for mental health programming makes it unfeasible for local NGOs to try to develop sustainable mental health programming. These limitations affect the quality and availability of mental health services. The lack of infrastructure limits the quality of any services, whereas the lack of funding limits the ability of NGOs to provide these services.

These findings show that the questions of why nobody is focusing on the right to the highest attainable standard of health, and why mental health is not a priority are very complex questions. Not only is the Cambodian government failing to meet its legal obligations, but the international community is failing in its obligation to assist. This creates a trickle-down effect, limiting local NGO ability to advocate, set their own health programming priorities, obtain funding for sustainable operations, and provide services that meet the AAAQ standards. The fact

that mental health and the full meaning of the right to health do not have a strong presence on the global development agenda also limits the ability of local organizations to focus on mental health. This is a multi-faceted problem which has significant implications for both research and policy.

Implications of my findings for research

Most existing literature assigns Cambodia's enduringly high trauma rates primarily to trauma experiences, and does not sufficiently examine mitigating macro-level factors, such as the poor health infrastructure, internationally-influenced program design, participation strategies, and funding shortages. Taking a human rights and critical development approach to international mental health policy and services in Cambodia provides a new perspective to identify why and how the gaps in perspectives, frameworks, priorities, and approaches develop and are sustained. My research adds understanding of the program approaches local NGOs use in terms of priority setting, program implementation strategies, and operating around the environmental obstacles of government corruption, misaligned and insufficient funding, poor infrastructure, and why nobody has addressed these issues despite the legal mandate of ICESCR. Broadly, my research contributes the knowledge that local NGOs face severe limitations to addressing mental health and creating programs that meet the AAAQ standard. The current approach of the international community has been ineffective due to its external priority setting, funding restrictions, and top-down relationship structures. These international efforts largely ignore the local Cambodian context and local NGO experience, which has severe negative consequences for the availability, accessibility, acceptability, and quality of mental health services.

There is evidence in the literature to support my conceptual approach to understanding the gap between international aid for health and stubbornly high rates of trauma. Beginning with

the need, multiple studies have found strong evidence for an enduringly high rate of trauma in Cambodia, including among children (Mollica, Poole, Son, Murray, & Tor, 1997); (Field, Muong, & Sochanvimean, 2013). Another study found an insufficient provision of mental health services in Cambodia compared to the trauma rates (Henderson, et al., 2005), indicating the presence of a gap in service and the need for service and program improvement to adequately address the mental health need in Cambodia. One study about health policy and quality of service in Cambodia however did find evidence that the health structures which show the most potential for improving access, quality, and usage of health services are those structures which are based in the community (Grundy, Khut, Oum, Annear, & Ky, 2009). My findings confirm that more participation and collaboration with communities and local NGOs would improve service quality and usage by allowing more focus on local needs and making resulting services align with the AAAQ standard. Additionally, participatory methods shape the direction of development projects and thus have important implications for program development (Gilfillan, 2010). My findings show clearly that this also includes collaborations with other organizations and sectors. Again, this highlights the importance of considering the mechanisms and prevalence of participatory methods used by international NGOs to implement health services in order to understand the service gap in Cambodia. My research contributes understanding of international and local NGO approaches to these issues, specifically the need for better collaboration, participation, local autonomy, and funding flexibility. My research also clearly shows the limitations the international community's strategy is currently placing on local NGOs.

The essential contribution of my research to this topic is its focus on the local NGO experience. No existing research has asked the question of why the gap between mental health need and services is so large in Cambodia, or why the international community and local NGOs

are not addressing the right to health. Research has also not asked about the local NGO experience with mental health and human rights issues in Cambodia. One study identified a lack of research and knowledge about how post-mass-violence mental health services are being implemented and should be implemented in Cambodia (Henderson, et al., 2005). This is another area where my research contributes to our understanding. My research adds knowledge about how local NGOs maneuver within this context of high trauma rates, poor health services, poor human rights realization, and the need for local context in program development. My findings contribute an understanding of the effects of poor human rights realization and internationally-dominated health priority setting on the ability of local NGOs to meet the culturally embedded mental health needs of the community.

Implications of my findings for policy

My research shows that mental health and trauma are still important issues in Cambodia, as identified by local NGOs, international NGOs, and the literature, but there are many policy barriers that need to be addressed before these issues can become forefront priorities. This is important for policy because it confirms that mental health and the right to health are still issues, but are not priorities. This illustrates clear failures in ensuring the right to the highest attainable standard of health. Government corruption, funding issues, and international agendas were the main issues that I found which prevent mental health from even being on the development agenda. The two biggest policy issues which I found local NGOs to be concerned about were the government-sponsored NGO law and the insufficient, restricted nature of international funding and priority setting. My observations confirmed these as major concerns in the local NGO world in Cambodia. Additionally, my research showed priorities not informed by the right to health, but instead by measurable, global indicators. Overall, despite best intentions, international aid

and international involvement in Cambodia is not as beneficial for the local people as it is made out to be or as it has the potential to be. Development endeavors often have significant negative ramifications. In Cambodia, there needs to be more autonomy and agency for local NGOs to address community needs. Currently, priority setting lies with the international community which gives aid to the government which is violating its human rights obligations, and misses culturally significant aspects of trauma and mental health, thus limiting AAAQ.

Another important policy implication of my research relates specifically to human rights. Even though Cambodia is legally bound by many of the international human rights conventions, the government does not uphold these agreements and takes illegal action that limits the right to health. One very clear finding is that the local NGOs don't have any trust in the government to protect rights or support human rights work. Some NGOs even have to creatively implement their programs to avoid government retaliation for addressing health and rights issues. Although these organizations would also agree that there should be more structure and regulation for social services, including mental health, the local NGOs were very resistant to the idea that this regulation would come from the government. Here is where international assistance can come into play. Because the government is not respecting the right to health, and because local communities do not trust the government and don't have the power or capacity to advocate, the international community should partner with local communities and NGOs to address these rights violations. Such a collaborative effort that responds to local needs and concerns would improve realization of the right to health, including mental health. There is evidence that international legal accountability mechanisms are becoming stronger over time (Sikkink, 2011). In this context, it is important for the international community to take more seriously its obligation to assist Cambodia in realizing the right to the highest attainable standard of health.

The realization of the right to the highest attainable standard of health is a legally binding obligation of the international community.

Another important policy implication from my findings is the ineffectiveness of current international funding structures. Local NGOs face a real challenge trying to secure funding, especially for mental health issues. NGOs in Cambodia are very dependent on international grants for their financial viability. This creates a reactionary impression, with programs and priorities responding to international grantor priorities. According to Western best practice, organizations should stick to its core competencies and focus its efforts rather than creating programs in response to a request for proposal in order to win a grant.

Funding opportunities and service delivery infrastructure need to be improved to allow for more programmatic flexibility for NGOs. Aid and funding also needs to go to local organizations working with local communities instead of government ministries. As several interviewees pointed out, funds that go to the government do not make it to the people, they line the pockets of government leaders. Donors need to work more closely with local communities to provide funding for projects that benefit the people. On the other side of the coin however, there is the clear and consistently identified need of better infrastructure and service standards, especially in mental health. Availability, accessibility, acceptability, and quality are all elements that need to be improved through better collaboration and more responsive funding. In addition to improved community engagement, focusing on improving the realization of the right to health in funding opportunities is another way in which the international community can make a stronger impact in Cambodia and fulfill its obligation to assist.

Another important policy conclusion from my research is the importance of including considerations of cultural differences in different international approaches, for example human

rights and the focus on measurable health issues. International NGOs operate primarily from a Western perspective, informed by international agendas including the Sustainable Development Goals and other international tools. This established approach in international development efforts limits the consideration of local factors that need to influence programmatic priorities. Approaches coming from a Western construction are less culturally relevant and therefore less acceptable to the Cambodian community than interventions that adapted these tools to fit local culture and ways of thinking. In addition to differences in ideal program structure, there are also cultural differences about the causes and understandings of mental health and trauma, which limits the AAAQ of related programs. This illustrates a need for collaboration, communication, and more participatory approaches to addressing health concerns, specifically mental health concerns, in Cambodia and other post-genocidal societies.

Although participation is an elusive term that is used to justify many different approaches, some guidelines around participatory approaches have been defined. One of these guidelines is the ladder of participation. From highest (most participative) to lowest (least participative), the ranking is as follows: citizen control and partnership in the project, followed by consultation with citizens, followed by ‘non-participation’ including therapy and manipulation at the bottom (Cornwall, 2008). Although many development actors claim participation, in reality there is a wide spectrum of what this actually means in program implementation and actual citizen involvement and influence. My research in Cambodia found that most participatory approaches fall under the middle to bottom end of the ladder. The most participatory approaches I saw consulted somewhat with local NGOs on how their programs were going, but these programs were still based on the donor's established priorities. The least participatory approaches I encountered were international, electronic calls for proposals to

implement a program that addressed an international priority that was not catered to the Cambodian context.

International efforts are prominent in Cambodia, but their priorities are not addressing the needs or health rights of local communities in Cambodia. My research shows a lack of adequate collaboration and participation with the international community, local NGOs, This is a violation of the right to health and the obligation to assist, specifically related to mental health care. This lack of accounting for cultural influences and contexts very likely increases the relevance gap between development workers and recipient communities. Engaging in full participatory methods described above is one way in which international NGOs can improve service relevance and reduce the development gap in mental health in Cambodia.

Better participation and collaboration between actors would generate programs based on international research as well as the knowledge, beliefs, and priorities of the local context. This improved collaboration would foster partnerships among local NGOs as well as international organizations and communities. From the data I gathered, local-to-local collaborative efforts are primarily to join efforts to get grants and implement other projects. International-to-local collaborations are limited, structured around funding relationships, and defined by preset priorities and programming ideas on the part of the international donor entity. Some relationships are more engaged with the local community than others, but there still exists a hierarchical relationship. Additionally, prominent barriers that local NGOs face are largely unrecognized by the donor community. This leaves little room for true collaboration or participatory projects with the local NGOs and the communities they serve, because their limitations are unrecognized and their priorities are pre-defined. Additionally, needs assessments are relatively rare and are almost never required or implemented by international development organizations in Cambodia. Donor

communities need to account for the local perspective in priority setting in order to make a large impact toward reducing barriers and truly empowering Cambodian civil society to address the needs of the communities. This is important because it shows that international organizations should take more time to research and understand the local, cultural context in which they are working, which would in turn improve participation and program effectiveness.

To help with this, organizations should take a culturally-based intervention approach that is responsive to the local context. Availability, accessibility, acceptability, and quality need to be prioritized, because this standard is a good foundation to ensure health interventions are effectively targeting the community's needs. Existing research in the medical anthropology field shows the current the top-down nature of global mental health approaches, which do not account for cultural context (Drake, 2015). Another issue with global mental health is its tendency to ignore the stress of daily hardships such as poverty, violence, and inequality (Drake, 2015). All of these, as identified by NGOs in my research, play a major role in contributing to stress and seeking mental health care in Cambodia. Research in other post-genocidal societies has shown that these populations prefer societal healing over psychiatric care (Drake, 2015). My research supports this finding in Cambodia, where local NGOs adapt international procedures to a more culturally appropriate healing approach. In this way, international initiatives and aid allocations need to become more participatory and shift to prefer programs and organizations that understand the local trauma context and desired healing approaches. Again, focusing on AAAQ would address these failures.

Another significant implication of the current heavy international aid with low collaboration in Cambodia's health system that I found in my research is that it creates aid dependence and limits options for the state moving forward, also known as path dependency. In

general, as my findings have described, organizations must follow Western ideas in order to maintain their existence. As a result, both the government and local NGOs are dependent on international support for their money, support, and to some extent priorities. This limitation in turn de-motivates domestic progress and government accountability to health and human rights, and facilitates corruption (Diaz Pedregal, Destremau, & Criel, 2015). This also limits the ability of local NGOs to respond to local need in a culturally acceptable way that abides by AAAQ. Overall however, I found that Cambodian NGOs generally agree international aid is better than the alternative government-run services, which still suffer many shortcomings. This implies an important obligation for international development entities, specifically those working on health issues, to collaborate with the local population to develop services that are relevant to their needs and culturally driven priorities.

These policy implications are important because they reveal a missing piece in all the existing efforts to provide aid and development assistance to post-conflict societies like Cambodia. The discontent on the part of the local actors is an essential piece of the puzzle of why progress lags behind the efforts, and why some elements are neglected despite the need. This has significant implications for development priority setting and programming in other developing or post-conflict societies. Understanding the gaps and how local actors think about international aid and health policy would allow for significant improvement in development efforts and collaborative approaches with local communities, which in turn could create better health outcomes for these communities. To do this, interventions should prioritize AAAQ, and incorporate the local perspective.

In conclusion, my research identifies a need for more engagement on the community level, more engagement with culturally relevant ways to address social issues, and a stronger

focus on AAAQ and the right to the highest attainable standard of health. Before anything as specific as mental health can be prioritized locally, infrastructure and internal sustainability need to be achieved as well as collaborative, participatory work between the international community and local recipient communities. The right to health needs to be recognized in Cambodia as a legal obligation and point of intervention. Cambodia could very well be subject to international human rights accountability mechanisms in the future.

There are several limitations to this study that I should address. I was only able to interview staff members from a few organizations, and I was unable to get a response from most of the major donors in Cambodia. The information I got on the donor perspective was through interviewing with one major donor and observing several meetings between local NGOs and donor entities. Limited time and resources prevented me from being able to conduct more interviews with more local NGOs. I received very few responses to my requests for interviews. Most of my sampling was through the snowball method, which raises the possibility of skewed sampling. This was an inductive study which extrapolated patterns and themes from the field work I conducted for one month in Cambodia. These patterns and themes can provide a starting point for future research on this topic.

There are several areas in which I think there is a need for further research. One is on the donor perspective of the patterns I found in my interactions with local NGOs. More research is needed on these themes in other social issues, and in other contexts. There is also room for further research into the tension between poor regulation and excessive government control in Cambodia and how NGOs perceive this to be affecting their ability to provide relevant and effective services.

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Appendix A: Interview Questions

1. Please describe all your projects related to health, including conferences, workshops, and trainings related to mental health concerns and services.
2. Who are your organization's main donors? Main partners?
3. What are the main health-related priorities of your organization?
4. How has your organization addressed mental health issues?
5. What is your organization's process for program development? Implementation?
Evaluation?
6. How would you describe your organization's participatory methods or policies for engaging with the community?
7. Who is involved in setting organizational priorities?
8. What does your organization see as the biggest health-related need for children in Cambodia?
9. What are the biggest challenges your organization faces in health policy or programming?
What has been most frustrating about working on these issues in Cambodia?
10. How does your organization define mental health? Trauma?
11. What is the nature of your organization's relationship with the Ministry of Health? Local health workers?
12. For bilateral organizations: Do you have a list of all funded health programs and projects over the last 10 years? Which ones addressed mental health concerns?
13. How has your organization worked to meet Cambodia's Ministry of Health policies?

14. Is your organization familiar with Cambodia's human rights obligations (CRC, ICESCR, CEDAW, CRPD)?
15. Are there any opportunities for shadowing a member of your organization as they provide your services?