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Abstract

This case study illustrates a participatory framework for confronting critical community health issues using 'grass-roots' research-guided community-defined interventions. Ongoing work in Cambodia has culturally adapted research, theory and practice for particular, local health-promotion responses to HIV/AIDS, alcohol abuse and other challenges in the community of Siem Reap. For resource-poor communities in Cambodia, we recycle such 'older' concepts as 'empowerment' and 'action research'. We re-imagine community health psychology, when confronted with 'critical', life-and-death issues, as adjusting its research and practices to local, particular ontological and epistemological urgencies of trauma, morbidity and mortality.

Keywords

Cambodia, community health, critical, empowerment, HIV/AIDS

Introduction

This case study describes health-promotion practices for marginalised groups facing a critical challenge in Cambodia – the HIV/AIDS pandemic – using trusted concepts such as 'empowerment', 'action research' (Lewin, 1946, 1947), participatory action research (PAR) (Chataway, 1997) and 'grass-roots' community participation (Campbell et al., 2010; Lubek et al., 2002). Many articles in this special issue advance new, community health psychology 'ways of seeing'; yet, 'classic' concepts, methods and models can still work well. For instance, in Cambodia, at our project's outset, our local stakeholders, unfamiliar with TV images, rejected our videotape presentation arguing for 100 per cent condom-use and

replaced it with an audio-only soundtrack cassette for their 'walkmen'. Our Powerpoint

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presentations on preventing HIV and trafficking of child souvenir vendors – requiring electricity – were also replaced by local staff and peer-educators with outdoor role-playing sessions, Cambodian classroom-style. The same health-promotion messages, ‘older’ technologies (Lubek et al., 2002) and a growing cultural sensibility to health-promotion practices were borrowed from a ‘global’ psychology, which exchanges ideas between its centre, which remains Western, and its many peripheries, including Southeast Asia (Liu et al., 2008).

Background of project

In 2000, Cambodia had the highest HIV rates in Southeast Asia, and Siem Reap’s prevalence rates made it an epicentre, with 42 per cent brothel-based sex workers and 20 per cent women beersellers testing HIV positive (National Centre for HIV/AIDS, Dermatology and STD Control (NCHADS), 2004). A non-governmental organisation (NGO), Siem Reap Citizens for Health, Educational and Social Issues (SiRCHESEI) was formed after the first author, Ian Lubek, a social psychologist, learned of the community’s vulnerable health situation as an ‘accidental tourist’ in 1999 (Lubek et al., 2002). Lubek returned to the community and used his training as a ‘professor’ to combat HIV/AIDS, and conducted a needs assessment about patterns of community transmission and determinants of sexual health. He conducted in-depth interviews, guided initially by Lewin’s ‘action research’ framework and later by PAR (Chataway, 1997). Both advocated community immersion, continuous bi-directional feedback-loops between researchers and participants and cultural sensitivity (Kerr et al., 2010; Liu et al., 2008). Lubek fed back to interviewees their rank-ordered, critical concerns – HIV/AIDS that was killing their neighbours, gendered educational inequalities that made women become sex workers and the impact of poverty on social and health conditions. At this meeting, SiRCHESEI was formed, and local stakeholders agreed to work together to educate their community

members about HIV/AIDS, though they lacked training and resources for this. Lubek then assisted with fundraising and health education training and networking; contacted Cambodian health authorities, NGOs and HIV/AIDS foundations; and sought international health researchers’ collaboration. The latter suggested ‘tried-and-true’ ‘best practices’. Lubek was joined by Mee Lian Wong, who adapted her ‘action research’ approach and materials (Wong, 1990; Wong et al., 1998) to the Cambodian epidemic; the authors were taught by Cambodian colleagues about ‘cultural anchoring and adaptation’ of health practices and research measures.

Project ethos

The project’s ethos and basic principles are organised around an ‘empowerment via participation’ framework. It is run by community stakeholders, including health workers/educators, tour guides and entertainment workers, supported by international advisors. Day-to-day operations of 6 part-time staff and 23 community outreach peer-educators are discussed at staff meetings; goals, new directions and risk groups emanate from the NGO’s Annual Meetings (<http://www.angkorwatngo.com>), which followed a 1- to 2-day community contextualisation ‘conference’ (2001–2005), bringing together all NGOs and agencies to summarise community progress against HIV/AIDS.

SiRCHESEI constantly conducts research, so that programme decisions can be informed by evidence/evaluations, as part of the PAR framework. Contrary to international development projects, with proposals designed by external consultants in distant offices and ‘parachuted in’ (see Campbell, 2003), SiRCHESEI’s development has been organic and ‘bottom up’ in nature, and framed by community-generated suggestions for improvisation in context, rather than trying to fit to a granting agency’s terms of reference or other external blueprints. SiRCHESEI’s research and health interventions start with the grass-roots suggestions of community stakeholders. Such a community

dialogue about ‘what to tackle next’ sees all participants as equal (Freire, 1970; Vaughan, 2010). The programme seeks not only to promote behaviour change but also to create social environments that support and enable it (Campbell et al., 2010), including SiRCHESI’s ‘hybrid model of capacity building’ for strengthening local health services (Kirkwood, 2009; Lubek et al., 2002, 2013). For individual community members, its overarching goal is to increase vulnerable citizens’ sense of empowerment and agency over their own lives. People with positive experience in controlling life changes may also be likely to take control over their own health (Wallerstein, 1992). SiRCHESI’s original goals to alleviate inequities of health, education, gender and socio-economic level are all interconnected in this community, as elsewhere, and all affect peoples’ health (Farmer, 1999).

Project strategies

Building knowledge and critical consciousness through peer education

By 2003, monogamous married women and their non-monogamous husbands had replaced sex workers as the highest risk groups in Siem Reap, as HIV raced through the community, ‘bridging’ among tourists, sex workers, husbands and their wives (NCHADS, 2004). In 2002, SiRCHESI trained health-promotion peer-educators, 23 of whom continue educating an increasing number of village men and women, and also restaurant-based entertainment workers – almost 12,000 in 2012 (Lubek et al., 2013).

‘Empowering’ women to change their lives: career alternatives

Lee et al. (2010) describe the ‘toxic workplaces’ of beersellers and hostesses, linked to HIV risk (21% HIV positive, 1995–2003), harmful/hazardous nightly alcohol use, sexual coercion and violence. Their employers’ unwillingness to

provide ‘living wages’ forces many to sell sex occasionally for economic survival. To escape these health risks, 26 beersellers joined SiRCHESI’s Hotel Apprenticeship Programme (HAP) which operated between 2006 and 2008; HAP was designed to provide safer, healthier work environments, long-term career-path alternatives and living wages, by creating a literacy-training school and partnering with 9 hotels offering on-the-job mentoring. SiRCHESI continues to monitor, through three yearly interviews, the health and socio-economic progress of this group, whose members immediately became monogamous, ceased drinking alcohol and, once rid of the negative ‘beer-seller/sex-worker’ community stereotype, transformed themselves into upwardly mobile hotel workers. Most then found spouses at work, joined their lives and salaries together in marriage and had children. SiRCHESI is currently considering creating with these women a community-instigated self-run babysitting service or day-care centre as many families require both adult partners to work full-time. Outside of Siem Reap, scholarly debates may continue on the meaning of ‘empowerment’; in this community, ‘empowerment’ is the term the women themselves use in their conversations with us: they have become ‘empowered’ because men no longer force them to drink beer and have sex, they chose to leave toxic workplaces and follow another career pathway and they have selected partners and begun families, all impossibilities, had they remained beersellers. They are now assertive, they manage their finances, several of them have started their own businesses and they plan the early education of their children (Lee et al., 2010; Lubek et al., 2013).

Challenging negative social, community and global structures

Given that employment practices of international beer companies are a key driver of beersellers’ health risks (Lubek, 2005; Lubek et al., 2013), the NGO lobbied beer companies annually since 2002, with documents, emails, websites and personal

presentations at the headquarters of Heineken, Carlsberg and AB/InBev, informing their executives of negative health consequences of their practices in Cambodia, while advocating economically secure, and safer, working conditions for beersellers (see <http://www.beergirls.org> and <http://www.fairtradebeer.com>). In 2006, Heineken scientists (Van der Borgh et al., 2006) advocated emulation of their corporate strategy by offering free Highly Active Anti-Retroviral Therapy (HAART) to all of their HIV-positive brewery workers in Africa. *The Lancet* (Editorial, 2006) supported this show of global corporate responsibility for workers' health. But three co-authors of this article joined the Siem Reap Provincial Health Director, Dr Dy, to publish a rejoinder (Van Merode et al., 2006), suggesting 'gender discrimination', as no HAART was given to women workers in Africa or beersellers in Cambodia. In 2012, Heineken ended employment of all its 220 beersellers at risk, before acquiring Tiger Beer, with over 800.

Dissemination of lessons learned in Cambodian health settings

SiRCHESI's local staff, international advisors and students and interns spend much of their time 'on the ground' in the community, with delivery of health education programmes and related data-collection. Some findings do appear in academic publications across several disciplines (Lubek et al., 2013; Wong et al., 2003), and SiRCHESI team members co-produce conference presentations, seminars or colloquia in academic community/public health programmes. The project has been described as a model case study (Liu and Ng, 2007; Marks et al., 2011; Stephens, 2011). However, in reporting the community's latest 'state of health' from our longitudinal monitoring surveys and evaluating the impact of interventions, SiRCHESI often forgoes the pathway of academic, peer-reviewed journal reports (and publication lags) to produce timely feedback to community stakeholders, putting its latest data into the public domain through annual meetings, newsletters, websites and 'press releases' (<http://www.fairtradebeer.com>).

Perhaps community health psychology should be more about the impact on the community's health rather than researcher-practitioners' own high-impact visibility and career health.

Still more challenges

Response from beersellers' global employers

Despite provision of reliable, annual data about health risks and impacts of their marketing practices, international beer companies proved 'recalcitrant' in acting on reasonable suggestions for workplace health and safety for their beersellers in Cambodia (Lubek, 2005). Rather than taking strong corrective actions at little cost, these companies turned to their Public Relations departments, adept at handling 'academic' claims. While the industry did create a professional association (BSIC) with a Code of Conduct in 2006, data in 2013 still show little progress (Lubek et al., 2013; SOMO, 2012; <http://www.bsicambodia.com>). SiRCHESI's data are cited by ethical shareholders at Heineken's annual meetings (SOMO, 2012) and by unions for Cambodian beersellers (Lubek et al., 2013).

Shifting face of risk groups

In 2002, SiRCHESI targeted beersellers and married women as groups requiring peer-educator health-promotion outreach, and in 2003, after stakeholder suggestions at its annual meetings, SiRCHESI added workshops and outreach for men, and the child souvenir vendors, exploited by touring sexual predators. Currently, about 80 per cent of outreach is to married men and women in villages; in 2012, 11,910 peer-educator health-promotion contacts were completed. Government statistics saw Siem Reap's HIV prevalence rates for sex workers drop from 42 per cent in 2001 (NCHADS, 2004) to 0 in 2008. However, anti-trafficking legislation outlawed sex-work in 2009, so this risk group disappeared underground, invisible to government

HIV/AIDS surveillance or SiRCHESI's community monitoring (Lubek et al., 2013; Wong et al., 2003).

Health-risk groups are often identified 'top down' by international agencies defining worldwide risk categories (Campbell, 2003; NCHADS, 2004). But while breathalysing beersellers in their Siem Reap workplaces, SiRCHESI's staff, working at 'grass-roots' level, discovered many male drinkers in the same restaurants drove home inebriated. This new community health/safety risk group is associated with vehicle crashes accounting for 20 per cent of hospital bed occupancy. Sadly, one of our HAP students was killed in 2011 in a traffic accident. SiRCHESI may study drunk-driving more closely in the future. In addition, SiRCHESI's staff are aware of (1) the need for continuous, ongoing community prevention campaigns, as new cohorts of teenagers become sexually active; (2) 'AIDS' orphans, untested, who may need HAART; (3) trafficking of urban street children 'begging' from tourists; (4) endemic tropical diseases with high morbidity and mortality rates, some of which can be prevented by mosquito nets, clean water and elimination of household, pooled water; and (5) Provincial Health Department statistics in 2012 identifying drug users as a new HIV/AIDS risk group for Cambodia (Lubek et al., 2013).

Drivers of success

SiRCHESI remains optimistic about accomplishing its goals, expanding its work on HIV/AIDS and alcohol overuse and teaching these prevention skills to others (including interns), while looking for emerging community challenges requiring joint NGO-public health cooperation. The project harnessed expertise of external change agents and built local skills capacity, neither violating the community's sensitivities and priorities, nor pirating staff away from public health (Lubek et al., 2002). The 'grass-roots' participatory emphasis on all project activities is a result of a constant dialogue and negotiation among SiRCHESI staff, volunteers, interns, community stakeholders and international advisors.

Sustaining SiRCHESI's programme after 13 years of successes

Programmes now run on SiRCHESI's shoestring budget. Initial grants from Elton John AIDS Foundation and M.A.C. AIDS Fund ended by 2009 as community HIV prevalence rates significantly improved. Community 'business partners', facing economic downturns, chose not to continue/take over local programs such as HAP, while global corporations primarily extract profits from Cambodia for their foreign shareholders, contributing little to local health and educational and economic infrastructure, and not paying 'living wages'. SiRCHESI's programmes are supported by student fundraising, personal donations, selling fair-trade items and 17-day internships in community participation (<http://www.fairtradebeer.com/miscdocs/brochure2013.pdf>).

Conclusion

SiRCHESI's 'grass-roots' PAR versions of critical community health interventions remain 'old fashioned'. For its community-defined 'problems', recycled 'best practice' solutions may work effectively, provided they are culturally sensitised and they build local capacity and generate research evidence of their success in solving critical health and social issues in resource-challenged communities (Kirkwood, 2009). The concept of 'empowerment' still works well in such communities, where gender inequity, illiteracy, sexual coercion, trafficking, the commodification and objectification of women and lack of living wages still require more work. While many of the 26 HAP women who changed careers have talked about being 'empowered', there are far more women in the community still with challenges ahead. A critical community health psychology can still promote 'empowerment', as it assesses social and health consequences of personal life-changes.

But the Cambodia study, because it looked directly into the face of HIV/AIDS ravaging a community, suggests that the term 'critical' takes on a graver meaning than just a 'critique of

mainstream practices'. A critical community health psychology might be more about persons and communities 'in critical condition'; focussed at the larger community level, it confronts particularistic local rates of life-threatening illnesses, where death becomes the researchers' dependent variable (Lubek et al., 2009). For the critical health community, the challenge is epistemologically profound to recognise that the scientist-practitioner, now as in Kurt Lewin's day, has a responsibility to get their hands dirty and engage in health research/interventions that actually make differences in people's lives. This will be more and not less important in a globalising world where income inequality within states is growing, and where places like Siem Reap begin rubbing shoulders with Washington, London and New York daily (Liu and Liu, 1997).

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