DEVELOPING CONTINUING EDUCATION CURRICULA IN A DEVELOPING COUNTRY

ACKNOWLEDGING CULTURE AND CONTEXT

Submitted in partial fulfilment of the requirements

of the degree of Doctor of Philosophy (PhD)

Juliet Anne Fleischl

Faculty of Human Development

Victoria University

November 2001

ABSTRACT

The influences on, and process by which design and content are decided and the realities of developing and implementing continuing education curricula for health workers Cambodia provided the direction for this study. Human resource development and improving the knowledge and skills of health workers through programmes of continuing education is one of the central platforms of health sector reform. Within the reform process curricula are being developed either by expert groups out-of-country as pre-packaged courses in isolation of the country of implementation or by expert groups in-country without acknowledging the context of implementation. Developing curricula and curriculum practice (activities related to enacting the curriculum) are inextricably linked to social context. Broad historical, cultural, economic and political forces inter-relate to form and shape teaching and learning. The existing models using out-of-country and in-country experts often fail to consider this.

The analytical framework for this study consists of the concepts from the work of Michael Apple and Basil Bernstein. The parallelist model of Apple allows the researcher to use relational analysis in developing an understanding of the political, cultural, economic and social relationships (class, race and gender) from a critical perspective. Bernstein's code theory of pedagogy allows the curriculum researcher to explicitly examine

the power relationships in deciding "the what" (content and subject matter) and control relationships in deciding "the how" (interactive forms of teacher and participant relations). In combination, the parallelist model and the code theory enables a social and cultural analysis of education as well as the relations within education and curriculum.

Using a critical approach, the overarching aim of this study was to examine the process of developing continuing education curricula in a developing country. The following foreshadowed issues that provided direction for the study are drawn from personal knowledge and experience obtained working in the health sector in less developed countries undergoing a process of reform, as well as from the limited research literature available in this field:

- that a contextually appropriate process for developing curricula from the Cambodian perspective is not understood by expatriates;
- an understanding of the power relations in which health worker curricula are being developed is a significant factor in providing training that will enhance service delivery; and,
- an understanding of the relationships between economy, culture and politics are crucial to the development of contextually appropriate continuing education curricula in a developing country that is undergoing health sector reform.

The qualitative data obtained through the stories of the six participants in the study described their understanding of the process of developing continuing education curricula and curriculum practice. These data were complemented by field visit data and document analysis. Together these data sources provided insight into the complexities of the power-knowledge relationships within the country, the institutions and within the programme where the six participants, two doctors and four midwives worked and in which the study was undertaken.

The primary themes that emerged from analysis of the data included those pertaining to:

- *The role of development agencies and experts* in driving the health sector reform process and with it the development of continuing education curricula. One of the immediate effects of transferring western paradigms is to unwittingly destroy existing patterns of health care, curriculum development and curriculum practice, many of which are closely linked to cultural norms. Thus leading to less developed countries becoming dependent on western knowledge in the delivery of health care, curriculum development and curriculum practice.
- *The effects of the power knowledge relationship* of dominant groups and individuals in the culture that has a significant impact on deciding the content and design of continuing education curricula and shaping curriculum practice. In this particular country context, the training of health professionals and teachers has been so erratic that the underlying

philosophy of education is that the teacher must have more knowledge than the student. This is reflected in a non-participatory teaching style. Within the class structure of the health sector, the dominant group is the medical doctor. This study illustrates the role of the dominant group in deciding the official knowledge to be transmitted in any continuing education curricula developed.

- *The nature of health and education* which are seen as commodities that can be traded for money in the private sector. The programme invests in human capital and the participants of the courses use this capital to increase their earnings. The continuing education courses provide ways of thinking, feeling and speaking that are traded in the private sector. The very low salaries paid to staff in the health sector mean that private sector employment constitutes the core workday and livelihood.

The study provides implications for developing continuing education curricula in a developing country in terms of policy development, health worker training and curriculum practice. The study also highlights influences of the economic, cultural and political environment that impinge on the ability of programmes in a reform environment to provide more culturally and contextually appropriate continuing education curricula.

TABLE OF CONTENTS

LIST OF FIGURES AND TABLES

STATEMENT OF ORIGINAL AUTHORSHIP

This thesis is less than 100,000 words in length, exclusive of quotations, bibliographies, appendices and footnotes. Except where explicit reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma. No other person's work has been relied upon or used without due acknowledgement in the main text and reference list of the thesis

Author's note:

This study was conducted in Cambodia while I was Senior Training Advisor on a Reproductive Health Project and reflects Cambodian conditions at this time.

Juliet Anne Fleischl

ACKNOWLEDGEMENTS

Many thanks to Charya, Vandara, Khim, Sopheap, Sophoan and Kimny without whose stories this work would not have been possible.

An essential to the completion of any thesis is the relationship with one's supervisor. I am indebted to Derek Colquhoun, who never gave up hope that I would re-emerge from some far off land looking for immediate supervision assistance that was always forthcoming. His expectation of quality and thought provoking comments and questions ensured that I maintained direction.

Family and friends have played an important part in this undertaking. Many thanks to my daughter Sandra, without her understanding through the whole of my professional development this would not have been possible. To my father, brothers and sisters thank you for your support. Many thanks also to my friends and in particular Yoshiko who has been there to encourage me to complete this thesis before embarking on further career directions.

1. INTRODUCTION

Overview

> The problem at the heart of attempts to sustain recovery and reconstruction in post conflict situations is lack of capability
> (World Bank 1997: p161)

Since the Second World War many changes have been experienced in less developed countries with the emancipation from the authority of colonial administration being the most important for many of them. This period has been accompanied by significant changes in political, economic and social conditions. In less developed countries social inequalities remain marked and in many countries they increased particularly in the areas of health, education and access to social services. In addition, in recent years, there has been a trend towards restructuring and deregulation of the health and education sectors in many less developed countries. The reform policies promulgated in the health sector have three main platforms: planning, management and human resources. In order to progress the human resource aspects of the reform package, continuing education curricula are being developed to increase the skills of health workers to deliver specific services.

This chapter outlines the aim of the study and then reviews some of the specific country and health sector issues that are examined in detail throughout the study in relation to developing continuing education curricula.

The Aim of the Study

This research is a study about the experiences and interpretations associated with developing continuing education curricula in a developing country. The initial research question for the study was:

> ***How do we ensure the curriculum development process goes beyond skills transfer: acknowledging culture and context?***

It emerged out of a concern with the current trend towards technical approaches to curriculum development. Drawing on personal knowledge obtained by working in the health sector in developing countries undergoing a process of reform as a trainer and curriculum developer the following were seen to be foreshadowed issues which provided direction for the study:

- that a contextually appropriate process for developing curricula from the Cambodian perspective is not understood by expatriates;
- an understanding of the power relations in which health worker curricula are being developed is a significant factor in providing training that will enhance service delivery; and,

- an understanding of the relationships between economy, culture and politics are crucial to the development of contextually appropriate continuing education curricula in a developing country that is undergoing health sector reform.

Background to the Complexity of the Factors, Relationships and Issues in Developing Continuing Education Curricula

There is a growing body of literature on development studies and the "New Right" or neo-liberal policy and reform environment. Developing human resources through education and training is one of the components of these reforms. Literature covering concepts relating to developing continuing education curricula is addressed in chapter two. However, at this stage it is relevant to suggest that often the policies, reforms and continuing education curricula promoted under neo-liberal politics are influenced by apparent 'progress' in developed countries. Before the policies, reforms and continuing education curricula are adopted they need to be examined for their appropriateness for the contemporary Cambodian context.

An extremely wide range of factors and relationships in this developing country influences the development of continuing education curricula and curriculum practice (activities related to enacting the curriculum). In developing continuing education curricula, we are often most conscious of the immediate features within

the learning environment such as teaching materials, classroom resources and assessment. Whilst we are aware of other factors they are seldom explored in any depth and their relationship to the process of developing continuing education curricula and the consequences for health worker practice are often overlooked. This study attempts to identify the range of factors and their relationships which influence the development of continuing education in this developing country and the issues they raise for course content, course design and curriculum practice.

Changing Approaches to Education and Training within the Context of Human Resources Development

The World Health Organisation has been a central organisation in the development of human resources for health over the last 50 years in developing countries. During the earlier years of involvement by the World Health Organisation, many developing countries first sought to increase the number of health workers and then to improve their quality. Quality in the earlier years was primarily equated with training of higher level personnel i.e. doctors and some senior nurses. The model adopted was to adapt patterns of education and training already existing in more developed countries (Egger, Adams and Dussault, 1998; World Health Organisation, 1990; Abel-Smith, 1987). With the realisation that these developments still left much of the population under-served, attention was shifted to improving the efficiency of training and utilisation, and then towards better planning. Improved planning however, is proving to have only a limited

impact on human resources development (Ministry of Health, 1999c; World Health Organisation, 1999). During the 1960s and 1970s, much human resource policy and planning tended to focus on numerical targets, to the detriment of training for quality. In the 1980s, the central objective was to ensure that human resources were relevant to the health needs and demands of the population, a process of integrating health systems and human resource development was pursued. The development of the educational and the health services along two historical paths before this time had created many problems in developing countries (Egger, Adams and Dussault, 1998; Abel-Smith, 1987). The changing approaches to education and training as a component of human resources development are outlined in Figure 1.

Years	Nature of Approach
1950 – 1960	Increase numbers of doctors and nurses Reaching academic excellence and standards of highly developed countries Cross-national equivalence (credentials)
1960 – 1970	Increase numbers of doctors and nurses Increase relevance (curricula adaptation to local needs and development of social and preventive medicine)
1970 – 1980	Improved technologies (planning by objectives) Management training
1980 – 1990	New cadres of providers in developed countries Networks of community oriented schools Problem based learning
1990 – 2000	Education institutions as an active partner in health policy development and implementation Greater congruence between population and individual health

Figure 1 ***Changing Approaches to Education and Training for Health (Adapted from: Egger, Adams and Dussault, 1998)***

Reviewing the Recent History of Cambodia

To have a more complete understanding and appreciation of the complex issues surrounding the development of continuing education in the Cambodian context it is important to review the recent history of the country.

The name Cambodia is synonymous with terror. When the Khmer Rouge captured Phnom Penh on 17 April 1975, they promised political stability. They achieved a one-party system by killing anyone who disagreed with their policies. For three years, Pol Pot led the Khmer Rouge in a campaign of genocide, famine and ethnic cleansing (Woods, 1997; Chandler, 1996):

> Money was abolished and therewith any form of financial institutions and transactions; private property was abolished and all the land was bought under the control of the state; agriculture was collectivised; the fragile industrial system was neglected, those that were retained were under state control for essential production; economic infrastructure was neglected; educational institutions beyond the primary level ceased to function as did the remaining but elementary health care system ... Chinese economic help, including military assistance, was crucial to the sustenance of the regime. A limited external trade was conducted by exporting primary commodities such as rice, rubber and timber (Kannan, 1997: p7)

During this reign of terror, alongside the genocide campaign which resulted in the killing of all teachers and health workers, most texts were destroyed thereby destroying the means to educate the future generation. The Khmer Rouge as an organisation was not altogether in agreement with its internal policies as this extensive quote illustrates:

> Towards the end of 1977, stepped-up party cleansing caused many former Khmer Rouge loyalists to defect to Vietnam. When the Vietnamese invaded Cambodia in December 1978 they allied with the renegade Khmer Rouge. Vietnam sought a semblance of legitimacy in Cambodia by propping up these former Khmer Rouge leaders. They created the People's Republic of Kampuchea and its eventual leader, Hun Sen, was indeed a former Khmer Rouge leader who had defected to Vietnam during June 1977. This political arrangement remained throughout the 1980s. However, the People's Republic of Kampuchea was propped up by Vietnam which, in turn, received aid from the Soviet Union. As the Soviet Union came apart, so too did the aid flowing to Vietnam. Pressured by China, the Association of South-East Asian Nations, Russia and the United Nations, the various factions struggling for control of Cambodia agreed to peace talks. Agreements were ironed out and signed by the various factions in Paris during 1991.
>
> According to the Paris agreement, free elections were to be held during 1993. All parties agreed to participate. The United Nations Transitional Authority in Cambodia assisted in carrying out the elections. The United Nations Transitional Authority made its presence felt throughout Cambodia during this period. However, the country continued to be run by Hun Sen. When the elections were held, they were boycotted by the Khmer Rouge who thought that free elections were impossible. To their surprise, and the surprise of many others, Hun Sen's party was not the big winner in the elections. Rather it was the Khmer Rouge's old ally, Sihanouk, and his party the National Front for an Independent, Neutral, Peaceful and Co-operative Cambodia that carried the day in the 1993 elections. Unwilling to relinquish power, Hun Sen and his Cambodian People's Party agreed to share power with the Front for an Independent, Neutral, Peaceful and Co-operative Cambodia. There would be two prime ministers: Hun Sen and Norodom Ranariddh, the son of King Sihanouk. Every province would have two leaders, one each from the two competing parties. This is how Cambodia has been run since 1993 (Woods, 1997: pp419-420).

Even after the defeat at the elections, the Cambodian People's Party managed to hold on to power. "The formation of a democratically elected government in 1993 was followed by an international initiative to support a reconstruction programme for Cambodia" (Kannan, 1997: p9). The International Monetary Fund approved a

programme of activities. Bilateral programmes were expanded and by early 1993 "in excess of 30 international providers, United Nations, bilateral and non-government organisations, had installed around 100 programmes" (Duggan, 1996: p369) in the education sector alone.

Between 1993 and 1997 the coalition government became more and more fragile, with dissenting political parties being persecuted and an undercurrent of fear pervading the community. My first arrival in Phnom Penh was in February 1997. At that time, the number of military, police and civilian personnel carrying vast arrays of guns and rocket launchers came as a shock to me.

On 5 July 1997, Hun Sen the second Prime Minister ousted the first Prime Minister Prince Norodom Ranariddh in a bloody coup. The investigation of a number of human rights violations has continued since the coup and the United Nations mandated Hun Sen to hold 'free and fair' elections within the year. Many international organisations and non-government organisations reduced the size of their development commitments to Cambodia over the next eighteen months as they awaited the outcome of the elections.

Cambodia is one of the poorest and least developed countries in South-East Asia. The reproductive health situation in Cambodia is characterised by high rates of maternal and infant mortality, high prevalence of sexually transmitted diseases

including human immuno-deficiency virus. Health services in both the public and private sector are generally of limited quality, and utilisation of the public sector in particular is low (National Institute of Public Health, 1998; United Nations Consultative Group on Policy, 1998; United Nations Population Fund, 1997). The position of women in Cambodia is crucial to a healthy society:

> One in five households in Cambodia is headed by a women (and this is more than one in four in Phnom Penh); their literacy rate is only 53 compared to that of 80 for men; and the average years of schooling are a little more than half of men's 4.7 years. But women's labour force participation and unemployment rates are closer to men. Their participation in agriculture, especially food production is crucial as they provide much of the work time in such activities. This is also true for a wide range of other primary production and processing activities not to speak of their visible presence in retail marketing and food sectors (Kannan, 1997: p26).

Western Pressures on the Health Sector: What does it mean for Developing Continuing Education Curricula?

The Ministry of Health is undertaking a series of reforms to improve the quality, coverage and affordability of essential health services. Within the Ministry of Health, there are a number of vertical programmes that are gradually being integrated under the health sector reform policies (Australian Agency for International Development, 1995). The programme in which the research was undertaken is a vertical programme that has as its overall strategy to:

> ensure that reproductive health inputs are integrated with, support and complement the direction being taken by the Ministry of Health for health services as a whole ... There are four major cross cutting issues: institutional strengthening; expanding and

> improving services; increasing awareness; and, creating sustainability (United Nations Population Fund, 1997: p5).

Developing countries are under pressure to take guidance from the experience of industrialised and other developing countries in formulating programmes for health sector reform (McPake and Machray, 1997; World Bank, 1991). The health sector reform movement being lead by the larger international organisations and bilateral aid programs, involves the guiding principles of equity, decentralisation, privatisation and quality of care. This health sector reform is being implemented as a top down approach to achieving essential change. The reform is based on three platforms of planning, management and human resource development.

Community health development projects represent an important complementary bottom up approach to the health sector reform. These projects tend to be implemented with assistance from non-government organisations who have the ability to provide participatory health service delivery methods at the level of the community more effectively than the larger international organisations. Figure 2 shows the direction of activity of international organisations and non-government organisations across the health sector.

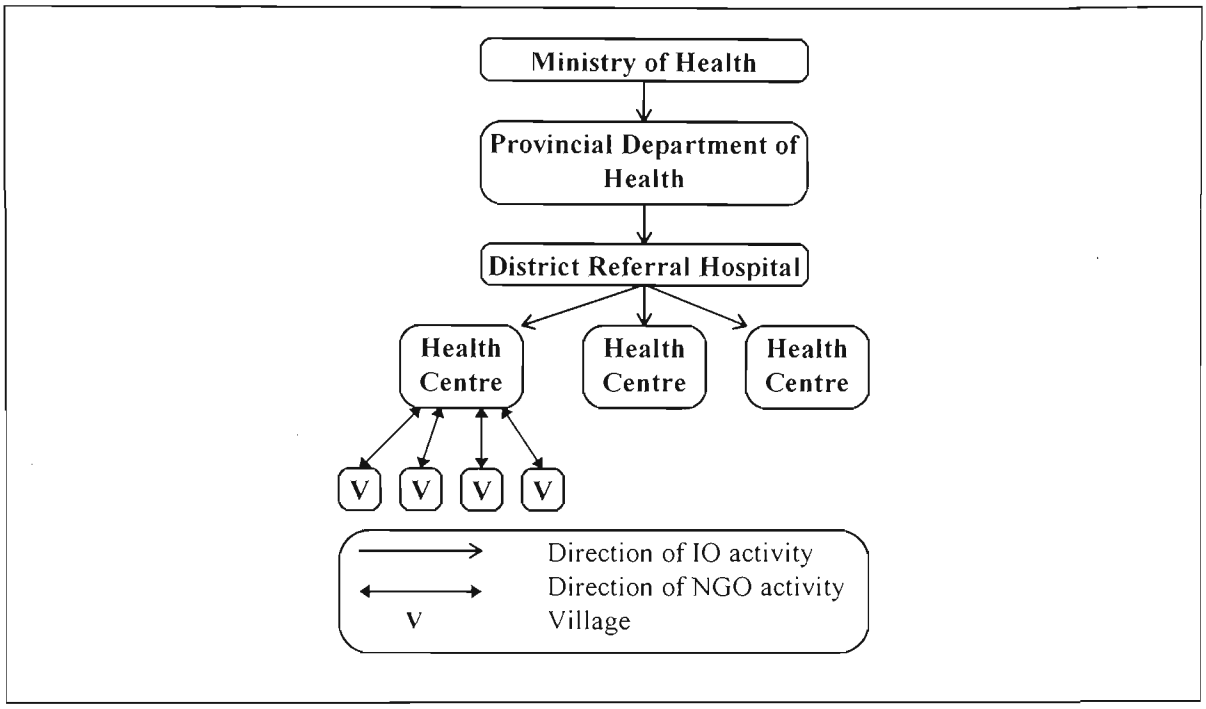


Figure 2 ***Direction of flow of International Organisation (IO) and Non-governmental Organisation (NGO) activity across the health sector***

The relationship between health, the environment and development is inextricably linked, thereby making health an essential cross sectoral issue. Even where large amounts of financial and technical aid are provided to developing countries, health sector and community development projects often find their efforts fail to make an impact on the overall well-being of the communities they serve. Recommendation 7.5 of the Committee to Review the Australian Overseas Aid Programme states the Australian Agency for International Development (1997) "should develop a new health policy giving clear priority to primary health care ... and health sector management and reform" (p128). Primary health care activities most commonly occur at the rural health centre level where health workers often

encounter very difficult conditions. Some common examples (Stefanini, 1995; de Winter 1996) of difficulties at the rural health centre level are:

- basic supplies are unavailable;
- staffing is inappropriate; and,
- referral centres are too distant.

Planners drawing up targets, regulations and procedures often insufficiently take the weak infrastructure at this level into account. In addition, measures to strengthen the structure are not adequately covered in health management and health worker training programmes as design teams often make false assumptions about the circumstances in which health workers practice.

Richter, Ouattara, Heilenkotter, Gueye and Fischer (1996) found health workers given inadequate support to improve the systems in which they work are liable to lose interest, give up their professional aspirations within the system and refuse responsibility. Inadequate development of the structure to support the services also leads to their under-utilisation by the intended beneficiaries.

Education and training assistance is a significant component of the overseas aid programmes provided by multi-national and bilateral donors, however, much of this educational assistance has traditionally focused on tertiary scholarships. In August 1996 the Australian Minister of Foreign Affairs announced a new education and training policy for Australia's aid programme which changed the

focus of assistance in this area (Thomson, 1996). The new policy has increased the emphasis on basic, vocational and technical education with targeted support for higher education and tertiary scholarships. The new policy also focuses on institutional strengthening needs and incorporating distance education where appropriate. Most importantly, the policy emphasises the need to tailor assistance according to the needs and priorities of recipient countries. Moon and Murphy (1999) assert that curriculum development and curriculum practice are inextricably linked to social context where broad historical, cultural, economic and political forces inter-relate to form and shape teaching and learning. Therefore, any efforts undertaken in the area of curriculum development and curriculum practice need to be cognisant of the complexity of these forces.

Conclusion

This chapter has introduced the overarching aim of the study and identified some of the issues relevant to the study. It has also sketched an outline of some of the historical features of the country in which the study was undertaken. There is an expectation that any continuing education curricula developed for health workers in this developing country will be cognisant of the complex factors and relationships that exist.

The following chapters of this study will therefore seek to describe, explore and critically examine the contextual factors and influences on developing continuing education curricula within the programme where the six participants are based. Chapter two examines the literature that has been used to guide the study and focuses in particular on the currently in-vogue concepts and processes related to development, reform and curriculum development and curriculum practice. Chapter three describes the research method used in this study. Included in this chapter is a description of the procedures followed in the research including data collection and analysis procedures. Chapter three also outlines the content of the subsequent four chapters. Chapters four to seven are the data chapters. Chapters four and five are set at the macro level and discuss the context of the country, describing the power and knowledge relationships of the Ministry of Health and programme along with the development agency's and experts. Chapters six and seven illustrate and examine experiences in developing continuing education curricula and the teaching practices in implementing curricula, curriculum practice. Chapter eight draws together the experiences of the research participants to provide recommendations for policy development, health worker training and curriculum development. Chapter eight also contains the concluding statement about this study of developing continuing education curricula in a developing country context.

2. CONCEPTS AND PROCESSES: A LITERATURE REVIEW

Overview

Much has been written about the historic and future directions of development projects and the effect on the recipient country economy as many development agencies and governments grapple with justifying their aid spending (Australian Development Studies Network 1996; World Bank 1997). History has shown that development is more than getting the right economic and technical inputs. It also includes the underlying institutional environment. Development is now geared towards getting governments of less developed countries better focused on the core public activities targeting social development, human resource development and institutional capacity building (World Bank, 1997; Rollason, 1996).

This literature review examines the linkages of various concepts and processes that are relevant to developing continuing education curricula in a developing country. The literature reviewed comprises three main categories that are interrelated:

- selected development concepts with links to developing curricula and training;

- reform concepts and processes and their meaning for developing curricula and training; and,
- continuing education curricula concepts.

Selected Development Concepts with links to Developing Curricula and Training

This section of the literature reviews the concepts of development, sustainable and sustainability led development.

The literature related to development considers two meanings of development that are interlinked. These include:

- social development of communities; and,
- political development of economies.

Hughes (1994) argues the expressed prime focus of development for governments and international organisations is economic development - "increased output of goods, services, employment and wealth" (p18). Brundtland (1987: p87) describes development as involving a progressive transformation of economy and society.

In the 1980's, the World Bank argued that there was sufficient evidence to indicate that "economic growth generally contributes to alleviation of poverty" (World Bank, 1991: p67) and that "human development depends on economic

growth to provide the resources for expanding productive employment and basic services" (World Bank, 1991: p97). These philosophies lead to a decade of structural adjustment programmes. This concept is developed more fully in the section relating to reform processes in less developed countries later in this chapter.

A commonly cited definition of development is:

> Development covers a complex series of interrelated change processes by which a social system, with optimal regard to the wishes of individuals and sub-systemic components of that system, moves away from patterns of life widely perceived as more satisfactory and more human. These changes may be gradual or abrupt, but some degree of calculation must be present on the part of society's influential decision-makers regarding optimum speeds at which change ought to proceed and minimal costs paid, because *how* development is gained is no less important than *what* benefits are obtained at the end of the development road. (Goulet, 1971, p332)

The major Marxist and neo-Marxist development theories were severely criticised in the 1980's leading to what Schuurman (1993) describes as an impasse in development theory. Theories before this impasse included:

- Dependency theories of the 1960's
- Modes of production theory 1970's and
- World system theory mid 1970's

Booth (1985) argued that metatheoretical influences within Marxism had forced discussion into grand simplifications that were either wrong or pitched at a level of generality that made them irrelevant to the most important practical issues

facing developing countries. Appendix three contains diagrammatic representations of how Hettne (1995) and Larrain (1989) interpret theories of development.

Later theories and definitions of development (Brett, 1996; Edwards, 1993) encompass the concepts of "participation" and "empowerment". They argue that development must increase the control which poor and powerless people are able to exert over aspects of their lives they consider important to them and that we should always examine wider forces and trends through the eyes of those who experience and act in them. This support for participation has moved into mainstream donor and private sector agencies notably the United Nations Development Programme and the World Bank. Now, participation, empowerment and sustainability are basic tenets of community development along with programmes specifically tailored to women in development.

The requirement to monitor women in development indicators is an integral component of aid project reporting formats (United Nations Population Fund, 1997; Australian Agency for International Development, 1995). Moser (cited in Townsend, 1993) describes women as having a triple role in development within "developing countries: in production (or income generation), in reproduction (biological and social) and in community development" (p173). However, Moser and others, notably Kandiyoti (cited in Townsend, 1993) argue that women's

projects from the Food and Agriculture Organisation or the World Bank are not about change or treating women on equal terms but about women being a cheap means to deliver the project objectives.

According to Adelman and Morris (1997):

> both the modern pioneers of development economics (Rosenstein-Rodan, Chenery, Hirshman, Leibenstein, Lewis, Myrdal, Nurske, Rostow, Scitovsky and Streeten) and the neoclassical development theorists (Bhagwati and Krueger) view economic development as a growth process that requires systematic reallocation of factors of production from low-productivity, traditional technology, decreasing returns, mostly primary sector to a high-productivity, modern, increasing returns, mostly industrial sector (p831).

This study views the process of developing continuing education curricula for health workers as supporting and promoting participation, empowerment and intersectoral collaboration, while being cognisant of the economic, social and political environment.

Definitions of 'sustainability' abound and reflect specific points of view as well as value judgements. Interest in sustainability has sparked a number of studies and discussions in a range of development fields, though literature on the health sector is scarce[1].

[1] See Redclift M. (1987) *Sustainable Development: Exploring the Contradictions.* Routledge, London. Brinkerhoff D. and Goldsmith A. Eds (1990) *Institutional Sustainability in Agriculture and Rural Development: A Global Perspective.* Praeger, London. Grindle M.S. and Hilderbrand M.E. (1995) Building sustainable capacity in the public sector. *Public Administration and Development,* V15, N5, pp441-463.

La Fond (1995) defines sustainability as "the capacity of the health system to function effectively over time with minimum external input" (p17). She argues this places the focus clearly on:

- securing sufficient resources locally;
- using resources effectively and efficiently to meet health needs; and,
- establishing self reliant and effective health systems.

By contrast, the United States Agency for International Development defines sustainability as "the ability of a health project or programme to deliver health services or sustain benefits after major technical, managerial and financial support has ceased" (cited in La Fond, 1995: p28). This definition has a narrow project focus which absolves donor governments of the responsibility of funding long term the recurrent costs of health activities.

Brinkerhoff and Goldsmith (1992) in developing a framework for interpreting sustainability and Bossert (1990) in a study of five countries in both Central America and Africa concluded there are some lessons that can be learned to assist the sustainability of agriculture and health projects. These include:

designing and managing projects so as to:

1. demonstrate effectiveness in reaching clearly defined goals and objectives;
2. integrate their activities fully into established structures;
3. gain significant levels of funding from national sources during the life of the project;
4. negotiate project design with a mutually respectful process of give and take; and,

5. include a strong training component (Bossert, 1990: p1022).

Bossert (1990) also asserts that other project characteristics sometimes cited as being significant for sustainability are not important. These include the length and size of projects; the type and time period of technical assistance; coordination among donors; and, the involvement of the private sector. The concept of ownership by the recipient country at all levels is clearly a significant lesson to be learned for ensuring sustainability. Participation, empowerment and collaboration when developing continuing education curricula for health workers are essential for sustainability.

In many ways, sustainable development is more a slogan than a tight theoretical concept. The most quoted definition of sustainable development is:

> development that meets the needs of the present without compromising the ability of future generations to meet their own needs (Brundtland 1987: p43).

The Brundtland Report (1987), Our Common Future, places the elements of sustainable development within the economic and political context of international development and puts environmental issues on the political agenda. The Brundtland Report vision of sustainable development presented as Figure 3, is predicated on the need to maintain and revitalise the world economy.

1. Reviving growth.
2. Changing the quality of growth.
3. Meeting essential needs for jobs, food, energy, water and sanitation.
4. Ensuring a sustainable level of population.
5. Conserving and enhancing the resource base.
6. Reorientating technology and managing risk.
7. Merging environment and economics in decision making.

(Source: Brundtland 1987, p93)

Figure 3 ***Critical Objectives for Environment and Development Policies proposed in the Brundtland Report.***

The Australian National Health and Medical Research Council (1991) supports arguments in the 1990 Canada Green Plan, recognising health as an essential cross sectoral issue. The Canada Green Plan defines sustainable development as:

> an activity in which the environment (including health considerations) is fully incorporated into the economic decision making process as a forethought not as an afterthought. It holds that resources must be treated on the basis of their future, as well as their present, value. That approach offers genuine hope of economic development without environmental decline (cited in National Health and Medical Research Council, 1991: p4).

Another national statement included in the National Health and Medical Research Council document comes from the "After - Environment in Trust - one world conference" of the Department of the Environment, United Kingdom, September 1989. The conference presented a diagram of the relationship between health and sustainable development (National Health and Medical Research Council, 1991: p11) which is reproduced as Figure 4.

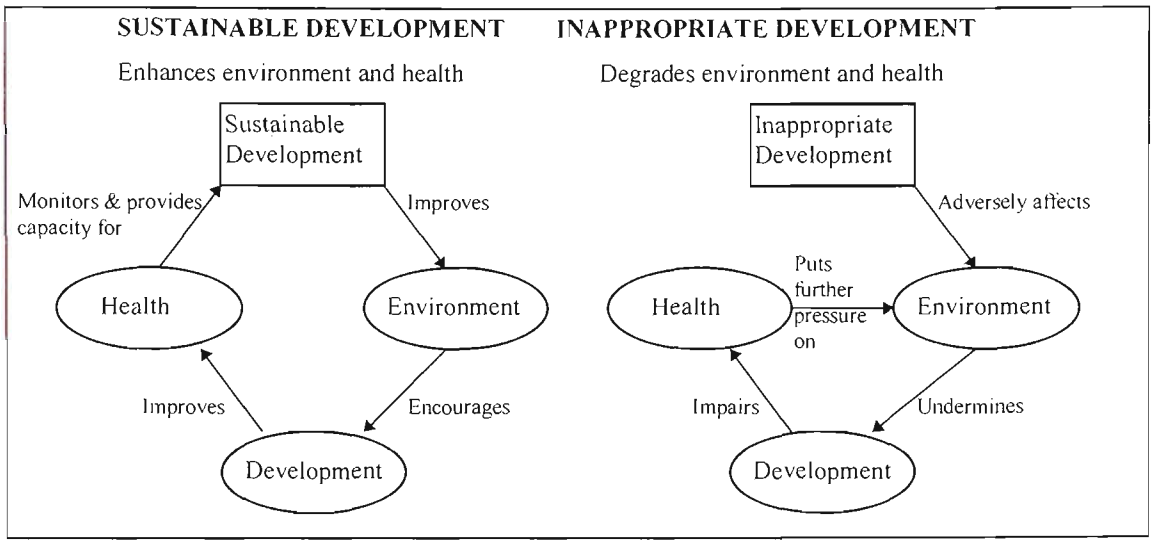


Figure 4 ***The Relationship between Health and Sustainable Development: from After - Environment in Trust - one world conference (1989).***

O'Riordan and Voisey (1997) agree there are four significantly differing perspectives of sustainable development in the literature, but argue each of the four components of sustainability contain attributes that resonate and are interdependent. The four components:

- markets - secure wealth creation
- regulations - stewardship
- equity - empowerment
- revelation

are described in Appendix four. In an attempt to explain the interdependence, O'Riordan and Voisey break down each component into seven dimensions and outline the pattern of discourse around each component and dimension (1997:p10). Diagrammatically this is presented as Figure 5.

	Market	Regulatory	Equity	Revelatory
myths of nature	expandable limits	pre-cautionary limits	breached limits	negotiated limits
social values	enterprise	protection of vulnerable	citizenship	community
policy orientation	price signals	rules to contracts	equality of opportunity	inclusion
distributional arrangements	markets	by agents of rule-makers	by democracy	by negotiation
generating consent	compensation	by agreed rules	negotiation and compensation	by reasoned discourse
inter-generationality	future looks after itself	future helped by present	future planned by present	future envisioned
liability	spread losses	fine redistribution	burden sharing	by negotiation

Figure 5 ***Patterns of Discourse around Sustainable Development: Adapted from O'Riordan and Voisey (1997).***

Developing continuing education curricula for sustainable health worker training involves participation by the community, recipient country counterparts and acknowledgment of the impact of the environment.

Reform and the Meaning for Developing Curricula and Training

This section explores literature related to:

- reform programmes in less developed countries;

- health sector reform in less developed countries; and,
- the role of non-government organisations in development projects.

Mosley (1991, p224) states:

> The World Bank in the 1980's staked its reputation on the claim that 'outward-looking' economies showed higher levels of production efficiency than 'inward-looking' economies and that governments of all developing countries could increase living standards by making their economies more 'outward-looking'.

Moreover, Slater (1993) asserts the 1980's were a decade of structural adjustments and the streamlining of states by cutting, differentiating, dismissing and privatising.

Many developing countries have formally agreed to implement structural adjustment programmes supported by loans from the International Monetary Fund and World Bank. According to Slater (1993) and Mosley, Harrigan and Toye (1991) the World Bank has never given unconditional loans and the most important conditions of the loans have been a requirement for policy change. The structural adjustment programme initiated by the International Monetary Fund and World Bank address issues in macro economic management and contain the core elements of: devaluation, increased producer prices, reduced wage bills, wage freeze, decline in real wages and salaries, elimination of subsidies, and privatisation. According to Kannan (1997) the long term objectives for structural adjustment programme of economic growth are anchored in the development of

the private sector and restricting the role of the public sector. A limited role for the public sector is recognised in the sphere of economic infrastructure but in practical terms, it is no more than rehabilitation. A sample of the policy changes required in the health sector to be eligible for a World Bank lending agreement is outlined in Figure 6 below.

Structural Issue	*Measures taken by government*	*Verifiable Indicators*
Consolidate gains of past health investments, especially in primary and preventive health care	Focusing programme on lowest income groups	Improve preventive health care and broaden action to include chronic diseases of adults including cancer, cardiovascular and other diseases
Improve efficiency in use of resources allocated to National System	Partial decentralisation and municipalisation of the health system	Implement administrative systems to improve cost containment, accounting, user fee collection and hospital management
Improve efficiency of the private health care system		Strengthen regulation of private health care industry and clarify contracting relations with public sector
Improve efficiency of investment in health		Undertake two year programme to rehabilitate machinery and hospitals

Figure 6 ***A sample of World Bank Structural Adjustment Programme Lending Conditions. Adapted from Mosley, Harrigan and Toye (1991)***

This type of reform process has been seen in Indonesia in recent years. Walters (1998) asserted that "reform in Indonesia is almost impossible because everyone is part of the system (p24)". However, the article goes on to state:

> The International Monetary Fund program is the most far reaching economic restructuring package in recent history ... It has begun to attack some of the patrimonial system ... of Indonesia.
>
> On Thursday some of the long-standing and most often criticised monopoly and cartel arrangements ... were summarily scraped (p24).

Payer (1991) and Chossudovsky (1991: cited in Schuurman, 1993, p11) contend the structural adjustment programme of the International Monetary Fund is the cause rather than the solution to the economic problems experienced in the third world. Chossudovsky argues that the withdrawal of the state, the liberalisation of the economy and the growing emphasis on export-led industrialisation resulted in a dual economy. In the dual economy, one sector produces for the international market and another sector produces for a shrinking national market leading to increasing impoverishment of low-income groups.

Multi-nationals, the World Bank and donor agencies have considerable influence on health all over the world. There is a growing recognition that in many countries, monopoly public providers of infrastructure, social services and other goods and services are unlikely to do a good job.

Activities traditionally confined to the public sector, such as health and education, are increasingly being undertaken by private sector organisations in a competitive way. To take advantage of the better allocation of scarce public resources governments are now beginning to separate the financing of infrastructure and services from its delivery and to unbundle competitive segments of the health and education markets from the monopoly segments. The state no longer sees itself as the sole provider of these services.

Separate programmes and privatisation in health and education means that the government can free up monies for social assistance programmes meant to assist the poorest in society.

Developing countries are under pressure to take guidance from the experience of industrialised and other developing countries in formulating their own programmes for health sector reform (McPake and Machray, 1997; World Bank, 1991). Health sector reform in the current political context, often referred to as the New Policy Agenda, is based on economic rationalism. Bates (1996) indicates that the strategies of economic rationalists serve to privatise health and education and create structural controls through nationally set standards e.g. national curricula for health personnel continuing education training. These types of reforms he argues reduce professional autonomy and reduce education and health sector reforms to a level where they serve the interests of the economy rather than

the people. The tension created by economic rationalism on development is in direct opposition to the social development tenets of community participation and empowerment.

Health transition, a term coined by Caldwell (Chen, Kleinmann and Ware, 1992, p3) is a concept that encompasses those changes in social norms, social structure and individual behaviour that result in better health. Under the health transition concept, health in developing countries is viewed as being in transition from diseases that are linked to natural infection processes to ones which are largely the consequence of the man (sic) made environment.

The World Health Organisation is promoting the decentralising and integration of health services worldwide in its strengthening basic health services strategies[2] which is part of the move toward health for all for the year 2000. Integration of health services is defined as the "process of bringing together common functions within and between organisations" to solve common problems, developing a commitment to shared vision and goals and using common technologies and resources to achieve these goals. The aim is to "promote health services which are fully integrated under the management of a district health team, led by a

[2] The Basic Health Services strategy sets up "a network of institutions that provide certain indispensable medical care and preventive health services to individuals. The services are rendered by professional and nonprofessional staff who have been selected without prior consultation with the community they serve, and the community itself is not necessarily involved in the action taken to improve its health" (cited in World Health Organisation (1996) from: Glossary of Terms used in the "Health for All" Series No 1-8 Geneva, WHO, 1984)

district health manager, in order to make the most efficient use of scarce resources" (World Health Organisation, 1996: p 4).

Cassells (1995) identifies the main components of health sector reform. These are set out in Figure 7.

Improving the performance of the civil service	Reducing staff numbers, new pay and grading schemes (including performance related incentives and salary decompression), better job descriptions and appraisal systems, improved financial disbursement and accounting, establishing executive agencies.
Decentralisation	Decentralising responsibility for the management and / or provision of health care to local government or to agencies within the health sector. Establishing self-governing hospitals or autonomous district boards.
Improving the functioning of national ministries of health	Through organisational restructuring, improving human and financial resource management, strengthening policy and planning functions, setting standards for health care provision and developing systems for monitoring performance, defining national disease priorities and cost effective clinical and public health interventions.
Broadening health financing options	Through the introduction of user fees, community finance, voucher systems, social insurance schemes and private insurance.
Introducing managed competition	Promoting competition between providers of clinical care and / or support services through single or multiple purchasers.
Working with the private sector	Establishing systems for regulating, contracting with or franchising providers in the private sector including non-government organisations and for-profit organisations.

Figure 7 Components of Health Sector Reform: Adapted from Cassells (1995)

Cassells (1995), Richter, Ouattara, Heilenkotter, Gueye and Fischer (1996), and Nugroho, Macagba, Dorros and Weinstock (1997), explored the meaning and

some of the practical implications of health system development in less developed countries. They noted that problems faced by many of the less developed countries when implementing health sector reform remain constant. These constraints Cassells (1995, p2) classifies under the following headings as:

- Scarce resources are used inefficiently. Public funds are spent on cost-ineffective services, the budget for salaries is inappropriately high when compared to operating costs, and tertiary levels of care are funded rather than primary care. In short, the services are badly managed and the systems fail to ensure value for money.
- People cannot access the health care they need. This results from a variety of factors including - personal poverty, geographical location, employment status, services are not available or badly planned and managed.
- Services do not respond to what people want. In the public sector, people face unmotivated and poorly trained staff, long waiting times, inconvenient clinic hours, inadequate supplies and drugs and lack of privacy and confidentiality. In the private sector, they risk financial exploitation with no safeguards against poor or dangerous treatment.

Projects to strengthen district health service delivery as part of the decentralisation process in less developed countries are tending to have two key areas of focus (United Nations Population Fund, 1997; Australian Agency for International Development, 1995). Firstly, management training for provincial and district

managers and secondly, modules for health workers related to primary health care elements.

Programmes of management training for provincial and district managers have tended to include the following topics (United Nations Population Fund, 1997; Richter, Ouattara, Heilenkotter, Gueye and Fischer, 1996; Australian Agency for International Development, 1995):

- Management and leadership;
- Planning of health services;
- Essential drugs;
- Health Information Systems;
- Budgeting;
- Human resource development including job descriptions; and,
- Communication including conducting meetings.

Through a series of workshops covering these topics, a body of competence within the District Management Team is developed. In addition, a management structure is established to promote collaborative planning. Other activities to promote capacity building at the District level include team building and the use of formal and informal networking for decision making.

According to the World Health Organisation (Tarimo and Webster, 1994), primary health care programmes should include at least eight elements to be

comprehensive. Many of these elements have until now been promoted through vertical rather than integrated programmes. The relationship between the principles and elements of primary health care is presented in La Fond (1995: p16) in Figure 8:

Principles of Primary Health Care	*Elements of Primary Health Care*
1. Equity	1. Education concerning health problems and methods of preventing and controlling them.
2. Self Reliance	2. Promotion of food supply and proper nutrition.
	3. An adequate supply of safe water and sanitation.
3. Prevention	4. Maternal and child health care including family planning.
	5. Immunisation against the major infectious diseases.
	6. Prevention and control of local endemic diseases.
	7. Appropriate treatment of common diseases and injuries.
	8. Provision of essential drugs.

Figure 8 ***Principles and Elements of Primary Health Care (La Fond p16).***

The literature indicates concern about the current trend whereby non-government organisations are becoming major implementors of third world development projects. Bennett (1995) asserts that the shift in favour of using non-government organisations as implementors of humanitarian assistance is symptomatic of a profound crisis in the international relief system and argues there are recurrent

themes in this increasing use of non-government organisations. These include the:

- scale of the needs;
- underlying policies of the donor states; and,
- increasing use of the relief model as a device for disengaging from a wider political responsibility towards chronically traumatised societies.

Non-government organisations are increasingly being used by aid donors as a more cost effective and arguably sustainable way of assisting developing countries (Edwards and Hulme, 1996; Bennett, 1995; Gates and Hill, 1995). While the role of the non-government organisations in this context is important and necessary, the philosophies and motivating factors behind many non-government organisations are questionable. "What is happening to the links - to their values and mission, and to their relationships with the poor, supporters and others - through which they derive their right to intervene in development?" (Edwards and Hulme, 1996: p966).

Non-government organisation accountability is also debated in the literature as a contentious issue (Davies, 1997; Edwards, 1997; Edwards and Hulme, 1996; Gates and Hill, 1995) particularly where non-government organisations are substituting for government and growing larger on the basis of foreign donor funding.

Ritchie, Minsek and Conner (1995) and Stefanini (1995) describe a number of approaches commonly used by non-government organisations in health development - relief and welfare, community development, development of sustainable systems and people's movements. These approaches are analysed by Ritchie, Minsek and Conner against the systems model of rural society. According to this model there are two primary systems in rural societies - a delivery system and an acquisition system. It is suggested if the links between these two systems are strong it should be possible to fulfil the society's needs and desires. The approach to health development supported by Ritchie, Minsek and Conner (1995) tends to perpetuate a situation whereby non-government organisations working at community level can be at odds with the National Policy of the government.

Unlike Ritchie, Minsek and Conner who see their role as separate from the work of the State, Stefanini (p46) envisages a new role for non-government organisations in the future: working within the government structure to build capacity and implement effective government policies. This new role would mean that non-government organisations work with the district health system to solve real problems and enhance local sustainability rather than being seen as a substitute for the functions of the State. Training health workers in health education methods, health programme management and the development of

information systems is described as a mechanism whereby non-government organisations may seek to influence delivery systems so they respond appropriately with the required goods and services.

Continuing Education Curricula Concepts

This section of the literature review explores the notions of capacity building, curriculum, education and training as they relate to developing continuing education curricula for health workers in less developed countries. There is however, a dearth of literature on these topics in the developing country context.

Capacity Building is a commonly used term in the literature on development. The activities associated with capacity building concentrates on increasing the ability of individuals and collectives to undertake and promote actions effectively.

Grindle and Hilderbrand (1995) used the following definitions for their study[3]:

> Capacity... the ability to perform appropriate tasks effectively, efficiently and sustainably ... Capacity building refers to improvements in the ability of the public sector organisations, either singly or in cooperation with other organisations, to perform appropriate tasks.

[3] The Grindle and Hilderbrand study is part of a larger research project funded by the United Nations Development Programme. The framework used for the study is presented in *Appendix four.*

Capacity building initiatives focusing on organisations and training activities typically rest on the belief that constraints on performance can be addressed by organisations or their employees (Jain, 1994 and Moore, 1995; cited in Grindle and Hilderbrand 1995)

This type of capacity building often fails to acknowledge and address the broader constraints within which individuals and organisations operate. Stefanini (1995) and Grindle and Hilderbrand (1995) argue for individualised programmes being developed following assessment of a relatively broad set of variables which encompass the whole system, including economic, political and social variables. These programmes, they assert would transfer a sustainable learning process rather than ready made products and solutions.

There is a substantial body of literature surrounding the inappropriate transfer of Western paradigms in less developed countries. The essential arguments of McLaughlin and O'Donoghue (1996), Watson (1994) and Thaman (1993) are as follows. Western paradigms have shaped and influenced the educational systems including curriculum development and curriculum practice and thinking about issues such as economic growth and development. Thus, not only did colonial powers leave behind a legacy of government, administration, education and health, which in many cases has continued into one of dependency, but also

Western thinking, especially from development agencies has continued to influence thinking about education, training and health.

Terms such as curriculum and culture are defined differently by different people. Thaman (1993) in exploring the difficulties related to curriculum in a less developed country follows the definition of Lawton who defines curriculum as:

> a selection from the culture of a society, of aspects which are regarded as so valuable that their survival is not left to chance, but is entrusted to teachers for expert transmission to the young (1975: p9: cited in Thaman, 1993: p250).

Lawton also suggests that our view of culture affects our attitudes towards education in general and the curriculum in particular. Examining the perspectives of three educational theorists, illustrates this and explores the implication for curriculum planning:

> Bantock's (1968) view of culture is expressed in terms of high and low (or elite / mass) options. He is especially concerned with preservation and development of high culture through separate curricula for differing social classes. Hirst's (1974) view, on the other hand is unitary in the sense that he sees education as the passing on of culture-independent knowledge and skills. This implies a common curriculum for everybody, based on common forms of knowledge. Finally, Williams' (1961) historical approach focuses on the need to change curriculum in order to keep pace with social and cultural change although, like Hirst, he too is in favour of a common curriculum (Lawton, 1975: pp25-26: cited in Thaman, 1993: p250).

Within the culture of the health professions, Williams' historical approach is possibly the most common curriculum perspective.

A divergent debate over curriculum and teaching has continued over the last two decades with one argument urging for returning schools to a vision of academia with an increased emphasis on the 'great books' and 'life of the mind' and the other argument pursuing a course that would turn the educational system into an overt arm of conservative elements in the government (Apple, 1986). However the belief amongst many teachers, which is gaining considerable momentum, seems to be that teaching involves uncovering student deficiencies in skills and implementing instructional systems to correct the deficiencies i.e. a deficit model of education. To substantiate this belief terms such as individualisation, student needs, "at risk" students, student welfare etc. and continuous progress are being used (Apple, 1986, Popkewitz, Tabachnick and Wehlage, 1982).

In more developed countries, Shaffer and Pfeiffer (1995) assert that typically in the continuing education of nurses, a nurse educator or supervisor updates staff through lectures. They contend that it can be difficult to find a competent person who is available to teach and that the lecture only approach has not proven especially effective in changing people's behaviours or increasing retention of learning. They therefore developed pre-packaged training modules in collaboration with a team of trainers, instructional designers and medical experts that were then distributed to the nurse educators for use. Apple (1982) suggests that teachers and in the case above, nurse educators, are being deskilled as educationalists and re-skilled in techniques and ideological visions of

management - "curricula are prepackaged with goals, procedures, evaluation and even student responses pre-specified" (p24).

The 1990's were characterised by an increasing interest in medical curriculum reform in more developed countries (Burton and McDonald, 2001) and the issues about who should determine curriculum content (Sanson-Fische and Rolfe, 2000). This is in response to a recognition that the traditional medical curriculum is factually overloaded and thereby fails to prepare students for clinical practice in the twenty first century (Godfrey, Jones, McManus, and Taylor: cited in Burton and McDonald, 2001). A study in China found deficits in their Public Health curriculum as well. Lee (1996) argues that the Public Health programme is a hindrance to meeting the needs of development of modern health care in China. In 1989, Lee surveyed students who graduated from the School of Public Health, Beijing University after 1953. The results showed that students educated under the Public Health programme had obvious drawbacks in knowledge, skill and attitude[4]. So much was the deficit that "we cannot imagine how they can perform

[4] Areas of Knowledge, Skill and Attitude deficit identified in the survey (Lee 1996). "***Knowledge:*** lack of knowledge of society, economy, law, ethics and morality; lack of knowledge about demography, mental health, medical psychology; lack of knowledge of behavioural sciences, health education and health promotion; lack of knowledge of women and children's health care and family planning. ***Skill:*** lack of ability to gain and to use comprehensive information to study independently; lack of ability to design, measure and evaluate all kinds of Public Health programmes; lack of method and skill to do statistical analyses of modern Public Health problems; lack the ability to think, point out, analyse and resolve the practical problems independently; lack of training of Public Health services and skill of administration. ***Attitude:*** both the units which hire the personnel and the graduate students themselves have the opinion that they have little knowledge about the practice of Public Health in China, especially those who graduated after the cultural revolution. People have no interest in immersing themselves in the grass roots health services and have no endurance and patience,

positively in modern health care undertakings and promote Public Health and Health Management to a high level" (p61).

According to Tomlinson (1988: cited in Neary, 2000: p4) teaching is an open, complex skill composed of a combination of cognitive, interpersonal and motor skills which are in turn a function of an overlap of insight and action. Like all skills, teaching skills can be deliberately taught and learned if certain conditions are met (Fitts and Posner, 1969). Kyriacou (1991: p33) asserts:

> the essence of effective teaching lies in the ability of the teacher to set up learning experiences which brings about the desired educational outcome.

There are some references in the literature to the types of teaching and / or training required in less developed countries. McMurray (1996) argues that training aid is an effective form of aid for less developed countries, which is relatively easy to administer. The types of training McMurray believes are particularly important are:

- general professional training which brings about improvement in economic management and living conditions;
- population and health education which brings improvements in general health and maternal, child health; and,
- education in gender issues which improves the lives of women and encourages benefits for economic growth.

---

which is necessary to the work of Public Health. Leaders of many units do not want graduates

In addition; Bradford (1978) states:

> training should be based on the premise that an integrated-promotive-preventive-curative service will be provided and accessible to the bulk of the population ... technical training will be entirely relevant to the job description of the worker in terms of content and teaching methods 'task oriented' (p165).

Tarimo and Webster (1994) assert that training programmes in less developed countries retain an overly biomedical bias whilst community education remains weak. Therefore, all training should be reoriented to include field visits and that attention should be paid to continuing education, supportive supervision, the preparation of teachers of health workers and health training for workers from other sectors.

Gow (1996) supports training people to train particularly in health care training where health workers work under a decentralised health care structure. The effects of training of trainers are thought to be more beneficial than conducting training programmes that require leaving the country (Linh 1995:27 cited in Gow). The length and content of training of trainers courses and needs for on-going in-service and follow up of the trainers are not discussed and yet this is a key issue for sustainability.

The Oxfam Handbook of Development and Relief, a key resource for many non-government organisations involved in development projects, uses the United Kingdom Manpower Services Commission definition of training:

---

like this" (p61).

> A planned process to modify attitudes, knowledge, skills and behaviour through learning experience to achieve performance in an activity or range of activities. Its purpose in the work situation is to develop the abilities of the individual and to satisfy the current and future manpower [sic] needs of the organisations (Eade and Williams, 1995: p360).

This definition supports the contentions of Apple and Popkewitz, Tabachnick and Wehlage, demonstrating it is being promulgated for use in development projects. Two projects in Cambodia that have developed packages along the lines of this model are the Ministry of Health and Asian Development Bank Basic Skills Project and the Ministry of Health and United Nations Population Fund Birth Spacing Project. However, there is no evidence of the process of package development having been documented.

O'Heir (1997) outlines a study conducted to "determine the usability (relevance, clarity and quality of content), applicability (ease of use) and accessibility (structure and form) of a series of new safe motherhood midwifery education modules" developed by the World Health Organisation Maternal Health and Safe Motherhood Programme. The field testing study design used a mainly qualitative methodology including questionnaire survey and focus group discussion. It was undertaken in hospital and community settings in five countries, the closest to South East Asia being Nepal and Fiji, and concludes that the modules have the potential to strengthen and support the education of midwives in developing countries. The method of training employed in midwifery education for safe

motherhood appears to be a cascade type of training of trainers[5]. The changes most commonly required included "modification of the content in keeping with local conditions" (p120). The report is silent on whether these changes were a result of cultural or contextual conditions and the extent to which they were required.

A model for educational courses proposed by Neary (2000), a writer in a more developed country is presented at figure 9:

[5] Using the modules as a basis for teaching ten midwife teachers from each of the countries attended a skills upgrading course followed by an orientation to the use of the modules workshop. These teachers then used the materials included in the modules to provide in-service midwifery education or post-nursing midwifery education (O'Heir, 1997).

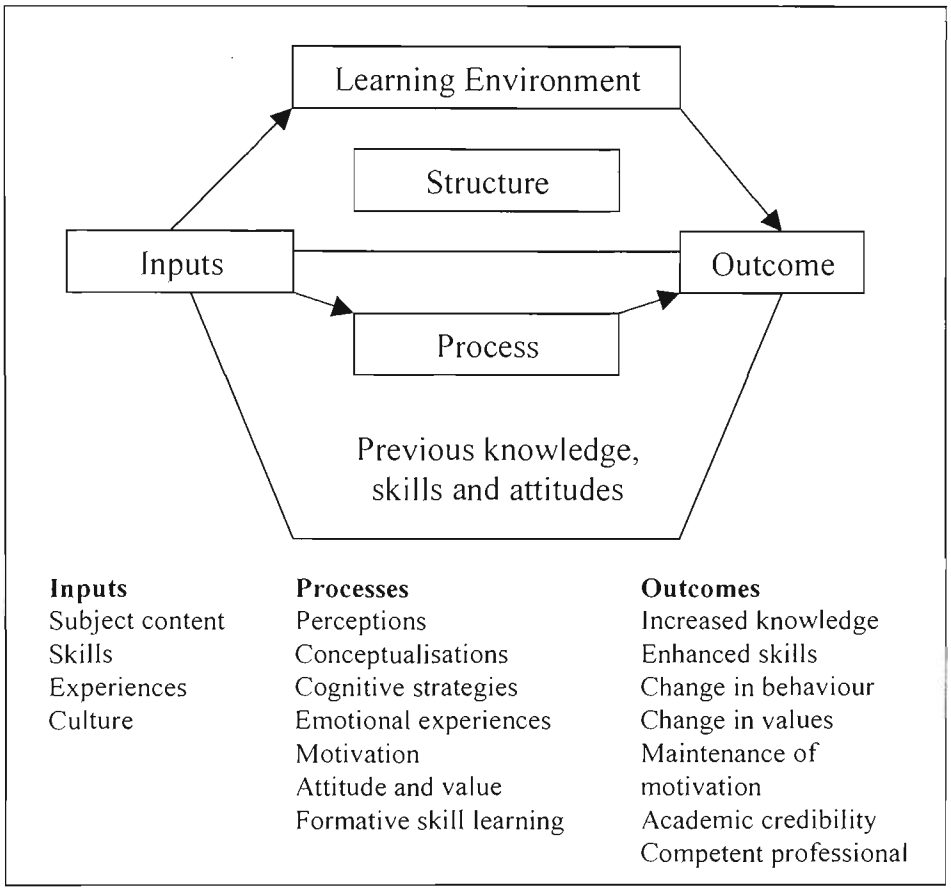


Figure 9 ***Educational Courses – key factors and dynamics (adapted from Neary, 2000)***

An important input in the current study is the context, which is not included in the model at figure 9. According to Brown (1998), the application of the term learning to the development arena is fairly limited and it is often used with an assumed rather than a defined meaning. Its importance is acknowledged without spelling out the mechanics of achieving it and evaluating it. Education in the development literature is sometimes associated with formalised attempts at training and at other times, it is acknowledged as an important source of new individual or collective practices. Occasionally, it is also used in a way that

suggests that the primary concern is with the empowerment of the workforce or the democratisation of the workplace. Brown (1998) argues that:

> Learning is far more than the collection and collation of data ... it is a process of collective and collaborative cognition and reflection on experience, and requires the inculcation of positive attitudes to learning and the development of analytical and cognitive abilities (p63).

According to Honadle and Van Sant (1985, p99: cited in Brown, 1998, p63):

> Learning starts by realising and admitting that a mistake was made and not repeating it. Learning also takes place by repeating a practice that appears to have worked. But when it is not understood why something did or did not work, it is much harder to predict whether different circumstances will lead to different results.

Through the search of literature, there was no evidence of research being undertaken on the process of developing continuing education curricula for health workers in the context of less developed countries.

There is only one study set in Cambodia before the war years that discusses maternal and child health in general. It does not address teaching or curriculum development in maternal and child health (Ebihara 1968: cited in Kulig; 1995: p150). More recent research (Kannan, 1997; Woods, 1997; Duggan, 1995), focuses on the Cambodian political situation since the elections or adjustment issues. Other available literature on maternal and child health issues classifies

Cambodians within the South-East Asian grouping[6], with little consideration of the historical and cultural differences (Kulig, 1995).

Conclusion

The development of continuing education curricula in a developing country is neither static nor simple. This literature review has highlighted that health and subsequently developing continuing education curricula is a political process and outlined some of the ways this is evidenced in a developing country. The literature shows that for development to occur through health sector reform the continuing education curricula must be about more than simply teaching tasks and skills that deliver health services. The power knowledge relationships in developing curricula and curriculum practice need to be uncovered and acknowledged and the skills required to provide quality health services, at all levels of the system must go beyond mere technical competence. If health is to be understood in broader terms, health workers will have to be able to identify the social and economic factors that are the main contributors to health in a given situation or among particular groups. They should be able to communicate with community leaders and other sector professional in the search for solutions. Skills

[6] "Studies in the United States have focused on South-East Asians' (Cambodian, Laotian and Vietnamese) adjustment ... (Mitchell, 1987; Walter, 1981) ... Minkler et al (1988) interviewed South-East Asians, including Cambodians, about their knowledge, attitudes and practices regarding family planning ... One other study examined the differences in parity, pregnancy spacing ... among white, black, Hmong and other South-East Asian mothers ... (Swenson et al, 1987)" (Kulig, 1995: pp150-151)

will be required in management, community development and epidemiology and content needs reorientation to reflect the development of these skills (La Fond, 1995; World Health Organisation, 1993).

The next chapter provides an overview of the theoretical concepts pertaining to critical theory that provided direction for this study. Chapter three also contrasts these underpinning concepts to curriculum and relational analysis as they are defined in this study. In addition, the chapter outlines the methods of data collection and analysis used in this study.

3. RESEARCH METHODOLOGY

Overview

This research is a study about the experiences and interpretations associated with developing continuing education curricula in a developing country. The initial research question for the study was:

> ***How do we ensure the curriculum development process goes beyond skills transfer: acknowledging culture and context?***

It emerged out of a concern with the current trend towards technical approaches to curriculum development.

Critical theory has been chosen as the framework underpinning the selection of the methodology for this study. It was chosen because it mediates between various domains of reality, between parts and whole, between appearance and essence, and between theory and practice thus stressing the interdependency of all facets of social life. Apple (1986) argues that traditional research in education has left educators powerless in political and ethical debates whilst alternative research traditions disclose the socio-economic and cultural realities of schooling[7]:

> work influenced by a cultural marxist perspective has provided an important counterbalance to both the unrelational and the more

[7] Because of the dearth of literature on developing continuing education curricula in the developing country, much of the literature related to methodology is derived from work on education in general and schooling specifically.

> positivist styles that have dominated education ... what has been called "qualitative research" have their own problems, to be sure, some of them substantial. But it is much harder to ignore the surrounding conditions, the class, the gender and race relations, and the role of the researcher in constructing her or his questions, interpretations and results here. In fact these kinds of issues, perhaps especially the latter, seem to evolve naturally in more critically oriented research. The politics of the researcher, how one's subjects are constructed in the act of research, who the research is for, the role of the institution one is studying in the larger society, what that larger society looks like – these are often the driving questions that lie behind critically aware ethnographies. (p6)

Research from a critical theory perspective encourages the researcher to investigate developing continuing education curricula from a qualitative rather than quantitative perspective.

The purpose of this chapter is to discuss the theoretical concepts pertaining to this study along with the methods of data collection, analysis and interpretation.

Choice of Methodological Approach

As researchers, we make sense of the world through varied sets of paradigms. These paradigms are described as "collections of logically connected concepts and propositions that provide a theoretical perspective or orientation that guides research approaches" (Morse and Field, 1995: p243). They provide us with frameworks for seeing the world based on a set of assumptions about the nature of

truth and reality (Sparkes, 1992). The debate and discussions about the value and limitations of quantitative and qualitative research stems from the underlying paradigmatic differences.

Positivism refers to empirical approaches that apply natural science methods to social phenomena (e.g., behaviourism, cognitive psychology, and systems theory). The positivist paradigm underpins quantitative research. It is founded on the "external-realist ontology" and guided by the belief in the need for "objective, replicable, reliable and empirical measurement using standardised data collection and statistical analysis to predict and control events" (Sparkes, 1992: p32).

By contrast to the positivists, both interpretive and critical approaches to research use qualitative research methods and are founded on different assumptions. Interpretivism refers to any approach that stresses a socially constructed reality that must be interpreted (e.g., semiotics, hermeneutics, and ethnomethodology). The interpretivists take "reality to be mind-dependent" (Sparkes, 1992: p34) arguing multiple realities in which the mind takes the central role. An individual's interpretation and understanding of events, objects and actions constitutes their social reality (Connole, Smith and Wiseman, 1993; Schulman, 1988). Harris (1983: cited in Sparkes, 1992: p37) maintains three levels of interpretation are necessary for good interpretive research:

> The research must be grounded in the shared understandings about the culture developed between the researcher and the members of the group being examined; it must include the researcher's insights

> about details of culture that are not well articulated by members of the group; and it must include theoretical generalisations that go beyond the particular details of the culture to link the study to relevant portions of other research (p92).

Critical approaches ask "meta-theoretical questions and seeks to draw attention to the relations of power that shape social reality" (Morrow and Brown, 1994, p. 59). Critical researchers seek to promote change by becoming part of the self consciousness of oppressed social groups (Hoy and McCarthy, 1994; Freire, 1972).

According to Lather (1986: cited in Sparkes; p. 40) critical research has been developed within the frameworks of feminist research, neo-Marxist critical ethnography and Freirian 'empowering' research with a tendency to focus on the issues of class, race and gender.

The term qualitative research is given different meanings by different people. Miles and Huberman (1993, p21) use the term to apply to research when "the data concerned appeared in words rather than numbers". Leninger (1985) claims that:

> In general, qualitative research methods focus on identifying, documenting and knowing (by interpretation) the world views, value, meanings, beliefs, thoughts and general characteristic of life events, situations, ceremonies, and specific phenomena under investigation ... [with the goal being] to document and interpret as fully as possible the totality of whatever is being studied in particular contexts from the people's viewpoint or frame of reference (p5).

Others have provided descriptions of the main features of qualitative research. Clifford (1990) for instance characterises qualitative research by three features:

1. the focus is commonly about unearthing new knowledge or getting new insights and so it is at the *inductive* end of knowledge development;
2. it considers the *emic* perspective, that is, from the perspective of the individual participants being studied, as distinct from quantitative research designs which use the *etic* perspective: the perspective of the researcher or outsider; and,
3. it is more *holistic* as the focus on the individual includes consideration of the context in which the research takes place (p76).

Burgess (1985) expands on this and outlines some of the procedures of qualitative research[8].

Qualitative research focuses on finding out what is happening in a given situation rather than trying to explain relationships or cause and effect. These research studies seek to tell it how it is rather than identifying trends or finding relationships in the data (Connole, Smith and Wiseman, 1993; Clifford, 1990).

---

[8] "(1) The focus is on the observed present, but the findings are contextualised within a social, cultural and historical framework. (2) The research is conducted within a theoretical framework. While there may only be a small number of questions to orientate the study, further questions arise during the course of the investigation. (3) The research involves close, detailed, intensive work. The researcher participates in the social situation under study. (4) The major research instrument is the researcher who attempts to obtain a participant's account of the social setting. (5) Unstructured or informal interviews in the form of extended conversations may complement the observational account. (6) Personal documents may give depth and background to the contemporary account. (7) Different methods of investigation may be used to complement qualitative methods with the result that different methodologies may be integrated by the researcher. (8) The decisions regarding the collection and analysis of data take place in the field and are products of the enquiry. (9) The researcher attempts to disturb the process of social life as little as possible. (10) The researcher has to consider the audience for whom he or she is producing a report and the main concerns to be included. (11) Research reports disseminate the knowledge which informants have provided without rendering harm to them, taking into account ethical problems that confront the researcher and the researched. (12) The researcher monitors

For me, this research was a political and social action. I saw it as part of my role as researcher to construct the data rather than just to discover hidden truth "out there". It was political because part of my mandate as advisor, although this is not the major focus of the study, was to ensure that after my work was completed, the counterparts would be able to sustain the training programme without external assistance. Thereby the people involved in the training component of the programme could free themselves from outside structures and situations that are often oppressive. The next section outlines the theories underpinning methods of educational inquiry before suggesting a framework for the current study.

Methods of Inquiry in Education

Marxist theory has exercised a major influence on the development of the broad range of socialist or radical approaches to education and theories of schooling[9]. Radical pedagogy has drawn heavily on particular forms of political economy, cultural criticism and ideology critique to challenge the ideology of traditional

---

the dissemination of materials and provides feedback to those who have been researched" (Burgess, 1985: p4-5).

[9] The researcher signals that are inadequacies associated with attempting to apply Western theories to a developing country. The critical theories are however the most appropriate of the Western theories to be applied because they require an acknowledgement of the wider social context rather than a wholly autonomous setting.

educational theory and practice (Kemmis and Stake, 1988). According to Giroux and McLaren (1992):

> Traditional educational research attempted the paradoxical feat of depoliticising the language of schooling while reproducing and legitimating the cultural and political authority of dominant groups. In opposition to the traditionalist's attempt to theoretically suppress important questions regarding the relations which obtain among knowledge, power and domination, critical theorists were able to develop new ... modes of criticism to suggest that schools were largely agencies of social, economic and cultural reproduction (p8).

One of the major organising ideas of the radical theorists is the concept of reproduction (Aronowitz and Giroux, 1985). Radical educators have given the concept of reproduction a central place in developing a critique of liberal views of schooling, culture and curriculum and have used it as a theoretical foundation for developing a critical science of education (Kemmis and Stake, 1988). According to the models developed by radical educators, schools came to be portrayed as reproductive in three senses 1) the political economy model of reproduction, 2) the cultural reproductive model; and, 3) the hegemonic state reproductive model (Aronowitz and Giroux, 1985).

The premise behind the political economy model of reproduction is that schools provide different classes and social groups with the knowledge and skills they needed to occupy their respective places in a labour force stratified by class race and gender. Based largely on the work of Bowles and Gintis, the major influence

of this model is on theories about hidden curriculum[10], education policy studies and a wide range of ethnographic research. The basic questions this model attempts to address include: How does the education system function in society? How do schools fundamentally influence the ideologies, personalities and needs of students? Focussing on the relationship between school and the workplace, under this model 'power' is defined:

> in terms of its function to mediate and legitimate the relationship of dominance and subordinance in the economic sphere ... power becomes the property of dominant groups and operates to reproduce class, gender and racial inequalities that function in the interests of accumulation and expansion of capital (Aronowitz and Giroux, 1985: p74).

Within the cultural reproductive model schools were seen as reproductive in the cultural sense, functioning in part to distribute and legitimate forms of knowledge, value and modes that constitute the dominant culture and its interests. Bordieu's theory of cultural reproduction is the major influence in this model. This position argues against schools being simply a mirror of the dominant society, claiming that schools are autonomous and influenced only indirectly by economic and political institutions (Aronowitz and Giroux, 1985). Within this model:

---

[10] Extensive research and writing have addressed multifarious aspects of the concept of hidden curriculum (Apple, 1983, 1980; Giroux, 1981; Seddon, 1983). Seddon (1983: p1-2) asserts "the hidden curriculum refers to the outcomes of education and / or the processes leading to those outcomes, which are not explicitly intended by educators. These outcomes are generally not explicitly intended because they are not stated by teachers in their oral or written lists of objectives, syllabuses, school policy documents or curriculum projects."

> Class control is constituted by the subtle exercise of symbolic power waged by the ruling classes in order to impose a definition of the social world that is consistent with its interests (p80).

Under the hegemonic state reproductive model schools are viewed as part of state apparatus that produced and legitimated the economic and ideological imperatives that underlie the state's political power. Therefore, an "understanding of the role of the state is central to any analysis of how domination operates" (Aronowitz and Giroux, 1985: p87). Gramsci is most prolific in documenting this model (Kemmis and Fitzclarence, 1986).

In spite of the successes in developing insightful theoretical and political analyses of schooling, radical educational theory has suffered from some serious flaws (Giroux and McLaren, 1992; Aronowitz and Giroux, 1985; Apple, 1982). Most significantly, the theories failed to move beyond the language of critique and domination as schools were almost exclusively seen as agencies for social reproduction. While the theory was extended to a set of wider concerns (gender relations and politics of publishing), the underlying logic did not change:

> everything operated within and in response to the logic of capital. Put bluntly, the reproductive theory of schooling is a reactive mode of analysis, one that repeatedly oversimplifies the complexity of social and cultural life (Giroux and McLaren, 1992: p9).

Giroux and McLaren (1992) assert that the radical educational theory failed to explore and develop a number of important concerns that are central to a critical theory of schooling. These concerns about radical educational theory are summarised as:

- Its failure to develop a public philosophy integrating the issues of power, politics and the role of the school in public spheres. Radical theorists concentrated on describing the reality of schools rather than taking up the question of how schools should be.
- Its lack of a theory of ethics to justify the language or legitimate the vision of what schools might be.
- Its inability to analyse schools as sites which "actively produce and legitimate privileged forms of subjectivity and ways of life ... how power organises space time and the body, how language is used to both legitimate and marginalise different subject-positions" (p10).
- Its ineffectiveness in promoting the importance of redefining the role of teachers in terms of critics and intellectuals in both the classroom and as part of the wider social change.

This section has outlined the major theoretical perspectives to education and schooling under the radical theorists. It has also identified the major failings of these perspectives. In the next section, I will outline a framework for developing continuing education curricula from a critical perspective that draws on the

concepts from the work of Bernstein and Apple. Bernstein (1996) has consistently stated his concern to establish a link between micro and macro analysis in his research. This is consistent with a 'relational analysis' (Apple, 1979) which locates developing continuing education in the broader social context.

Towards a Critical Framework for Developing Continuing Education Curricula

Critical theory also known as the Frankfurt School or neo-Marxism articulates activity as striving to transform society. It is based upon the use of critique as a method of investigation (McCarthy, 1991) and is always a critique of authority. Bronner (1994) conceptualises critical theory as "a cluster of themes transpired by emancipatory intent" (p3).

Central to the critique of modern society is the analysis of culture and its role in perpetuating the masses[11]. Thus critical theory attempts to show the relationships between ideas, theoretical positions and their social environment by providing a context in terms of their roots within society[12]. Critical theorists consider that

[11] Critical theorists are most celebrated for their cultural criticism and critique of "mass culture". "Mass culture" is not a "popular culture" rising from the experiences and concerns of the people but rather a form of administered culture imposed from above (Bronner and Kellner, 1989).

[12] Critical theorists argue that the concept of "society" is historical in nature, and that it should not be used to simply denote abstract relations of individuals to one another. "Society" refers to the

modern society is irrational, oppressive and takes away the basic features of human life.

Curriculum is inextricably linked to the social context in which it is developed and practiced. The traditional curriculum theorists have focussed on the question - How does one plan a curriculum? Under these models:

- Tyler prescribes four questions that any curriculum planner must address;
- Taba provides seven steps to follow;
- Walker describes three elements of curriculum planning;
- Johnson represents the curriculum as an output of one system and an input of another; and,
- Goodlad describes three different levels of curriculum decision-making.

Under these different approaches, curricula are planned based on a set of responses to the different curriculum planning questions focusing on procedural, descriptive or conceptual. Posner (1988) argues that it is not enough to look at curriculum technique alone. Curriculum conscience is essential as well from either a technical of critical perspective. Posner (1998: p93) suggests that the work of Freire is important in moving to this critical curriculum consciousness which links curriculum to the social context as he provides:

---

system of social organisation and the ways that social institutions, roles, practices, and the organisation of the economy come to dominate the activities of human beings in specific constellations (Kellner, 2000; Bronner and Kellner, 1989).

- a descriptive account of the way teaching and by implication curriculum planning is conducted through the use of the banking metaphor;
- a procedural model by which curriculum should be planned through the use of generative themes; and,
- a conceptual analysis of the fundamental elements of education and their relationships through an analysis of key concepts including oppression, liberation, critical reflection, dialogue, problem posing, praxis, humanisation, the theme, codification, object, subject etc.

Kirk's (1988: cited in Colquhoun, 1989) definition of curriculum as comprising: context, knowledge and interaction is used in this study. Under this interpretation, the body of knowledge in the curriculum and the transmission of that body of knowledge through interaction are located in a specific cultural and social context.

Curriculum practice is another term used in this study. Although there are a number of definitions of curriculum practice (Cornbleth, 2000; Short 1991), for the purposes of this study, curriculum practice is defined as activities related to enacting the curriculum. Curriculum practice in this sense conveys the idea that curriculum does not end with a document but must be turned into educative reality through the teaching of students.

Johnson (cited in Apple, 1986) would suggest that the current study is influenced by cultural marxism based on three main premises:

> The first is that cultural processes are intimately connected with social relations, especially with class and class formations, with sexual divisions, with the racial structuring of social relations and with age oppressions as a form of dependency. The second is that culture involves power and helps to produce asymmetries in the abilities of individuals and social groups to define and realise their needs. And the third, which follows the other two, is that culture is neither an autonomous nor an externally determined field, but a site of social difference and struggles (p19-20).

In addition to this influence and in accord with Apple (1986: p20) "from the early functionalist work of Bowles and Gintis to the later analyses of Bernstein ... there has been a clearer recognition that our educational system can only be understood relationally".

Bernstein's sociological theory attempts to conceptualise the relationship between the requirements of the education system and the way in which these requirements are fulfilled. Bernstein (1977: p55) asserts:

> How a society selects, classifies, distributes and evaluates the educational knowledge it considers to be public, reflects both the distribution of power and the principles of social control. From this point of view, differences within the change in the organisation, transmission and evaluation of educational knowledge should be a major sociological interest.

Bernstein's work locates the relations quite specifically within the curriculum development and curriculum practice whilst acknowledging the contribution of society.

Bernstein asserts that "knowledge production is made up of three contexts: a primary context where discourse is produced, a secondary context where discourse is reproduced and a recontextualising context which regulates the passage between the primary and secondary contexts" (Kirk and Colquhoun, 1989: p420). The term 'recontextualisation' refers to the creation of imaginary discourses from real discourses according to the recontextualising principle:

> a principle which removes (de-locates) a discourse from its substantive practice and context and relocates that discourse according to its principles of selective re-ordering and focusing. In this process of the de-location and the re-location of the original discourse the social basis of its practice including its power relation is removed. In the process of de- and re-location the original discourse is subject to a transformation which transforms it from an actual practice to a virtual or imaginary subject (Bernstein, 1999: p171).

Bernstein argues that pedagogic discourse is produced through the interaction of various agencies in their respective contexts. In addition, it comprises instructional discourse and regulative discourse, where instructional discourse (specialised skills) is embedded in regulative discourse (moral order) (Dowling, 2000; Kirk and Colquhoun, 1989). Bernstein's conception of pedagogic discourse is important to understanding how the sites of meaning production in the development of texts are linked and then how different groups attempt to make sense of a text in their practice.

Bernstein has employed the notion of code, together with concepts of classification and framing, visible and invisible pedagogies, to the way that symbolic power[13] and symbolic control[14] is exerted over the education system including the development of continuing education curricula. For Bernstein, a code is a "regulative principle which underlies various message systems, especially curriculum and pedagogy" (Atkinson, 1985: p15). The code theory articulates that:

> there is a social class-regulated unequal distribution of privileging principles of communication, their generative interactional practices, and material base with respect to primary agencies of socialisation (e.g. the family) and that social class, indirectly, affects the classification and framing of the elaborated code transmitted by the school so as to facilitate and perpetuate its unequal acquisition. Thus the code theory ... draws attention to the relations between macro power relations and micro practices of transmission, acquisition and evaluation and, the positioning and oppositioning to which these practices give rise. (Bernstein, 1990: pp118-119)

Codes then are "regulators of the relationships between contexts, and through those relationships, regulators within contexts" (Bernstein, 1990: p101). Through analysis, Bernstein attempts to separate the underlying regulative structures

---

[13] Symbolic power relations refer to the boundaries between pedagogic agents (development agencies – curriculum development teams, teachers – participants), discursive resources (transmitted and acquired by pedagogic agents in courses, community contexts) and the contexts of pedagogic communication in the institutions (such as: programme, health facility and community). Through relations of power, the categories of persons interact in pedagogic communication and the categories of discursive resources are transmitted in these interactions (Kirk, 1999; Singh, 1999).

[14] Relations of symbolic control refer to the communicative relations within the programme and courses (amongst teachers, and participants) and in the community (between government and development agencies). They also refer to the relations between the communicative forms of these institutions, for example, control over the flow of communicative forms between the ministry of health, the programme and the health facilities (Bernstein, 1996). Thus symbolic

(codes) from their surface realisations (social practices). Two concepts that are key to Bernstein's work are classification and framing which refer, respectively to the structural relations and interactional practice levels of analysis of curriculum development and curriculum practice (Dowling, 2000). Classification can be described as a measure of the extent to which categories, such as curriculum topics are structurally distinct. In other words, classification refers to the nature of power and 'what' content is included in the curriculum. Framing on the other hand is a measure of the degree to which the transmitter of a message maintains control over the communicative context. Framing refers to the nature of control and 'how' the content is made available to students. Classification has its roots in the work of Durkheim and framing in the work of Goffman. In Bernstein's work they carry, respectively, the principles of power and control (Dowling, 2000):

> control establishes legitimate communications and power establishes legitimate relations between categories. Thus, power constructs relations between, and control relations within given forms of interaction (Bernstein, 1996: p19).

Dowling (2000) illustrates the opposing sets of terms associated with the concepts of classification and framing, these are set out as figure 10:

---

control refers to the "plans, recipes, rules, instructions, ... 'programmes' for the governing of behaviour" (Geertz, 1990: p49).

Classification	Framing
power	control
space	time
between	within
what	how
voice	message
recognition rules	realisation rules

Figure 10 Classification and Framing (Source: Dowling, 2000)

Classification then, governs relationships between contexts and framing regulates the transmission of appropriate practice within the context.

Kirk (1999) determines 'relational analysis' to be one of the key tasks of social science as it suggests that social phenomena are best understood when examined in relation to their ties to the larger set of institutions and institutional arrangements. Apple (1979) has argued that 'relational analysis':

> involves seeing social activity – with education as a particular form of that activity – as tied to the larger arrangement of institutions which apportion resources so that particular groups and classes have historically been helped while others have been less adequately treated. In essence, social action, cultural and educational events and artifacts (cultural capital) are defined not by their obvious qualities that we can immediately see. Instead things are given meaning rationally by the complex ties and connections to how society is organised and controlled. The relations themselves are the defining characteristics. (p10).

Through relational analysis, we are urged to go beyond the notion of curriculum design as a syllabus or a course of study and instead to think of it as a complicated

and continual process of construction and design. In this study, relational analysis provides a means of theorising relationally the issues in developing continuing education curricula for health workers in this particular country context, specifically the relationships between the programmes, the institutions and the practice sites.

McCarthy (1990) describes relational analysis as a parallelist model which assumes that action in one arena will have an effect on action in another, see figure 11. Through this parallelist framework, the relationship between the spheres and structures of social life: economic, political and cultural and the dynamics and relations in which they operate class, race and gender are examined.

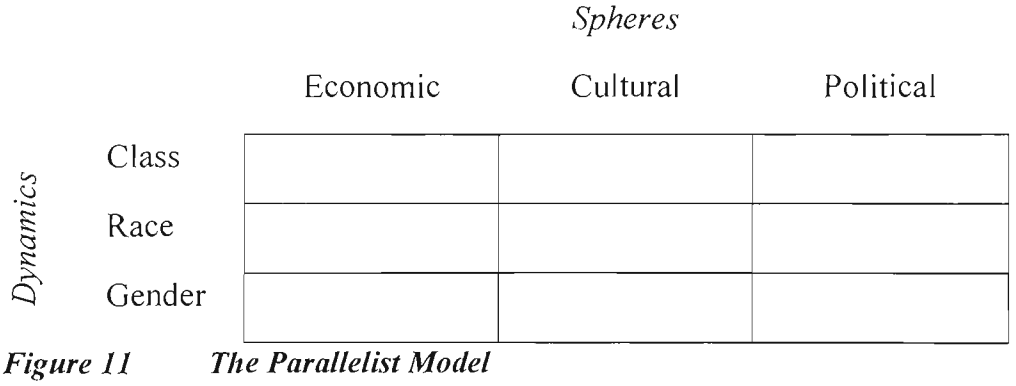


Figure 11 ***The Parallelist Model***

Kemmis and Fitzclarence (1986) and White (cited in Aronowitz and Giroux, 1985) suggest that one major task of critical educators is to rethink the

relationships between the curricula and other forms of social life that point to a desirable future:

> the curriculum ought to be one which lays the basis for increasing the ability of as many students as possible to become active, participatory adults. By active participants I means that students learn some real skills (White, 1985: p155).

This study will situate the process of developing continuing education curricula within the practice environment as well as the larger social framework.

In addition to the theoretical grounding, three assumptions serve as organising principles for critical curriculum development. These assumptions are that: 1) education is not neutral; 2) society can be transformed by the engagement of critically conscious persons; and, 3) praxis connects liberatory education with social transformation.

First, education and by implication curriculum development is not neutral. Freire (1972) describes education and thereby curriculum as domesticating or liberating. Strengthening the dominant ideology by socialising learners is an expression of a domesticating curriculum. By contrast, a curriculum liberates when it challenges the dominant ideology, includes the teaching of critical literacy and how to learn. Drawing from the work of Bernstein, in the process of developing curricula use of power and voice can suppress or liberate and in curriculum practice in the classroom, use of control and message can suppress or liberate.

Constructionism lies behind the second assumption. The central idea of constructionism, that reality is socially constructed, logically precedes the idea that social relations can be deconstructed, reconstructed and/or transformed. In a liberatory process of developing continuing education curricula, the curriculum development team, teachers and students will realise that the way things are has been constructed and serves the interests of some group(s).

In realising the third assumption in developing continuing education curricula a reflexive approach moving between text or theory, application, evaluative reflection and back to theory needs to be adopted.

The focus of critical curriculum theorists then is to develop critical consciousness described by Freire (1972) as 'conscientization'. The critically conscious curriculum theorist recognises the connections between individual problems and the social context within which they are embedded. Shor (1992) summarised critical consciousness with four qualities: power awareness, critical literacy, permanent desocialisation and self education / organisation. The qualities of these are briefly described as:

- Power awareness is based in understanding that just as structures and systems are constructed with human effort, they can be transformed by collective human effort.
- Critical literacy includes "habits of thought, reading, writing and speaking which go beneath surface meaning ... to understand the deep meaning, root causes, social context, ideology and personal consequences" (p129).
- Permanent desocialisation is "questioning power and inequality in the status quo; examining socialised values in consciousness and in society which hold back democratic change in individuals and in the larger culture; ... nurturing a passion for justice and a concern for the environment, for the community and for public life" (p129-130).
- Self education / organisation means knowing how to learn critically and how to organise transformative education projects with others.

I have outlined in this section a framework for critical curriculum research that uses the constructs of Bernstein and Apple as well as taking into account wider social processes to describe the developing continuing education curricula in a developing country. Critical curriculum research uses dialogue as one method to gather data and as a researcher I must move beyond customary methods of interpretation because participants' reports will include meanings that are hidden

from them by their oppression[15]. Fulton (1997) suggests that "these hidden meanings should be explained as such by reference to existing theory" (p531).

Summary of the Positivist, Interpretive and Critical Approaches to Research

Figure 12 provides a summary of positivist, interpretive and critical approaches to inquiry.

[15] I recognise that this assumption could be seen to be "paternalistic" and that only I (the researcher) can "free" the participants from their false consciousness.

	Empiricist	Interpretive	Critical
Approach	Classical physical sciences investigation.	Historical, literary and existential studies in which the subjective understanding of subjects are significant.	Marxist, interpretive and psychoanalytic studies which focus on the insights and judgements of the subjects.
Assumptions	Reality is unitary and it can only be understood by empirical analytic inquiry.	There are multiple realities which require multiple methods for understanding them.	There are multiple realities that are problematic through distorted communication.
Data foundations	Disciplined sensory – perceived observation; i.e. rules for observation.	Meaning is the basis of data: meaning precedes logic and fact.	Meanings are found in language and social behaviour and they precede logic and fact.
Observation methods	Using clear and unambiguous rules that are not modified by the setting and are totally independent.	Through the social, linguistic and cognitive skills of the researcher; i.e. dialogue.	Interpretive methods, plus critical self reflection concerning the grounds of observation.
Knowledge generated through inquiry	Evidence and generalisable laws which are not affected by context and have nothing to do with the way in which they were discovered in the first place. Objectivity depends upon the removal of error and bias that is related specifically to the logic of observation and measurement.	Knowledge is dependent on the process of discovery. The integrity of the findings depends upon the quality of the social, linguistic and cognitive skills of the researcher in the production of data analysis and conclusions.	Knowledge which falls within the interpretive framework, but that also serves the purpose of assisting personal liberation and understanding and emancipation from forces constraining the rationale independence of individuals.
Interests inherent in the inquiry	Prediction and control. Technically exploitable knowledge. Explanations.	Understanding at the level of ordinary language and action. Discovering the meanings and beliefs underlying the actions of others	Interpretive interests plus revealing the interests that underlay other forms of inquiry. Radically improving human existence. Practical and public involvement in knowledge formation and use.
Values inherent to the inquiry	Science and scientific knowledge are inherently value free.	Science and scientific knowledge have both to be interpreted in terms of values they represent.	Science and knowledge are never value neutral; they always represent certain interests.

Figure 12 ***Summary of Approaches to Inquiry.***
(Adapted from Locke (1988) and Schaffer (1991) as cited in Connole, Smith and Wiseman (1993)).

Data Collection

Since the issues this research focused upon were concerned about understanding "from within" (Burrell and Morgan, 1979), multiple data collection strategies were employed as these provide flexibility for the various contexts in which data were obtained. Denzin (1978: cited in McLaughlin and O'Donoghue, 1996) argues that research designs based on a combination of data collection strategies provide a substantially more complete and complex data on phenomena, than a unimodel research. Such strategies are more likely to expand understanding than generate facile data. Moreover, they possess more credibility because they increase reliability and validity of results.

Data collection in this study was primarily through eight months fieldwork using three major strategies: participant observation, interviewing the informants and document analysis (Stake, 1995; Patton, 1990; Crossley and Vulliamy, 1984). A combination of observing the phenomenon and relationships in curriculum development and practice; interviewing participants; and, analysing documents provides a wealth of qualitative data in the form of verbal and non-verbal behaviours as well as interactions, actions and non-actions (Wilson, 1977). The design of qualitative studies is frequently ambiguous as often little is known about the nature of the phenomenon before the study (McLaughlin and O'Donoghue, 1996). Design modifications are common in response to the needs of participants

in the study or because of the nature of preliminary findings. Some modifications occurred in the beginning stages of this study as realities dictated that some data were collected from site based interviews and small group meetings and other from field visit interviews when considerable time was spent travelling between destinations with individuals.

The social nature of participant observation is perceived as a source of distortion and bias, rendering it more appropriate for certain types of study. Jorgensen (1989) argues:

> Participant observation is especially appropriate for exploratory studies, descriptive studies and studies aimed at generating theoretical interpretations. Though less useful for testing theories, findings of participant observational research certainly are appropriate for critically examining theories and other claims to knowledge (p13).

The method of participant observation "stresses a logic of discovery, a process aimed at instigating concepts, generalisations and theories ... [participant observation] aims to build theories grounded in concrete human realities" (Jorgensen, 1989: p18). Patton (1990) describes participant observation as an 'omnibus field strategy' because it combines document analysis; interviewing of respondents and informants; direct participation and observation; and, introspection. As a participant observer I was able to be fully engaged in

experiencing the setting under study[16] while at the same time trying to understand that setting through my personal experiences, observations and talking to others about what was happening. Participant observation allowed me to share in the life and activities of the participants and the setting under study. Bruyn (1996: cited in Patton 1990: p272) suggests the "role of participant observer requires both detachment and personal involvement". Participant observation during this study took place in a variety of settings including meetings of the curriculum development team and during classroom sessions observing curriculum practice. Curriculum practice means activities related to enacting the curriculum or in this case observing teachers teach. The meetings of the curriculum development team took place weekly over a period of three months and observations of teachers teaching in the classroom took place four times during the course of the research. One course where teaching sessions were observed was at the national level and the other three courses were at the province level.

There are different approaches to participant observation, which vary depending on the role of the researcher takes the study. Gans[17], Schwartz and Schwartz[18],

---

[16] "Physical gestures, postural attitudes and distance" between the participants and the researcher "are all organised in patterned sets, much as words and sentences are organised in language (Leach, 1976). Adequate analysis of cultural others can only take place when the nonverbal as well as the verbal communication is accounted for, an issue to be addressed in data collection" (Barnes, 1996: p433)

[17] "Gans classifies the different approaches in terms of the differences in the actual behaviour of the researcher: (1) the researcher acts as observer - being physically present but not actually involved in the events he studies (2) researcher participates, but as researcher - the researcher is actually involved, but this participation is determined by his research interests (3) researcher participates - the researcher abdicates hie research role and is involved 'for real'. After the event

and Gold[19] have developed different classification systems (Ball, 1983). My role varied throughout the study along what Schwartz and Schwartz (cited in Ball, 1983, p38) call "a continuum of role activity" depending on the degree to which my role as advisor to the group was required.

Rice (1996) and Shaffir and Stebbins (1991) outline a number of stages involved in field research and suggest they may be analytically separable although, they are interwoven: entering the field setting; learning how to play one's role; maintaining the role; and, leaving the setting. Access to the field and the group was obtained before my arrival in Cambodia in the form of a contract between the development agency and me. I had lived and worked in Cambodia for a period of ten months in 1997 and was invited back to work with the programme as Training Advisor. Experience in living and working with, or in the culture of the participants is helpful in order that the researcher is sensitive to approaching the community and using appropriate questioning and interview techniques. Without sufficient

---

he returns to the role of the observer and perhaps analyses his own actions as participant" (Ball, 1983: p38).

[18] Schwartz and Schwartz describe a "continuum of role activity according to the degree of participation by the participant observer" (Ball, 1983: p38).

[19] The typology developed by Gold includes: "(1) Complete participation where the true identity and purpose of the participant is known, role-pretence is the basic theme of this kind of activity, the researcher functions within the day-to-day roles that are accessible to him in the research situation (2) participant-as-observer is different from the above in that the observed are aware of the research functions of the participant observer, observation done formally and informally and subsidiary techniques may be brought into use with the open cooperation of the subjects (3) observer-as-participant studies involving one-visit interviews, a formal setting to the research, more brief and perhaps superficial than other formats (4) complete observer the field worker is removed from all interaction with the subjects, he attempts to observe in such a way that the subjects do not have to take him into account in any way" (Ball, 1983: p39-40).

cultural experience, an analysis may not be culturally relevant and may create description rather than interpretation (Barnes, 1996; Rice, 1996).

As I became more familiar with the participants and the programme, I found that my role as observer reduced and my role as participant increased. The use of field notes written following group meetings or during field visits provided a rich source of data about the context and culture of the interactions. Consequently, concepts requiring further exploration were uncovered. Street (1992) raises the issue that some disquiet has been expressed about the researcher taking on the role of both observer and participant within a research project. The participant role of the researcher - to represent and understand the values and actions of the research participants, is seen to be in a competing role to that of an observer in an evaluating role. In addition, I had the role of advisor to the participants and the programme. As the participant observer in this dual role I was able, to uncover meanings within a situation in order for the participants to identify and understand the issues involved. Benner (1984) and Marshall and Rossman (1995) remind us that the participant observer role may also provide experiences for the researcher that they may find uncomfortable or that may represent an ethical dilemma for them. In the role as researcher and advisor, I needed to be aware of the power differentials between myself and the participants. I was aware that I was presenting arguments to support my research and the potential for using my advisory position to influence the direction of the study.

There are a number of ways of categorising what Rubin and Rubin (cited in Berg, 1998: p59) refer to as 'the family of qualitative interviews'[20]. Guided semi-structured interviews using open-ended questions provided the framework for questioning in this study. The guided semi-structured interviews involved using a number of predetermined special topics related primarily to the curriculum development process. These topics for the interview questions and the concerns for the observations came from the foreshadowed problems which had largely developed as a result of my experience in the field and from the literature. A sample of questions, provided a comfort zone and prompt for me as the researcher when at times there were awkward questions. The work of Patton (1990) assisted in framing the questions because of the flexibility of the model that enables questions to be asked in the present tense, past tense and future tense[21]. A sample of questions is shown as Appendix Five.

---

[20] Categories of interview types (cited in Berg, 1998: p59-60). Some sources use only two - formal and informal - Fitzgerald and Cox, 1987, pp101-102. Other sources refer to this research process as either structured or unstructured - Leedy, 1993; Fontana and Frey, 1995. At least three major categories were identified by Babbie, 1995; Denzin, 1978; Gorden, 1987; Frankfort-Nachmias and Nachmias, 1996; Nieswiadomy, 1993 - the standardised (formal or structured) interview, the unstandardised (informal or non-directive) interview, and the semi-standardised (guided-semi-structured or focused) interview.

[21] Patton asserts that there are six kinds of questions that can be asked of people and on any given topic. 1) *Experience / Behaviour Questions* that elicit descriptions about what a person has done. 2) *Opinions / Values Questions* are aimed at obtaining responses which indicate what people think about some issue. 3) *Feeling Questions* geared to tap the affective dimension. 4) *Knowledge Questions* which find out the factual information that the respondent has. 5) *Sensory Questions* are about what is seen, heard, touched tasted and smelled. 6) *Background / Demographic Questions* identify characteristics of the person being interviewed.

Communication and language provide the primary mechanism for meanings to be shared by people and are the building blocks of data collection and analysis in qualitative research (Chenitz and Swanson, 1986; Barnes, 1996). Khmer is the national language of Cambodia. English is the second nationally acknowledged language. English is a second or third language for the participants working in the programme. When there is a language barrier between the researcher and the respondents, a researcher's ability to assess meanings, intent, emotions and reactions may be limited[22]. The use of a translator can, to some extent overcome this limitation, however, translators often interpret concepts rather than translating literally and certain concepts have either no translation equivalents or many translation equivalents in some cultures. The use of a translator was not required in this study as the participants had varying levels of command of the English language. This is outlined in chapter four where bio-data on the participants are presented. Barnes (1996) argues that adequate analysis of other cultures can only take place when the verbal as well as the non-verbal communication is accounted for in data collection[23]. Collecting both verbal and non-verbal cues was important within the context of this research and provided a basis for later verification.

---

[22] Grounded theory authors (Glaser, 1978; Strauss and Corbin, 1990: cited in Barnes, 1996) have stated that the qualitative researcher should assume that what the researcher thinks or feels about a word or concept found in the data were also what the respondent thinks.

[23] Barnes (1996) acknowledges that the data will automatically be recorded and analysed through the researcher's cultural bias. "The filter of culture ... guides what the researcher will ask, how he or she records interviews, what observations he or she chooses to make, and how analysis is conducted "(p435).

It was important that I make explicit to the participants the ongoing nature of the research process and re-negotiate as appropriate the nature of the research. On more than one occasion when I was recording an interview or making field notes on what appeared to the participant an ordinary situation, I was asked to "explain what you are doing again?" or "are you sure you're not going to use our names in your book?"

In order to understand the situations being faced by participants it was important to listen to their stories. In listening to the participants, I became aware of my inability to comprehend the full extent of the cultural, economic and political situations facing them as individuals.

Ten (10) interviews were recorded during the study with each interview ranging between 30 and 45 minutes in duration. The interviews, by mutual negotiation took place in the offices where the programme is sited and had to be conducted at a times when outside regularly scheduled meetings in a quiet office in order to have time to listen to the stories as well as to avoid the pitfalls that other researchers have discovered. Morse and Field (1995) outline common pitfalls of interviewing. The pitfalls I encountered included:

- Stage Fright: initially, the interviewees were nervous at the prospect of the interviews. Therefore, I spent time obtaining more demographic type data

than I had originally intended so that the presence of a recorder reduced in significance.

- Awkward Questions: it was important that I was clear on the purpose of the interviews and that questions were constructed in a way that was unambiguous and did not make the participants feel uncomfortable.
- Presenting One's Own Perspective: I was aware that I was trying to present an argument in this thesis and had to avoid leading the interviewees into giving the 'correct' answers.

A significant finding of the interviews was however, that the participants consistently tended to provide almost identical data. As a researcher in a culture other than my own, I was not sure if this reflected what the participants believed I wanted to hear. Therefore, participant observation was essential to assess the relationship between the interview data and the reality. Kulig (1995) used participant observation at community events and within families' homes as part of a study with the refugee community in America to discover information about Cambodian women's and men's knowledge and use of family planning methods. The advantages of this closeness with the Cambodian community were many however, there was a blurring of roles as a researcher[24]. In the curriculum development group, the most common question from participants was "tell us

[24] "There were times when it seemed as if some of the Cambodian individuals withheld private information because they did not want it recorded, or shared some information to the author as a friend and not as a researcher. As well, the author had to deal with multiple roles and

what you want us to do" whereas in the interview information provided indicated that in cases they were clear about where they wanted to go. This signaled that for the group to move from a position of feeling dominated to a position of feeling empowerment would necessitate incremental steps.

The use of official documentary records, an unobtrusive method of data collection was used in this study to supplement the intrusive methods of participant observation and interviewing. Official documentary records were able to offer interesting sources of data and new perspectives. Minutes of meetings, logs, announcements, formal policy statements etc are all useful in developing an understanding of the setting or group participating in the research.

Maning, Johnson, Bromley and Shupe and Jorgensen (cited in Jorgensen, 1989: p92) used documents and human artifacts extensively in their studies. The documents presented invaluable information of "codes of ethics and conduct, correct beliefs and practices, political aspects of the community and society" (p92). These materials were then found to be extremely useful in locating the current context of the study in its history and providing unobtrusive support for illustrations of findings derived from participant observation and interviewing.

---

expectations of a nurse, researcher, doctoral candidate and women which would sometimes lead to frustration and exhaustion" (Kulig, 1995: p151).

As mentioned earlier, English is the second acknowledged language after Khmer in Cambodia. The health sector reform related policy documents are available in both languages, usually being produced first in English and then translated to Khmer. In addition, within the programme, the curricula were developed in English as a team process with the team comprising both Khmer and expatriates. Before translation, a person with English as their first language completed the final editing of the text. The supplementary materials e.g. students handouts etc. prepared in support of the curriculum were often taken directly from English language texts produced specifically for developing country settings or from texts already translated by other agencies. The funding agency of the training in most cases requires an English language set of the training materials in order to satisfy their monitoring requirements.

In this study, national plans, policies and documents relevant to reform and human resource development were used and are referenced within the text of the study. Apple (1986) advises caution in using reports as they are as much political documents as well as being educational documents:

1. All discussions of educational (or health) policy, to the extent that they deal with change of content (or structure) are political. The knowledge that is taught is always someone's knowledge and debates over it sponsor certain groups' visions of legitimate culture and disenfranchise others;

2. Reports will be couched in a language of the 'common good' a language that seeks to have something in it for everybody so that as many people as possible with power can fit under their linguistic umbrella; and,

3. Documents are calls for action – calls to use scarce resources and political power for specific ends (p130).

Therefore, reports needed to be analysed in terms of their 'truth value' and rhetorical use (Bowling, 1997; Apple, 1986).

The literature identifies a number of strengths and limitations of participant observation (Ashworth, 1995; Patton, 1990; Jorgensen, 1989; Ball, 1983; Spradley, 1980) semi-structured-open-ended question interviews (Morse and Field, 1995; Marshall and Rossman, 1995; Patton, 1990; Chenitz and Swanson, 1985) and document analysis (Bowling, 1997; Patton, 1990). The specific strategies I employed to minimise the factors that detract from the reliability of data collected included: the collection of data in the work setting; tape recording interviews; and, the use of an interview guide.

Roles of the Researcher

This section examines the issues related to my research roles. As outlined in the data collection section, I assumed multiple roles and had to reconcile these participant, observer and advisor roles. In addition, during the study I have had to span the boundaries across groups, settings and cultures. I have assumed the role more as participant at times such as when asked to participate in curriculum development activities and at other times during the training, my role has been

primarily one of observer. The third role as advisor had the capacity to bring risk to the study. In addition any subjectivity had to be managed so that it did not compromise my interpretations. I am suggesting that "we cannot rid ourselves of this subjectivity, nor should we wish to; but we ought, perhaps, to pay it very much attention" (Cheater 1987: cited in Peshkin, 1988: p17). It was not enough for me simply to recognise and attempt to erase the biases bought about by the various roles as they will continue to exist. Peshkin points out the need to see subjectivity specifically as a positive aspect of the research because "it is the basis of researchers making a distinctive contribution, one that results from the unique configuration of their personal qualities joined to the data they have culled" (Peshkin, 1988: p18).

I had to acknowledge my biases at the outset, as recommended by Le Compte (1987), because my role as advisor made me positively predisposed to all efforts involved in developing continuing education curricula. I have had to balance my reactions to events with my findings and the emic perspectives of my informants (Clifford, 1990). The power associated with my role as advisor had to be monitored and as much as possible curbed. In this study, the needs for monitoring of and reflection about my various roles as researcher became very apparent as there is no denying its potential to shape the study in matters such as questions posed and conclusions drawn. In addition, it has been necessary for me to differentiate between my roles and the nature of the research, the interpretations

and the conclusions. By keeping the personal reflective journal, I had a vehicle to separate the roles and the subjectivity.

The next section in this chapter examines the data analysis methods used for this study into developing continuing education curricula in a developing country.

Data Analysis

Qualitative studies ultimately aim to describe and explain (at some level) a pattern of relationships which can be done only with a set of specified analytical categories (Huberman and Miles, 1994). According to Marshall and Rossman (1995), data analysis is the process of bringing order, structure and meaning to the data collected during the research. They suggest "reading, reading and reading once more through the data ... to become familiar with the data in intimate ways" (p113) and generally "cleaning up" the data as the first step in the process.

In this study, I used the constant comparative method to process the data arising from the study. Glaser and Strauss (cited in Lincoln and Guba, 1985: p339) describe the constant comparative method as following four stages:

1. comparing the data applicable to each thematic / conceptual category;
2. integrating the categories and their properties;
3. delimiting the emergent theory; and,

4. writing up the theory.

According to Goetz and Le Compte (1981) the constant comparative method "combines inductive category coding with a simultaneous comparison of all social incidents observed" (p58). As social phenomena are recorded and classified, they are compared across categories. Thus, the discovery of relationships begins with the analysis of initial observations. Inductive analysis (Patton, 1990) means that patterns, themes and categories of analysis "emerge out of data rather than being imposed on them prior to data collection and analysis" (p390). This process undergoes continuous refinement throughout the data collection and analysis process (Huberman and Miles, 1994). "As events are constantly compared with previous events, new topological dimensions as well as new relationships may be discovered" (Goetz and Le Compte, 1981: p58).

The process of data collection, coding and analysis of data occurred simultaneously with the fieldwork conducted in the study. A simultaneous process of data collection and analysis allowed for emerging understandings in relation to the range of factors that were associated with developing curricula and curriculum practice in the context.

The first step in the process of developing categories was to code the data. Before coding, the transcribed interviews were presented to each informant for validation.

As I read the transcribed interviews, field notes and documents I began to develop provisional codes that fitted the data. The coded data were then assigned categories according to their "look alike, feel alike" qualities (Lincoln and Guba, 1985). Categories created through grouping and clustering of data became the basis for the organisation and conceptualisation of that data. Categorisation therefore is a crucial element in the process of analysis (Dey, 1993). Patton (1990: p406) asserts that "the qualitative analyst's efforts at uncovering patterns, themes and categories is a creative process that requires making carefully considered judgements about what is really significant and meaningful in the data".

In making sense of the data and categories during this process of analysis, I began by asking questions of the individuals of the informant group (Charya, Vandara, Khim, Sopheap, Sophoan and Kimny). At times, the interview data were used as a basis to guide further questioning and discussion about each informant's perceptions of curriculum development within the programme. At times, points of clarification were required about the observational data recorded. The answers to these questions and points of clarification were kept as field notes to be later transcribed into a computer file established for this purpose. I was then easily able to check any new information against previous information ensuring a more complete picture of the relationships.

As I became comfortable with analysing the content of interviews, observations and documents I was quickly able to compare newly coded data with previously coded materials in the same and different categories. As I became more familiar with the recurring nature of the data, I was able to assign categories based solely on the data.

For each category, an analytic memo was written and as new data were added to the categories and subsequently the memos, they increased in sophistication. Because access to academic literature proved difficult whilst posted in Cambodia, it was not until after the data collection and well into the memoing process that I was able fully to relate the memos to the literature.

As I completed the research period, I found that little new information was emerging and that the data were repetitive, to the point of saturation. In the final analysis of data, all field notes, documents and transcripts were reviewed and I undertook a final verification of my interpretations and perceptions with the participants.

In this study into developing continuing education curricula in a developing country, the primary themes that emerged from the analysis of the data included those pertaining to:

- The role of development agencies and experts;

- The effects of the power-knowledge relationship; and,
- The way health and education are perceived.

The following figure illustrates the links between the themes and the categories. This is a selective snapshot of the data as the subsequent four chapters discuss in detail the themes that emerged from the study.

Theme: The role of development agencies and experts. (Chapter five entitled Western Transference develops this theme, which is also woven through subsequent chapters.)	
Categories	**Illustrative Snapshot**
Donor Driven Development	Donors have provided a blueprint for an integrated health sector, but vertical programmes want "not too much integration" of some donor-funded programmes and training.
Expert Driven Curriculum Development	With expert driven curriculum development participants felt they did not learn a complete set of skill. Skills in "training needs analysis is done by the donor" and "we miss out on helping learners learn".

Theme: The effects of the power knowledge relationship (The effects of the power knowledge relationship are woven throughout the subsequent four chapters of this study.)	
Categories	**Illustrative Snapshot**
Medical Knowledge	Secondary midwives viewed doctors as unapproachable in discussion and difficult to correct. One secondary midwife was hesitant about approaching the senior doctor because he "laughs at what I say". Other secondary midwives checked all their work with the doctor before presenting it for discussion.
Status Issues	Through observation and in pouring over the interview transcriptions, I noticed that the interactions of the research participants were either complementary or non-complementary. This varied according to the perceived status of the person with whom the interaction took place. Complementary interactions took place when the status of participants was nearly the same and they built on the ideas of one another. On the other hand, non-complementary interactions tended to be imposed top down from a person of higher status to a person of perceived lower status.
Content and Design of Curricula	Both doctors and non-doctors alike articulated the direct power of doctors in shaping curriculum content.
Curriculum Practice	The more experienced teachers from the national level of the programme exhibited self-confidence in their interactions at the provincial level training courses. Their presence at the courses was often enough to ensure that the course ran more smoothly.

(Figure 13 continued overleaf)

Theme: The way health and education are perceived. (The way that health and education are perceived is woven throughout the subsequent four chapters of this study.)	
Categories	**Illustrative Snapshot**
Acquiring Practical Skills for Health Care Delivery,	Informants expressed that they "had never done some of the skills before" they were subsequently teaching these skills. The learned health seeking behaviours in the community are such that there is a dearth of relevant practical experience for participants of training
Health and Education as Commodities to be Traded for Money	"... you are foolish if you do not take advantage of others ...". The skills learned in public sector training courses are applied in private practice.

Figure 13 Links between the themes and the categories

Data Organisation

The themes arising from the data collected as part of the study are presented in the following four chapters of the study. These chapters are divided into two main parts. Part one focuses particularly on relations at the macro level whilst part two is situated at the programme level.

Chapter four, entitled **Appreciating the Context of the Country** provides the context of the country in which the study was undertaken. The subsequent chapters depend on an understanding of the context of the country particularly the political, economic and cultural context. In this way, we can start to situate the present relations within that history.

Chapter five, entitled **Western Transference** examines contemporary developments including the policies and processes of health sector reform. This chapter increasingly brings together the dynamics of class, race and gender and their relationship with power and knowledge. Increasingly close connections between official dominant culture and economic power are defining the practices in health worker education.

The second part of this study situated at the programme level is covered first in chapter six entitled **Influences Determining Development of Curriculum.** As the title suggests, the knowledge-power relationship is examined as I work with the curriculum development team – Charya, Vandara, Khim, Sopheap, Sophoan and Kimny – on aspects of developing continuing education curricula.

Chapter seven, **Contextual Realities of Curriculum Practice** follows *how* the teaching is done and *who* is doing it. Additionally the rituals and rewards associated with curriculum practice and learning are examined.

The Value and Logic of the Study

Lincoln and Guba (1985) propose four constructs to better reflect the assumptions of the qualitative research paradigm than "the inappropriate use of the terms reliability and validity" (Morse and Field, 1995: p146). In this section, the study

is considered under each of these four constructs: credibility; transferability; dependability; and, confirmability.

Credibility

The strength of the qualitative method is that the description of the process will be its validity. The in-depth description showing the complexities of variables and interactions will be embedded with data derived from the setting.

This study was conducted in a culture significantly different to the researcher's. In the initial entry period, I spent time finding out about the different use of words, narratives and explanations, alternative interpretations in order that they could be picked up. To increase the credibility of the research findings a number of strategies were employed. First, prolonged engagement, I was involved in the fieldwork for a period of eight months and spent a further twelve months in the setting. This gave sufficient time to build a trusting relationship with the participants, be able to detect distortions in the data collected and learn a small portion of the culture of the programme and the participants of the study. It also gave time to check the data and themes with the participants during the data analysis process.

Second, I undertook persistent observation. The time spent in participant observation meant that tentative categories identified were explored in during interview and discussion. Third, the participants checked the data, analytic categories and interview transcriptions.

The last strategy was to enlist the support of the expatriate educator group for debriefing and support sessions. This enabled me to check my perceptions of the data collected in the fieldwork activities. It was also a mechanism to check concerns and questions that arose as part of the research but were inappropriate to raise with participants or in other forums.

Transferability

Lincoln and Guba argue that:

> It is not the naturalist's task to provide an index of transferability; it is their responsibility to provide the database that makes transferability judgements possible on the part of potential appliers (Lincoln and Guba, 1985: p316).

This type of single programme study will always raise questions as to how typical the subjects of research are (Crossley and Vulliamy, 1984). Countering such a criticism, Spindler (1982: cited in Crossley and Vulliamy, 1984) argues that:

> An in-depth study that gives accurate knowledge of one setting not markedly dissimilar from other relevant settings is likely to be generalisible in substantial degree to those other settings ... it is better to have in-depth, accurate knowledge of one setting than

> superficial and possibly skewed or misleading information about isolated relationships in many settings (p8).

The purpose of this research was not to provide generally transferable findings. However, the findings of this study will raise some issues and will provide some answers about processes in developing continuing education curricula in a developing country context. Professionals reading this thesis (and other papers written from it) will be able to make professional judgements about the application of this study to their practice.

Cambodia, the country in which the study was be undertaken, has a history that differs from many other developing countries, mass genocide of intellectuals (people with a university education and all people who wore glasses) and an upper class has left an impact on Cambodians that is beyond the scope and intention of this research project to discover (Woods, 1997; Duggan, 1996; Chandler, 1996). The history of the country and its people will have some bearing on how useful the findings are for other countries with a different historical background.

Dependability

It was also not the intention in this case study on developing continuing education curricula to detail a replicable research study in the same setting with the same participants. Indeed, the findings from this study will not be in a form that is

replicable with the same participants in the same context. Because of the collaborative and participatory nature of the research, an intended outcome was that the participants have grown beyond the initial starting point of the research.

An audit trail of the process, data collection and data analysis methods was kept for the purpose of confirming the research as reported.

Confirmability

Guba (1981) suggests that the keeping of a reflective journal adds to confirmability. Throughout the study, I maintained a personal reflexive journal as a means of confirming the finding of the study. Based on the work of Schon (1983) reflection is a process that enables connections to be made between various elements of an experience. Best known for his use of the term "the reflective practitioner", Schon postulates, "our knowing is in our action, and that such knowledge is tacit" (1983, p49). Journaling is a method of recording the complexities of our practices and experiences and the emotions that accompany them (Holly, 1997; Street, 1995; Taylor, 2000).

In the original field notes, I continually identified points that were then recorded in my personal reflexive journal. This method of journaling enabled me to detail my experiences during the research and then analyse them alongside the data

analysis process. I recorded both the subjective and the objective dimensions of an event at times during the journaling. Holly (1997) suggests that journaling permits a dialogue to occur between the objective and the subjective views of the writer. As this dialogue continues, the writer is able to become less critical of actions taken and independent actions take on added meaning. The written account of events allowed me to return to the event over time so that the reflection was an ongoing process and in part, I became a more sensitive observer. Establishing this journaling as a type of audit trail increased the dependability or confirmability of the study.

Conclusion

This chapter has examined the positivist, interpretive and critical approaches to research and their underlying assumptions and then outlined the analytical framework for this study. The methodology for this study was based on the critical paradigm. Critical theory allows a collaborative process between the researcher and the research participants and goes beyond providing a structural understanding through critique of the society in which it is situated. Critical theory perspective also enabled an investigation of the process of developing continuing education curricula in a developing country from a qualitative rather than quantitative perspective.

In review, the analytical framework for this study consists of the concepts from the work of Michael Apple and Basil Bernstein. The parallelist model of Apple allows the researcher to use relational analysis in developing an understanding of the political, cultural, economic and social relationships (class, race and gender) from a critical perspective. Bernstein's code theory of pedagogy allows the curriculum researcher to explicitly examine the power relationships in deciding "the what" (content and subject matter) and control relationships in deciding "the how" (interactive forms of teacher and participant relations). In combination, the parallelist model and the code theory enable an analysis of the relations to education and the relations within education and curriculum.

In the next chapter, we examine in more detail the country context issues signaled in chapter one.

4. APPRECIATING THE CONTEXT OF THE COUNTRY

Overview

In order to understand the context in which this study was undertaken, this chapter locates it within the economic, cultural and political dimensions of the country. According to Hastrup and Elass (1990: cited in Wilson, 1992: p181) when fieldwork is undertaken in a developing country:

> the researcher should 'seek to comprehend the context of local interests'; that is, why people conflict over certain things in certain ways, and why and how people with different access to power interact in the way they do: indeed, this 'context' should also be presented explicitly to the reader in the analysis.

Leading on from the overview of the history set out in chapter one, this chapter briefly depicts the events surrounding the second free election in 1998. The build up to the election coincided with my arrival in Cambodia.

The chapter then moves on to review current knowledge about the development and health status of the country. This begins to put a context around the realities in which health workers work and the human resources available in the country today following the genocide regime of 1975 - 1979.

The programme[25] and the informants for the study are introduced by means of short vignettes. Within the programme, there are six informants, three of whom had a more dominant role in sharing their experiences. My place within the programme in which this study is situated is explored. Whilst I had a role of an advisor to the programme this is not the focus of the study.

As part of entering the field of the study, I soon realised that terminology relating particularly to status and class needed clarification early. This clarification meant my effectiveness both as advisor to the programme and as a participant observer for the study could be enhanced as I gained an understanding of the cultural protocols. The final section of this chapter examines the relationships between position and status within the context of the country.

The Country Context: a sketch of relevant factors

As mentioned in chapter one, Cambodia was to hold elections within a year of the factional fighting of July 1997. These elections were held on 26 July 1998. By this time:

> Most of the destroyed homes are rebuilt, and many who fled have returned. But several thousand of Prince Ranariddh's troops are still holed up on the Thai border, observing a tense cease-fire for upcoming elections. About 80,000 refugees from border fighting

[25] The term programme is used to protect the identity of the study location.

> remain in Thailand. The economy has steadily slid (The Cambodia Daily Weekend Edition, 1998: p1 and 20).

By 25 July 1998, the Joint International Observer Group pre-election statement made no mention of whether the polls would be free and fair. They instead conveyed a list of concerns including intimidation, efforts to undermine belief in ballot secrecy, unequal access to media and appeals to ethnic hatred.

The three main parties to watch during the election included the Cambodian Peoples Party, the United Front for an Independent, Neutral, Peaceful and Co-operative Cambodia and the Sam Rainsy Party. These three parties won all the 122 parliamentary seats. Their election promises for Health and Education are outlined at Figure 14.

Cambodian Peoples Party	Front for an Independent, Neutral, Peaceful and Co-operative Cambodia	Sam Rainsy
Health ▪ Upgrade the quality of public health services by giving priority to rural health services. ▪ Boost education on the prevention of infectious and chronic diseases in order to decrease diseases such as malaria, tuberculosis, sex-related disease, AIDS, diarrhoea, dengue cancer etc. ▪ Improve health conditions of women and children through the expansion of a birth spacing programme, vaccination, nutrition and family health care. ▪ Provide access to necessary public health services for older persons, handicapped and poor.	**Health** ▪ Retrain public health officials and to upgrade the quality of clinics and hospitals. ▪ Provide education on the importance of individual and family health. ▪ Control the distribution of fake medicine or expired date medicine. ▪ Launch a vaccination campaign against tuberculosis, polio and measles for all children. ▪ Provide education on the use of medicine and birth control methods. ▪ Spread information on the dangers of AIDS. ▪ Conduct a blood testing campaign for sex workers.	**Health** ▪ Set up a public health care system such as hospitals, health centres, medicine to provide services to people both in the cities and in rural areas. ▪ Organise a compatible system of treatment and prevention to reduce the number of sick. ▪ Set up a permanent programme for health care education.
Education ▪ Enable children old enough to go to school to enroll in public school without paying school fees. ▪ Promote informal education to achieve the goal "Education is for everyone" in order to eliminate illiteracy. ▪ Upgrade the quality of education by connecting education with production.	**Education** ▪ Reform the curriculum, provide books and materials, and train teachers and education officials to govern schools. ▪ Ensure equality in schooling, reduce illiteracy, and ensure that every child has the opportunity to go to school. ▪ Direct education toward human resources development for effectiveness in jobs. ▪ Encourage partnerships from various sectors of the society, particularly the private sector.	**Education** ▪ Set up a modern standard of education. ▪ Boost technological training namely in agriculture, industry, the electronics business, electric power construction, so that Khmer children have real technical skills to participate in nation building in all areas. ▪ Completely eliminate the certificate buying and corruption within the education system.

(Edited extract of the Voter's Guide (1998) published by the Centre for Social Development, a non-partisan organisation which supports all parties in furthering democracy in Cambodia.)

Figure 14 Promises, promises: a post-election reminder.

The policy promises for the health sector provide a platform for the government to play a central role in ensuring the provision of basic health services. They do not outline whether the government will be the only provider or a provider at all. The current situation is elaborated in chapter five. The policy promises tend to support the notion of the individual and community taking responsibility for their own health care either in the public or private arena (World Bank, 1997; Walt, 1994).

The education policy objectives presented by all three parties were closely associated with what Apple (1996) describes as the neo conservative / neo liberal direction of education. For example: connect education with production; encourage partnerships with the private sector; and, develop real technical skills to participate in nation building in all areas. Neo conservative / neo liberal movements of the political Right stress the same values of family, free enterprise etc. by "making the needs of business and industry the goals of education" (p99).

In the week following the election, allegations of "serious irregularities and fraud" continued to be made by two of the three main parties. It had become obvious that the Cambodian Peoples Party had won the majority of the votes. Official results were released the second week following polling day when votes had been recounted and the allegations investigated.

All appeared calm until the 22 August 1998, when marches and demonstrations by people opposed to the Cambodian Peoples Party began. Slogans and rumors abounded and newspaper headlines attempted to capture the mood. The pro-democracy demonstrators as they called themselves gathered in the National Assembly Park outside the National Assembly Building and erected a sign re-naming the park as "Democracy Square". This situation lasted until 8 September 1998 when the police moved in to evict demonstrators.

Into early 1999, there was a period of relative calm as the coalition government was formed. Neither of the two main parties had won enough seats to govern alone. There were trade-offs in portfolios which resulted in some ministries changing from Cambodian Peoples Party to Front for an Independent, Neutral, Peaceful and Co-operative Cambodia and vice versa. Many International Organisations and Non-governmental Organisations during this period reduced the size of their development commitments to Cambodia awaiting the outcome of the election reshuffles. Cambodia is now classified as a country in unstable political democracy (Sagoe, 1998).

Cambodia is a poor country. In the United Nations Development Programme Human Development index for 1997, it ranked 153 out of 175 countries, with life expectancy of 52.4 years, adult literacy at 65% and an adjusted real Gross Domestic Product of $1084. Two unique features of Cambodian history have a

bearing on both its economic and human development record and thus the health indicators, specifically those related to women. First, it is probably the only country in the world that experienced not only genocide on a scale hitherto unseen, but deliberate state-sponsored destruction of economic, social and human capital. Anywhere from one to two million people lost their lives due to torture, execution, disease and starvation during the Khmer Rouge years of 1975 – 1979. Two consequences of the Khmer Rouge period are (i) a very low sex ratio (ratio of males to females), especially in the age group 40 – 44 years. These individuals would have been 21 – 25 years of age in 1975 - 1979, and (ii) a deficit of individuals aged 35 – 39 years (National Institute of Statistics, 1999). Thousands of young males lost their lives during the Pol Pot era and vast numbers of young adults lost the opportunity of acquiring secondary or tertiary education owing to the abolition of formal education during the 1975 – 1979 period. The implications of this lost educational opportunity will become evident later in this study.

The second unique characteristic of Cambodia is its very long history of political conflict:

- The armed conflict and the insecurity it has produced among the population have led to a large displacement of people;
- The land mines have resulted in a relatively large proportion of the population being disabled; and,

- The long period of conflict has left a high rate of female headship of households.

As a result of the internal conflict, 60% of the adult population is female and children under the age of 16 years make up 50% of the population (National Institute of Statistics, 1999).

Demographic and socio-economic data on Cambodia are scarce, however this situation has improved in recent years with major surveys being conducted:

- The 1996 National Demographic Survey;
- The General Population Census 1998. This is the first nationwide census since 1962; and,
- The 1999 Demographic Health Survey.

Following the population count from census night of 3 March 1998, the estimated population is found to be 11.4 million (National Institute of Statistics, 1999). This means a slightly higher population in the year 2000 than was estimated. This rapid population growth estimated at 2.49 % (National Institute of Statistics, 1999), is outpacing economic growth and development. It is expected to lead to further strains on the government's capacity to provide basic infrastructure needs for the majority of its population – shelter, water, sanitation and access to health services. With over 50% of the population in the under 16 age group high population rates are expected to continue. Additionally, the contraceptive

prevalence rate for modern methods[26] is relatively low although higher than anticipated at 16.1%.

The United Nations Joint Consultative Group on Policy produced a Cambodia Common Country Assessment in January 1998. In the situation analysis, the social indicators of poverty[27], employment, education and literacy, food security, child nutrition, health and population and fertility are presented. These social indicators analysed against the cross-cutting issues of gender, environment, human rights, land mines and access to social and public services provide the following conclusion for policy makers:

> The social and policy challenges facing Cambodia are formidable. Cambodia's performance on so many social, political and economic indicators is so poor that a policy maker might wonder where to begin in terms of interventions and policy actions. Yet it is important to remember that many of the problems affecting Cambodia are interconnected. For instance, women with no schooling are less likely to use contraceptives and more likely to have large numbers of children, and this is turn keeps them and their families in mire poverty. The children of such women are more likely to be malnourished and unhealthy and less likely to be enrolled in school. This means that illiteracy is perpetuated across generations. A holistic policy intervention that recognises these interconnections between female illiteracy, poverty, fertility, child schooling, child health, child nutrition will have a much greater effect than piece-meal efforts to address each problem individually.
>
> It is also important to remember that poverty is the root cause of many social problems in Cambodia. Poverty alleviation is

[26] Modern methods are classified as pill, intra-uterine device, injectable, condom, female and male sterilisation and periodic abstinence.

[27] Defined as the inability to attain a minimal standard of living – typically taken to imply adequate income to consume a food basket that provides at least 2,100 calories of energy per person per day (with a small allowance for nonfood consumption, like clothing and shelter) (Prescott and Pradhan, 1977).

> therefore central to any development strategy in the country (United Nations Joint Consultative Group on Policy, 1998: p44).

Prescott and Pradhan (1997) found that the incidence of rural poverty averages 43% which is four times higher than the 11% poverty incidence found in Phnom Penh. In addition, at least 85% of all the poor are concentrated in rural areas with the highest poverty rate of 46% found among people living in households headed by farmers.

Poverty alleviation is a strategy endorsed by the Non-government Organisations (Non-government Organisation Forum, 1999). They assert that in the period of high economic growth in Cambodia, prior to mid 1997, economic indicators showed growing disparity between sections of the population. The most noticeable being that the productivity of agriculture was not keeping up with the growing population and increase in the rural labour force. This equates to the majority of the population, 80% residing in rural areas being worse off.

In the second half of 1999, in preparation for renewed donor meetings, the government declared poverty alleviation as the most important goal of the "Economic Government" and acknowledged the need to concentrate on the 85% of the population living in rural areas. It also acknowledged that the proportion of the population living in poverty had declined only a little since 1993-94, from 39% to 36% despite economic growth. The stated reason for this small decline

was that the poorest 20% had increased their real consumption expenditure per capita by only 1.7% during this period whilst for the richest 20% the increase was 17.9% (National Institute of Statistics, 1999).

The health profile in Cambodia is one of the worst in the region. Based on figures for 1998:

- The mortality rate for children under 5 is 115 / 1000 live births and infant mortality is 89 / 1000 live births. Maternal mortality is estimated at 473 maternal deaths / 100,000 live births (National Institute of Public Health, 1998; Sprechmann, Soeung, Kerr, Long, and Meakea, 1996). Huot (1993) estimated the hospital based maternal mortality between 580 – 600 per thousand live births. However, since only 13% of all births in the country are estimated to take place in hospitals this is likely to be an underestimate.
- Ministry of Health / World Health Organisation estimates deaths from malaria at over 5,000 each year and from tuberculosis at over 10,000 each year (Ministry of Health, 1999c).
- Ministry of Health / World Health Organisation estimates for Human Immuno-deficiency Virus indicate that about 180,000 people aged 15 – 49 years are infected each year (Ministry of Health, 1999c).
- Only 29% of households are considered to have regular access to safe drinking water. In urban areas the percentage is 60% but in rural areas it is only 24%, according to the General Population Census (National Institute of Statistics,

1999). Water borne diseases are under reported but are one of the main reasons for presentation at referral hospitals and health centres.

- Whilst mine related deaths and injuries are decreasing, dropping to under 1000 reported cases in 1998, the number of injuries in traffic accidents increased to 8000 according to the health situation analysis (Ministry of Health, 1999c).
- The extent of mental health problems is not clearly known but it is acknowledged in the situation analysis (Ministry of Health, 1999c) that mental health services need to be further developed[28].

The position and health of women is crucial to a healthy society. In Cambodia, it has been suggested that women are not culturally or legally in a situation of inferiority rather it is the country's modern political history and poverty that has resulted in a gender imbalance detrimental to women with regard to access to education and social services and to participation in decision-making bodies (United Nations Population Fund, 1996). The section on power relations, position and status later in this chapter sheds an alternative perspective on gender relations.

Increasingly, studies are being conducted into the health status of women in Cambodia. The National Institute of Public Health conducted two surveys (1998 and 1999) in which it looked at antenatal care. In the 1998 survey, it found that on average, only 60% of the women who delivered babies in the last 12 months

reported having a checkup during pregnancy. The National Health Survey (National Institute of Public Health, 1999) conducted later and looking back over five years found that for the majority (54.4%) of live births, the mother did not receive antenatal care. There was also a strong relationship between where the mother lives, their socio-economic status, number of years of schooling and literacy and the receipt of antenatal care and type of provider. In the capital of Phnom Penh, for 81.3% of births the mother received antenatal care. By contrast, among women living in remote or isolated provinces, less than 40% of births were preceded by any antenatal care. Of the total receiving antenatal care in the capital of Phnom Penh the provider for 76.7% of women was a medically trained person (doctor, nurse or trained midwife). By comparison, only 24% of the total receiving care in the remote and isolated provinces used a medically trained provider.

Of those deliveries reported to the Ministry of Health in 1996[29], slightly higher proportions were assisted by traditional birth attendants (56.8%) compared with 42.3% assisted by midwives from health centres and hospitals (Ministry of Health, 1997a). The national household survey on the demand for health care (National Institute of Public Health, 1998) and the National Health Survey (National Institute of Public Health, 1999) indicate that the vast majority of deliveries occur

[28] By 2001, the International Organisation on Migration is the lead partner with the Ministry of Health in an initiative to train mental health workers.

[29] Approximately 36.8% of the estimated total number of expected deliveries.

at home (89.9%) or in other non-medical facilities. The one exception is for mothers living in the capital where 70% of births occurred in a medical facility. Births in non-medical facilities are equally likely to be attended by Traditional Birth Attendants (44.6%) as midwives (45.3%). The main reason stated for not delivering at a health facility was that the facility was too far. Other important reasons include the family not being able to participate, the cost higher than home delivery, lack of drugs, and public facility deliveries not fitting with Cambodian tradition. Differences between rural and urban areas are striking with midwives attending 73.9% of deliveries in urban areas compared with 34.8% in rural areas (Long, Soeung, Meakea, Sprechmann and Kerr, 1995).

About 2000 Cambodian women die every year from childbirth related causes primarily complications arising from abortion, eclampsia, haemorrhage and obstructed labour. A study of traditional beliefs and practices of Cambodian women found that women's greatest fear during pregnancy, birth and postpartum was that "they would die in childbirth" (White, 1995: p33).

In relation to use of health services for other illnesses and injuries, the national health survey (National Institute of Public Health, 1998) found that the government sector was used in only one fifth of all illnesses and injuries. In addition, the percentage of illnesses and injuries untreated was almost three times higher in rural provinces than in Phnom Penh.

The survey also found that the poorest people were more than four times more likely to forgo treatment than the most affluent. The poor bear impoverishing effects of illness through the cost of treatment, travel costs and unofficial payments to health staff. A health care demand survey (National Institute of Public Health, 1998), showed that 45% of hospital in-patients had to borrow money to pay for their stay in hospital. My experience with health staff reinforced the notion that health staff become gate-keepers of access to health care as I found the following about money and access to health expressed on several occasions.

Me: What if a woman comes in with no money?

Midwife: Cannot treat her

Me: What if her condition deteriorates?

Midwife: Do not treat ask her to get her relatives to find money

Me: What if she dies?

Midwife: Write in the record that she died

Speaking at the National Health Congress in 1999, the Secretary of State for Health encapsulated the problems by stating "A cycle of poverty, ill-health and debt economically cripples many Cambodian families" (Awcock, 2000).

The Programme, the Participants and their Stories

My arrival back in Cambodia in April 1998 was three months before the general election. I had worked in Cambodia for eight months in 1997. The programme staff were welcoming and the workload was heavy from the first week. The process for gaining access to the programme as the site for the study was negotiated between the employing agency, the programme director and myself as part of my employment contract. So whilst I had a role of an advisor within the programme this is not the focus of the study although I was aware that the multiple roles of a researcher, advisor and doctoral candidate had the potential to lead to role confusion.

The main actors in this early part of the return were from the Cambodian programme personnel and the expatriate project personnel working in the programme. The expatriate project personnel comprised nine people including me from five different countries.

The role of the development agency[30] in entering the field was not integral to establishing relationships, as there was little contact between the donor agency

[30] Development agency(s) is used to protect the identity of International Organisations and Non-government Organisations.

personnel and me in daily interactions. The effect of the development agency influence assumed some importance in some aspects of the work as it progressed.

The project expatriate staff had resided in Cambodia for varying lengths of time between three to nine months. The variety of groupings established between the expatriates on the project often related to the age range and cultural mix.

One of the first decisions was therefore, what relationships to form with the various members of the team. My work location was on a different site from other members of the team. My chosen role within the team became the focal point of contact for the provincially located project staff. This enabled good use of technical skills and rapid response to requests, an important feature if one is located away from the centre. Having this type of role involved travel to the provinces both to support the staff based in the field and to promote the project. During times of entering the field about twenty five percent (25%) of my time was spent in the two primary provinces one to the north-west and one to the south-east of Phnom Penh. Staff based in these two provinces outside Phnom Penh had a training component to their work. My relationship with these provincially based staff was to critique the work and training plans and assist in the development of the training programmes and find or procure training resources for the implementation of the programmes. A key assumption behind many of the first

drafts of teaching programmes was that as health workers had a basic training in the discipline, learning time could be short with too many topics being covered in a short time frame.

My position in the project is described above with my main working base being at the programme offices based on a hospital site. In the structure of the hospital, the programme comes under the Director of the hospital, however the Director was appointed to a higher level in the Ministry of Health. In this move to the new position, control of the programme was retained by the higher level position bypassing the newly appointed Director of the hospital. During the initial few months the reporting relationships were a bit cloudy and a number of interesting protocol mistakes on my part occurred.

In terms of my training advisory role, commitments were both to the programme and to the hospital, in terms of my doctoral candidate role my research focus was within the programme and its relationships. Although the process of developing continuing education curricula was supported with technical and financial inputs through the programme structure / purse, the membership of the curriculum development advisory groups, beneficiaries of the technical and financial inputs, came from the hospital. It soon became evident that information needed to be disseminated to the hierarchy in both groups on an individual basis.

It is worth noting that the programme in which I undertook the research and had the advisory role is a national vertical programme. This means that the project staff, national and expatriate, located at the National level had a policy as well as an implementation role. The training programme for health workers occurs at all levels of the health system i.e. national, provincial, district and health centre levels with the training audience being prescribed within the boundaries of the public sector health system.

Following ethical approval by the University of Ballarat Ethics Committee, shortly after my arrival back in Cambodia, the recruitment of informants and subsequent field-work for the collection of data was able to begin. See appendix 1 for a copy of the letter of approval from the University of Ballarat Ethics Committee. Within the eight month period of fieldwork the process of developing continuing education curricula by a group of staff of the programme was observed. This was supplemented by observations at field sites, meetings with other technical assistance providers in the health and education field and examination of relevant literature on human resources in health in Cambodia.

Each of the six informants had been given a plain language statement and consent form outlining the focus of the study before the study commenced. On signing

this statement they were deemed to have provided their consent to being a participant in the study. Appendix 2 outlines the information given to the informants prior to the commencement of the study. One of the informants had undertaken Masters level study in an English language environment, and a second informant was embarking on a Masters level programme by distance mode in English. The other four informants were undertaking English language training and at the time of the study had reached Grade eight or higher. A translator was not required when interviewing these informants from the programme. They stated that answering the questions without a translator would assist in their English language development and instead chose to assist each other if it was required for the study. Ten semi-structured interviews were conducted during the course of the study.

My interaction with three of the six informants occurred on almost a daily basis. My involvement with the other three was to a lesser extent two to three times a week. The three main informants were Charya[31], Vandara and Khim. A short vignette of their life is presented below. The other informants were Sopheap, Kimny and Sophoan. In way of further information about these three informants, Sopheap and Kimny are in their late 30's, female and secondary midwives by basic training. Sophoan is in his mid forties and holds a medical degree obtained

[31] Pseudonyms are used to protect the real identity of the respondents.

in Cambodia and a Master's degree obtained abroad. In general, this is a group of motivated national staff with differing English ability and limited teaching skill.

Charya aged 35 years is a secondary midwife by training. She is a single woman who lives with her father. During the Pol Pot regime she was sent from Phnom Penh to the countryside. Here she spent her days delivering rice seedlings from the nursery to the fields for planting. Charya undertook her training at one of the five Regional Training Centres in Cambodia and afterwards worked at a national level hospital. She runs a small private clinic at her home in the evening primarily providing ante-natal care and advice for expectant mothers. This practice is smaller since she joined the staff of the programme. In this new position she obtains a significant salary supplement and no longer relies on her private practice to make ends meet.

Charya participated in her first training of trainers during the second month of the entry and commencement of the study by the writer. This was her first and only formal teaching course during the year that she had been with the programme. Charya's main responsibility is for training. From the time she completed the training of trainers course she became regarded as the prime trainer and teacher for the training conducted under the programme.

Vandara in her early 40's is a mother of two. She has been with the programme since its inception in 1994 and oversees day to day activities. She holds a position of responsibility within the programme. Vandara spent her early years in one of the Provincial capitals in Cambodia. She came from a well-educated family and lost her father to the Pol Pot genocide campaign early in 1975. Vandara, although young at the time was able to demonstrate an ability to weave silk in the factory owned by her father and thereby avoided capture and execution. Following the Pol Pot era, she spent seven years in Russia training to become a doctor.

Vandara is very committed to progressing development in Cambodia particularly in the area of reproductive health and is one of the few people who never participated in the lottery for a green card to work in the United States of America. During the course of the study, Vandara obtained a scholarship from a development agency, to undertake a distance learning course of study at the Master's level.

Khim aged 39 years, like Charya is a secondary midwife. She lives alone. Khim is a private person, reluctant to share her experiences during her growing up years[32]. In respecting her privacy, and because of the nature of the political

[32] Some of the survivors of the Cambodian holocaust of 1975 – 1979, witnesses to the near total destruction of their cultural identity, have coped so far by adopting what has been described as a "dummy" personality, a kind of psychological withdrawal or numbing which allows avoidance of the past. Some say they do not remember what happened. Summerfield, D. (1997) The

history, I did not actively pursue information about her past life experiences. Khim is well esteemed by the managers of the programme and holds a portfolio that requires her to link frequently with central level ministry personnel.

Position and Status: Distribution of Power

As I became more familiar with the informant group, the pecking order became more evident. In order to check out my observations we would often discuss the dimensions or the perceived hierarchy of various properties. Through the initial encounters with the national project team, it became clear that an understanding of the cultural meanings of the titles and the espoused status (high or low) of the dimension was essential. Without this understanding, it would be impossible to make progress.

When referring to health workers, the doctor has high status and the other cadres are progressively lower. In the maternal and child health sphere the order is: doctor, medical assistant, secondary midwife, secondary nurse, primary midwife, primary nurse and traditional birth attendant. This does not differ from other cultures. Walt (1994) outlines a situation in Uganda, during the period of

---

psychosocial effects of conflict in the Third World, In Eade, D. (ed) *Development for Health,* Oxfam Print Unit, UK. – p67.

reconstruction in the 1980's that bears similarities to the situation in Cambodia today. The medical profession holds the key advisor roles in the Ministry of Health and is able to capture vital resources for reconstruction of large hospitals. Although endorsing primary health care policies, vital funds for implementation get channeled to large centralised infrastructure projects thereby restricting access to health care for the vast majority of the population.

For Cambodians, because of the nature of the political past and the philosophy of the Pol Pot regime[33] there were few professionals left alive in the country by 1979. In the early emergency training after this time, Cambodians went out of the country for professional training. Many went to Russia and other eastern block countries. The hierarchy of professions again saw doctors at the top followed by engineers, a small number of both professions sent abroad for training in the early post conflict period as the university and medical school in Cambodia were being established. The perceived lower level professionals for example nurses received training in Cambodia. Vandara recounted a professional desire for engineering. It was an ambition since childhood however, because her school grades were too high the profession chosen by the state was medicine with training in Russia. Within the project Vandara is in charge of the process of developing the

[33] Within two weeks of Pol Pot coming to power, the entire population of the capital and provincial towns were forced to march out into the countryside to prepare the rice fields. Currency was abolished and the postal services halted. Over the next four years in a campaign called 'auto-genocide', thousands of Cambodians, branded as parasites because they wore

curriculum with no formal teacher training or teaching qualifications – there by dint of her professional background. Charya coordinates and conducts most of the training.

In the culture of Cambodia, men are seen as having higher status than women. Gender relations in Cambodia are predicated on idealised images of womanhood conveyed in popular stories and poems. A "good woman" is able to juggle her care-giving role at home with a gift for business savvy that helps support her family financially. A CARE report (1992: cited in Goodyear, 1996) states:

> With perhaps the exceptions of a few areas, Cambodian society is male dominated. There appears to be no question of women being equal partners in society, nor acceptance of a wife as co-equal in the family home. The statements of men ... show that men feel invincible and that they have rights and freedoms greater than women in Cambodia today. To a great extent women appear to accept this situation. Marriage and family were seen as the paramount concern to women along with respectability and honour (p5)

Gender and the relationships of power between men and women are of special significance in a country such as Cambodia where women head 25% of households and the majority of small businesses are run by women. A survey (Lott, 1995) conducted in the capital entitled "Gender and Development in Cambodia", found that gender training and policies exist within many development agencies and local non-government organisations, but that the

---

spectacles or spoke a foreign language were systematically liquidated (Robinson and Wheeler, 1992, p15). It is believed that there were only six doctors alive after the Pol Pot regime.

interpretation of what constitutes gender was conflicting. In many cases, respondents indicated that they had gender programmes when they simply had programmes that targeted women but did nothing to challenge the inequality between men and women.

A tragic consequence of women's second class status is that violence against women is socially tolerated within families and communities. The excuses for domestic violence include: alcohol consumption, jealousy, money problems, talking back to a husband or merely that food is not deemed delicious. The proper code for female behaviour is taught at home by the widely recognised verse "The rules of the Lady":

> Always speak sweetly and accomplish your tasks with dexterity, you must grow old without a moment of distraction you must take care of your parents and never contradict them never tattle to your parents anything negative about your husband or this will cause the village to erupt, respect and fear the wishes of your husband and take his advice to heart avoid poising yourself as equal to your husband and never above he who is your master, if he insults you, go to your room and reflect, never insult or talk back to him prove your patience, never responding to his excessive anger but using gentle language in response (cited in Goodyear, 1996: p6).

As is evidenced in this statement with age comes greater status and the greater or higher the level of status the less able a person of lower status is permitted to challenge them.

Late in the duration of the study, an expatriate doctor arrived to fill the, until then, vacancy of team leader. This altered the dynamic of my interactions with the informants who were managers of the programme. These managers began to relate less directly to the writer and more to the team leader who assumed a responsibility for transferring messages back and forth.

The emerging classifications related to high and low status evident early in the study are outlined as figure 15.

Property	**Dimension**		
	High		**Low**
Health Worker	Doctor	Midwife and Nurse	Traditional Birth Attendant
Professional	Doctor	Engineer	Nurse
Gender	Male		Female
Age	Old		Young
Political Affiliation	Cambodian Peoples Party		Front for an Independent, Neutral, Peaceful and Co-operative Cambodia
Personality	Quiet		Noisy
Role Description	Coordinator	Teacher and Trainer	Facilitator

Figure 15 Classification of Status

Gintis (cited in Apple, 2000: p17) would argue that these status issues relate to ongoing conflicts between property rights and personal rights. He defines property rights and personal rights in the following way:

> a property right vests in individuals the power to enter into social relationships on the basis and extent of their property. This may include economic rights of unrestricted use, free contract, and voluntary exchange; political rights of participation and influence; and cultural rights of access to the social means for the transmission of knowledge and the reproduction and transformation of consciousness. A person right vests in individuals the power to enter into these social relationships on the basis of simple membership in the social collectivity. Thus, person rights involve equal treatment of citizens, freedom of expression and movement, equal access to participation in decision-making in social institutions, and reciprocity in relations of power and authority.

Apple (2000) suggests that in society dominant groups defend the prerogatives of property while subordinate groups seek to advance the prerogatives of persons.

Charya, Vandara, Khim and to a lesser extent Sopheap and Kimny were involved in preparing the training courses and the process of developing continuing education curricula. In the initial period of course design, the group worked from a perspective of critiquing what was written rather than writing from the beginning. Moving from the written word to see if it fitted the present structure rather than proposing how they believed things should be. My role in this part of the process was to provide the written word based on the thoughts of the group and development agency requests:

Vandara: It would be good for you to listen to our thoughts and then write them down for us in English so we can look at them. That way we can look and see how to change or go on. You know what [development agency] want I haven't read the report yet.

Bernstein (1990) would suggest that in the relations of symbolic control the 'expert' is the leader within this context. In addition, the pedagogic communication practice of the programme had historically been that the 'expert' had a strong voice in deciding the curriculum content.

Conclusion

The chapter has set a context in which I as the researcher undertook the study. It outlined the main issues that I needed to understand before moving to developing any curricula for health workers that would take into account the specific economic, cultural and political relationships of the country. As this chapter has evidenced, the contextual complexities further increased as Cambodia held a general election resulting in the country entering a phase of unstable political democracy.

The process of entering the field for the study was relatively smooth. This is due partly to the process being well facilitated by the programme personnel where I was based and partly because I had prior experience working with the programme.

Additionally, I had a role of advisor as well as doctoral candidate, the focus of this study though is not that of my advisory role. This chapter also introduced the participants of the study Charya, Vandara, Khim, Sopheap, Sophoan and Kimny and explained the nature of the reporting mechanisms in the programme.

The last section of the chapter explored the power status issues of the dominant and subordinate groups, an important contextual reality that I needed to recognise early.

In chapter five, the focus is more specifically on the health sector and the relationships between the organisations, programmes and people working in the health sector that had contact with, and impact on, the study.

5. WESTERN TRANSFERENCE

Overview

Cambodia is no exception in the trend towards a market driven economy and the ideologies of economic rationalism, which increasingly is behind the new understandings and new meanings promulgated in a number of "third world" countries under the guise of development.

This chapter examines the status of health sector reform in Cambodia, which has as its three main platforms planning, management and human resource development. The reform package brings with it a number of development agencies and "experts". In order to progress the human resources development aspects of the reform package a number of education and training advisors are working with a variety of development agencies. The problems associated with this type of cross-cultural transfer are well documented (Carnoy, 1974; Altbach and Kelly, 1978; Watson 1982: cited in Watson, 1994). In the 1990's in spite of the data accumulated, concern is not with analysing the cultural and national differences but concentrates rather on international similarities and performance indicators.

The expatriate educators, an umbrella term for education and training advisors, working in Cambodia became an integral part of checking my realities as the study progressed. I was however aware of the cautions in the literature on transference based on western terms of reference.

The changing nature of expert assistance to Cambodia both in terms of who is employed in-country and who can be sent overseas for training is beginning to be felt. In this chapter, this is examined within the context of the study.

Reform: changing policy priorities

In recent years, there has been a trend towards restructuring and deregulating state education and health. Such policies have received encouragement from the New Right governments (such as United States of America, United Kingdom and Australia) and have subsequently been fostered by the International Monetary Fund and the World Bank (Whitty; cited Halsey, Lauder, Brown and Wells, 1997).

However, because of the imposed structural adjustment policies of the International Monetary Fund and the World Bank, in many countries maternal mortality and morbidity rates have increased. Stewart, Hall and Wangwe (cited in Walt, 1994: p126) suggest that in some countries, the "entire fabric of society has

been put at risk from cuts in health and education budgets and diminishing state sectors leading to unemployment". Other countries moving from more co-operative organisations to neo liberal free market economies have also suffered in terms of public health. Coburn (2000) contends that neo liberalism produces higher income inequality and lower social cohesion. This negative effect of neo liberalism on health status is due to its undermining of the state support for education and health.

The health system in Cambodia is in such a state of transition. In 1995, the Ministry of Health conceived its Health Coverage Plan, an ambitious plan to create a new health system based on operational districts each with a referral hospital and a network of health centres. Walt (1994) argues that international actors and actions influence policy makers within countries even where the country takes the lead in defining the key objectives and priorities. Countries make policies in an interdependent world. The reforms initiated in 1997, aim to improve the quality, coverage and affordability of essential health services. The criteria of accessibility and population were the basis for the Health Coverage Plan. First the location of a health facility should be within ten kilometres or two hours walk. Second, the optimal population covered by a health centre is 10,000 and for a hospital between 100,000 and 200,000. The justification being that this allows sufficient workload for the resources invested (Health Sector Reform Project, 1998).

After three years, a lot has been achieved. Most of the new organisational structures are in place and an extensive programme to refurbish existing buildings and construct new ones is underway. Despite these improvements, health services in both the public and private sector are generally of limited quality, and low utilisation remains a problem in the public sector (National Institute of Public Health, 1999; United Nations Population Fund, 1997). In addition, the health system in Cambodia remains pluralistic. Throughout the country there are four (4) different options to seek treatment. They are:

1. public health care, through district based hospitals and commune based health centres;
2. self medication, usually following consultation with a drug seller;
3. traditional healers (Kru Khmer); and
4. private practitioners, who are usually public practitioners as well.

Researchers from the Royal University of Phnom Penh (1998) found the government health centre ranked third in preference for women seeking reproductive health care after the drug seller / pharmacy first and the traditional healer (Kru Khmer) second. This current disjunction between the Ministry of Health's policy and the realities of health care provision and health seeking behaviour presents a difficult dilemma for development agencies. Official policies that promote government health centres as front line health care service

sites are probably many years away from becoming a reality in the lives of most Cambodian people.

"Human resources for health" are commonly referred to as the most important asset to the delivery of health services, influencing many changes in the health sector. A number of countries around the world are currently engaged in health sector reforms and many of these reforms are focussed on increasing efficiency and reducing waste in the use of human resources including human resources for health (Martinez and Martineau, 1996: cited in Sagoe, 1998: p1). In Cambodia, a continuing education programme of thirteen (13) modules has been developed as part of the reform process to provide health centre staff with the skills necessary to provide what is called the Minimum Package of Activities. Each module comprises five to ten days of teaching that can be conducted as a stand alone course. Because of the time needed to deliver all 13 modules, the Ministry of Health with funding and technical assistance from two development agencies jointly developed Foundation Health Centre Training. This is a short course based on the first three modules of the Minimum Package of Activities. The Foundation Health Centre Training covers the operation of a health centre, clinical examination of patients and the basic clinical skills needed to treat common health problems presenting at health centres (Ministry of Health / German Technical Cooperation / United Nations Children's Fund, 1999).

The health reform plan also decentralises decision-making and gives new responsibilities to managers of Operational Health Districts. The changes at all levels of the system are outlined in Figure 16:

Level	Changes in Responsibilities
National	The Ministry of Health is changing from implementing services directly to setting policy, monitoring and overseeing implementation.
Provincial	The provincial health departments are putting into place new organisational structures to support the integration of health services. The vertical system of supervision, training and monitoring is changing into an integrated system.
District	Staff are taking on new managerial responsibilities. Organisational structures and positions have changed to represent the increased responsibilities of staff in management and technical areas.
Health Centre	Staff are being trained in many technical programmes to better serve the people.

Figure 16 ***Changes in responsibilities at all levels of the Health System***

Adapted from: Guidelines for Developing Operational Districts (Ministry of Health, 1997b)

Saide and Stewart (2001) indicate that despite political, cultural and geographical diversity, health care reforms implemented in many developing countries share a number of common features regarding decentralised management and structural issues. They argue that:

> in the absence of clear guidelines, continuous monitoring and adequate supply of financial and human resources, decentralisation is likely to have a low impact on the process of health care reform (p165).

Management training for provincial and operational district managers needs to prepare them for the new decentralised environment is provided by the six month Health Services Management Training Course run by the German Technical Cooperation (Ministry of Health, 1999b). The course is presented in eight consecutive modules.

The low salary of health workers tend to affect their productivity as well as use of public services as most of the public health workers are engaged in private and other ventures to supplement their salaries. To address the problem of informal charging as a result of the low salary, user fee schemes are being introduced with published scales of charges and exemptions for the poor. Income from the schemes can be used to maintain buildings, upgrade equipment and to pay salary supplements to staff (Health Sector Reform Project, 1998; Ministry of Health, 1996). It has been reported that revenues from cost recovery are divided among health staff on an informal seniority basis[34] (Reproductive and Child Health Alliance, 1998).

Experience from other developing countries (Centro de Informacion y Servicios de Asesoria en Salud, 1997) shows that cost recovery, user fee schemes can

[34] "A relatively new [health worker] stated she and her colleagues received R4,500 (approx. US$1.20) monthly for several months. More senior staff with greater family responsibilities received somewhat more. But on other months, revenues had to be used for health centre operating costs and materials. Revenues were also used on occasion to pay for the 'entertainment costs' of visiting high-ranking officials. In short health centre staff receive a meager, almost inconsequential, share of the revenues" (p8).

further limit access to government health services, even where there are exemption schemes for the poor. The Reproductive and Child Health Alliance (1998) study found that in Cambodia an inverse incentive structure has been created. The low salaries of health workers and the very real need to resort to alternative employment mean there is no reason to encourage people to come to health centres rather the goal is to build their private practice. In addition, the established patterns of health seeking behaviour (described briefly earlier and expanded upon later in this chapter) reinforce the inverse incentives to health centre use. The result is a powerful, pervasive incentive structure that runs completely contrary to the promotion of health centres as the frontline or principal source of health services for villagers, as envisioned by the health reform programme.

As outlined in the "Health Situation Analysis 1998 and the Future Directions for Health Development" (Ministry of Health, 1999c), the government is considering adopting a sector wide approach to health development. Sector wide approach allows donors to move away from funding specific projects and, instead, become stakeholders with the government in the planning and execution of national strategies. This approach needs common arrangements for planning, financial management, procurement and performance monitoring. It is not clear how this will be achieved in Cambodia or when the process might start. The Department for International Development is known to favour a sector wide approach as their

preferred mechanism for putting funds into Cambodia and, since the European Commission is one of the originators of the approach, the same may be true for European Union funds (Department for International Development, 1999; Cassels, 1997). The World Health Organisation is actively supporting a sector wide approach and can be expected to press for its adoption by other United Nations agencies (World Health Organisation, 1999).

A sector wide approach would increasingly see the vertical programmes originally established to deal with particular diseases or target groups (e.g. diarrhoeal disease, vaccine preventable diseases, AIDS, maternal and child health) integrated into a comprehensive approach to health care. Walt (1994) and Cassels (1995) assert that where vertical programmes have attracted funding from external sources, there can be considerable resistance to sharing resources. Cambodia's experience to date in integrating its maternal and child health activities has been slow as senior officials within this section grapple with the power shift away from relative autonomy[35]. They often state they support sector wide management but are reluctant to embrace all parts of a sector wide approach, specifically when it involves the pooling of funds:

[35] "Ministries of health at the national level are increasingly trying to reduce their involvement in the management and delivery of services, restricting their activities to policy formulation, monitoring, coordination and regulation. In practice a number of difficulties have been encountered, especially when restructuring has appeared as part of donor conditionality... Few staff have experience of working at a strategic or policy level – being far more used to functioning as programme managers. If management responsibilities are removed, technical experts have to adapt to an advisory role... A less recognised problem concerns the power exerted by professional cadres – doctors, nurses, pharmacists and others. Recent experience

Sophoan: We want to integrate but not too much. Then we can still make the decisions for the programme. I have good links in the ministry. they understand so this way I can work for the programme and the ministry.

Despite the considerable progress made, much remains to be done and the Ministry of Health is now considering ways of accelerating the implementation of the Health Coverage Plan by further devolving management and financial responsibilities to operational districts (Awcock, 2000; World Health Organisation, 1999; Ministry of Health, 1999b and c). The operational district is the level of the health services below the provinces, at this level, the accelerated implementation of the Health Coverage Plan termed boosting comprises:

- an increase in government spending on health services;
- finding new "top up" funding from donors for recurrent expenditure;
- additional clinical training;
- improving management skills in operational districts, referral hospitals and health centres;
- giving provincial health departments and operational districts greater control over their own budgets;
- creating a social development strategy for each operational district to ensure access for the poor; and

---

suggests that this form of vertical organisation is probably more refractory than the well documented issues surrounding vertical programmes" (Cassels, 1995, p13).

- a new role for the Ministry of Health in contract management.

The boosting proposal is dependent on the Ministry of Health having sufficient funds for salaries, drug purchases and operating costs of health facilities. In 1999, there was a big increase in recurrent expenditure as the gap between the planned health budget and the amount of money made available to the Ministry of Health was reduced as shown at table 1.

Year	Recurrent Budget $M	Recurrent Expenditure $M	% of Budget Implemented
1996	23.0	16.2	71%
1997	20.7	15.4	70%
1998	16.6	11.7	73%
1999	22.5	19.9	88%
2000	31.8	-	-

Table 1 Government Expenditure on Health from 1996 - 2000

If a similar level of actual versus planned recurrent expenditure can be achieved on the larger budget figure of 2000, the financial constraints on staffing should be eased. Any increase in funding for staff salaries is likely to be a start towards re-motivating a de-motivated workforce.

Shaping Change: the use of experts

Technical assistance and the use of 'experts' occurs at all levels of the health sector in Cambodia. My contact with these other experts occurred through two main contexts that are important for this study:

- at the national level through the interests of the educational context; and,
- at the level of the programme through programme related workshops and consultancies.

A problem for experts in the field of educating health workers and for me as a researcher and expert is that literature related to curriculum development is based in schools: primary, secondary and higher education institutions with nursing and medical programmes. This study looks at curriculum in an unusual context where to date there is a dearth of literature. Therefore, as mentioned out earlier, literature related to curriculum and the process of developing curricula draws from the body of knowledge in more developed countries from schools and institutions providing nursing and medical programmes.

National Level Experts

A forum for expatriate educators working in the health field had been established in late 1997. It was within this forum that I met with a number of expatriates from

European countries, America and Australia employed in training related activities including the development of curricula specific to the needs of staff in the health sector reform. The work of the expatriate educators in this group was closely related to the topic of my thesis. Therefore, I requested approval from the group to record aspects of our meetings that might assist me to gain insights into their experiences in curriculum development and training. It was agreed in principle that I could record the meeting with the proviso that at the beginning of each meeting the request was repeated, because of the changes in group members. Additionally, the names of the expatriate educators were not to be used. It was agreed that "expatriate educator" would precede any information incorporated as a result of the group meetings to identify the source of the information.

Crossley and Broadfoot (1992) drew attention to a concern emerging in the use of so called experts in developing countries. This related to the increasing numbers of educationists working in the developing world without training in the international context of education or health or indeed relevant past experiences of the context in which they were to work. Apple (1993) argues that the neo-conservative and neo-liberal strands of the New Right have combined forces with key business interests providing an educational environment based on increasing international competitiveness and profits. In this increasingly competitive market, many experts are encouraged by their consortiums to seek funds in developing countries. The first step for any expert working in this context is to become

familiar with the physical and cultural environment as not surprisingly, some consultants have done a disservice to less developed countries. As Little (1988: p19) warns:

> Only when prepared to spend time doing our homework to learn and understand more about the situation on which advice is sought and only when prepared to share responsibility when things go badly wrong, should we erect our "for sale" sign. International consultancy work is difficult and time and energy consuming, if it is to be done well.

Although all the expatriate educators in the forum came from a health background, primarily nursing and / or midwifery, many had no previous background or further professional employment or education in teaching or curriculum development. They had been differently prepared for their role with some having years of experience in developing countries and others embarking on Cambodia as their first assignment abroad. The World Bank (1997) suggests an additional problem confronting experts in attempting to sustain recovery and reconstruction in post conflict countries such as Cambodia. This relates to the lack of capability within the country and therefore the need to clearly define the role of the expert:

> Conventional assistance is rarely effective in settings where even minimal rules and restraints on arbitrary action are lacking. ... Thus, it is vital that imported technical assistance comes with efforts to implement and enforce the basic rules of accountability and restraint within government and so begin to rebuild its lost credibility. (p161)

Advisors and experts in this context need to complement their advisory role with a 'hands-on' approach to development.

In Cambodia, the conventional power of dominant occupational groups is clearly evident. One of the most obvious problems that all expatriate educators appeared to encounter as a result of this power dynamic was establishing and maintaining a good working relationship with the Cambodian technical experts. These technical experts tended to be Cambodian medical staff, which led to perceived knowledge, and status imbalances that needed to be sensitively addressed. A number of interesting discussions were held in the forum where I gained insight into their approaches to managing the power dynamic to ensure appropriate human resource development and more about the influence of the class relationship in determining how Cambodians learn.

As expatriates our identity has been formed in different cultural contexts where certain forms of knowledge are given status in a hierarchy and where certain theories are held in deference. Our personal identity is strongly tied to our field of expertise and within that to certain models of curriculum development. It may be difficult for us to restructure our identity to meet the needs of a different culture. In order to be effective we may be asked to rethink our ways of developing courses so that they grow out of the reality of the country (McLaughlin and

O'Donoghue, 1996). One of the expatriate educators had a consultancy to work collaboratively with a group of medical officers developing a Minimum Package of Activities training package. The process undertaken by the expatriate educator was in isolation from the Cambodians in terms of input into the design and writing. It became evident early that the ownership of the process by government staff was not occurring. Eventually, the expatriate educator was relocated outside the work site of the medical officers and although the training package documentation was completed, translation and piloting were not commenced. Within this example, culturally, Cambodians will not confront expatriates where there are areas of conflict but will instead withdraw from them. In addition, the dynamics of gender and class possibly played a part in the withdrawal of involvement.

Other expatriate educators expressed the same difficulties I had experienced in developing a framework in which to forward plan and manage training courses. Most of the expatriate educators counterparts, who were managers had undergone management training, however, forward planning appeared to be a concept not easily applied in the real situation. Although no adequate explanation could be provided, several reasons were thought to contribute to this including:

Expatriate Educator: never having learned to conceptualise during their growing up period.

Expatriate Educator: teachers at school used "chalk and talk" approaches rather than problem solving approaches.

Expatriate Educator: a hang over from the previous regime when nobody wanted to appear brighter than the others.

As expatriates, we tend to view course content from our own western frame of reference. We often fail to take account of the country context or the resource constraints at the work place. With an expatriate educator, I explored the behaviours displayed by staff at the health centre in relation to basic clinical skills. These behaviours would therefore guide what content should be included in the training guide. For taking of a temperature three procedures are commonly used depending on the circumstances (e.g. age of person, level of consciousness etc), these include placing the thermometer (1) in the mouth, (2) under the arm, or (3) in the rectum. The length of time that the thermometer is left in-situ varies depending on where it is placed. The expatriate educator was interested in my perception of how the length of time should be included for each situation:

Me: What would I observe at the health centre? How are temperatures taken?

Expatriate: Temperatures are always taken under the armpit. There is no way to clean the thermometer if they are taken any other way. Also there is no rectal thermometer at the health centre.

Me: Is timing about all three procedures necessary in the content guide?

Expatriate: Yes we are covering all three procedures.

Me: Earlier you stated that there was a problem with time constraints in preparing the module to ensure that all the content was covered in the time allocated. Surely then the module should concentrate on essential knowledge leaving out the nice to know content?

This illustrates a common problem with determining appropriate curriculum content that the writer experienced during this study. The classification of content is often geared to currently known knowledge of the technical expert rather than focusing on knowledge for the set of job tasks the health worker was able to perform within the constraints of the workplace.

At one expatriate educator meeting the topic of discussion moved to the development of clinical competency. It was noted that most of the training programmes designed to increase the competency of clinical service providers were classroom based. Although all expatriate educators agreed that the most effective method of teaching skills and competencies was in the clinical area. Access to sufficient relevant clinical experiences is the limiting factor to providing suitable competency based training. One expatriate short term consultant had noted the following in their report:

> Health worker education is generally too didactic, not sufficiently clinical nor competency based. However low levels of utilisation of public sector health services means that there is often insufficient clinical material in hospitals to provide sufficient experience for students (Mola, 1998; p2)

This raises two issues that need addressing. First the use of competencies in education and second the perception of the quality of health services by the community. There has been much debate over the last 20 years on issues relating to objectives, competencies and competence within in the general context of education, including health worker education. Runciman (1990: cited in Neary 2000) describes "competence" as over-defined rather than ill-defined. The critics of the competence movement (Hyland, 1993; Marshall, 1991; McAleavey and McAlleer, 1991; Ashworth and Saxton, 1990; and Fagan, 1984: cited in Neary, 2000; Apple, 1986, 2000) have claimed that competence based education is essentially concerned with performance in employment. They argue that the attempt to specify what is to be achieved and measured is nothing more than reconstituted, traditional behavourism fusing behavioural objectives with accountability. Additionally, Neary (2000) suggests that other accounts of competence seek to remain true to the behavioural tradition by insisting that the assessment of competence is independent of any learning process and should ideally be undertaken in the workplace. An expatriate educator from one of the voluntary organisations working in Cambodia described their perceived problems with the current courses:

> Pre-service and continuing education courses are largely theoretical and need to be followed up by practical training in hospitals and health centres. I do not see this function as being just that of the supervision system where it's currently placed. It is more a

> function of the trainer. In regard to the current supervision [system] its not performed well, its about completing checklists rather than being about solving problems ... My impression is that intensive on-the-job training of supervisors and of health staff is required. For the supervisors this training would develop their ability to apply a problem solving approach to supervision and for the health staff the list is endless ...

An additional problem identified was that insufficient time and resources were provided for follow up of participants for training in the clinical areas. This situation has arisen from the model of training promoted and funded by development agencies that focuses on the classroom learning time only as it is an easy indicator to measure. This suggests that the situation of competence in this country context supports the behavioural tradition. Whereas, common features of the countries involved in the debates on competence are that they are more developed and have professional bodies to oversee registration and regulation of education practice and health worker practice. I made a conscious decision to work with the known terms of objectives and skills with the curriculum development group because in Cambodia at present the regulatory mechanisms overseeing health worker practice are in their infancy. The following extract from the first edition of the Health Workforce Development Plan 1996 – 2005 illustrates the situation:

> In order to regulate the activities of people delivering health services and to enable the Ministry to monitor the size and

> distribution of the active workforce, it is proposed that a system of registration and annual licensing will be established and maintained by the Ministry of Health, covering all categories of professional health personnel. It will cover health workers in both the government and private sectors of the health system thus providing a comprehensive mechanism for their registration, regulation and quality control. It is essential that, in order to keep the workforce database up-to-date, this registration system include arrangements for annual licensing of all active health personnel (Human Resources Development Office, 1997: p8).

By the first biennial review of the Health Workforce Development Plan, progress had been made however the completion date is still some time away:

> The Integrated Human Resource Database is in process of development. It is expected that the database be fully operational in the year 2000.
>
> Target date for complete registration of all Ministry of Health personnel is the end of the year 2000 and registration of personnel working in the private sector is scheduled for the year 2001.
>
> ... Details regarding licensing of health personnel have yet to be worked out, but consideration is being given to the introduction of a licensing system for private health sector personnel in the year 2002 (Human Resource Department, 1999: p 14)

By the end of 2000, registration of Ministry of Health personnel was approximately 80% complete.

A study into health centre use and health seeking behaviour sheds some light on to the low use of government health care services and the resulting inability to find appropriate clinical to support training. This study found that in general people requiring health care follow the traditional views and practices accepted by their immediate circle of family and friends regarding health care and coping with illness. "They avoid seeking medical treatment because they consider it too

expensive unless the illness is clearly life threatening. They rely on medically ill-trained (or untrained) providers and will self medicate themselves or their children for an extended period of time with different drugs until they find something that works" ((Reproductive and Child Health Alliance, 1998: p13). Clearly then the power of the group and economics influence the actions and beliefs of the person in relation to decision-making about health and health seeking behaviours.

Programme Level Experts

Cambodian technical specialists and expatriate experts were beginning to develop four sets of guidelines for clinical management at a participatory workshop shortly after my arrival in Cambodia. The guidelines were for use at various levels of the health system – the community, the health centre, the referral hospital and as a reference for medical staff. These guidelines are based along a medical model with the management of normal and selected medical problems as the focus of content. The following figures provide extracts from the health centre protocols.

CLINICAL MANAGEMENT PROTOCOLS FOR HEALTH CENTRE STAFF

PURPOSE OF THIS DOCUMENT

This document is to serve as a handy guide for comprehensive maternal health care basis. It outlines step-by step management protocols for dealing with the common pregnancy-related complications seen in our Cambodian environment. It has been structured to provide guidance at all levels of the health system. It is hoped that all personnel involved in the care of our women, e.g. midwives, nurses and public health workers will find this manual useful. The guidelines need to be adapted to the local circumstance, as resources vary from place to place. Where human resources, medical supplies or equipment are not available adequate improvisation will be done.

Although designed for use as a reference guide, it will also serve as a resource document for pre-service and in-service training.

Figure 17 ***Introduction to the Guidelines (National Maternal and Child Health Centre, 1998a: p1)***

As is evidenced in the introductory statement to the guidelines (figure 17), they are legitimised to become the official knowledge and text for curriculum development. According to Bernstein's code theory (1996) the protocols classify the 'what' of curriculum content thereby providing a strong frame of control over curriculum practice. It is worth noting that the content acknowledged common complications occurring during pregnancy but did not address morbidity issues directly attributed to poor practices of health workers while caring for women during pregnancy. Figure 18 provides an example of the structure and content of the guidelines.

1. ANAEMIA

Moderate	Severe	Very Severe
Hb 70-109 g/l Ht 24-37%	Hb 40-69 g/l Ht 13-23%	Hb < 40 g/l Ht < 13%

- **fatigue and/or breathless**
- any history of bleeding
- malaria
- hookworm
- last delivery within a year
- paleness of tongue, conjunctiva or palms

▪ *CLINICAL ASPECTS*

- Ask for clinical signs:
  - Fatigue and/or breathless on the slightest exertion
  - Palpitations or dizziness
  - Chronic disease
  - Bleeding
- Examine the conjunctiva, tongue, palms and nail beds for pallor
- Prevention; Supply at first visit, 120 tablets to for 2 months. Encourage the woman to come back for re-supply.
  Inform woman to take one tablet twice daily; **Ferrous Sulphate 200 mg Folic Acid 0.25 mg**

Tests

- Do laboratory investigations (if available) Hb/Haematocrit
- ***If moderate anaemia:***
  - Advise on diet
  - Give 1 tablet, 3 times daily until anaemia is resolved; **Ferrous Sulphate 200 mg Folic Acid 0.25 mg**
- ***If severe clinical signs of anaemia; breathlessness, pallor, fatigue etc. or Hb < 5 g/l:***
- Diagnose severity of anaemia with laboratory investigations:

– Hb/Hct

- Do blood grouping (if severe or very severe anaemia)
- Depending on severity and state of gestation:
  - **Treat with** oral iron
  - Give 1 tablet, 3 times daily until no longer anaemic; **Ferrous Sulphate 200 mg Folic Acid 0.25 mg**
  - or **blood transfusion** (when very severe, e.g. life threatening Hb < 60 g/l, Ht 13%)

Treat associated conditions

- ***If clinical signs for intestinal parasites:***
  - Abdominal pain — Bulging abdomen
  - Fatigue — **Give broad spectrum antihelminthics**
  - Mebendazole 200 mg/day, 3 days
- ***If clinical signs for malaria:***
  - Fever — Chill
  - Sweating — Head ache
  - Muscle pain — Mild pallor
  - Hepato-splenomegali
- Monitor fortnightly

Figure 18 ***Example of Content and Form of Guidelines (National Maternal and Child Health Centre, 1998a: p10)***

Apple (2000) asserts that texts through their content and form signify particular constructions of reality and particular ways of selecting and organising "that vast universe of possible knowledge". Organising the texts along the model of particular medical terminology maintains the class relation between the doctor and the other health workers. In this instance, a symptomatic approach to the development of the guidelines may have been more appropriate as health workers at health facilities treat patients according to the symptoms with which they present[36]. A symptomatic approach to the guidelines was later developed, however at the time of the research looking at the process of developing continuing education curriculum, the format presented above acted as our guide. The same content presented in a symptomatic way is included as figure 19.

[36] "The notion that individuals should not have their autonomy constrained by more powerful others is central to the medicalisation critique ... becoming medicalised denies rational, independent human action by allowing members of an authoritative group to dictate to others how they should behave" (Lupton, 1997, p96)

3. PALLOR (anaemia)

Assessment

ask / review	*look / feel*
4 chronic disease – TB 4 any bleeding 4 other causes of anaemia (symptoms of malaria) 4 has had worm treatment	4 count respirations 4 look at conjunctiva and palms for pallor 4 order haemoglobin/haematocrit, if possible

Action / Intervention

result of assessment	*action / intervention*
Anaemia ⇐ pallor ⇐ **or** haemoglobin 7-9 g/100 ml or haematocrit 24-37%	⇐ advise on foods rich in iron ⇐ give iron with folate ⇐ give mebendazole ⇐ follow up every 2 weeks
Moderate Anaemia ⇐ pallor ⇐ **or** haemoglobin 5-7 g/100 ml or haematocrit 13-23%	⇐ advise on foods rich in iron ⇐ give iron with folate ⇐ give mebendazole ⇐ follow up every 2 weeks
Severe Anaemia ⇐ severe pallor ⇐ **or** any pallor and 30 or more breaths per minute ⇐ **or** haemoglobin < 5 g/100 ml or haematocrit < 13%	⇐ counsel on need to refer ⇐ arrange blood donors ⇐ **refer to Referral Hospital** with blood bank ⇐ follow up every 2 weeks after return from hospital (if not followed up at the hospital)

Medications:

⇐ ferrous sulfate 200mg with folic acid 0.25 mg until anaemia is resolved

⇐ mebendazole 100 mg orally 2 times a day for 3 days **after the 1st trimester**; give 1 time during pregnancy

Treat associated conditions

▪ *result of assessment*	*action / intervention*
Possible Anaemia ⇐ fever ⇐ **and** lives in or visited malaria area	⇐ **refer to facility that can treat malaria** ⇐ **or** classify and treat according to National Malaria Centre Guidelines
Anaemia with Chronic Disease ⇐ history of chronic disease ⇐ **or** symptoms of TB	⇐ **refer to appropriate hospital**
Anaemia and suspected Parasites	⇐ give mebendazole

FOLLOW UP VISITS FOR ANAEMIA

Assessment

- repeat history and exam
- ask if taking iron as directed

Action / Intervention

⇐ if improving, continue iron treatment and see every 2 weeks until normal

⇐ if not taking iron as directed, find reason and counsel appropriately

⇐ if worse, refer to hospital

Figure 19 *Example of Content and Form of Guidelines using Symptomatic Approach (National Maternal and Child Health Centre, 1999a: p14)*

The nature of expert assistance in Cambodia is changing and a review of the development agencies recommended that:

> National Capacity building is considered the highest priority and is to be strengthened as much as possible through the project. Short term consultants required by the project are to be first sourced through the national market (National Maternal Child Health Centre, 1998b; p8)

Following this recommendation there was increasing pressure to employ and pay for local expertise from a pool that was incredibly small and stretched in its current workload. At present most local experts are involved in public practice in the morning, private practice in the afternoon and often other responsibilities within the Ministry of Health or with development agencies. This pool of people at times has limited perception of their own limitations in relation to clinical skills.

Within the programme we began more frequently to look locally for expertise. In one discussion related to ways of planning for sufficient relevant clinical experience under the guidance of sufficiently expert clinical teachers a number of options for skill upgrade were explored. These included: 1) the use of the private sector and non-government organisations to train the public sector; 2) providing national level courses in Phnom Penh; and, 3) training a core group in clinical teaching skills in another country.

The use of a private sector provider or non-government organisation provider to train the public sector was a solution rejected outright:

Sophoan: The NGO clinics are not good quality. The staff are trained by people not well recognised by the ministry. We cannot use them for training because they will ask for more money than government health centres and at less quality training.

Vandara: Many of the staff at the NGO clinics do not have qualifications that the ministry will allow them to use on the people.

These private and non-government facilities attract more patients because, amongst other reasons, there are staff available at all times. However, under the current forms of cultural and social capital[37] valued in the public sector, these facilities are not suitable as skill training sites. Cambodians trained at the border camps during the 1975 – 1979 regime staff many non-government facilities. These health workers cannot gain employment in the public sector and there are differing perceptions about their skill and capacity.

[37] Bourdieu (1986) suggests that capital can present itself in three fundamental guises: 1) as *economic capital* which is immediately and directly convertible into money and may be institutionalised in the form of property rights, 2) as *cultural capital* which is convertible, on certain conditions, into economic capital and may be insitutionalised in the form of educational qualifications, and 3) as *social capital* made up of social obligations, which is convertible, in certain conditions, into economic capital and may be institutionalised in the form of a title of nobility.

The overseas training option provided a lot of debate. The stated objection in relation to this option was that the clinical skills could be taught in-country at the national hospital.

Sophoan: A number of [health workers] went to [more developed country] for a seven month course and they can teach the skills. I can teach the theory.

Me: Did the [health workers] learn how to teach clinical skills? Curriculum content of their courses appears to be based more on classroom teaching rather than clinical teaching.

Sophoan: They went to [more developed country] for seven months isn't that enough?

Me: To develop clinical teaching skills requires more than just working in the clinical setting. There are a group of teaching skills and specific knowledge and attitudes to be acquired.

Sophoan: You can put together the course and just teach us what to do, we can ask [development agency] to fund.

As described by Bernstein (1996) pedagogic work is constituted by the principles of power and control. In maintaining this position as the trainer for skill development, Sophoan ensures transmission of the discursive resources of the programme that then maintains his dominant position as a technical expert within the programme. By ensuring that the training programme is run through the government health system reinforces the notion that Ministry of Health hospitals

provide quality clinical teaching and contribute to new medical knowledge in Cambodia. This has a flow on effect of being able to validate requests for ongoing input from development agencies.

Overseas training provides health workers from developing countries an opportunity to experience the realities of new health contexts first hand. Apple (1979) and Foucault (1980) suggest that access to "knowledge" as a cultural concept, is unevenly distributed according to class, occupational groups, age and perceived power. Until recently, in Cambodia as in many other less developed countries medical officers were the only health staff to receive these opportunities (Eggers, Adams and Dussault, 1998). The cited reason being that they had a greater level of English language ability than other health workers:

Charya: I went on training to [more developed country] with [doctor]. We both found it difficult because of lack of understanding, sometimes they spoke very fast and we could not understand the words. Even [doctor] said she did not understand how to do the exercises.

Increasingly, other cadre of health workers are being afforded the opportunity to learn English and to travel to neighbouring countries to experience a new world of health either through focussed study tours or skill training. The written Ministry of Health selection criteria for overseas training are based on age and as much as

possible equitable distribution. However, the final selection choice rests with one person.

In addition to the problems with the selection of participants for overseas training, there are problems associated with the selection of overseas venues for training. McLaughlin and O'Donoghue (1996) caution that health workers are often sent overseas by state and development agencies without being adequately prepared for the reality of the new health situation and as a consequence use new health technologies inappropriate for a developing country. At several of the health facilities visited, I found sophisticated equipment still in its original packing. In many cases, this equipment required electricity to operate it and had been donated by well meaning groups to facilities that lacked a power supply:

Khim: [Development agency] gives the equipment for staff as part of their course. One day we want electricity at the health centres.

Conclusion

This chapter has examined the relationships between the spheres of economics, culture and politics and dynamics class and gender as Cambodians and expatriates have come together to progress the development of the health sector in Cambodia. Curricula aimed at developing the human resource capacity of health workers are

an integral part of this development process. Before the curricula were prepared. assessment and treatment guidelines were developed thereby classifying curriculum content. These guidelines once sanctioned by the Ministry of Health became the official knowledge expressing the power-knowledge relationship of the dominant group.

There is much debate over developing competence, competencies and competency standards in more developed countries. However, in this study, I use the language of objectives and skills because the professional bodies established to oversee registration and regulation are in their infancy and associated registration policies are only beginning to be developed.

In chapter six, we examine the influences that determined the curriculum developed under the specific programme in the Ministry of Health where I was based.

6. INFLUENCES DETERMINING DEVELOPMENT OF CURRICULUM

Overview

This chapter examines the nature of training and skill development promoted in Cambodia and in doing this; the chapter takes into account the policies and directions that the process of health sector reform advocates.

Posner (1995) identifies factors that have a critical influence on curricula as falling into two main categories, both of which have a power – knowledge base. These categories are:

1. Structural related to organisations, institutions and programmes – the political factors (including curricula and testing) and the organisational factors (such as administration, class size and grouping arrangements)
2. Prevailing attitudes and beliefs of the curriculum development team – the personal factors (such as background, abilities and interests) and cultural (including values and beliefs about knowledge).

As I conducted fieldwork alongside Charya, Vandara and Khim, in the various roles of advisor, observer and participant depending on the areas of the curriculum under consideration, influences determining decisions about the design, content and testing of courses are examined. My role of advisor is not the major focus of

the study. Examples of various parts of the continuing education curricula illustrate aspects of the development process.

The final section draws attention to issues of coordination of training between organisations, institutions and programmes at different levels of the health system.

Becoming Skilled: tomorrow's health workers

Human resources development is one of the three main components of the Cambodian health sector reform along with planning and management. According to the national policies and strategies for human resources for health, the restructuring of the health care system requires health workers that:

> possess skills to manage the change and skills to deliver services according to the new health system (Ministry of Health, 1999b: p2)

Cambodia seeks to ensure that all training is "relevant, cost effective, of high quality, competency-based and addresses the priority health needs" (Ministry of Health, 1999b: p6). In order to meet this policy, strategies relate to development of standards, coordination, monitoring and supervision, review of funding practices and registration / licensing of health workers. Sagoe (1998) suggests this is a common feature of all human resource policies in countries undertaking a health sector reform process and that development agencies play a significant role in this policy formulation.

Judgements about the quality of training can focus on any number of things, from basic standards (physical space, staffing ratios etc) and resources for teaching and learning to the quality of relationships, notions of cost-effectiveness etc. The indicators to measure training for the programme where Charya, Vandara, Khim and I are based are selected by the Ministry of Health in collaboration with development agencies. They appear to have been selected, not because they are the most appropriate to measure skill acquisition, but because they are the easiest to measure. They have identified standardised training courses developed and numbers of competent trainers and trainees as the indicators for the programme[38]. To assess whether training is cost effective requires close collaboration with any development agency involved in funding and preparation for longer term training impact evaluations. At present, many programmes and projects operate within a two or three year funding cycle. In several evaluations, attention has been drawn (Hughes, 1997; Goodyear, 1997; Australian Development Studies Network, 1996) to the need to encourage development agencies to adopt more appropriate time frames, given the longer term nature of ultimate goals.

[38] According to Brown (1998) "donors still insist on measuring performance by using objectively verifiable production or output indicators which bear little relationship to capacity" for example in the health sector "output is often measured by number of people immunised, number of persons trained and the ratio of medical staff to population. Brown suggests that while these performance indicators are important, "they tend to cloud more significant issues by making measurement of output and monitoring and evaluation into a trite numbers game."(p62).

Before the adoption of the human resources for health policies and strategy guidelines, a number of draft papers outlining the concepts had been prepared. Sagoe (1998: p5) states that the policy development process in Cambodia:

> starts with a policy presentation to a team of "experts" by the Minister of Health. A draft policy is then prepared based on the priorities outlined by the Minister of Health. The draft policy document is discussed by top management of the health sector with the involvement of political parties ... the final decision rests with the Ministry of Health.

In a draft paper (Unknown, 1997) to the Ministry of Health, competency based education is defined as "education which provides the students with the required knowledge, skills and attitudes to perform their work to an identified standard". According to the paper, these competency-based courses are to be based on the job description of the worker and a job task analysis.

Under the influence of the neo-liberal ideologies, education has increasingly taken on the character of "training" directly related to the requirements of the profession. My job title within the programme is training advisor. This title for me enhanced the notion that my education role was not valued instead providing training courses focusing on the required job skills only was to be my role. This type of political influence leads to the de-skilling of teachers and health workers (Halsey, Lauder, Brown and Wells, 1997, Bullough and Gitlin, 1994).

Alongside the above-mentioned changes in education and training, there has been a significant change in the nature of skill. Halsey, Lauder, Brown and Wells (1997) assert this is due to employers' definition of individual competence rather than a secular trend toward a more technically skilled workforce. Several studies cited in Halsey, Lauder, Brown and Wells (1997) have shown how professional associations, trade unions and employers are involved in power struggles over the definition of skill and the way skill levels are used to legitimate differences in remuneration, which typically disadvantage women, young workers and ethnic minorities. Halsey, Lauder, Brown and Wells (1997: p158) argue therefore:

> if we are going to understand how skill differentials have been used to establish initial occupational segregation and how they have been used to maintain gendered divisions of labour, skill like gender, needs to be understood as a relational concept. This requires consideration of how skills are embedded in different forms of social and cultural capital and how such differences advantage or disadvantage different individuals and social groups.

Blackmore (1992: p229) concurs that skill is a relational concept. "It is how one activity, attribute or form of knowledge is compared with others". In the statement following a development agency forum on human resources development there is a recommendation that "donors should continue to include upgrading of technical skills in all sectors as a priority" (Non-government Organisation Forum, 1999: p3). The importance of education in meeting the changing demand for technical, personal and transferable skills again raises the question of the relationship between skills, income and productivity.

Curriculum Decisions: a way of happening

The classic work of Eisner and Vallane (1974) points to the existence of five different curricular orientations "in terms of the goals and assumptions embedded within them" (p2). These five curriculum orientations share assumptions about learners, instructional (teaching) practices, curriculum content and other assumptions such as the need for integrated curriculum. Informed by this work, Joseph, Bravmann, Windschitl, Mikel and Green (2000) identify six main cultures of curriculum and describe them against their ultimate goals[39]. One of the curriculum cultures training for work and survival orientation, shares many similarities with that of the present study. For example in the study, assumptions of the development agency and programme about the students stem from needs or lack of knowledge in the current health workers. Additionally, this is a hands on orientation with a narrow range of practical skills. The content is geared to the workplace needs and the curriculum is shaped in response to given guidelines.

---

[39] 1) Training for work and survival – to gain the basic skills, habits and attitudes necessary to function in a workplace and to adapt to living in within a contemporary society. 2) Connecting to the Canon – to acquire core cultural knowledge, traditions and values from the dominant cultures exemplary moral, intellectual, spiritual and artistic resources as guidelines for living. 3) Developing self and spirit – to learn according to self directed interests in order to nurture individual potential, creativity and knowledge of the emotional and spiritual self. 4) Constructing Understanding – to develop active autonomous thinkers who know that they themselves can construct knowledge. 5) Deliberating Democracy – to learn and to actually experience the deliberate skills, knowledge, beliefs and values necessary for participating in and sustaining democratic society. 6) Confronting the Dominant Order – to examine and challenge oppressive social, political ad economic structures that limit self and others and to develop belief and skills that support activism for the reconstruction of society.

The dictionary defines the curriculum as "a course of study at a school, university etc; the subjects making up such a course" and distinguishes it from a syllabus which is described as "a statement or outline of the subjects covered by a course of study" (Oxford English Dictionary, 1993). As outlined in the methodology section, the definition of curriculum used in this study envisions curriculum as comprising: context, knowledge and interaction. The Guidelines on Standards for Training in Cambodia, are being drafted and include a standard in relation to curriculum. Figure 20 provides the text of the standards in relation to curriculum. This is a direct transcription inclusive of grammatical errors from the guidelines at 27 December 2000.

Curriculum
Title: Curriculum
Aim: A standard curriculum available for training for the whole country
General Principle:
A standard curriculum should [be]:

1. Relevant to Ministry of Health policies and training priorities:
   - be consistent with Ministry of Health training priorities.
   - be relevant to health system reform.
2. Consistent with national health policies, protocols and guidelines.
3. Respond to service needs and job description of those level.
4. Reflects to training needs assessment at those levels.
5. Reflects course objective and course contents.
6. Should undergo through pilot testing.

(Figure 20 continued overleaf)

Expected outcomes

- a standard curriculum that can be measured through credit system and lead to quality training with similar technique / approach be produced.
- non-standard training curriculum can be eliminated.

Pre-requisites

Time Allocation

- overall course length appropriate to meet objectives of the course.
- training duration is not over 7 hours per day and 35 hours per week.
- each course length should be consistent with overall course objective by using pilot training as a basis for calculation:
  - appropriate duration for theory / practice / self study and interval
  - course with self study.
  - duration of critical practical skill should be more than 50% compared to theory duration.
  - less important practical skill duration should have less than 50% compared to theory duration.

Teaching / Learning Methods

- should be consistent with each course objective by using appropriate strategies such as participatory and student centred approaches.
- appropriate opportunities for practice and self study; guidance for peer educators.
- competency based learning / teaching

Teaching / Learning Materials

- Appropriate range of quantity of materials relevant to course objective:
  - Teaching aids: book, demonstration material, medical equipment.
  - Teaching materials: audiovisual, flipchart, microphone and overhead projector.

Evaluation / Assessment of Training

- Assessment should be commenced at the end of each year / course that will focus on global score assessment and score of final assessment.

Pilot training should be conducted before training implementation.

Process

- set up a working group for curriculum development.
- analyse training needs and training priorities.
- draft training curriculum.
- implement pilot training of the drafted curriculum and revise after testing.
- the revised curriculum submitted to Ministry of Health for approval.
- disseminate the curriculum for official use.

Evaluation

- curriculum developed is consistent with norm of curriculum development
- relevant documents for curriculum development compared to curriculum submitted for approval.
- availability of Ministry of Health policies and Ministry of Health training plan.
- availability of national health policies, protocols and guidelines.
- availability of job description of level / unit concerned.

Figure 20 ***Curriculum Standard from Standards for Training (Human Resource Development Department, 2000)***

This standard on curriculum acknowledges the context and content of the curricula to be developed, as evidenced in the general principles. It also outlines expectations in relation to interaction in the teaching / learning methods. The programme has the prime responsibility of classification[40] of the curriculum content on behalf of the Ministry of Health and a high degree of responsibility for framing the context of curriculum practice. In the programme, the curriculum and course planning group comprises Charya, Khim, Sopheap and Kimny under the leadership of Vandara:

Vandara: We cannot get good input from the provinces for putting courses together. It costs too much to bring them in each time we meet ... the roads are bad ... its better for us to do it that's what is expected. They make changes at the pilot ... The main change is translation that's a big problem they do not understand what many of the terms mean.

The curriculum and course planning group acts as what Bernstein would call a recontextualising agent.

The Curriculum Content

Curriculum content, Sanson-Fishe and Rolfe (2000) argue is optimally determined by an evidence-based approach. They assert we should be wary of assuming

[40] Under Bernstein's concepts (1977) classification refers to the relative strength of the boundaries between categories or contexts (subjects within the curriculum) framing refers to the locus of

expert opinion is the best or only option for decisions about content. However, in the absence of evidence as in Cambodia, opinion based processes are required. It is suggested one advantage of the opinion based process of selection is that it can involve a range of stakeholders, including staff from service delivery points thereby facilitating ownership of the results (Sanson-Fishe and Rolfe, 2000; Shaffer and Pfeiffer, 1995). They caution however that in all opinion based approaches it does depend on who takes part and that "groups with more or greater representation in terms of numbers can influence results" (Sanson-Fishe and Rolfe, 2000 :p566). The role of practitioners from service delivery points is to provide feedback on the course and support materials. Whilst centralised systems of curriculum and support material development guarantees some form of quality control and the development of consistent educational aims, implementation and outcomes, this can in some cases be at the expense of responding to local circumstances (Le Metais, 1999; Bourdieu 1977[41] cited in Lareau, 1987). This is particularly so in Cambodia where there are local variations related to minority group areas, problems in access and differences in language use across the country. For example, the national policy on family planning, developed at the national level with limited provincial input uses the

---

control within a category or context (strong framing indicates strong control by the teacher or the programme).

[41] "Schools utilise particular linguistic structures ... and types of curricula; children from higher social locations enter school already familiar with these social arrangements". This is what Bourdieu calls cultural capital (Lareau, 1997: p704).

term 'birth spacing' and uses a consistent translation in Khmer[42]. This translation is used in relation to all activities. When I visited one of the ethnic minority areas of the country with Khim and Sopheap, we found that the term in Khmer did not translate and meant nothing to this minority group who had their own language. Additionally, the posters used to promote the use of birth spacing methods showed a recognised film star whose popularity and face was not known in the ethnic minority area.

I digress slightly at this point to examine the birth spacing policy, its policy statements do however embody those relevant to developing continuing education curricula within the context of the programme. The general principles underlying the birth spacing policy are stated as:

> Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. Cambodia will take all appropriate measures to ensure on a basis of equality of men and women, universal access to health care services, including those related to reproductive health care, which includes birth spacing and sexual health. Reproductive health care programmes should provide the widest range of services without any form of coercion. Couples and individuals have the right to decide freely and responsibly on the number and spacing of their children and to have the education and means to do so (Ministry of Health, 1995).

There are then 20 statements of policy related to how the services will be provided and the education of the service providers. One statement of policy locates birth spacing within the wider range of reproductive health services:

---

[42] Khmer is the name given to the national language of Cambodia.

7. Women and men should have access to a range of reproductive health services including treatment and prevention of reproductive tract infections (including HIV / AIDS), antenatal and delivery care as well as birth spacing services as part of maternal and child health services (Ministry of Health, 1995).

As outlined earlier in the health profile for Cambodia, reproductive health indicators are poor; in particular HIV infection rates are high and antenatal care and delivery rates in public institutions are low. This policy statement acknowledges the importance of addressing these issues in the continuing education curricula developed.

A further statement of policy describes the potential of the policy in the wider context of the country:

20. The prime aim of this policy is to promote maternal and child health through greater birth intervals, however it is recognised that achievement of this aim may help to balance population growth with the social and economic growth on the country (Ministry of Health, 1995).

It is under this policy that the curriculum development group was preparing the curricula and courses and that this study was undertaken.

In general, detailed curricula for pre-service education programmes as well as continuing education programmes are not available in Cambodia. What usually exists is a list of topics commonly relating to diseases without identified teaching resources and student learning materials for planning and implementing the lessons. Teachers and trainers have rarely prepared lesson plans and objectives

for the lessons. This then would be classified as a syllabus under the Oxford English Dictionary (1993) definition outlined previously. Surveys (Girault, Chanary and Seng, 1998; Human Resources Department, 1997; Duggan, 1996) have found that teachers and trainers tend to read directly from the limited and often dated texts available. Apple (2000) asserts that textbooks are really a form of cultural politics. By using these limited texts, teachers and trainers through instructional discourse are recontextualising in order to maintain the connections with their cultural vision.

Sophoan was adamant that the continuing education curricula developed under the programme should reflect the ideal:

> Policy, strategies and protocols are what we want not necessarily what we have now. Teach to the ideal.

However, discussions about what happens at present in the training room and the clinical practice sites raised many issues about whether clinical practice sites would be able to provide enough appropriate clinical for skill development necessary to match Sophoan's ideal. As outlined earlier, at present service utilisation is low and most women approximately 85% deliver at home. Because of the dearth of relevant clinical, Sophoan believed it would take ten years before there are sufficient quantity of trained midwives with quality skills:

> Many nurses do not see a delivery during their training because in many hospitals there are only three deliveries a month. ... In the rural areas, women would rather call an older [Traditional Birth Attendant] than a young midwife to assist their delivery.

Hafferty and Kelly (cited in Burton and McDonald, 2001) maintain that "medical education had failed to change because only the curriculum has been changed rather than the overall learning environment" (p189). Thus signaling that any development of continuing education curricula needed to go hand in hand with change in the way that curriculum practice is undertaken. Chapter seven outlines curriculum practice realities for the participants in the study.

According to Ryle (cited in Neary, 2000: p95) "learning is what occurs when a person makes sense out of what he encounters or experiences in interacting with self and the environment". Child (1981) suggests that learning occurs whenever one adopts new behaviour patterns or modifies existing ones in a way which has some influence on future performance or attitudes. In my discussions with Charya, Vandara, Khim and expatriate educators, I found that no research had been conducted into the question of how Cambodians learn or what influences Cambodian learning. One interesting observation made by Charya, Vandara and Khim related to home pressures and their influence on women learners. Apparently, the proximity to the home base had a negative effect on how women

learned. The informants thought that it was preferable for learning if the women were away from their home for the duration of the course. Although this had a positive effect in most cases, women with young children were often precluded from attendance. Charya explained this from her perspective:

> Many women on the course come because the ministry or the provincial chief instructs them. Sometimes their husbands are not happy ... if they are at home at night they make trouble for them because they want them to make more money and cook and look after the children.

Notions of power knowledge relations would suggest gender inequality in the relationships at home has had a major impact in supporting the development of cultural norms (Halsey, Lauder, Browns and Wells, 1997; Foucault, 1980).

Other commonly espoused reasons why there was no research into how Cambodians learn fell into two categories. The first of these reasons being that the majority of training was totally development agency driven and tended to be geared to obtaining numbers as an indicator of how well the course was doing. This focus missed out on addressing how to help learners learn. One experienced teacher with the Ministry of Education, met at an expatriate educator workshop expressed the following concern about the development agency driven nature of courses:

> We want to learn new ways of learning but [development agencies] are not giving us enough time. We have to meet targets very fast for [development agencies] its not in good time for the people to learn.

Another reason for the scarcity of research on Cambodian learning styles possibly relates to the norms of society about the knowledge imparted by a person with greater status. According to Broadfoot (1999: p86), "knowledge is not true or false but legitimate or illegitimate for a particular set of power relationships". Charya, Vandara and Khim expressed these power relationships in several ways:

> When two people meet one is always higher than the other.
>
> A leader must have more knowledge than followers.
>
> If a leader is wrong don't say so as you will lose face.

In Cambodia there appears to be an informal or implicit value system similar to that described in research from Korea where obedience and respect to elders and people perceived as having more status is more highly valued than learner independence (Le Metais, 1999). Within this context, obtaining valid information could pose a problem unless respondents had experienced western styles of teaching and learning.

The traditional form of education has been centred in village life or in the case of health worker educators on the life in the health facility (Duggan, 1996).

Ramsden (1992) suggests that unlike western knowledge that is meant to be challenged, traditional knowledge is finite and not tested. Health workers are schooled then in the accurate reproduction of received knowledge and customs. At no point are they encouraged to question or innovate as this would alienate them within the work environment. Therefore, the kind of analytic thinking and deep approaches to learning necessary for success in western education are at variance with peoples' experience of traditional culture. As knowledge is perceived as static and related to survival demands, a tendency to rote learning is understandable. This assertion is elaborated and explored in chapter seven on curriculum practice.

The Curriculum Team

Before beginning work on curriculum design, I discussed with the Charya, Vandara, Khim, Sopheap and Kimny their expectations about what we should be striving for as an end result or outcome. In addition, I sought guidance from some of the expatriate educators. I found that flexibility was a key concept discussed in relation to preparing curricula and teaching guides.

Vandara: The curriculum should act as a guide for teachers and students. But it must be structured enough so that everyone gets the right knowledge.

Charya: Course content must be regularly reviewed so that new knowledge can be introduced. The trainers want more technical knowledge.

Expatriate: Attention should be given to fundamental ways of thinking. Up to now participants have expected that courses will be conducted in a particular way. There is a set of expected behaviours for teachers and for participants.

Expatriate: In order to improve the effectiveness of knowledge transfer a diverse range of teaching methods should be appropriately used. We found it worked better to timetable clinical activities in the morning, and if possible reduce class size in order to obtain practice.

These comments characterise curriculum from the perspective of the group as being planned, formal and inseparable from teaching delivery (Burton and McDonald, 2001).

The training undertaken by the Programme where Charya, Vandara, Khim, Sopheap and Kimny are situated is wholly financed by the development agency. As Vandara explained:

> We don't have experience with needs analysis. It is not paid for by the [development agency] they tell us what courses we should do. Sometimes they are good suggestions sometimes we don't know what they want.

Most usually throughout the development of the programme, an outside reviewer of the programme had identified the job tasks that needed to be included in curriculum supporting the programme. Under this type of institutional arrangement, there has been little incentive for the planning group to independently conduct task analysis or assess skill needs of service providers. So although development agencies are citing capacity development and skill development as their core platforms for sustainable human resource development, they are adding to the de-skilling effects by directing course content (Sagoe, 1998).

The curriculum development team is a cohesive group that works in a participatory manner. Vandara as leader of the curriculum development team, although possessing a higher status, occupational class encouraged equal participation from all members and demonstrated a consensus style of decision making in all aspects of course design. My role within this team tended to move along what Schwartz and Schwartz (cited in Ball, 1983: p38) describe as the "continuum of role activity according to the degree of participation by the participant observer" depending on the area under investigation. My role as an advisor is not the major focus of the study as I worked with the group as researcher, doctoral candidate and advisor.

In one of the group sessions of the curriculum team where task list selection was being discussed, some work had been done by Khim and Kimny and was presented for critique. The list was described as ".. very broad not really a task list ..". The list was a classification of stages in a patient illness rather than tasks needing to be performed by health workers. The discussion and brainstorming progressed further into what type of form should be used by the group in preparing a list of tasks and subtasks. Two ideas more clearly gained approval and warranted further development. One idea developed and presented by Charya was thought to be very comprehensive but crowded. The other idea presented for discussion missed the step of task analysis and went straight to a lesson plan format. Eventually the group resolved that both formats be used at different times during the process of developing continuing education curricula.

In another brain storming session, the group prepared a generic list of the tasks that needed to be considered before the training of trainers and training of service providers. This session was lead by Vandara. A schedule of pre-training tasks had not been documented previously although all the people in the group had some involvement in preparing for training:

Charya: I prepare the main planning calendar for the programme ... also prepare the course materials to send for training.

Khim: My job is to correct translations and help Charya prepare materials. I count the stock sometimes.

Vandara: One main responsibility is to make sure the money is ready when the trainers come from the province. That means getting the signature from the ministry and going to the bank ... keeping the budget records are also part of my role.

Kimny: I make sure there is enough IEC [Information, Education and Communication] material for the provinces and teach them how to use them.

Sopheap: I have other jobs but do supervision of training as well.

Charya and Khim perceived knowledge as discrete bits of information about the particular topic or subject of the course. They were unable to describe the course as a holistic entity in which the parts or topics related as one whole. For students, the acquisition of the knowledge information during the classroom sessions was tested through processes of repetition and testing of recall at the end of each session. This recall testing was directly against "what" type questions, for example "what are two hormonal methods of contraception?" rather than being based on questioning against case studies or given situations. In observations of classroom teaching, I found the teacher was generally the centre of attention in the classroom[43]. They initiated the classroom discussions and orchestrated the interaction around brief factual questions, if there was any discussion at all.

[43] Freire (1972: p54) identifies several characteristics of this Banking Concept of education. The teacher teaches and the students are taught. The teacher knows everything and the students know nothing. The teacher thinks and the students are thought about. The teacher talks and the students listen – meekly. The teacher disciplines and the students are disciplined. The teacher

In an attempt to move away from trainer domination of classroom practice the curriculum development team spent time discussing the differences between goals and objectives, then focussing on writing the course aims and behavioural objectives from a student centred perspective. Although Lawton (1983: p23) asserts "there appears to be considerable evidence to link the behavioural objectives model to an extremely narrow concept of education concerned with job training and conformity rather than improving the quality of human life", this strategy did begin a process of focussing on the learner rather than the teacher. By the end of our sessions, in most cases the objectives written were student centred and behavioural however the objectives tended to focus on knowledge acquisition rather than application of knowledge to practice and associated skill acquisition. The following figures outline a sample of the objectives before (Figure 21) and part way through (Figure 22) our process of curriculum development for teaching one of the sessions related to communication skills and counselling.

---

chooses and enforces his choice and the students comply. The teacher acts and the students have the illusion of acting through the action of the teacher. The teacher chooses the programme content and the students (who are not consulted) adapt to it. The teacher confuses the authority of knowledge with his or her own professional authority which she and he set in opposition to the freedom of the students. The teacher is the subject of the learning process, while the students are mere objects.

- **Communication and Counselling** **Time: 2 hours**

After this session the student will:

- Understand why they need good communication
- Understand verbal and non-verbal communication
- Know what is counselling
- Know how to use simple language in counselling

Figure 21 *Sample of Objectives at the beginning of Curriculum Development*

In figure 22, the objectives for each session have been identified and written in behavioural terms, the content is sequenced from communication basics to skill practice and the possible resources for each session have been identified. The final part of this process will be to format the sessions into the accepted programme format and detail the content of the sessions further. The objectives for session 3, shown in figure 22, stress the importance of addressing the general health status of the population. The issue of access to safe water supply was highlighted in the general population census (National Institute of Statistics, 1999) the results of which were outlined in chapter four.

Charya, Vandara, and Khim had an understanding of the logic of content progression, that is, from known concepts to unknown concepts, or simple tasks to complex tasks. Once we had prepared a broad outline of the concepts and skills to be included in a course, they were ordered in a manner that ensured foundation

skills were reviewed before going on to more complex sets of skills and procedures. For example, reviewing how to take a blood pressure comes before introducing completion of a physical examination on a client. It was through this process of sequencing content that the communication skills session in figure 22 was developed.

- **Session Title: Communication Skills** **Total Time: 9 hours**

- **(1) Introduction to Communication Skills** **Time: 2 hours**

By the end of this session, the health worker will be able to:

- Describe the importance of good communication skills for the health worker and the patient
- Define verbal and non-verbal communication
- List positive and negative aspects of verbal and non-verbal communication
- Practice using different tones of voice
- Practice using simple language to explain concepts
- Determine when and how to use paraphrasing and clarifying

Video Counselling

- **(2) Counselling** **Time: 2 hours**

By the end of this session, the health worker will be able to:

- Define the term counselling
- Compare motivation, information giving and counselling
- Discuss the purpose of counselling
- Discuss the knowledge needed by a good counsellor

Video Counselling

- **(3) GATHER** **Time: 3 hours**

By the end of this session, the health worker will be able to:

- Demonstrate the appropriate use of open, closed and probing questions
- Explain what GATHER means
- Describe Greet norms for counselling
- Practice asking about an individuals needs and current knowledge base about infection control measures in the home
- Practice telling about the benefits of handwashing
- Practice explaining the common problems associated with an unsafe water supply for the family / community

Exercises and Role Plays for Asking, Telling and Explaining

- **(4) Practice Counselling** **Time: 2 hours**

By the end of this session, the health worker will be able to:

- Demonstrate appropriate skills in interviewing and counselling individuals

Skills Checklist for counselling

Role Plays for counselling

Figure 22 ***Objectives part way through Curriculum Development***

Because of the dearth of relevant clinical experience in the practical settings, simulated exercises and role-plays were developed as learning activities supporting skill development. Figure 23 presents a sample of a role play and case study developed by the curriculum development team as a teacher resource and study learning activity. The case study in particular illustrates how Charya, Vandara and Khim began to reinforce the use of the assessment and management protocols to guide practice. In addition, these assessment and management protocols acknowledge the health profile and the key issues for reproductive health outlined earlier in the country context.

ROLE PLAY – BIRTH SPACING

Sokheang, a 29 year old woman with six children does not want any more children. She knows nothing about birth spacing methods.
In your small group decide who will play Sokheang and who will play the health centre staff she sees today. Any other group members should play family members and other health centre staff. In the role play demonstrate how to find out about Sokheang's problems and how to help her solve them.

Points for discussion:
What information is useful in helping the client make a decision?
What are helpful questions to ask in this case?
Who makes the final decision in this case?

CASE STUDY – ANTENATAL CARE

Ravy is a 19 year old prima-gravida. She is 38 weeks pregnant and has come for her 4th antenatal visit. When you review the Mother's Health Record you find that she had a blood pressure of 130 / 90 at her last visit. The midwife told her to go home and rest.

- Today her blood pressure is 130 / 86. What reference in the Assessment and Management Protocols do you use for this problem?
- What questions did you ask during the current history part of her antenatal visit?
- Do you need to ask more questions? If yes, what questions?
- What examination should you do?

Ravy tells you she has had some headache but no blurred vision or abdominal pain. She has oedema in her feet but not pitting oedema. Her fingers have mild swelling. Her face is without swelling. You cannot test urine at your health centre.

- What reference in the Assessment and Management Protocols do you use for this problem?
- What action / intervention should you take?

Ravy goes home and returns two days later. You take her blood pressure as soon as she arrives and it is 166 / 114.

- What should you do next?

When you repeat her blood pressure it is 160 / 112. She has pitting oedema and her fingers are very swollen. Her headache is worse. She does not have blurred vision or upper abdominal pain.

- What reference in the Assessment and Management Protocols do you use for this problem?
- What action / intervention should you take?

Figure 23 Sample Role Play and Case Study

In order to reinforce appropriate skill development Charya, Vandara and Khim worked to prepare performance checklists for the skills that they believed were essential for good and safe service delivery. In the programme some skill checklists had been used in the past and the content, layout and use of these were reviewed as part of the process of developing continuing education curricula. At times during this process my role as participant observer and researcher needed to be reduced and my advisory role increased to illustrate particular points. Several essential procedures had been prepared as skill checklists and annexed to the assessment and management protocols. These provided a basis for the development of further skill checklists and ensured that current best practice in the Cambodian context would be the basis for assessment. Halsey, Lauder, Brown and Wells (1997) and Blackmore (1992) describe skill as a fixed and measurable attribute defined by the technical needs of the workplace. One of the most obvious deficits highlighted during this process was that Charya, Vandara and Khim did not posses adequate clinical skill levels of their own to prepare many of the skill checklists for participants of training. As Charya outlined:

> I have not ever worked in the other clinics. They did not have birth spacing or STD clinics when I was training. I had a private practice in antenatal. I need to ask Vandara to help with many of the skills. She has to say yes to everything I do because she is the doctor.

Only Vandara had worked in the clinical area where the skills were required and was familiar with the methods in use although Charya and Khim were involved with teaching the clinical skills. The content of the checklists in use concentrated on technical sides of procedures omitting the important social skills[44]. Basic social skills of infection control and communication were lacking. The skill of handwashing before and after each procedure was not evident in the clinical skills checklists in use. Communication with the client before, during and after the procedures was not mentioned. Charya and Khim indicated that this was "part of the procedure ... not written" "they must do it in class" and "I show them as part of the demonstration". As a group, it was decided after discussion that as they were primarily training the trainers and there was then a cascade model to train service providers that the areas of infection prevention and communication should become an integral part of all skill checklists. Figure 24 is the final version of the counselling checklist prepared during this process. It is used as an adjunct to the Communication Skills sessions outlined at figure 22 above.

[44] Empirical research indicates that each of these skills in viewed differently according to how the skills are acquired (training / experience), who possesses the skill (male / female, adult / youth) and in what context these skills are used (public / private). Individuals are generally only seen to have expertise or skill when such as skill is associated with paid work or such a skill has been acquired through training. Particular types of skills such as social skills (e.g. interpersonal and emotional management) and operational skills (carrying out routine tasks), which are generally possessed by women, are less highly valued (and paid) or defined as being lesser types of skills. Manual, strength related skills and technical skills which have a connotation of expertise those generally possessed by men, receive higher remuneration and status (Blackmore, 1997: p228).

▪	SKILL PERFORMANCE CHECKLIST FOR BIRTH SPACING COUNSELLING	Self assess	Peer assess	Teacher assess
1.	Greet the client and ask about reason for the visit			
2.	Show friendly gestures			
3.	Ask about when she wants her next child			
4.	Ask about medical history			
5.	Ask about last menstrual period			
6.	Perform physical examination			
7.	Determine if some methods may not be suitable			
8.	Ask about previous birth spacing			
9.	Determine what she knows about birth spacing methods			
10.	Ask about partner involvement in the choice of method			
11.	Determine the client's risk of STD: • Person had more than one sexual partner • Person had sexual partner who had more than one partner • Person had a STD • Person had sex with someone who had a STD or HIV/AIDS • Person had injection from dirty needles			
	Discusses each of the following methods - COC, POP, Injection, Condom, IUD (Write 1, 2, 3, or 4 in the box) 1 = gives correct and complete information 2 = gives correct but not complete information 3 = gives incorrect information 4 = not discussed			

(Figure 24 continued overleaf)

12.	How it works			
13.	How to use it			
14.	Advantages / Benefits			
15.	Side Effects			
16.	Management of side effects			
17.	Use simple language			
18.	Use educational materials available: • Flipchart • Leaflets / booklets • Models • Samples of contraceptives			
19.	Give client an opportunity to express concerns and misconceptions			
20.	Clarify misinformation or misconceptions			
21.	Encourage the client to participate in choosing the method			
22.	Explain again in details how the chosen method works and possible problems related to its use			
23.	Ask the client to repeat important instructions			
24.	Give a follow up appointment			
25.	Mark when to return on the pill / injection calendar if appropriate			
26.	Tell the client to come back if there are problems			
27	Complete the client clinic card correctly			
28	Complete the birth spacing register correctly			
29	Complete the interaction in a friendly manner			
30	Replace equipment used during examination			
31	Sterilise equipment as required following the examination			
	Date and Signature			

Figure 24 Counselling Skills Checklist

Step 11 of the counselling skills checklist presented as figure 24 clearly reinforces investigation of STD and HIV risk as a health issue that is causing increasing

concern in Cambodia. The current estimates for HIV infections outlined in Chapter four provide the basis for this concern and therefore the inclusion of questions related to risk in the skill checklist.

In preparing one of the new records for use by health workers and subsequently the course content list and skills, the issue of whether or not to include weight had been debated at length. The consultant developing the record had been reluctant to include weight as a measure based on international standards and following visits to the clinical sites. At these sites, it was found that the scales for measuring weight, if available and used was not accurate. Additionally, if as a result of the weight measurement a referral to the next level of the health system was required the mechanism for referral and the appropriate back up expertise to manage the problem were missing. The wording in the pilot version (National Maternal Child Health Centre, 1998c) of the tool related to weight was:

> Very thin? If yes: refer.

By the final version (National Maternal Child Health Centre, 1999b), which was signed off after the end to the study period, this had been reworded to:

> Weight? If looks <u>very thin</u> refer.

In preparing the curriculum, Charya, Vandara and Khim were adamant that this skill be taught:

Khim: [Patients] like to know their weight

Me: Why

Khim: To see if it goes up or down between one visit and the next

Me: What does a change in weight mean

Khim: If the rise is not too much it is good

Me: How does knowing the weight change what you will do for [patients]

Khim: Would know whether to talk about [what lifestyle changes to make]

Me: What else would you do for instance if the weight was lower than last time?

Khim: Nothing

Skills can be seen as being relative to previous experience and context bound in that they do not exist without prior knowledge and a framework within which they are defined (Blackmore, 1992). Indeed skills take on new meanings in specific historical contexts and different work-sites. This appeared to be true for the measurement of weight in the context of the health worker's actions as even the text of the assessment and management protocols does not include this measurement as an integral part of either the first visit or subsequent visits. Figure 25 provides the text from the assessment and management protocols relating to subsequent antenatal visits.

SUBSEQUENT ANTENATAL VISITS: At every subsequent visit, records from previous visits should be reviewed and followed up. New findings are recorded on the antenatal card. Routine management and documentation on clients' record as follows:

A) History
i) General assessment
ii) Health problems or complaints
iii) Ask the woman about foetal movements
B) General Examination:
i) Measure blood pressure
C) Laboratory Investigation, if available:
i) Test urine for protein
ii) Test blood for Hb/Haematocrit (at 1st visit with a routine repeat one month or more later, if anaemic)
D) Physical Examination:
i) Fundal height, growth
ii) Foetal Heart Rate
iii) From 32 weeks onward, lie and presentation of foetus
iv) Check for signs of anaemia
v) Check for signs of pre-eclampsia
E) Routine Administration of Drugs:
i) Resupply of iron/folate as necessary
ii) Give second dose of tetanus toxoid vaccine
F) Client Education
2nd Trimester
i) Review what to expect during labour and preparation for delivery
ii) Review danger signs and immediately seek treatment for any danger signs
3rd Trimester
i) Preparation for breast feeding
ii) Preparation for delivery
iii) Preparation for place of delivery
iv) Review danger signs and immediately seek treatment for any danger signs
v) Transport problem solving, in case of emergency
vi) Birth spacing
vii) Money needed for delivery if hospital is recommended

Figure 25 ***Excerpt from Assessment and Management Protocols (National Maternal and Child Health Centre, 1998a, p6)***

Any assessment programme is based on an unequal distribution to power which is initially accepted by both parties as a matter of necessity (Neary, 2000). In order to modify these power relations, the first task is to identify the nature of the

relationship. In Cambodia, student assessment has historically taken the form of written testing rather than practical assessment. Some of this is due to the limited skills of the teachers and some because of the dearth of clinical experience on which to assess skill development. Additionally, all forms of assessment and examination provide the potential for teachers to earn money. Written examinations as part of pre-service final examinations are possibly the easiest way for teachers to make money. For the continuing education courses which we were developing there was little potential for teachers to make money from examinations. The end of course result had no bearing on whether or not the status of the participant changed. However, the programme appears to take for granted their position of power in the assessment relationship and a legacy of written examinations has remained, for courses for health workers. This is inappropriate for the skill based nature of the continuing education courses. At meetings of the curriculum group the question of final examinations was often raised:

Sophoan: we need to build some time into the end of the course for examinations

Me: this is a competency-based course with continuous assessments and skill logbooks with checklists to complete

Sophoan: but we need an end of course exam it's traditional to have an exam

This practice of end of course examinations is based on tradition rather than educational or certification reasons. Through this practice, members of the

programme seek to confirm their expertise and establish the subordination of the participant in power terms (Neary, 2000). In many instances, this written examination practice remains unchallenged.

Charya, Vandara and Khim develop written tests as a form of student assessment. Pre and post tests are the most common methods used to evaluate training provided by the programme. Although the tests are conducted and the results are collected, little is done to analyse the results between one course and another and at the central level. There is no system for collection or analysis of the pre and post test results. In line with the nature of the sessions, where there is a great deal of "telling", the pre and post tests set for the courses demand recall of what has been told. The focus is on readily measurable areas of knowledge, skills and understanding and usually takes the form of multiple choice questions quickly constructed, easy to mark and with dubious validity. Because of this method of assessment, there is little real opportunity for participants to think for themselves and to question what they have been told. Most participants seem conditioned by previous schooling to expect information to be poured over them and tests that check retention and regurgitation[45] (Freire, 1972).

[45] With the introduction of competency based testing in America, Apple (2000) suggests there has been a negative impact on teaching. Although "quality control" is the rhetoric behind this form of state-wide testing, in reality, teachers are now teaching simply for tests (p117).

The reporting requirements of development agencies includes providing information about numbers of health workers trained, at times these number are disaggregated by sex but they do not take into account the results of the pre and post test data. Mohanty (1990) argues that curricula and pedagogical transformation has to be accompanied by changes at a number of levels. These may include a change of the culture of the institution or programme as well as radical shifts in the relation of the institution or programme to other state and civil institutions. For example changes in the relationships between the Ministries of Health and Education and the development agencies. In addition, changing practices requires taking seriously the relation between knowledge and learning, on the one hand and student and teacher experience and expectations on the other. Burton and McDonald (2001) support this latter assertion. There is little attempt made on the part of development agencies, programmes or trainers to minimise the expectations related to course assessment and reporting requirements. This relates to the newness of the programme and the incremental change expectations between one funding cycle and another. It is expected that development agency requirements for monitoring, supervision and reporting mechanisms will change.

Within the current structure of the Ministry of Health, there is no national unit responsible for the production of suitable teaching and learning resources for health workers. This has resulted in a shortage or absence of appropriate teaching and learning material and reference sources in the Khmer language. Most library

books are in a foreign language either English or French. The translations of texts from English and French to Khmer, is often poorly managed and lack quality control mechanisms. Having no suitable reference material has affected the quality of basic training of health workers and thereby quality of graduates from these programmes. Under the programme where Charya, Vandara and Khim are working, they have a national responsibility for preparing and distributing resources to enable the training courses under the programme to be conducted. In Western countries in the late 1800's as in Cambodia today, teachers faced with difficult working conditions, insufficient training and few resources, texts and guidelines were and are seen as essential tools. They solved practical problems "which led not only to de-skilling, but led to time to become more skilled as a teacher as well" (Apple, 2000: p51).

The trainer guides are standardised across the programme in a format that has been used since the beginning of the courses in 1995. The format is described by trainers as being simple for them to use. As a result, the training course development as part of this study used the same format. With no record keeping or archive system in place to ensure previous lessons plans in Khmer are readily available, this system of standardised formats works well. Figure 26 is a sample of the standardised session format. This sample session illustrates how the curricula are geared to address current knowledge about the health seeking

behaviour in the general population. Health seeking behaviours of the general population were outlined in chapter five on western transference. They suggest that the publicly funded health centres are the last port of call for people requiring medical assistance.

- **Session Title:** **Traditional beliefs – good or not good**
- **Learning Objectives:**

By the end of this session the health worker will be able to:

- Distinguish between traditional practices that are – beneficial, questionable and harmful.
- Recognise the danger signs of certain traditional practices.
- Describe ways to alter their own practice to the benefit of the community.

Resource for this session includes the discussion and recommendations section of the research by Patrice White (1995) Crossing the River: Traditional Beliefs and Practices of Khmer Women During Pregnancy, Birth and Postpartum (p33 – 35 and K1-5)

(Figure 26 continued overleaf)

Time	Topic	Content	Method	Resources
5 min	Traditional Practices	Explain to the health workers that research done in Cambodia in 1995 showed that not all traditional practices are harmful. In this session we will look at the practices that are beneficial and provide satisfaction to the mother and family and can be continued. As well as those that are questionable and could be altered; and those practices that are harmful and should be stopped. Ask the health workers to tell you about any other traditional practices and rituals that are common in their community, at any time during the session, so that they can also be discussed.	Discussion	
10 min	Beneficial Practices	Discuss why the following practices that were found to be beneficial: • Ambulation and continued eating while in labour • Postpartum checks for three days • Supportive presence of friends and family during delivery • Avoiding heavy physical work when possible during pregnancy • Postpartum uterine massage "to get all the blood out" Explain that there is no reason to stop these practices.		Excerpt from Crossing the River by Patrice White

(Figure 26 continued overleaf)

Time	Topic	Content	Method	Resources
15 min	Questionable Practices	Explain why the following practices were found to be questionable: • Use of some traditional medicines • Ingestion of high salt diet postpartum • Drinking large amounts of Khmer medicine with alcohol while roasting Discuss why these practice may be harmful	Lecture and discussion	Excerpt from Crossing the River by Patrice White
15 min	Harmful Practices	Explain why the following practices were found to be harmful: • Manual removal of blood during the second stage • Pushing on the fundus during second stage • Injections of unneeded medicines with unsterile syringes and needles • Use of traditional means to induce abortions • Roasting with co-existing problems Emphasise that the health worker should help families improve their health by discussing harmful practices with them. They should help mothers to understand the dangers of these practices so that they can stop them.	Lecture and discussion	Excerpt from Crossing the River by Patrice White
15 min	Other practices	Ask the health workers to declare some of the traditional practices they used before the training. Try to reach consensus about good and harmful practices.	Open Discussion	

Figure 26 Sample of Standardised Session Format

Because there is guaranteed funding from the development agencies for the training courses for the length of the programme, materials required to perform skills have also been secured and distributed to the field sites for use post training. In many of the other training programmes the procedure taught in the classroom and the resources available to perform the same procedure at the field site are quite different.

Most typically training institutions and training sites in Cambodia lack the barest essentials in terms of student texts, books, stationary and course guides (Girault, Chanary, and Seng, 1998). Not surprisingly therefore, Charya, Vandara and Khim most commonly cited teachers and equipment as the resources required to provide quality training. In relation to teachers, they believed that a minimum of two people who had completed the training of trainers were required. These teachers were only thought of in terms of numbers and even with prompting, their knowledge and skills were not identified as valuable resources that could be employed during the conduct of a course. Participants and their experiences are not articulated as a resource in the teaching setting.

Charya, Vandara and Khim verbalised equipment resources in terms of those relating directly to the most common training programme currently being conducted. The resources they identified related to administrative needs for conducting the training and included "enough chairs and tables for the group",

"folders for the participants", "large sheets of paper" and "writing pens" as well as materials provided by the development agency.

Along with the lack of teaching resources, there are inadequate facilities for teaching and learning in all training establishments. Classrooms are inadequate in terms of space, lighting, and furniture is often not available for students or teachers. Whilst some points raised focused on problems with the seating and layout of the training room as Charya describes:

> In some rooms it is a problem to arrange the chairs in the training room so all participants can hear and see ... it is better if the chairs have a table attached to write on.

Charya, Vandara and Khim also discussed the problems they had encountered that were outside the control of the staff working at the training sites as they related to access to government funding, facility design and environmental factors:

> Many of the training sites do not have good electricity supply so the rooms are often dark.
>
> There is a problem with flooding in the wet season.
>
> Some rooms are too small to arrange the seats properly.
>
> Cleaning is a problem. There is no money to hire a cleaner ... the staff pay for the cleaner.

Coordination and Communication: topics largely ignored

Health care is covered by the public sector, private businesses and non government organisation but no real coordination exists between them, nor are there recognised standards of service. The organisation and running of the health care sector thus depend on the various agencies and participants interests, with the state handing over more of its previous responsibilities.

Sector reform is seeking to maintain a centralised policy and coordination function within the Ministry of Health and devolve the management and implementation to the provinces. To date, many of the national vertical programmes with funding from development agencies conduct training in the provinces without providing adequate feedback on content, coverage, numbers and grades to the relevant department in the Ministry of Health. Additionally, many smaller non-government agencies carry out training in the provinces on an ad hoc basis. The reform process has identified a need for strengthened coordination between the development agencies, the national programmes, the non-government agencies and department in the Ministry of Health. This would ensure that the training activities are in line with the national training and continuing education plans. This would also improve information for planning and monitoring of human resources (staffing requirements and skill mix) and support effective use of the development agency and national programme inputs

into capacity building. However, under the present structure, funding is provided directly to the programme by the development agency so there is little incentive for the programme to inform the department in the Ministry of Health with overall responsibility for training.

Vandara, who is responsible for coordinating the training in the programme in which I was based, found that the responsiveness of the department in the Ministry of Health was too slow for her to meet the development agency's funding requirements:

> By the time I send the information to the [department] at the ministry and they come back, we are in the next quarterly funding cycle. It is easier to go and see [senior level person] directly because they have to sign the form.

For national level training under the programme, identification and call up of participants of training is the responsibility of the programme under delegated authority from a senior level Ministry of Health administrator outside the department responsible for coordinating training. At the provincial level, identification and call up of participants of training is the responsibility of the provincial directorate of health. Final approval of selection is however required from the senior level Ministry of Health person and is facilitated by the programme, bypassing the department responsible. On submission of a detailed

budget to the programme, provincial level trainers are able to obtain funding for their training courses and proceed with training.

Because of lack of coordination between the programme and the department in the Ministry of Health as well as development agency and other groups funding training, the national training plan does not shape up in reality:

Khim: [provincial trainer X] tells me she goes to see staff and sometimes they are away at another training from [another programme or development agency]. Some training is almost the same as our one other training is not really good for the work they do.

Charya: Sometimes the [provincial] trainers ask for the staff of a health centre to come [to the training] but they are not there or do not come because they have another training to go to.

Health Centre staff can be away from their workplace for several months at a time undertaking different training courses prescribed by the Ministry of Health and the programme interests and have problems finding time putting their newly acquired skills into practice.

Unlike continuing education programmes which are more attractive to development agencies because of the shorter implementation time frames, pre-service training is funded by the Ministry of Health. In relation to pre-service training, each training institution is responsible for managing the training

including implementation and monitoring and evaluation of their students rather than this process being central coordinated by a body against nationally agreed standards. Because of funding constraints and problems with communication mechanisms nationally, there is very poor communication between Ministry of Health and training institutes. The result is that training institutes largely operate in isolation from the Ministry of Health and each other. The acceptable level of performance identified centrally by different training institution varies greatly and in some cases is perceived as too low. This means that graduates from pre-service programmes often do not posses the necessary knowledge and skills to function at an acceptable level in the health facilities. In effect the funding crisis at the pre-service level sets up a cycle whereby development agencies and external funders will continually direct skill development in fields of their interest because these skills were not imparted in the basic training of health workers.

Conclusion

This chapter has outlined the policies for human resources development and training including curriculum development currently being promoted in Cambodia. It provided insight into the different perceptions of quality from the perspective of the development agencies, the Ministry of Health and the programme. The quality indicators at present rely on the collection of easily

accessible data related to numbers that focus on output rather than impact of training.

Additionally, the curricula have tended to be teacher centred and require reorientation to student centred learning. It has been determined that what becomes "official knowledge" and therefore incorporated into the training courses, is decided at the central level by the programme. There are therefore a number of political and personal influences in these decisions. A resultant tendency of this centralised system of developing continuing education curricula is to de-skill the work of teacher and trainers at other levels of the health system.

In order to overcome the lack of adequate clinical experiences to complement skill acquisition, the curriculum development team designed a number of new teaching methods. Examples of these are provided. As much as possible these new methods draw from contextual realities of the health situation of the country.

The data available on the learning process highlight the influences of social and cultural factors and suggest that women in particular contribute more to the learning process when removed from the influences of their home environment.

Traditional methods of assessment and testing for knowledge acquisition are still the prime methods in use within this country context. The practice of testing being linked to economic rather than educational purposes.

The experiences encountered in this process of developing continuing education curricula highlight that the relationship between development agencies, the Ministry of Health and the programmes in determining course design and content needs addressing. This is particularly important if decentralisation to meet the differing health workplace needs for training is the desired outcome.

Chapter seven examines curriculum practices in the classroom including the influences of class and the part that the hidden curriculum plays in fostering ritualised practices.

7. CONTEXTUAL REALITIES OF CURRICULUM PRACTICE

Overview

This study uses a definition of curriculum as context, knowledge and interaction (Kirk, 1988: cited in Colquhoun, 1989). In curriculum theory, there has been a tendency to separate curriculum development and teaching (McGee, 1997). However, this study links the processes of curriculum development and curriculum practice, the term used in this study to describe all activities related to enacting the curriculum, In this chapter, we examine curriculum practice within the programme where Charya, Vandara, Khim, Sopheap, Sophoan and Kimny work as the continuing education curricula are introduced at the different levels of the health system. The dynamic created by class and position plays an important part in the relationships during curriculum practice at both the national level and the provincial level.

According to the theory of Bernstein, in any pedagogic relation such as the continuing education courses of the programme, the teacher (transmitter) has to learn to be a teacher and the participant (acquirer) has to learn to be a participant.

That is, participant and teacher must function according to accepted forms of symbolic control within the context. As Bernstein (1990) argued:

> the process of learning how to be a transmitter entails acquiring the rules of social order, character and manner which become the condition for appropriate conduct in the pedagogic relation. It is these rules which are a pre-requisite of any enduring pedagogic relation. In any one such relation, the rules of conduct may to different degrees permit a space for negotiation (p55).

The teacher is always in the dominant position in relations of symbolic control with the participant (Bernstein, 1990). However, the hierarchical relation depends on the display of power and control relations in pedagogic practice (Bernstein, 1996; Jones, 1997). Control is overt, explicit or visible when exercised physically or verbally or through reference to rules concerned with status (e.g. age, sex, and ethnicity), a specific context (e.g. the classroom), or cultural rules (e.g. politeness rules). Alternatively, control is covert, implicit or invisible when exercised through interpersonal rules protecting individuals from damage, disturbance or violation (Bernstein, 1990). The form of hierarchical relationship between teacher and participant affects the selection and organisation of content, as well as the criteria which the participant is expected to exhibit in exploring and evaluating the content. This chapter illustrates aspects of pedagogic discourse as well as relations of control in the continuing education courses conducted by the programme.

Rituals or aspects of the hidden curriculum became evident during curriculum practice and these are explored in terms of their meaning in the context of this study and the programme. My role in the programme is as participant observer, researcher, doctoral candidate and advisor. The advisory role however is not the major focus of this study.

The final section of the chapter reveals that there are however, rewards in being involved in the continuing education courses under the programme. It supports the contention that the continuing education curricula and associated training courses have social and economic consequences, although these consequences may differ from the originally intended consequences.

Curriculum Practice: pot luck or planned menu?

In Cambodia, the teacher training was so erratic[46] that the underlying philosophy is that the teacher must have more knowledge than the participant (Duggan,

[46] The objective of the post Pol Pot time was 'massive rehabilitation' and saw teachers recruited from the city streets and village pathways being provided with a range of highly variable short term training. These courses focused on upgrading general knowledge. The emergency approach left a legacy of high levels of repetition and overcrowding of schools. Duggan (1996, p368) asserts that repetition was indicative of the low skill level of teachers and corruption. Students wishing to progress from one year to the next were required to pay a bribe. This practice is still evident to day where one informant told me of their child coming home in tears because they were placed fourth in the class. When questioned as to why this upset her because it was a good level, she stated that she could have come higher if she had more money to bribe the teacher.

1996). This supports a non-participatory passive recipient concept of education rather than encouraging the students to become independent learners (Knowles, 1990). So whilst the notion of the teacher or health worker being a "reflective practitioner" is enjoying popularity in the literature on teacher education and nursing education in the developed world, taking into account the philosophy of teaching and present reality of skills of teachers and health workers, this is possibly inappropriate at the present time in Cambodia.

In order to appreciate the realities of practices in the classroom, I spent time as a participant observer and researcher watching teachers in action in the real situation and coaching teachers in practice teaching sessions. Commonly, teachers of adults apply adult learning principles, teaching methods and teaching skills that encourage the students to share their knowledge and learn together. However, in Cambodia because of the dearth of adequately trained teachers transfer of knowledge is by traditional "teacher centred" methods such as reading directly from texts, writing on the board or dictating notes (Girault, Chanary and Seng, 1998; Human Resources Development Office, 1997; Duggan, 1996). Freire (1972) describes the type of traditional education as being oppressive. Oppressive education is illustrated in his "banking" concept" where the student is transformed into a "container" to be "filled" by the teacher or "bank clerk". This oppressive education process allows only for the mechanical memorisation and narration of

information and "facts". It does not allow students to fully understand the meaning of the words they are being filled with; or skills they are being taught nor are they allowed or encouraged to use dialogue or question the facts. This is a form of controlling the thoughts, actions, and creative power of students and is said to lead to dehumanisation of students / people because they are not being allowed to dialogue.

My initial observations supported those of Girault, Chanary and Seng (1998) and Duggan (1996) as I found that prepared structured teaching materials including often word for word notes were used. Sudden deviations in teaching sessions due to unexpected questions or interruptions meant the teachers had difficulty re-orienting their teaching session. From the learned social perspective in which the teacher is the font of all knowledge, these observations are not surprising. Together Charya, Vandara, Khim and I found that problems were compounded where curricula designed by overseas 'experts' emphasised teaching for understanding and stressed participation rather than didactic methods yet they ignored the need for in-service programmes for teachers.

In Cambodia, there are relatively few health workers involved in the training institutions trained in teaching methodology and even less at the level of the programmes. Bullough and Gitlin (1994) describe teaching as a relationship, a

way of being with and relating to others, and not merely an expression of having mastered a set of delivery skills. Some Government Institutions and Non-government Organisations do conduct short training courses for teachers of nursing and midwifery. These training programmes cover the basics of classroom delivery methods (lecturing, group work and use of overhead projectors) but include little about effective communication skills, problem solving methods or effective coaching for clinical skill development. The impact of this training is further limited for those teachers who return to schools and provincial training sites where they have limited teaching resources and no support as monitoring and supportive supervision systems post training have not been established.

National Level Curriculum Practice

The programme also conducts regular six day training of trainers for provincial level trainers. In order to support Charya and Khim in their teaching practice for the conduct of the training of trainer, a process of preparing and practicing interactive teaching sessions was introduced. They had both expressed a desire for a more participatory style of teaching and this process of practice teaching would enable them to move to a more reflective practice mode of teaching. This also supported my advisory role however this study is focussed on my role as researcher and doctoral candidate. In one practice teaching session which we prepared for use as an example during the training of trainers, the class was to be

given a case study scenario and prepared completed information on one of the tools used in the care of the woman. In the classroom situation, the front teacher[47] presented the scenario and questions, they did not hand out the completed record (tool) or encourage students to look at the blank record (tool) and analyse the material presented. The session was totally teacher led with no innovation and the scope of discussion was limited and did not encourage deeper level thought about the problems presented in the case study. When this is later discussed, the teacher seemed to have no concept of how to use this type of teaching material stating "I have not done any of this before ... you tell me what to do". During the session preparation, Charya, Khim and I had invested several hours in discussion and practice teaching. The following pages (figure 27) contain a copy of the training of trainers outline and topic list redesigned by Charya, Vandara and Khim. For some trainers this is a repeat course whilst for others it was new as part of the roll out training plan to all provinces.

[47] Charya and Khim were team teaching this session.

Day: 1	**Session**: 1	**Date**:
Session Title	Introduction to the TOT course	

Session Learning Objectives:

By the end to the session participants will be able to:

- describe their role as a Birth Spacing Trainer.
- use the different materials referred to throughout the course.

Time	Content	Method	Materials
0730	Opening Ceremony – Introductions	Lecture	
0740	Introduction to the TOT course and the Birth Spacing Policy in Cambodia	Lecture	OHP
0800	Introductory Exercise	Group Work	Handout
0820	Distribution and explanation of Birth Spacing resources - curriculum, manual, training materials etc.	Lecture	Training Materials

(Figure 27 continued overleaf)

Day: 1	**Session**: 2, 3 & 4	**Date**:
Session Title	Preparation for Teaching	

Session Learning Objectives:

By the end to the session participants will be able to:

- Describe the principles of adult learning
- Identify and describe a variety of teaching methods and when to use them.
- Demonstrate the use of TV, Video, OHP, Slide Projector
- Assess the good and bad features of these teaching aids
- Demonstrate how to plan a lesson

Time	Content	Method	Materials
1015	Adult learning methodology	lecture, discussion, groupwork	OHP, Exercise, Whiteboard, Flipchart
1045	Teaching Methods	lecture, group discussion	OHP, Handouts
1400	Lesson Planning	demonstrate	OHP, Handouts
1430	Use of checklists and procedure books	demonstrate, practical	Checklists, Procedure Books
1530	Instruction on how to use TV, Video, OHP, Slide Projector Practice in use of AV aids *Homework: Ask the participants to read the BS Manuals and prepare questions for revision during the technical session.*		TV, video, OHP, slide projector

(Figure 27 continued overleaf)

Day: 2 & 3	**Session**:	**Date**:
Session Title	Technical Session & Teaching Preparation	

Session Learning Objectives:

By the end to the session participants will be able to:

- Teach the topic allocated to them
- Review the teaching of each other and suggest improvement

Time	Content	Method	Materials
Day 2			
0730	Question and Answer Time	Panel Discussion	
1000			
1015	Topic Selection		
-	Preparation of Topic	Exercise	Package prepared
1700			
Day 3			
0730	Question and Answer Time (if required) and completion of preparation	Panel Discussion	
-			
1000			

Day: 3, 4, 5, & 6	**Session**:	**Date**:
Session Title	Teaching Presentation	

Session Learning Objectives:

By the end to the session participants will be able to:

- Teach the topic allocated to them
- Review the teaching of each other and suggest improvement

Time	Content	Method	Materials
Day 3			
1015	Teaching Practice		
Day 4			
Day 5			
Day 6			

(Figure 27 continued overleaf)

Day: 6	**Session**: 2, 3 & 4	**Date**:
Session Title	Scheduling and Review of Course	

Session Learning Objectives:

By the end to the session participants will be able to:

- Review the Birth Spacing materials
- Plan a schedule of Birth Spacing Training and supervision in their Province.
- Evaluate the course.

Time	Content	Method	Materials
1015	Review of Birth Spacing materials	Discussion	BS Materials
1400	Preparation of Plan for BS Training and Supervision	Provincial Groupwork	Supervision Planning Sheet
1515	Break		
1530	Course Evaluation		
1630	Presentation of Certificates and Closing Ceremony		
1700			

- **TOPIC LIST**

Topic from Curriculum	**Session in Curriculum**
1. Anatomy and Physiology	Day 1 Session 3
2. Natural method of contraception	Day 1 Session 4
3. Hormonal Methods – Pills (COC, POP) Injectable	Day 2 Session 1, 2 & 3
4. Barrier method of contraception and sterilisation of females and males	Day 3 Session 1
5. IUD – Knowledge	Day 3 Session 2
6. STD's & HIV / AIDS	Day 3 Session 3, Day 3 Session 4
7. Counselling	Day 4 Session 1 part 1, 2&3
8. Physical Examination including Birth Spacing History – Fill in Card	Day 4 Session 2 & 3 combined
9. Infection Control	Day 7 Session 1
10. Managing a Birth Spacing Program	Day 6 Session 2
11. STD	Day 7 Session 3
12. STD	Day 7 Session 4
13. Preparation for insertion of IUD	Day 8 Session 1
14. Insertion / Removal of IUD	Day 8 Session 3 & Day 9 Session 1

NOTE: COC Combined Oral Contraceptive POP Progesterone only Pill
IUD Intra-uterine Device STD Sexually Transmitted Disease

Figure 27 ***Outline of the Training of Trainers Course (conducted Nov 1998)***

The training of trainers introduces the provincial level trainers of a course to what Apple (2000) terms "a curriculum on the cart" or a prepackaged curriculum. In the example above, it is the Basic Birth Spacing Course. Shaffer and Pfeiffer (1995) call these training modules. These courses are very structured with detailed objectives, the equipment needed to conduct the course and the sessions planned for each day. A more detailed example of a session from one of these packages was presented in chapter six. The layout of the curricula and courses under the programme is historical and has become intitutionalised. Within the context of this study, it was deemed appropriate to continue with the same format as it was well known to the provincial level trainers and therefore would reinforce prior learning from other training of trainers courses.

Within the training of trainers course, trainers are required to produce lesson plans with careful outlines which divide the lesson into small elements. See day two of the course and the topic selection list in figure 27. For the exercise participants of the training of trainers select a topic from the topic selection list. Lesson plans related to these topics are then prepared using the resources currently available for the course. The expectation is that these lesson plans are not to be adapted or deviated from on the day. Through this process, new trainers learn to see the lesson in terms of its parts. In the case of Bernstein's theory of pedagogical

discourse, the instructional discourse of the training of trainers course is embedded in the regulative discourse of the Birth Spacing Curriculum documents and the clinical guidelines.

Avalos (1991) asserts that teachers may not really understand all that they are teaching thereby failing to provide for individual differences and focusing on the prescribed lesson detail rather than participants needs. The teachers learn to view teaching as being all about getting through a lesson in the 'correct' manner and to view the given curriculum and methods as the upper and outer limits of what is possible. It can be described as 'recipe book' teaching. What is usually presented is factual. There is little explanation and questioning of the teacher is rare. Indeed, lectures can be taken up almost totally with note-taking with the teacher presenting one prepared sheet after another and the participants copying down without receiving an adequate explanation of the content. When questions are posed, they rarely require lengthy responses and a high level of cognitive functioning. Therefore, although the trainer has spent extensive time preparing the sheets for the lesson, when an evaluation of the learning from the session is made, what is usually sought is simply naming and labelling.

During the interviews with Charya, Vandara and Khim, we discussed the qualities of a good teacher within the Cambodian culture. The Department within the Ministry of Health responsible for training is preparing standards for training.

One standard outlines the selection of trainers, this standard is presented as figure 28. The document has been in the preparation process for several years. This extract comes from the document as at 27 December 2001.

Selection of Trainers

Title: Selection of Trainers

Aim: Trainers with sufficient qualification both in pedagogy and expertise in relation with training programme.

General Principle:

Selection of trainers should be in accordance with selection criteria and course objective.

Expected outcomes

Sufficient qualified trainers to meet course requirement.

Pre-requisites

Identify selection criteria for trainers

- Good health – physical and mental.
- Good attitude and hard working.
- Technical work experience at least five years, competence in teaching in their field, teaching experience, research and pedagogy skills (has undertaken training of trainers).
- Commit to contribute and involve according to needs / contract of training course.
- Capable of using resources / materials standard for training implementation.

Ratio Trainers / Trainees

- Pre-service training: 1 trainer / 4 trainees in medium.
- Continuing training: ratio is related to course objective

Trainees must be recognised by Ministry of Health

Process

- set up selection committee.
- selection process according to identified selection criteria (interview or test or exam if necessary).
- official nomination by Ministry of Health.

Evaluation

- CV or reference document regarding selected trainer.
- Interview result, test to prove their qualification or result on individual exam.
- Prove (person, institution of individual person).

Figure 28 ***Selection of Trainers Standard from Standards for Training (Human Resource Development Department, 2000)***

From the perspective of the development agencies. teachers are encouraged to display teaching methods that are participatory and use a problem based learning, problem solving approach (Ross, 1998; National Maternal and Child Health Centre, 1998b; United Nations Population Fund, 1997; World Health Organisation, 1991).

Charya and Khim valued the characteristics that maintained the status of the teacher in relation to the participants:

Khim: The teacher has a higher level of knowledge than the student.

Charya: The teacher can answer all questions.

and that maintained a sense of order and respect for the administrative aspects of the course:

Charya: Is on time both at beginning and end of class.

Teaching in their framework remained confined to the classroom only and although the 'checklist for good teaching' used as a guide to critique the practice sessions contains interactive measures these were not expressed as teaching qualities by the curriculum team (refer figure 29).

As part of the training of trainers, doctors are timetabled to facilitate the feedback of the practice teaching sessions based on their technical content expertise. In general, these training of trainer facilitators tend to feel most secure in a dominant and direct instructor role in post-lesson feedback sessions and rarely adopt the role

of collaborative colleagues. The feedback which uses the 'checklist for good teaching' (see figure 29) as a guide, takes place immediately after the lesson and lasts about five minutes. A notable feature of these feedback sessions is the tendency on the part of the facilitator to "tell" the trainer what is right and wrong with her teaching both content and method. While questions such as: "Do you understand?" are used regularly, they are mainly to maintain the flow of speech rather than as genuine probing questions. Facilitators seldom pause after such questions in an effort to promote the trainers to reflect on their experience. This assists in reinforcing the notion that the teacher must take a more dominant role than the participants. A number of educators, Paulo Freire among them, have argued that education represents both a struggle for meaning and a struggle over power relations. Thus education becomes a central terrain where power and politics operate out of the lived culture of individuals and groups situated in asymmetrical social and political positions (Mohanty, 1990).

In terms of Bernstein's notion of the communicative process (1990), classroom communication is constituted by the rules of hierarchy (teacher – participant), in the selection and organisation of knowledge. Moreover, implicit or explicit power and control relations structure the form of the classroom communicative context. From the participants position, the point of the course is to discover and meet criteria of competence in the classroom communicative context – to supply the teacher with the right answer (Jones, 1997). Participants who do not recognise the

principles of power and control structuring the communicative context of the classroom will experience difficulty meeting the teacher's criteria of competence. Moreover, teachers may misread the competence displayed by participants if it does not meet the conventions of the classroom communicative context.

CHECKLIST FOR GOOD TEACHING

CLARITY

good structure
audible
visible
words understood

MADE MEANINGFUL

finds out what is already known
relates teaching to learners' own experience

ACTIVE

all learners are active

FEEDBACK

all learners told about their performance and what could be better

CHECKING

have the students learned?
are the learning objectives achieved?

Figure 29 ***Checklist for Good Teaching (National Maternal Child Health Centre, 1997)***

Provincial Level Curriculum Practice

Curriculum practice at the provincial level is similar to that experienced at the training of trainers. I observed a number of training courses conducted at the

provincial level. Some of these training courses had been running for a number of years and some were being newly implemented as part of the roll out plan from the national level. The training courses ranged between five and ten days in duration. All the courses followed the approved curriculum document and were conducted according to the standard timetable. The level of comfort of the teachers conducting the courses varied depending on the skill of the teacher, the number of times they had conducted the course before and the level of support they had in preparing for the training. Charya and Khim spent time with the provincial trainers assisting them to prepare lessons and practical sessions. When they arrived at the training site a day before the commencement of the course, the course seemed to run more smoothly than when they arrived after the course had commenced.

Heterogeneity of the education level of the participants educated and working in different Provinces leads to a very diverse range of entry knowledge to the courses. Participants of the courses observed are primarily women health workers from the health centre. Most commonly, the basic level of education is that of primary midwife or primary nurse. These cadre of health workers have had one year of formal training. Charya, Vandara and Khim unanimously expressed knowledge and skill deficits as the main issues that teachers confronted in working with these health workers. This they related to the basic training:

Khim: Students have to be at home sometimes for the family or to make money so they don't go to the hospital to work and learn.

Charya: Some people pay to get the certificate ... I have also heard of some that do the primary course and pay for a secondary certificate.

Naidoo and Searle (1999) suggest that an extremely wide range of environmental factors influence learning. However, students bring with them many things that influence the way they learn, what they learn and how successful they are in achieving the intended objectives of the course. Fraser and Walberg (1991) maintain that the "home and school environments interact and co-determine school achievement. These affect student motivation, expectations, understandings and engagement with tasks and materials" (p85).

The learning style of both the provincial level trainers and the participants of courses was a cause of concern for Charya and Khim - "learners and teachers need time to read", "learners are lazy to read". There is a growing awareness that previous learning experiences, reading habits and access to resources all influence both classroom environment and student learning (Naidoo and Searle, 1999). In relation to problem based learning or analytical methods of learning Charya and Khim expressed that it was "difficult ... learners and teachers like to describe rather than explain", "situational discussions are the best method". In order to

overcome these concerns, instructions provided for teachers to prepare for a session were presented in checklist format:

- Arrange the chairs in the training room so all participants can hear and see
- Prepare all equipment and materials before you give the lesson
- Make sure you know how to use all the equipment
- Make sure all equipment works
- Read the teaching materials very carefully before the start of the course
- Make the room interesting with relevant posters and pictures
- Do not talk at the participants – make the participants think for themselves by asking for ideas
- Allow plenty of time for practice – each participant should practice all skills
- Use the facilitators effectively. (National Maternal and Child Health Centre, 1997: p3)

This reinforces the class relationship between the national and the provincial trainers as well as reinforcing the notion of "recipe book" teaching.

According to Sanson-Fishe and Rolfe (2000):

> It makes intuitive sense that both curriculum content and educational process can influence educational outcomes. A course with little or no emphasis on clinical sciences is unlikely to produce high levels of clinical competence. Similarly, it seems unlikely that students taught clinical work exclusively through lectures, and with no patient contact, would be clinically competent (p565).

Clinical supervision has been defined as:

> an intervention that is provided by a senior member of a profession to a junior member of that profession. This relationship is evaluative and extends over time and has simultaneous purposes for enhancing the professional functioning of the junior member monitoring the quality of the professional services offered to

> clients, she or he sees and serving as gatekeeper to those who are to enter the particular profession (Bernard and Goodyear, 1992: p4).

In Cambodia, where there are courses with a clinical component at health facilities, the health service providers of the health facility are responsible for monitoring and supervising the participants. As well as assisting them with clinical skill development including the development of appropriate behaviour. According to Neary (2000), Stake (1986) and Fitts and Posner (1969), giving feedback to the learner is the most important way to facilitate appropriate skill learning. In many instances, these health service providers lack the motivation to effectively monitor and supervise the activities of the participants. Supervision from the training institutes and programme to the practice sites for the purpose of clinical skill and attitude assessments of students is not a regular part of the current teaching role. In addition, many of the teaching staff do not have the teaching ability or clinical skills to adequately support students. Values and attitudes, highly important attributes for health workers are not assessed. Le Metais (1999) suggests that values and attitudes if untested are less likely to be taught, particularly when there are financial consequences linked to learner performance.

The Department responsible for training in the Ministry of Health outlines the aim of monitoring and evaluation to make sure that training activities meet course objectives. Evaluation of the course by the trainers has been undertaken in the

past however, evaluation of the course by the trainees was a new activity for the provincial training teams. One member of a provincial training team in particular expressed caution when Charya presented them with evaluations for the trainees to evaluate the course including the administrative aspects:

Provincial trainer: We have not asked the participants before. What will you do with the information? What does it mean for us?

A copy to the teacher feedback form which was used to provide information to reorient the curriculum and training materials is shown at figure 30.

TEACHER FEEDBACK FORM

SESSION TITLE:

	Yes	No	Comment
Was the session clearly outlined in the curriculum guide?			
Were the resources stated correct for the session?			
Was it easy for you to prepare for this session?			
Would you feel comfortable giving this session again?			
Was the content at the correct level for the students?			
Were students able to participate during the session?			
Was the student participation good?			
Was the timing for the session correct?			

What suggestions do you have to change / improve the curriculum guide for this session?

Overall how would you rate this session (circle one)

Very Good Good Changes Needed Needs Rewriting

Figure 30 Sample of Teacher Feedback Form

The teacher feedback form was used after each session in the course. By contrast, the student feedback from presented at figure 31 was used once at the end of the

course. This meant that the course became the focus of the student attention for the feedback rather than individual teachers that would have been culturally sensitive.

PARTICIPANT FEEDBACK FORM

OVERALL GENERAL

	Excellent	Very good	Good	Fair	Poor
The content is relevant to my job					
The training methods and techniques are effective					
The course is well organised					
The materials provided are useful					

Please provide and comments and suggestions for improvement

ADMINISTRATIVE ISSUES

	Excellent	Very good	Good	Fair	Poor
Accommodation					
Training Room					
Transport					
Administration Support					

Please provide and comments and suggestions for improvement

Figure 31 Sample of Participant Feedback Form

In practice, during participant evaluations of courses, more time was spent filling in the portion related to the administrative issues of the course than commenting

on how the content could help them in their work. Participants most commonly provided written comments about:

- allowances for attending the training;
- the quality of the morning and afternoon snacks; and,
- whether the teacher is on time at the beginning and does not go over time at the end of the session.

Post training monitoring and supervision at the work place is sporadic and tied to funding and transport support rather than being planned at the time of training to ensure an appropriate sample of trainees to follow up is selected. In addition, the present follow up instrument developed for use at the work place covers all aspects of health facility management but neglects to provide feedback on staff practices and interactions with patients. Charya, Vandara, Khim and the Expatriate Educators indicated that post training follow up provides an opportunity for teachers and participants to work on solutions to problems that are not evident at the time of training. However, if nobody arranged for follow up of course participants back at their health facility, there would be no change in behaviour. Access problems in the more remote areas of the country particularly during the wet season, result in some health workers never being visited at their work place.

Charya and Khim conduct a semi-structured process of curriculum review in an ongoing manner in collaboration with the provincial trainers. Each of them spend time in the provinces assisting with the training that is managed and conducted by the provincial level trainers. During this time, they will observe how well the staff used the teaching materials, whether there is consistency between what is taught at one provincial site and another:

Charya: In some provinces the course is not so good.

Me: Can you give me an example?

Charya: In [X] province the trainer is very good, kind and quiet. She knows where everything is, who to see and has a good standing with her chief. But in [Y] province, you remember we went, the chief is not so easy. We send equipment for the programme and he keeps it in the store. Sometimes he is away and so that makes a problem to do the course.

Me: How can that be changed?

Charya: Vandara wants me to go for the next course. She will speak to him first and send a letter.

Rituals: many faceted, varied and intriguing

How people assign meaning and interpret their experience in organisations depends on culture. Fetler (1994) argues that rituals help members of an organisation to define what it means to be a member, what to believe, how to behave and what is important. Rituals help to instruct new members of a culture.

My observations lead me to believe that certain activities associated with training courses under the programme have become, over time rituals, routinised actions or ceremonies recognised as part of the culture of curriculum practice. Three common rituals became evident to me during the course of the study:

1. Paper folding and writing of content;
2. Opening and closing ceremonies; and,
3. Warm up exercises.

In preparing for courses, trainers are given large sheets of paper as a substitute for overhead transparencies as power cannot be guaranteed at all teaching sites. These sheets are then painstakingly folded at about five centimetre intervals to produce lines along which the trainer writes the content for the session. This phenomena was observed at all training course attended and Charya and Khim spent days before training of trainers courses preparing in this way. How to fold the large sheets of paper is not included as part of the formal teaching for the

training of trainers, but has become ritualised as part of the hidden curriculum[48] of the courses. Seddon (1983: p2) states the situation succinctly:

> There seems to be general agreement that the hidden curriculum involves the learning of attitudes, norms, beliefs, values and assumptions often expressed as rules, rituals and regulations. Taken as a whole, these learnings can be termed common-sense knowledge which we, as members of a given society, take for granted. as such, they are rarely questioned and often remain unarticulated ... in educational institutions learning associated with the hidden curriculum takes place in any situation involving two or more people: teacher teacher; teacher student; or student student.

Every time a course is conducted under the programme an opening and closing ceremony, which was described to me as a courtesy to the provincial hosts, accompany it. These ceremonies are presided over by a senior technical officer, usually a medical officer and the content of the talk, similar to a rally, usually includes political statements along with statements about how the course will benefit practice. At times when the key speaker has been unable to attend at the last minute, rather than finding a replacement, the ceremony is rescheduled to accommodate the schedule of the speaker.

Within the training programmes, time is allocated for a "warm up" activity after the opening ceremony in order that course participants can get to know each other. As the course is designed, it is the responsibility of the trainer to include their own personalised exercise. Under the heading "warm up" exercises trainers write what

[48] Apple (2000) suggests that when you start to recognise the hidden curriculum you can start to understand the culture of schooling.

they plan to do to introduce the course. My observations determined the trainer's interpretation of this is increasingly that some kind of gimmick or trick or fanciful short story is called for and it is becoming increasingly a ritualised part of the training courses.

Rewards of Involvement

The training teams at all levels of the health system National, Provincial and District are appointed positions. These appointments often relate to social relationships and involve either exchanges of money to buy the position or political affiliations. Training coordination, under externally funded programmes, is perceived as a prestigious job as it attracts per diems for attendance at training of trainers and money for the conduct of training courses. Bordieu (1986) terms this type of relationship as a reproduction of social capital. The reproduction of social capital presupposes an increasing effort of sociability, continuous series of exchanges in which recognition is endlessly affirmed and reaffirmed.

The programme invests in human capital and the participants of courses use this capital to increase their earnings. The concept of human capital refers to the fact that human beings invest in themselves, by means of education, training and other activities which raises their future income by increasing their lifetime earnings. Investment in human capital also produces benefits to society as a whole by

increased productivity of educated workers (Woodhall, 1987). For both trainees and trainers however, money appears to be more of a draw card to attend training than the new knowledge and skills acquired at the time of training:

Charya: People expect money for getting new skills

Sophoan: The [programme] is a vertical programme externally funded and we can do whatever we like with per diems

Expatriate Respondent: The [level of] per diems for overseas training are out and everyone wants it

The salary range for health workers is between US$8 – US$20 per month. As Sophoan related, it takes US$250 per month to live in Phnom Penh. Training per diems range between US$7.50 – US$15 per day for in-country training depending on the location and agency funding the training. Therefore participants can double their monthly salary for attending a two day training. For overseas training, the range in between US$35 – US$120 per day again depending on location, agency funding and what is included in training package (e.g. meals and accommodation). As mentioned earlier, ultimate selection choice rests with a few senior people at the level of the Ministry therefore the potential for exchange of "gifts" in exchange for training opportunities is high.

Too often, the training courses conducted under programmes provide skills, ways of thinking, feeling and speaking that are often not seen post training in the public

sector. The major factor accounting for these new practices not being seen and for the two – three hour work day at health centres is the very low salary paid to staff[49] (Reproductive and Child Health Alliance, 1998). The skills obtained at the time of training are traded in the private health sector market, as providers announce their new skills and technologies to draw clients from the public service to their private practices. This private sector employment for most staff constitutes their core workday and livelihood with their morning at the health centre being a secondary engagement. The 1998 study also asked the question why do health workers bother with their government job given the small and infrequent salaries they receive when they could use the time more profitably in private practice? The consistent response was that the health centre job constitutes an important connection to government that is beneficial in private practice:

> First, as health centre employees, they are eligible for training provided by donor [agencies].
>
> While intended to improve health centre services, this training is much more valuable to staff for developing marketable skills that are directly applicable to their private practice.
>
> Second, their government jobs serve as a gateway to other government services, making such services more accessible to their family and friends.
>
> For example health centre staff report that they will accompany their family members and close friends to the provincial hospital to get care for serious problems, assuring that they receive quicker attention and lower cost in some instances

[49] In addition, "Staff reported that in 1998, they were only paid for five out of twelve months. New staff reported receiving no salary until they became 'permanent' after two years of 'temporary' status" (Reproductive and Child Health Alliance, 1998:p8).

> Third, their government employment at the health centre is known by villagers and is reported to enhance their credibility as competent care providers
>
> Private practice is highly dependent on the practitioner's reputation and business grows through local reputations and word-of-mouth recommendations. In short, there is little meaningful distinction to be made between public and private sector employment – government employment directly supports the private practice health centre staff must have to survive (Reproductive and Child Health Alliance, 1998: p10).

It is suggested (Bruner, 1999), that in this sense, then the training courses, no matter how poorly constructed or delivered are never neutral and never without social or economic consequences.

Conclusion

This chapter has illustrated how pedagogic interactions associated with curriculum practice are learned through the training of trainers course conducted by the programme. Although Charya, Vandara and Khim are seeking to move to more dialogic and reflective practices, they are currently not in a position to pass these lessons on to the participants of training. Curriculum practice at the national level still seeks to affirm the class structure of society and the expectations of the dominant institutions (development agencies, Ministry of Health, programmes) and groups (doctors, programme staff, trainers).

Trainers involved in the programme perceive participants as passive recipients of information. To some extent, this is due to the trainers' lack of knowledge in their teaching area. However, another factor is that trainers dominate the sessions through constant talk possibly to avoid giving participants opportunities to draw them into debates where their knowledge deficits might become obvious. Examples from the field illustrated that trainers associated with the programme overall tend to rely on traditional classroom based teaching methods. The expectations of the development agencies and the learning styles of the participants promote the continuation of these traditional methods.

Over time, a number of ritualised practices have become essential components of the hidden curriculum of the continuing education courses conducted under the programme. This chapter has also asserted that continuing education courses are not neutral with the rewards of being involved having ongoing social and economic benefits for the participants of training.

Chapter eight concludes the study by reviewing the important findings and the implications of these for developing continuing education curricula in the developing country, especially in relation to policy development, health worker training and curriculum practice.

8. CONCLUDING COMMENTARY

Overview of the Study

This study using relational analysis from a critical theory perspective and methodology described and analysed influences of organisations and programmes on curriculum development and curriculum practice. In particular the study focused on the practices of Charya, Vandara, Khim, Sopheap, Sophoan and Kimny working in one of the programmes. All six people working in the programme are to some extent involved in the process of developing continuing education curricula in this developing country.

The initial research question for the study was:

> ***How do we ensure the curriculum development process goes beyond skills transfer: acknowledging culture and context?***

The focus being on the process by which decisions concerning continuing education curricula design and content are made and the realities of implementation under the programme within the health sector reform process in Cambodia. The foreshadowed issue that provided direction for the study emerged from my own personal experience as an expatriate technical advisor involved in

training health workers, as well as from the research literature on human resources for health was that:

- a contextually appropriate process for developing curricula from the Cambodian perspective is not understood by expatriates.
- an understanding of the power relations in which health worker curricula are being developed is a significant factor in providing training that will enhance service delivery.
- an understanding of the relationships between economy, culture and politics is crucial to the development of contextually appropriate continuing education curricula in a developing country that is undergoing health sector reform.

The data collection method for this study included eight months of participant observation in the programme where Charya, Vandara, Khim, Sopheap, Sophoan and Kimny worked, interviews, field visits, document analysis and meetings with other expatriates working in this field. Throughout the study, I explored the informant's responses to questions framed within the context of the foreshadowed issues. Interviews followed the lead of Charya, Vandara, Khim, Sopheap, Sophoan and Kimny as I sought to understand their perceptions of developing continuing education curricula and training in this country in the health sector reform climate.

Reflections

This study examining the influences on developing continuing education curricula in the developing country has been an enlightening experience for me. The definition of curriculum as comprising context, knowledge and interaction provided a broad focus that located curriculum development and curriculum practice within the political, cultural and economic dimensions of the country. Acknowledging the knowledge aspects of curriculum enabled investigation of the relationship between symbolic power and symbolic control and the influences of class, gender and race. The process has challenged me to look critically at my relationships with my counterparts and to work on the empowerment aspects of that relationship.

All too often, it is easy for us as expatriate technical assistants to see only the less desirable political, cultural and social aspects of development within a country. I realise also that we tend to fall into a category that chooses to empower or a category that likes to retain the colonial domination perspective. Through our actions and interactions, we can unwittingly transmit these categories as part of our hidden curriculum.

My perception while working in the field is that the tendency toward "New Right" neo-liberal philosophies as a driving force behind the provision of aid to developing countries is having a negative effect on sustainable development and effective capacity building. This theme was particularly evident when it came to deciding the content of the training curricula and the curriculum practice.

For Charya, Vandara, Khim, Sopheap, Sophoan and Kimny, there have been a number of intended and unintended outcomes resulting from this study. All participants are now able to formulate behavioural objectives in a logical sequence in the preparation of curricula and lessons. They are also able to go beyond formulating recall questions to developing case studies and situational questions that acknowledge the realities of the health situation in the country. An unintended but logically implicit outcome of the study has been a rapid increase in the English language ability of the participants of the study, particularly for Charya and Khim. Charya has progressed three levels to level 11B and Khim is now at level 12. It is expected that the level of input from an education expert in the next programme cycle will be reduced from full time to part time.

This study has significant implications for policy development, health worker education and curriculum practice for persons providing technical assistance in the development field. As well, there is the prospect of further research in the area of influences affecting how health workers in other cultures learn. The

implications arising from the study have in themselves made a significant contribution to the existing body of knowledge through raised awareness and increased understanding that thereby supports curriculum development and curriculum practice within the complexity of this developing country.

Implications for Developing Continuing Education Curricula

Policy Development

Throughout the information that Charya, Vandara, Khim, Sopheap, Sophoan, Kimny and expatriate educators shared, and my observations there has been a theme of power relationships between the development agencies and the organisations involved in health sector reform. Health workers and technical advisors need to be aware of events that place them under surveillance in a personal way and contribute to external means of control that encourages conformity within the organisation. A failure to scrutinise the actual political, cultural and social influences on the organisations and programmes supports and maintains existing class and gendered relations of power.

The complex nature of developing continuing education curricula in a developing country highlights the need for ongoing working relationships between development agencies, organisations and programmes working to provide health

services. Fostering organisational and programme collaboration will help ensure equity orientated capacity development strategies for health workers however, this collaboration will require systems that support such an undertaking.

In the current study, supportive monitoring and performance evaluation systems are in their infancy. From a developmental perspective, supportive monitoring and performance evaluation play a large part in defining the ongoing educational needs of trainers and health workers. There is therefore an expectation that they reflect the reality of the situation in which trainers and health workers work. Careful consideration of supportive monitoring and supervision systems should be a priority in future development initiatives. The outcome of such systems will then enable the curriculum development initiatives to be tailored to meet the needs of the changing health system.

Curriculum development teams across the health sector require resources that enable them to develop training programmes that meet the needs of trainers and participants. For example to translate and / or develop culturally appropriate texts and training materials into a language they understand. Further, trainers require additional training in the development of courses that are based on adult learning principles and foster dialogue about the real issues in practice.

The study raised an awareness of the need to develop guidelines based on symptoms rather than the traditional medical model of illness if they are to be useful in supporting appropriate treatment of the person presenting at the health facility. When doctors as the gatekeepers on medical knowledge are able to assist other health workers to prepare guidelines in a more meaningful way, then these health workers are more likely to contribute to the proposed model of health sector reform. Further, health workers will be able to take a more appropriate autonomous role in remote rural areas and undertake health interventions based on their level of skill and knowledge.

Finally, as the current study indicated staff motivation is a problem for trainers and health workers. This would signify the need for development agencies and organisations to reassess how to progress public sector reform. Public sector reform needs to be managed with support at the highest levels of government in a forum that is conducive to change.

Health Worker Education

The descriptions and observations that are the products of this study have provided insights into the values and realities of health workers working within this country context. They are therefore able to provide case studies of current

practice that may provide direction for future models of practice for both pre-service and continuing education of health workers.

The information collected during the study reveals the necessity for both trainers and trainees to be active partners in developing continuing education curricula and in the learning process. A reoriented process of developing continuing education curriculum that takes into consideration the political, cultural and social environment needs to be developed. This reoriented process would breakdown the traditional medical model of health worker teaching and learning thus enabling previously unexamined practices within the health system to be exposed and new contextually appropriate knowledge created. This has implications for the training of health workers, rather than simply imparting knowledge and developing skills identified within the curriculum an emphasis should be placed on learning methods that facilitate empowerment. An example would be the use of patient centered problem solving approaches developed within a political, cultural and social framework.

The findings from the study have highlighted that Charya, Vandara, Khim, Sopheap, Sophoan and Kimny, while mindful of practice realities in the health facilities, do not formally assess the current practice of trainers and health workers as a basis for course development. This finding identifies the need for trainer and

health workers to be enabled to provide input into the design and content of courses and course material that meets their work place needs.

Curriculum Practice

This study has shown that developing continuing education curricula and curriculum practice without participation by trainers and trainees is the common practice in this developing country. Curriculum practice, or activities related to teaching, as we understand it from a western educational perspective, is not an event undertaken by trainers to trainees. Instead, it is an activity that can provide the opportunity to come together to engage in dialogue about the issues confronting the everyday working life of health workers so that understandings can be shared and problems solved. Participatory curriculum practice has the ability to contribute to improved health outcomes and conveys to health workers the value of their contribution to these outcomes.

Within the study the intent of curriculum practice appeared to rely on the ability of those of higher status to maintain this stance whilst ensuring official knowledge was imparted. Furthermore, it was seen to be important for trainers to be conscious of the rituals involved in curriculum practice in this country context and to ensure they were transmitted through the hidden curriculum.

New Knowledge for Theory Development

The development of curriculum always reflects certain interests. When these interests are not examined, I believe that we run the risk of not addressing the role of knowledge as it relates to power. From the radical ideas of Bernstein at the time of the 1970's with the central argument that knowledge is a relative construct to the ideas of Apple about relational analysis, there is a commitment to bring theoretical and concrete analysis together. Drawing from the works of both Apple and Bernstein, in which arguments are illustrated with examples from actual classroom practices, I was provided a tangible way to examine the process of developing continuing education curricula in the developing country. This research has highlighted how the works of Bernstein and Apple can be applied to new knowledge and theory development in health workforce education in the developing country context. Relational analysis using the parallelist model has enabled me to show how health sector activities relating to the development of continuing education curricula are set within the broader societal processes. The use of the model has also illustrated the complex nature of the process of health sector reform. All those involved in the development of continuing education in the developing country, need to understand how the health sector policies and processes are being formulated, adopted and implemented.

For new knowledge development and theory development in the area of education for the health sector in the developing country context, I see the work of Bernstein and Apple as having potential benefits. One of these benefits is that the curriculum is seen as a process rather than a product. Knowledge selection and organisation is an active process that is embedded in particular interests and through interactions, curriculum development teams can choose to support or undermine those interests.

The work of developing continuing education curricula in the developing country, by nature needs to be fully contextualised, due to the variety of settings in which curriculum practice is undertaken. The work of Bernstein has been helpful here because it points out the importance of organisation factors and other features not commonly associated with the production of knowledge.

Future Directions for Research

This study has been able to address only a few of the many issues surrounding the process of developing continuing education curricula in a developing country in a neo-liberal economic climate. While seeking to discover how developing

continuing education curricula in a developing country undergoing health sector reform can enhance health service delivery the data in this study also suggests areas for further exploration.

Questions that might provide direction for further studies include: "How do Cambodians learn to learn?" "What can development agencies, organisations and programmes do to ensure more culturally responsive teaching and learning?" "Are the health sector reform initiatives of sector wide approach and boosting going to enhance supportive participatory curriculum development and curriculum practice?" "What structures and activities will most effectively increase the motivation of public sector health workers?" and "How can people providing technical assistance be most appropriately prepared for and supported during their assignments?" Further research that provides an understanding of the role of power within development agencies and organisational relationships would also be useful.

Limitations of the Study

While this study provides a basis for understanding the contextual realities and influences on the process of developing continuing education curricula in this developing country there are however limitations to the study.

The study is limited by the boundaries of language and time, which have affected the depth, continuity and length of observation, the number of participants and the alternative sources of data used in this study. Clearly the end point of this research cannot be specified, as the process of curriculum implementation and revision provides the research participants with the potential to continue to influence their skills in curriculum development and curriculum practice.

The research findings from this study can not be generalised to other situations, countries or to other programmes and groups and nor was this the intention of the study. The material in the study has of necessity been selective. Those reading this research report will however bring to the reading new perspectives gained from their own personal experiences. Whereas a study based on the findings in one developing country programme using six informants is not representative of all possible ways to investigate developing continuing education curricula, the findings provide a beginning to identifying the range of economic, cultural, political, class and gender factors that impinge on a programmes ability to provide contextually appropriate training courses.

Dissemination of Results

The dissemination of the results of this study, will be used as the basis for journal articles, poster displays and conference papers. It is also planned to disseminate results through national and international public health conferences and in public health and education journals. Copies of this thesis will also be placed in the Victoria University of Technology Library. Implications arising from the findings of this study have been sent to the participants as well as to the development agency that supports the programme where the participants are employed.

Concluding Statement

The task of critical theory is to examine and critique mass culture and the prevailing systems of domination and oppression administered from above (Bronner and Kellner, 1989). In my critique, factors that impinge on the ability of programmes and curriculum development teams in a specific developing country to provide culturally appropriate continuing education curricula have been exposed.

This study was a collaborative process undertaken with Charya, Vandara, Khim, Sopheap, Sophoan and Kimny who are all employed under the programme which was the central focus of the study. Through observation, interview and document analysis influences of the economic, cultural and political environment that have impinged on the ability of the programme to provide a culturally and contextually appropriate process of developing continuing education curricula have been identified.

REFERENCES

Abel-Smith, B. (1987) The world economic crisis. Part 2: Health manpower out of balance, *Health Policy and Planning,* V1: pp309-16.

Adelman, I. and Morris, C.T. (1997) Editorial: Development History and its Implications for Development Theory, *World Development*, V25, N6: pp831-840.

Apple, M.W. (2000) *Official Knowledge: democratic education in a conservative age,* 2nd Edition, Routledge, New York.

Apple, M.W. (1996) *Cultural Politics and Education,* Teachers College Press, New York.

Apple, M.W. (1993) What Postmodernists Forgot: cultural capital and official knowledge, Reprinted in Halsey, A.H., Lauder, H., Brown, P. and Wells, A.S. (eds) (1997) *Education: culture, economy and society,* Oxford University Press, Oxford.

Apple, M.W. (1986) *Teachers and Texts: a political economy of class and gender relations in education*, Routledge, New York.

Apple, M.W. (1982) Reproduction and contradiction in education, In Apple, M.W. (ed) *Cultural and economic reproduction in education*, Routledge and Kegan Paul, London.

Apple, M.W. (1979) *Ideology and Curriculum*, Routledge and Kegan Paul, Boston.

Aronowitz, S. and Giroux, H. (1985) *Education Under Siege,* Routledge and Kegan Paul, London.

Ashworth, P.D. (1995) The meaning of participation in participant observation, *Qualitative Health Research*, V5, N3: pp366-387.

Atkinson, P. (1985) *Language, Structure and Reproduction: an introduction to the sociology of Basil Bernstein*, Methuen, London.

Australian Agency for International Development (1997) *Annual report to Parliament of Australia's Development Cooperation Program and the*

Government's response to the Committee of Review of Australia's Overseas Aid Program, Australian Agency for International Development, Canberra.

Australian Agency for International Development (1995) *Cambodian Health Promotion and Primary Health Care Project*, Appraisal and Redesign - Final Project Design Document, Australian Government.

Australian Development Studies Network (1996) The future of Australia's aid programme. *Development Bulletin*, V38, N4.

Avalos, B. (1991) *Contexts, training theory and the teaching process*, Teaching and Teacher Education, V7, N2.

Awcock, D. (2000) *Nursing and Midwifery Training in North East Cambodia,* Voluntary Services Overseas, Phnom Penh.

Ball, S. (1983) Participant observation as a method of research, In *The Conduct of Fieldwork: case study methods 6*, Deakin University, Waurn Ponds.

Barnes, D.M. (1996) An analysis of the Grounded Theory Method and the Concept of Culture, *Qualitative Health Research,* V6, N3: pp429-441.

Bates, R. (1996) *Educational Reform: Its role in the economic destruction of Society,* (Keynote address at the Joint Annual Meeting of the Australian Association for Research in Education and the New Zealand Association for Research in Education) Deakin University, Geelong, Victoria.

Bennett, J. (1995) *Meeting Needs: NGO coordination and practice,* Earthscan Publications Ltd., London.

Benner, P. (1984) *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*, Addison-Wesley, California.

Berg, B.L. (1998) *Qualitative Research Methods for the Social Sciences*, Allyn and Bacon, Needham Heights.

Bernard, J.M. and Goodyear, R.K. (1992) *Fundamentals of Clinical Supervision,* Allyn and Bacon, Boston.

Bernstein, B. (1999) Vertical and Horizontal Discourse: an essay, *British Journal of Sociology of Education,* V20, N2: pp157-174.

Bernstein, B. (1996) *Pedagogy, Symbolic Control and Identity: theory, research, critique,* Taylor and Francis, London.

Bernstein, B. (1990) *Class, Codes and Control, Vol iv: the structuring of pedagogic discourse,* Routledge, London.

Bernstein, B. (1977) *Class, Codes and Control, Vol iii: towards a theory of educational transmissions,* 2nd Edition, Routledge and Kegan Paul, London.

Blackmore, J. (1992) The Gendering of Skill and Vocationalism in Twentieth Century Australian Education, Reproduced in Halsey, A.H., Lauder, H., Brown, P. and Wells, A.S. (eds) (1997) *Education: Culture, Economy and Society,* Oxford University Press, Oxford.

Booth, D. (1993) Development Research: From impasse to a new agenda, In Schuurman, F.J. (ed) *Beyond the Impasse: New directions in development theory,* Zed Books, London.

Booth, D. (1985) Marxism and Development Sociology: Interpreting the impasse, *World Development*, V13, N7: pp761-787.

Bossert, T.J. (1990) Can they get along without us? Sustainability of donor supported projects in Central America and Africa, *Social Science and Medicine,* V30, N9: pp1015-1023.

Bourdieu, P. (1986) The forms of capital, Reprinted n Halsey, A.H., Lauder, H., Brown, P. and Wells, A.S. (eds) (1997) *Education: Culture, Economy and Society,* Oxford University Press, Oxford.

Bowling, A. (1997) *Research Methods in Health: Investigating health and health services*, Open University Press, Buckingham.

Bradford, A.J. (1978) Village-based health and medical care resources, in Hetzel, B.S. (ed) *Basic Health Care in Developing Countries,* Oxford University Press, Oxford: pp146-169.

Brett, E.A. (1996) The Participatory Principle in Development Projects: the costs and benefits of cooperation, *Public Administration and Development,* V16, N1: pp5-19.

Brinkerhoff D.W. and Goldsmith A.A. (eds) (1990) *Institutional Sustainability in Agriculture and Rural Development: A Global Perspective.* Praeger, London.

Broadfoot, P. (1999) Assessment and the Emergence of Modern Society, *Curriculum in Context,* SAGE Publications, London.

Bronner, S.E. (1994) *Of Critical Theory and its Theorists,* Blackwell, Oxford.

Bronner, S.E. and Keller, D.M. (eds) (1989) *Critical Theory and Society*, Routledge, New York.

Brown, D.R. (1998) Evaluating Institutional Sustainability in Development Programmes: beyond dollars and cents, *Journal of International Development*, V10, N1: pp55-69.

Brundtland, H. (1987) *Our Common Future*, Oxford University Press, Oxford.

Bruner, J. (1999) Culture, Mind and Education, *Curriculum in Context*, SAGE Publications, London.

Bullough, R.V. and Gitlin, A.D. (1994) Challenging Teacher Education and Training: four propositions, *Journal of Education for Teaching*, V20, N1: pp67-81.

Burgess, R. (ed) (1985) *Issues in Educational Research: qualitative methods*, Falmer Press, London.

Burrell, G. and Morgan, G. (1979) *Sociological paradigms and organisational analysis*, Heinemann Educational Books, London.

Burton, J.L. and McDonald, S (2001) Curriculum or Syllabus: which are we reforming? *Medical Teacher*, V23, N2: pp187 – 191.

Cassels, A. (1997) *A guide to sector-wide approaches in health development*, WHO/DANIDA/DFID/EC, Geneva.

Cassels, A. (1995) *Discussion paper no.1 Health Sector Reform: key issues in less developed countries,* WHO, Geneva.

Centre for Social Development (1998) *Voter's Guide,* Phnom Penh.

Centro de Informacion y Servicios de Asesoria en Salud (1997) Adjusting health care: the case of Nicaragua, In Eade, D. (ed) *Development for Health,* Oxfam Print Unit, UK.

Chandler, D. (1996) *Facing the Cambodian Past,* Silkworm Books, Chiang Mai.

Chen, L.C., Kleinman, A. and Ware, N.C (eds) (1992) *Advancing health in developing countries: the role of social research,* Greenwood Publishing, Westport.

Chenitz, W.C. and Swanson, J.M. (1986) *From Practice to Grounded Theory: Qualitative research in nursing*, Addison-Wesley. Menlo Park.

Child, D. (1981) *Psychology and the Teacher*, Holt Rinehart and Winston. London.

Clifford, C. (1990) *Nursing and Health Care Research: a skills-based introduction*, 2nd Edition, Prentice Hall, London.

Coburn, D. (2000) Income inequality, social cohesion and the health status of populations: the role of neo-liberalism, *Social Sciences in Medicine*, V51, N1: pp135-146

Colquhoun, D. (1989) *Healthism and Health Based Physical Education: a critique*, Unpublished PhD, University of Queensland.

Connole, H., Smith, B. and Wiseman, R. (1993) *Research Methodology 1: Issues and Methods in Research, Study Guide*, Distance Education Centre, University of South Australia, Adelaide.

Cornbleth, C. (2000) *Curriculum Politics, Policy and Practice: cases in comparative context,* State University of New York Press, Albany.

Crossley, M. and Broadfoot, P. (1992) Comparative and international research in education: scope, problems and potential, *British Educational Research Journal*, V18, N1.

Crossley, M. and Vulliamy, G. (1984) Case-Study Research Methods and Comparative Education, *Comparative Education*, V20, N2: pp193-207.

Davies, R. (1997) Donor Information Demands and NGO Institutional Development, *Journal of International Development,* V9, N4: pp613-620.

Department For International Development (1999) *Better Health for Poor People*, Draft Report.

Dey, I. (1993) Creating Categories, *Qualitative Data Analysis*, Routledge, London, pp94-112.

Dowling, P. (1999) Basil Bernstein in Frame: 'Oh dear is this a structuralist analysis?' *Culture, Communication and Societies*, Institute of Education, University of London.

Duggan, S.J. (1996) Education, Teacher Training and Prospects of Economic Recovery in Cambodia, *Comparative Education,* V32, N3: pp361-375.

Eade, D. and Williams, S. (1995) *The Oxfam Handbook of Development and Relief*, Oxfam, London.

Edwards, M. (1997) Organisational Learning in Non-governmental Organisations: What have we learned? *Public Administration and Development,* V17, N2: pp235-250.

Edwards, M. (1993) How Relevant is Development Studies, In Schuurman, F.J. (ed) *Beyond the Impasse: New directions in development theory*, Zed Books, London.

Edwards, M. and Hulme, D. (1996) Too close for Comfort? The Impact of Official Aid on Non-governmental Organisations, *World Development,* V24, N6: pp961-973.

Egger, D., Adams, O. and Dussault, G (1998) *Human Resources for Health: policy formulation process and implementation,* World Health Organisation, Geneva.

Eisner, E.W. and Vallance, E. (1974) *Conflicting Conceptions of Curriculum,* McCutchan, Berkeley.

Fetler, M.E. (1994) Carrot or Stick? How do school performance reports work? *Education Policy Analysis Archives*, V2, N13.

Fitts, P.M. and Posner, M.I. (1969) *Human Performance,* Brooks Cole, Belmont, California.

Foucault, M. (1980) *Power / Knowledge: selected interviews and other writings 1972 – 1977,* Gordon, C (ed) Pantheon Books, New York.

Fraser, B. and Walberg, H. (eds) (1991) *Educational Environments: evaluation, antecedents and consequences*, Pergamon Press, Oxford.

Freire, P. (1998) *Pedagogy of Hope,* Continuum, New York.

Freire, P. (1972) *Pedagogy of the oppressed*, Seabury, New York.

Fulton, Y. (1997) Nurses' views on empowerment: a critical social theory perspective, *Journal of Advanced Nursing*, V26: pp529-536.

Gates, S. and Hill, J. (1995) Democratic Accountability and Government Innovation in the use of Nonprofit Organisations, *Policy Studies Review*, V14, N1/2: pp137-148.

Geertz, C. (1990) The Impact of the Concept of Culture on the Concept of Man. In Caton, H. (ed) *The Samoan Reader: Anthropologists take stock*, United Press of America, Maryland.

Girault, P., Chanary, M. and Seng, C. (1998) *Battambang Regional Training Centre Needs Assessment*, United Nations Development Programme, Battambang.

Giroux, H.A. and McLaren, P. (1992) Media hegemony: Towards a critical pedagogy of representation. In Schwock, J., White, M. and Reilly, S. (eds) *Media Knowledge: readings in popular culture, pedagogy and critical citizenship*, State University of New York, Albany.

Glaser, B.G. and Strauss, A.L. (1967) *The Discovery of Grounded Theory: Strategies for qualitative research*, Aldine de Gruyter, New York.

Goetz, J.P. and Le Compte, M.D. (1981) Ethnographic research and the problem of data reduction, *Anthropology and Education Quarterly*, V12: pp51-70.

Goodyear, L. (1997) *Lessons Learned: Cambodia Midwife and Traditional Birth Attendant Training*, International Rescue Committee, Cambodia.

Goulet, D. (1971) *The Cruel Choice - a new concept in the Theory of Development*, Athenaum, New York.

Gow, K. (1996) Training as a component of community economic development in rural Vietnam, *Development Bulletin*, V39, N4: pp75-76.

Grindle, M.S. and Hilderbrand, M.E. (1995) Building Sustainable Capacity in the Public Sector: what can be done? *Public Administration and Development*, V15, N5: pp441-463.

Halsey, A.H., Lauder, H., Brown, P. and Wells, A.S. (eds) (1997) *Education: Culture, Economy and Society*, Oxford University Press, Oxford.

Health Sector Reform Project (1998) *Briefing to the Minister of Health on Phase 3 from 1998 – 2000*, Ministry of Health, Phnom Penh.

Hettne, B. (1995) *Development Theory and the Three Worlds*, 2nd Edition, Longman Group, Harlow.

Holly, M. L. (1997) *Keeping a Professional Journal,* 2nd Edition, Deakin University Press, Geelong.

Hoy, D.C. and McCarthy, T. (1994) *Critical Theory*, Blackwell, Cambridge.

Huberman, A.M. and Miles, M.B. (1994) Data Management and Analysis Methods, In Denzin, N.K. and Lincoln, Y.S. (eds) *Handbook of Qualitative Research*, Sage, Thousand Oaks. pp429-444.

Hughes, H. (1997) Evaluating HIV/AIDS programmes, In Eade, D. (ed) *Development for Health,* Oxfam, UK.

Hughes, I. (1994) The Western idea of progress: The myth that prevents sustainability, In Keen, M. (ed), *Communities, Education and Sustainability: perspectives from Thailand and Australia,* Australian National University, Canberra.

Human Resources Department (2000) *Guidelines on Standards for Training,* (Draft) Ministry of Health, Phnom Penh.

Human Resources Department (1999) *First Biennial Review of the Health Workforce Development Plan 1996 – 2005*, Ministry of Health, Phnom Penh.

Human Resources Development Office (1997) *Health Workforce Development Plan 1996 – 2000,* 1st Edition, Ministry of Health, Phnom Penh.

Huot, E. (1993) *MCH Director and MCH Working Group, Maternal and Child Health National Health Plan to the end of 1996*, Ministry of Health Policy Document, Phnom Penh.

Jones, L. (1997) Talking about everyday issues in the formal classroom setting: a framework for understanding the dynamics of interaction. *Journal of Curriculum Studies*, V29, N5: pp559-567.

Jorgensen, D.L. (1989) *Participant Observation: A methodology for human studies*, Sage Publications, Newbury Park.

Joseph, P.B., Bravmann, S.L., Windschitl, M.A., Mikel, E.R. and Green, N.S. (2000) *Cultures of Curriculum,* Lawrence Erlbaum Associates, New Jersey.

Kannan, K.P. (1997) *Economic Reform, Structural Adjustment and Development in Cambodia,* Working Paper Number 3 Cambodia Development Resource Institute, Phnom Penh.

Kellner, D. (2000) *Critical Theory and the Crisis of Social Theory*, at Illuminations: The Critical Theory Web-site.

Kemmis, S and Fitzclarence, L. (1986) *Curriculum Theorising: Beyond reproduction theory*, Deakin University Press, Geelong.

Kemmis, S and Stake, R (1988) *Evaluating Curriculum*, Deakin University, Geelong.

Kirk, D. (1999) Physical Culture, Physical Education and a Relational Analysis, *Sport, Education and Society*, V4, N1: p63

Kirk, D. and Colquhoun, D. (1989) Healthism and Physical Education, *British Journal of Sociology in Education*, V10, N4: pp417-434.

Knowles, M. (1990) *The adult learner*, 4th Edition, Gulf, Houston.

Kulig, J.C. (1995) Cambodian refugees' family planning knowledge and use, *Journal of Advanced Nursing*, V22, N1: pp150-157.

Kyriacou, C. (1991) *Essential Teaching Skills*, Stanley Thornes, Cheltenham.

La Fond, A. (1995) *Sustaining Primary Health Care*, Earthscan, London.

Lareau, A. (1987) Social class differences in family – school relationships: the importance of cultural capital, Reproduced in Halsey, A.H., Lauder, H., Brown, P. and Wells, A.S. (eds) (1997) *Education: Culture, Economy and Society*, Oxford University Press, Oxford.

Larrain, J. (1989) *Theories of Development: Capitalism, Colonialism and Dependency*, Polity Press, Cambridge.

Lawton, D. (1983) *Curriculum studies and educational planning*, Hodder and Stoughton, London.

Le Compte, M. (1987) Bias in the Biography: bias and subjectivity in ethnographic research, *Anthropology and Education Quarterly*, V18: pp43-52.

Lee, L.M. (1996) Facing the Challenges of the 21st Century Professional Education in Public Health in China, in Yusof, K., Lok, W., Zulkifli, S.N. and Wong, Y. (eds) *Issues and Challenges of Public Health in the 21st Century*, University of Malaysia, Kuala Lumpur.

Le Metais, J. (1999) Values and aims in curriculum and assessment frameworks: a 16 nation review, In Moon, B and Murphy, P. (eds) *Curriculum in Context*, SAGE, London.

Leninger, M. (ed) (1985) *Qualitative Research Methods in Nursing*, Grune and Stratton, Orlando.

Lincoln, Y.S. and Guba, E.G. (1985) *Naturalistic Inquiry*, Sage Publications, Newbury Park.

Little, A. (1988) *Learning from developing countries*, University of London, London.

Long, C., Soeung, S.C., Meakea, M., Sprechmann, S. and Kerr, H. (1995) *KAP Survey on Fertility and Contraception in Cambodia*, National Maternal Child Centre, Phnom Penh

Lott, C. (1995) *Gender and Development in Cambodia*, Royal Netherlands Embassy, Phnom Penh.

Lupton, D. (1997) Foucault and the medicalisation critique, In Petersen, A. and Bunto, R. (eds), *Foucault: Health and Medicine*, Routledge, London.

McCarthy, C. (1990) Nonsynchrony and Social Difference: An alternative to current radical accounts of race and schooling, Reprinted in Halsey, A.H., Lauder, H., Brown, P. and Wells, A.S. (eds) (1997) *Education: culture, economy and society*, Oxford University Press, Oxford.

McCarthy, T. (1991) *Ideals and Illusions: on reconstruction and deconstruction in contemporary critical theory*, The MIT Press, Cambridge.

McGee, C. (1997) *Teachers and Curriculum Decision-Making*, The Dunmore Press, Palmerston North.

McMurray, C. (1996) Australian aid to Africa: Can donor interest and recipient needs be reconciled? *Development Bulletin*, V39, N4: pp22-25.

McLaughlin, D. and O'Donoghue, T. (1996) *Community Teacher Education in Papua New Guinea*, University of Papua New Guinea Press, Port Moresby.

McPake, B. and Machray, C. (1997) International Comparisons of Health Sector Reform, *Journal of International Development*, V9, N4: pp621-629.

Marshall, C. and Rossman. G.B. (1995) *Designing Qualitative Research* 2nd Edition, Sage Publications, California.

Merriam, S.B. (1985) The case study in educational research: a review of selected literature, *The Journal of Educational Thought*, V19, N3: pp204-217.

MEDICAM (1999) *The Health Sector Reform Process in Cambodia*, MEDICAM, Phnom Penh.

Miles, M and Huberman, A. (1993) *Qualitative Data Analysis: a sourcebook of new methods*, 2nd Edition, Sage Publications, California.

Ministry of Health / German Technical Cooperation / United Nations Children's Fund (1999) *Foundation Health Centre Training Manual*, Ministry of Health, Phnom Penh.

Ministry of Health (1999a) *Briefing note about government expenditure on health in 1999*, Ministry of Health, Phnom Penh.

Ministry of Health (1999b) *Planning Manual: Planning Process at Provinces and Operational Districts*, Ministry of Health, Phnom Penh.

Ministry of Health (1999c) *Health Situation Analysis 1998 and Future Directions for Health Development*, Ministry of Health, Phnom Penh.

Ministry of Health (1997a) *National Health Statistics Report 1996*, Planning and Statistics Unit, Ministry of Health.

Ministry of Health (1997b) *Guidelines for Developing Operational Districts*, Ministry of Health, Phnom Penh.

Ministry of Health (1996) *National Charter on Health Financing in the Kingdom of Cambodia*, Unofficial Translation.

Ministry of Health (1995) *Birth Spacing Policy for Cambodia.*

Mohanty, C.T. (1990) On race and voice: challenges for liberal education in the 1990s, Reprinted in Halsey, A.H., Lauder, H., Brown, P. and Wells, A.S. (eds) (1997) *Education: Culture, Economy and Society*, Oxford University Press, Oxford.

Mola, G. (1998) *Draft Short Term Consultancy Mission Report*, World Health Organisation, Phnom Penh.

Moon, B and Murphy, P. (1999) *Curriculum in Context*, SAGE, London.

Morrow, R.A. and Brown, D.D. (1994) Critical Theory and Methodology, *Contemporary Social Science, Vol. 3,* Sage Publications, Thousand Oaks.

Morse, J.M. and Field, P.A. (1995) *Qualitative Research Methods for Health Professionals*, 2nd Edition, Sage Publications, Thousand Oaks.

Mosley, P., Harrigan, J. and Toye, J. (1991) *Aid and Power: the World Bank and policy-based lending,* Volume 1: Analysis and Policy Proposals, Routledge, London.

Mosley, P. (1991) Structural Adjustment: a general overview 1980-89, in Balasubramanyan, V.N. and Lall, S. (eds), *Current Issues in Development Economics,* Macmillan, London.

Naidoo, K. and Searle, R. (1999) Many Faceted, Varied and Intriguing: factors influencing a disciplinary learning environment and the issues they raise for course and curriculum design, *Society in Transition,* V30, N2: pp168-176.

National Health and Medical Research Council (1991) *Ecologically sustainable development - the health perspective,* document prepared in consultation with the Department of Community Services and Health, The National Occupational Health and Safety Commission - Worksafe Australia, State and Territories Health Authorities, and non-government health bodies.

National Institute of Public Health (1999) *National Health Survey 1998*, Ministry of Health, Phnom Penh.

National Institute of Public Health (1998) *The Demand for Health Care in Cambodia: concepts for future research*, Ministry of Health, Phnom Penh.

National Institute of Statistics (1999) *General Population Census of Cambodia 1998*, Ministry of Planning, Phnom Penh.

National Maternal Child Health Centre (1999a) *Assessment and Management Guidelines for Health Centre Staff*, Ministry of Health, Phnom Penh.

National Maternal Child Health Centre (1999b) *Mother's Health Record*, Ministry of Health, Phnom Penh.

National Maternal Child Health Centre (1998a) *Safe Motherhood Clinical Management Protocols for Health Centre Staff,* Ministry of Health, Phnom Penh.

National Maternal Child Health Centre (1998b) *Tripartite Review Meeting 8 October 1998: Project CMB/97/P01 Reproductive Health / Birth Spacing and Sexual Health in Cambodia*, Phnom Penh.

National Maternal Child Health Centre (1998c) *Mother's Health Record*, Pilot Version, Ministry of Health, Phnom Penh.

National Maternal and Child Health Centre (1997) *Birth Spacing Curriculum*, Ministry of Health, Phnom Penh.

Neary, M. (2000) *Teaching, Assessing and Evaluating for Clinical Competence: a practical guide for practitioners and teachers*, Stanley Thornes Ltd, London.

Non-government Organisation Forum (1999) *NGO Statements*, Provided at the Internet address www.camnet.com.kh/ngoforum/CGPaper

Nugroho, G., Macagba, R.L., Dorros, G.L. and Weinstock, A. (1997) Challenges in health development, *World Health Forum*, V18, N1: pp44-47.

O'Heir, J.M. (1997) Midwifery Education for Safe Motherhood, *Midwifery*, V13, N2: pp115-124.

O'Riordan, T. and Voisey, H. (1997) The Politics of Sustainable Development, *Environmental Politics*, V6, N1: pp1-23.

Oxford English Dictionary (1993) *Oxford English Dictionary*, Clarendon Press, Oxford.

Patton, M.Q. (1990) *Qualitative Evaluation and Research Methods*, 2nd Edition, Sage Publications, Newbury Park.

Payer, C. (1991) *Lent and Lost: foreign credit and third world development*, Macmillan, London.

Peshkin, A. (1988) In Search of Subjectivity: one's own, *Educational Researcher*, V17, N7: pp17-21.

Popkewitz, T.S., Tabachnick, B.R. and Wehlage, G. (1982) *The Myth of Educational Reform: A study of school response to a program of change*, University of Wisconsin Press, Wisconsin.

Posner, G.J. (1995) *Analysing the curriculum*, 2nd Edition, McGraw Hill, New York.

Posner, G.J. (1988) Models of Curriculum Planning, In, Apple, M.W. *The curriculum: problems, politics and possibilities*, State University of New York, Albany.

Prescott, N. and Pradham, M. (1997) *A Profile of Cambodia,* World Bank Discussion Paper No 373, Washington D.C.

Ramsden, P. (1992) *Learning to teach in higher education,* Routledge, New York.

Redclift, M. (1987) *Sustainable Development: Exploring the Contradictions,* Routledge, London.

Reproductive and Child Health Alliance (1998) Rural Women and Health Care Use, Staff Employment and Health Seeking Behaviour, *RACHA Studies Number 4,* Phnom Penh.

Rice, P.L. (1996) Health Research and Ethnic Communities: reflections on practice, In Colquhoun, D. and Kellehear, A. (eds), *Health Research in Practice Volume 2: Personal experiences, public issues*, Chapman and Hall, London.

Richter, H.I., Outtara, G.G., Heilenkotter, I., Gueye, D., and Fischer, C. (1996) The right skills for health systems development, *World Health Forum,* V17, N4: pp392-395.

Ritchie, M.A., Minsek, M. and Conner, D.W. (1995) Roles and approaches of non-governmental organisations in health development, *World Health Forum,* V16, N1: pp36-41.

Robinson, D. and Wheeler, T. (1992) *Cambodia a travel survival kit,* Lonely Planet, Victoria, Australia.

Rollason, R. (1996) The Privatisation of Development. *Development Bulletin,* V38, N4: pp5-7.

Ross, S.R. (1998) *Promoting Quality Maternal and Newborn Care,* CARE, USA.

Royal University of Phnom Penh (1998) *Report on first phase of field work,* United Nations Population Fund, Phnom Penh.

Sagoe, K. (1998) *Preliminary Report on Country Case Studies: Human resources for health policy and implementation methods*, World Health Organisation, Geneva.

Saide, M.A. and Stewart, D.E. (2001) Decentralisation and human resource management in the health sector: a case study (1996-1998) from Nampula Province, Mozambique, *International Journal of Health Planning and Management*, V 16, N2: pp155-168.

Sanson-Fishe, R, and Rolfe, I. (2000) The content of undergraduate health professional courses: a topic largely ignored, *Medical Teacher*, V22, N6: pp564-567.

Schon, D. A. (1983) *Educating the Reflective Practitioner*, Jossey-Bass Publishers, San Francisco.

Schulman, L.S. (1988) The nature of disciplined inquiry in education: in Jaeger, R.M. (ed), *Complementary Methods for Research in Education*, American Educational Research Association, Washington.

Schuurman, F.J. (1993) Introduction: Development Theory in the 1990's. In Schuurman, F.J. (ed) *Beyond the Impasse: New directions in development theory*, Zed Books, London.

Seddon, T. (1983) The Hidden Curriculum: an overview, *Curriculum Perspectives*, V3, N1: pp1-6.

Shaffer, M.K. and Pfeiffer, I.L. (1995) A Blueprint for Training, *Training and Development*, V49, N3: pp31-33.

Shaffir, W.B. and Stebbins, R.A. (eds), (1991) *Experiencing Fieldwork: an inside view of qualitative research*, Sage Publications, Newbury Park.

Shor, I. (1992) *Empowering Education: critical teaching for social change*, The University of Chicago Press, Chicago.

Short, E.C. (1991) Setting Priorities in Curriculum Research, *Education*, V11, N4: pp491-496.

Singh, P. (1999) *Pedagogic Work, Social Class and Cultural Difference*, Manuscript accepted for the Australian Association for Research in Education Conference, Melbourne.

Slater, D. (1993) The political meanings of development: in search of new horizons. In Schuurman, F.J. (ed) *Beyond the Impasse: New directions in development theory*, Zed Books, London.

Sparkes, A.C. (1992) Validity and the research process: an exploration of meanings, *Physical Education Review*, V15, N1: pp29-45.

Spradley, J.P. (1980) *Participant Observation*, Rinehart and Winston, New York.

Sprechmann, S., Soeung, S.C., Kerr, H., Long, C. and Meakea, M. (1996) *Estimating the magnitude of Maternal Mortality in Cambodia: an application of the sisterhood method*, National Maternal and Child Health Centre, Phnom Penh

Stake, R.E. (1995) *The Art of Case Study Research*, Sage Publications, Thousand Oaks.

Stake, R.E. (1986) Progress evaluation, particularly responsive evaluation. In Madaus, G.F., Scriven, M. and Stufflebeam, D.C. (eds) *Evaluation models: Viewpoints in educational and human services evaluation,* Kluwer-Nijoff, Boston.

Stefanini, A. (1995) Sustainability: the role of NGO's, *World Health Forum,* V16, N1: pp42-46.

Strauss, A. and Corbin, J. (1990) *Basics of Qualitative Research: grounded theory procedures and techniques,* SAGE, Newbury Park.

Street, A. F. (1995) *Nursing Replay: Researching Nursing Culture Together*, Churchill Livingstone, Melbourne.

Street, A. F. (1992) *Inside Nursing: A Critical Ethnography of Clinical Nursing Practice*, State University of New York Press, New York.

Summerfield, D. (1997) The psychosocial effects of conflict in the Third World, In Eade, D. (ed) *Development for Health,* Oxfam Print Unit, London.

The Cambodia Daily Weekend (1998) One Year Later, Issue No 20 Saturday July 4 1998.

Tarimo, E. and Webster, E.G. (1994) *Primary Health Care concepts and challenges in a changing world*, Division of Strengthening Health Services, World Health Organisation, Geneva.

Taylor, B. F. (2000) *Reflective Practice: a Guide for Nurses and Midwives*, Allen and Unwin, St. Leonards.

Thaman, K.H. (1993) Culture and the Curriculum in the South Pacific, *Comparative Education*, V29, N3: pp249-260.

Thomson, A. (1996) The 1996-97 Aid Budget: A sharper humanitarian focus. *Development Bulletin,* V39, N4: pp5-7.

Townsend, J. (1993) Gender Studies: whose agenda? In Schuurman, F.J. (ed) *Beyond the Impasse: New directions in development theory*, Zed Books, London.

United Nations Consultative Group on Policy (1998) *Cambodia Common Country Assessment*, Phnom Penh.

United Nations Population Fund (1997) *Reproductive Health / Birth Spacing and Sexual Health in Cambodia Project*, Project Document between the Government of Cambodia and the United Nations Population Fund.

United Nations Population Fund. (1996) Recommendation by the Executive Director to the Royal Government of Cambodia, DP/FPA/CP/159, 25 July 1996.

Unknown (1997) *Background Document: education and Training of Health Workers and Proposed Strategies to Implement Competency-based Training.*

Walt, G. (1994) *Health Policy: an introduction to process and power,* Zed Books, London.

Walters, P. (1998) Suharto's Fatal Flaw, *The Weekend Australian*, January 17-18: p24.

Watson, K. (1994) Technical and Vocational Education in Developing Countries: western paradigms and comparative methodology, *Comparative Education*, V30, N2: pp85-97.

White, P. (1995) *Crossing the River: Traditional beliefs and practices of Khmer women during pregnancy, birth and postpartum*, Ministry of Health, Phnom Penh.

Whitty; G. (1997) Marketisation, the State and the Re-Formation of the Teaching Profession, In Halsey, A.H., Lauder, H., Brown, P. and Wells, A.S. (eds) *Education: Culture, Economy and Society,* Oxford University Press, Oxford.

Wilson, K. (1992) Thinking about the ethics of fieldwork, In Devereux, S. and Hoddincott, J. (eds), *Fieldwork in Developing Countries*, Harvester Wheatsheaf, Hertfordshire.

Wilson, S. (1977) Centre for New Schools: Ethnographic techniques in educational research, In Hamilton, D. Jenkins, D. King, C. MacDonald, B. and Parlett, M. (eds), *Beyond the numbers game,* Macmillan Education, London.

Winter, E. de. (1996) Material resources are not enough: good management is the key to effectiveness, *World Health Forum*, V17, N1: pp49-51.

Woodhall, M. (1987) Human Capital Concepts, In Halsey, A.H., Lauder, H., Brown, P. and Wells, A.S. (eds) *Education: Culture, Economy and Society,* Oxford University Press, Oxford.

Woods, L.S. (1997) The Myth of Cambodia's Recovery, *Contemporary Southeast Asia*, V18, N4: pp417-429.

World Bank (1997) *World Development Report 1997: The state in a changing world,* Oxford University Press, New York.

World Bank (1991) *World Development Report 1991,* Oxford University Press, New York.

World Health Organisation (1999) *Analysis of the Health Sector in Cambodia,* World Health Organisation, Phnom Penh.

World Health Organisation. (1996) *Integration of Health Care Delivery: Report of the WHO Study Group*, WHO Technical Report Series 861, Geneva.

World Health Organisation (1993) *Revitalisation of Human Resources for Health in Cambodia*, WHO, Phnom Penh.

World Health Organisation (1991) *Midwifery Education: action for safe motherhood*, WHO/MCH/ 91.3, World Health Organisation, Geneva.

World Health Organisation (1990) *Coordinated health and human resources development, Report of a WHO Study Group*, Technical Report Series, No 801, Geneva, World Health Organisation.

APPENDIX ONE: LETTER OF ETHICS APPROVAL

APPENDIX TWO: PLAIN LANGUAGE STATEMENT

UNIVERSITY OF BALLARAT

- **PLAIN LANGUAGE STATEMENT AND INFORMED CONSENT**

PROJECT TITLE:	**Developing Continuing Education Curricula in a Developing Country**
INVESTIGATORS:	**Juliet Fleischl** **Associate Professor Derek Colquhoun** Director, Health Promotion School of Human Movement and Sports Sciences University of Ballarat Mt Helen Victoria Australia Tel: +61 3 5327 9686 Email: d.colquhoun@ballarat.edu.au

PLAIN LANGUAGE STATEMENT	The purpose of this research project is to study the process of developing continuing education curricula in Cambodia. This project is part of my PhD studies. My supervisor for this study is Associate Professor Derek Colquhoun who can be contacted at the above. An interview will be conducted and will last approximately one hour. This interview will be conducted in an informal manner at a time and in a place convenient to you. During this interview questions will be asked regarding your impressions of the curricula being developed. Tape recordings may be made during this interview with your prior consent. A translator may be present at the interview with your prior consent. The tape recording will be for use only by the investigator, a translator if required and yourself. A transcription of the tape recording will be returned to you for editing. The tape recordings will be stored in a secure locked storage unit. Your total time commitment over the eight (8) months of this project is approximately three (3) hours. This includes one hour of interview time (during the latter of the project) plus time for you to edit the transcript of the interview. The final report, containing anonymous quotations, will be available to all at the completion of this study.

APPENDIX THREE THEORIES OF DEVELOPMENT

Historical Map of the Main Theories of Development (with especial reference to Latin America)

Centre	*Periphery*
Competitive Capitalism (1700 - 1860)	
Classical Political Economy (Smith, Ricardo)	
Historical Materialism (Marx, Engels)	
Age of Imperialism (1860 - 1945)	
Neo-classical Political Economy (Marshall, Walras, Jevons)	
Classical Theory of Imperialism (Hilferding, Bukharin, Luxemburg, Lenin)	
Late Capitalism (1945 - 1980)	
1945 - 1966 Expansion	
Theories of Modernisation (Hoselitz, Rostow)	ECLA's Analysis (Prebisch)
Theory of Imperialism Refurbished (Baran)	
1966 - 1980 Deceleration and Crises	
Neo-liberalism (Friedman)	Dependency Theories (Frank, Cardoso)
World System and Unequal Exchange Theories (Wallerstein, Emmanuel)	Unequal Exchange Theories (Amin)
Articulation of Modes of Production (Rey)	

(*source:* Larrain, J. (1989) *Theories of Development: Capitalism, Colonialism and Dependency*, Polity Press, Cambridge.)

Age of Competitive Capitalism - the production of final consumption goods by a multitude of small firms which bought and sold in competitive markets, used

rudimentary, labour-intensive technologies and simple organisational forms, and made rather low quality products.

Age of Imperialism - small firms replaced by monopolistic control of the markets by huge cartels and firms using corporate forms of business organisation.

Age of Late Capitalism - production of modern consumer goods by big transnational corporations. The production of raw materials ceases to be carried out almost exclusively in third world countries and is shifted on a massive scale to industrialised centres.

> ***Expansion*** - post Second World War, decolonisation begins. New wave of nationalism in the third world, issues of poverty and economic difficulties of less developed countries come to the fore and are recognised as real issues by more developed countries. Investment by international companies accelerates some processes of industrialisation in the third world.
>
> ***Deceleration and Crises*** - slowing down of economic growth and falling rate of profit in industrialised nations. This crises creates unemployment, inflation and increased political instability.

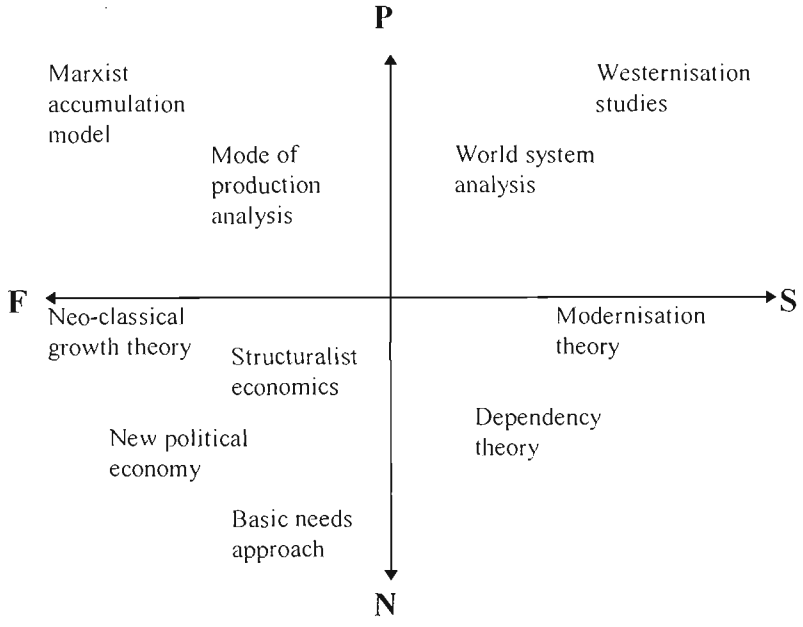
A Tentative Summary of Orientations in Development Theory

Formal Approach (F) - development defined in terms of a limited number of universally valid principles and quantifiable indicators which can be combined in a predictive model.

Substantive Approach (S) - development involves historical change of a more comprehensive, qualitative and less predictable nature.

Positive Approach (P) - studies that deal with the world as it is.

Normative Approach (N) - studies that deal with the world as it should be.

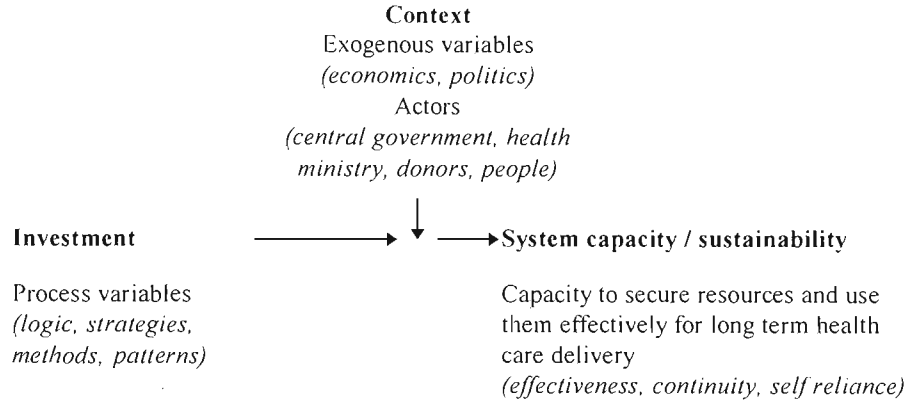


(*Source:* Hettne, B. (1995) *Development Theory and the Three Worlds*, 2nd Edition, Longman Group, Harlow.)

APPENDIX FOUR: SUSTAINABILITY FRAMEWORKS

This Appendix presents a number of conceptual and theoretical frameworks from the literature reviewed.

Factors Influencing the Process of Health System Development



(*Source:* La Fond, A (1995) *Sustaining Primary Health Care*. p33)

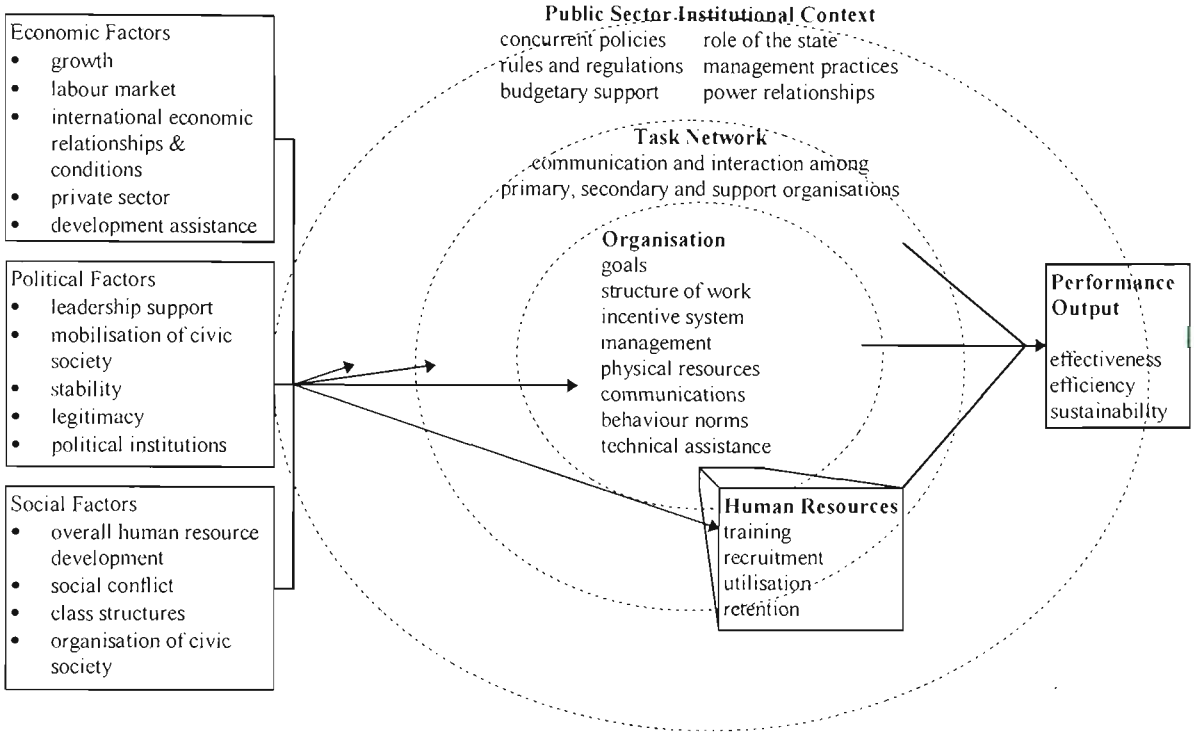
This framework is based on the premise that health systems develop in response to different influences internal and external. The two broad areas chosen for this study were the:

- *context or environment of development*; and,
- *investment patterns.*

Context is used to denote political, economic and organisational structures and actors which act upon the health system. Exogenous influences range from economic volatility to trends in international aid policies and practices.

Health systems depend on the investment process to obtain resource inputs and generate health outputs. Analysing the investment process raises questions about the actors or institutions which are responsible for investing in health. Are the actors and methods of investment suited to the developmental needs of the health system?

Dimensions of Capacity



(*Source:* Grindle, M.S. & Hilderbrand, M.E. (1995) *Building Sustainable Capacity in the Public Sector: what can be done?* p446)

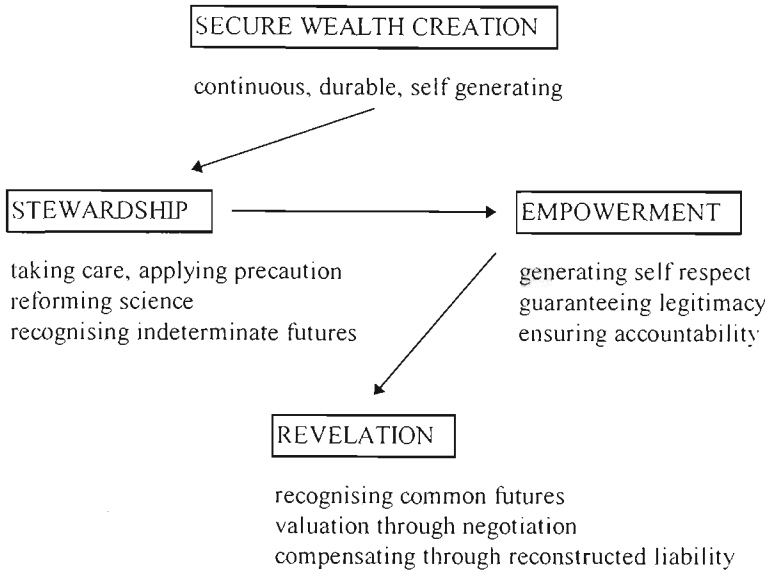
The framework identifies five dimensions and five levels of analysis that affect capacity and capacity building interventions. The dimensions are described as interactive and dynamic.

- *The action environment* sets the economic, political and social milieu in which governments carry out their activities. The diagram indicates a number of the factors that are most likely to have an impact on public sector capacity. Interventions to improve conditions in the actions environment take a long time to produce results because they attempt to alter basic economic, political and social structures.
- *The institutional context of the public sector* includes rules and procedures for government operations and public officials, financial resources of the government, government responsibilities for development initiatives, policies

and formal and informal influence that affect how the public sector functions. This context can constrain or facilitate the accomplishment of particular tasks.

- *The task network* refers to the set of organisations involved in accomplishing any given task. Performance is affected by the extent to which such networks encourage communication and coordination and the extent to which individual organisations within the network are able to carry out their responsibilities effectively. Networks can be composed of organisations within and outside of the public sector, including NGO's and private sector organisations.
- *Organisations* are the building blocks of the task network. The structures, processes, resources and management styles of organisations promote or constrain performance because they affect organisational output and shape the behaviour of those who work within them.
- The fifth dimension of capacity focuses on how *human resources* are educated and attracted to public sector careers and the utilisation and retention of individuals as they pursue such careers.

Four Components of Sustainable Development



(*Source:* O'Riordan, T and Voisey, H. (1997) *The Political Economy of sustainable Development*, p7)

- *markets* (secure wealth creation) refer to arrangements in the competitive economy ensuring that ecological and social tolerances to expansion and change are not exceeded. Though the mechanism of control may also be regulatory, the process of implementation is competitive and market driven.
- *regulations* (stewardship) apply to patterns of control and guidance imposed either by the state in the form of legal rules, or various informal restrictions, or by collective action supported by voluntary agreements or legal norms.
- *equity* (empowerment) relates to distributional fairness in dealing with both non-human and human life but mainly the latter, and encompasses both rights and duties towards future as well as present generations and ecosystems. Within equity will be legal norms that guide such institutional arrangements as monitoring, protecting, evaluating and compensating in cash or in kind.
- *revelation* encompasses the idea of capturing spirit of communal obligation and citizenship. It is a processes of discourse and negotiation towards consensus that shows that common interests have been recognised.

APPENDIX FIVE: SAMPLE OF QUESTIONS

	▪ What to Examine	Sample of Questions
Context	Goal / purpose of training Planning Assessing Evaluating	How should the curriculum / course be planned? Who should be involved in the planning of the curriculum / course? What constitutes the training cycle? What do health workers in Cambodia believe constitutes a good course? What makes you believe the teaching / course is good? How should participants of the course be assessed? How will we know that the curriculum / course is good?
Content	Subject matter Practice in clinical area	What is the course subject matter? How is the subject matter organised? How do you know that the subject matter is correct? What is the relationship between the subject matter of the course and the practice in clinical areas?
Interaction	Teachers Students Curriculum Development Team Classroom Environment	Are course participants seen as individual learners? How do health workers in Cambodia learn? What is the environment in the classroom? What constitutes a good teaching space? What resources must be available at the training site? What is the relationship between the teacher and the students?