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Community involvement in healthcare

A qualitative study

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LIST OF ACRONYMS

Azad Jammu & Kashmir	AJK
Basic Health Unit	BHU
Community Health Committees	CHC
Community Management Committees	CMC
District Health Boards	DHB
District Health Officer	DHO
District Health Management Teams	DHMT
Emergency Obstetric Care	EOC
Executive District Officer	EDO
Focus Group Discussions	FGDs
Family Health Project	FHPs
Human Development Research Foundation	HDRF
Health Centre Committees	HCC
Health Management Committees	HMCs
Implementing Partners	IPs
In-Depth Interviews	IDIs
National Immunization Day	NID
Neighborhood Health Committees	NHC
Partnership for Transforming Health Systems	PATHS
Primary Health Care	PHC
Primary Healthcare Revitalization, Integration and Decentralization in Earthquake-affected areas	PRIDE
Rural Health Centers	RHC
Research Questions	RQ
Terms of Reference	TOR
Voice & Accountability	V&A

EXECUTIVE SUMMARY

Community is a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings. Community involvement is elementary to the success of public health initiatives. Various strategies have been devised to increase community participation with partnerships at the center of these strategies. The project on Primary Healthcare Revitalization, Integration and Decentralization in Earthquake-affected areas commonly known as PRIDE (a USAID-funded project working in Bagh and Mansehra districts) conceptualized and launched a collaborative partnership initiative by the name of Health Management Committees (HMCs).

Many steps including the conceptualization, negotiation, formulation and implementation enabled the development of 47 HMCs in district Bagh and 69 in district Mansehra. These HMCs nearly completed the second year of their life in 2009. The HMCs contributed towards improving health care at the respective health facilities and adjoining areas. To document the experience, PRIDE commissioned Human Development Research Foundation to carry out a third party evaluation in the form of a qualitative study to capture the lessons learned from this collaborative partnership. The research looked into the experience as viewed by various stakeholders, the main contributions of these HMCs, the facilitating factors as well as the challenges, and the sustainable aspect of these committees.

A cross-sectional, qualitative design was selected for this study. The HMC initiative had various stakeholders including its conceptualizers, implementers, government and community partners, and ultimate beneficiaries i.e. patients, families and community. Knowing 'what' they felt about this initiative and 'why', was crucial and possible only through qualitative discussions. The study was conducted in two PRIDE districts namely Mansehra and Bagh.

Four levels of respondents were engaged in this study including those who conceptualized and implemented the idea (PRIDE and its IPs), those who were expected to share their responsibility and authority with the community (District health departments), those who represented community (HMC members) and the ultimate beneficiaries of this initiative i.e the communities served by the HMCs.

Since we aimed at getting informed about the contributions, facilitating and challenging factors for these HMCs, we devised a strategy to ensure both good performing and poorly performing HMCs were included in our sample.

PRIDE provided us with the information on HMCs regarding their annual plan review of 2008/2009 (which included number of meetings held since June 2009 to Dec 2009, number of meetings during this period attended by women members of the HMC, their annual plan reviews and their annual plan achievements). Thus using this information we categorized the HMCs into two groups, i) good performing HMCs which had achieved their annual plans or went beyond their annual plans irrespective of the number of meetings held in the last 06 months ii) poor performing HMCs which were either in the process of carrying out their annual plans or had not yet started carrying out their plans or could not carry out more than two monthly meetings in the last 06 months. Using a saturation sampling technique we approached both types of HMCs from the two Districts till no new information could be retrieved.

A total of 30 in-depth interviews (IDIs) and 13 focus group discussions (FGDs) were carried out during the study.

The committees were able to develop collaborative partnerships, foster leadership and improve service delivery through commitment and implementation of innovative ideas. The collaborative nature of the partnership facilitated many contributions made by these HMCs including addressing the needs of the facilities like water and electricity. The committees were also able to get link roads made which in turn facilitated easier access to the facilities. The HMCs helped improving the service delivery at the facilities supervised by them. They influenced the increase in the number of staff, improved their attendance, increased the number of essential services provided at these facilities, improved provision of drugs and supplies and helped the facility staff by getting the procedures of procurements expedited. All these important contributions to service delivery were the result of the voice that the HMCs had developed and this voice in turn made the health department more responsive.

Many factors helped the HMCs in their contributions including the nurturing role of PRIDE, the collaborative nature of the initiative, representation of different levels of community, fostering of local leadership and the fact that these committees were notified as official committees of the health department. At the same time, they also had some limitations as well as challenges. There were conflicts and frictions within the HMCs as well as between HMCs and the health departments. Lack of women participation and time constraints in completion of various steps in the formulation, notification and functioning of these committees also emerged as limitations.

Mixed opinions were shared by the respondents on sustainability of the initiative. The project (PRIDE) itself thought sustainability could be possible if higher authorities legitimized it through legislation. However, the implementation partners thought that HMCs was relatively a tiny experiment that may fail to grab the attention of provincial or federal authorities. The members of HMCs were more positive on the future prospects of these committees. The district health officers thought giving permanence to these committees through a higher-level legislation was crucial. According to them, a notification by a district officer has a time limit, and does not enjoy protection like a piece of legislation. However PRIDE, through their conceptual and operational framework of this initiative, was able to institutionalize the HMCs at the District level. The good performing HMCs did contribute to the health service delivery, which is the prime objective of such initiatives. Furthermore in poor resource settings like Pakistan, having a voluntary model of working, having the capacity to materialize contributions and the ability to mobilize community resources are some attributes of the HMCs that in our opinion provides a unique opportunity for the policy makers to explore the potential of HMCs further.

BACKGROUND

What is community?

The term *community* has been defined in various ways. According to Merriam-Webster's dictionary (1), community is "a group of people with a common characteristic or interest living together within a larger society." A public health definition was provided by McQueen (2) that describes community as a "group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings." When the focus is a community, those affected may include people who share a common place e.g. a rural or urban neighborhood, or even an experience e.g. being a child or living in poverty. Community participation, mobilization and empowerment are overlapping concepts in public health. According to Rosato et al (3), *participation* is active or passive involvement of community; *mobilization* is a process through which community individuals, groups or organizations plan, carry out, and evaluate activities in a participatory manner; while *empowerment* is the outcome of this process characterized by community's control over decisions pertaining to their own lives.

Community involvement in healthcare and various strategies

Community involvement is elementary to the success of public health initiatives. Alma-Ata Declaration describes participation to health care as a key principle in Health for All. The fourth article of the declaration states "people have the right and duty to participate individually and collectively in the planning and implementation of their health care". Similarly, its seventh article "requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care"(4) Ottawa charter; another landmark declaration in public health, describes five key strategies to achieve health promotion. Creating supportive environment and strengthening community action are two key strategies in this charter (5).

Public health experts have devised various strategies to increase community involvement or participation in public health. A review of the literature informs that community-based participatory approaches often adopt hybrid strategies including social planning; community development and policy advocacy; and act as a catalyst for bringing change to the community (6-10)). These partnerships are formed with representation from different community sectors; organizations; or constituencies, and together they form alliances to work towards a common purpose (11;12). These initiatives often use a public health framework to pursue goals related to community health and development (6;8) .

The over arching aim of involving communities along side the health sector is to help the health institutions to cater to the needs of the communities; and the communities can demand and control their health outcomes by influencing health services.

Over the last decade community involvement in improving health services has become popular. There is a growing body of literature and a growing consensus that involving communities is crucial for increased coverage of public health programmes. Since this can improve treatment outcomes as well as generate more effective local responses (13).

Community involvement therefore provides an opportunity for community members and health care workers to become active partners in addressing local health needs and related health service delivery requirements. Community participation also enables community members and other stakeholders to identify their own needs and how these should be addressed, fostering a sense of community ownership and responsibility.

Mechanisms of institutionalizing community involvement in health institutions:

As mentioned above that community involvement usually takes into account a number of strategies. Therefore community involvement in health can take many forms. It can be manifested at individual or collective levels. Similarly it can be formal or informal (occurring on an ad hoc or more structured basis) (14)

When it works at an individual level, it can include the use of community health workers, home based carers and lay counselors in order to support the services provided by the formal health services. This can also take the form of involving communities in conducting needs assessments and joint planning of health services, and assisting in the delivery and monitoring and evaluation of these services(15;16).

It is agreed that there are essentially two main modalities through which communities can impact on their own health. One by participating in health activities within the community; for example, community based health care. The second modality is by their representation on local forums which deal with the management of health issues; which include forums like community health committees or clinic committees which in turn help both the service providers and policy makers to align the health services to the needs of the communities(17).

Contributions of community involvement in health care

The developmental literature indicates that the involvement of communities in health interventions is desirable(16;18;19) . As Leonard and colleagues point out that communities have a very good sense of the problems they are facing. Not only this, but they have a sense as to what solutions are most amenable to their communities which may feasibly be implemented in their situation (20). Sound community partnerships with health establishments lead to the strategic guidance of clinics and improved quality and quantity of operations (21).

In Zimbabwe, Loewenson and colleagues (22) found a positive relationship between the existence of health centre committees and improved health outcomes. Similarly Baez and Baron (15) report that in Malawi, community's involvement in planning and managing health facilities at the district level resulted in a more responsive health service. Not only this, the communities have addressed needs

of the health centers in Jamaica, and were responsible for providing fencing, a water tank, the kitchen and refrigeration for a health centre. Thus the community reciprocating and addressing the needs of their health centre (14).

In South Africa, Padarath and colleagues (23) found clinic committees could act as a strategic entry point in facilitating and catalyzing HIV and ARV services. The research showed that where these committees were functional, they played a significant role in education on HIV and AIDS and facilitating dialogue between the community and health centre.

In Zambia, Neighborhood Health Committees (NHCs) embarked on income generating projects to provide home based care for HIV affected families, provide health information, food and medicine during home visits (15).

Apart from the above African examples of community involvement examples from Asian countries also report of similar improvement in health outcomes using community involvement in the health sector. Community participation has also shown to address maternal and neonatal health outcomes. Regarding this Manandhar and colleagues (24) from Nepal reported a significant decrease in maternal and neonatal mortalities through a community participatory intervention with women's groups. Other important findings of this study were that women in participatory groups were more likely to have antenatal care, institutional delivery, trained birth attendance, and hygienic care than those who were not part of the participatory women's groups.

Similarly community involvement in the form of Community Management Committees (CMCs) in Bangladesh (25) showed that within the project sites maternal mortality ratio reduced over time to 186 per 100,000 live births while the national average was 320 per 100,000 live births. These community management committees ensured that high quality, integrated maternal and child health services reached those who need them most. Thus community involvement was attributable to the impact on maternal mortality rates over time compared to where these CMCs were not functioning.

Studies from North America (26-35) have also reported some improvement in population-level outcomes in projects that involved communities. For example, the New York coalition achieved 43% reduction in lead poisoning among city-children within 4 years of the partnership while the level had been consistently higher for ten years before the partnership (31). Another initiative to reduce infant mortality in Boston, which then had one of the highest rates in the nation, achieved a 50% reduction in the infant mortality rate among African Americans within 2 years after beginning the partnership (28). Thus the results suggest that, at least under some conditions, implementation of community participation in health care is associated with improvements in population-level outcomes.

More recently the literature reflects upon another important aspect of community involvement, as a contribution, in the public health institutions. This aspect is referred to as Voice & Accountability (V&A). As defined by Goetz & Gaventa that Voice refers to *the ways in which citizens place pressure on health providers and policy makers to improve health services. This could be by complaining, seeking*

redress, protesting, lobbying or participating in decision-making forums (36). And it is this Voice that can hold both the health providers and the policy makers to be accountable or answerable to the communities for their actions. Or in other words they are obligated to justify their stance or approach and to be transparent i.e. demonstrate that they have delivered. Also important is the ability to enforce a response and to use sanctions if one is not provided. Both these V&A together help the responsiveness of the health providers and policy makers in addressing the needs and concerns of the community. This responsiveness can be in the form of a change in attitude, organizational culture, systems, procedures or policies.

Regarding this a recently published technical brief on *Nigeria Partnership for Transforming Health Systems (PATHS)* reported that involving members of the community through Facility Health Committees led to communities getting their voice heard at the policy level with some indication of improved responsiveness to their needs(37).

Community involvement in health care aims at changing the environment in which behaviors and contextual factors are operating. The premise is that, by changing the environment, this involvement can effect widespread behavioral change and eventually improve population-level health outcomes. Change within the environment (community and systems change) is hypothesized to be an intermediate outcome in the long process of community health improvement(7). Community and systems change refers to new or modified policies, programs and practices facilitated by a partnership to influence the community at large(7;38). Analysis of the process by which this creates environmental change and the variables that affect such change helps to clarify how community participation serves as catalyst for changing conditions that may affect community health. Although community participation facilitates environmental change, determining the degree of attribution is difficult, because weak designs do not rule out other plausible explanations for the observed effects.

It is important to note that measuring the contribution of community participation to more distant health outcomes is another challenge. Visible changes in population-level health outcomes take longer than the lifetime of majority of such initiatives. Changes in most community health areas may not actually be detectable for 3–10 years, whereas the more fundamental community health goals, such as changing income disparities or inequities in health outcomes associated with race, may actually take generations to achieve. There is also an absence of accurate/valid and sensitive indicators for many community health concerns. These and other difficulties may help explain why most studies have only evaluated more proximal outcomes, such as health behaviors, using selected population samples(39).

In conclusion community involvement or participation in public health sector is a promising and an increasingly popular strategy for engaging people and organizations in the common purpose of addressing community-determined issues of health and well being. Although currently limited empirical evidence is available on their effectiveness; however several case studies show improvement in population-level outcomes (both intermediate and distant outcomes) which can be attributed to community participation(39).

Factors influencing the performance of community involvement in health care

Following are the factors that can influence the overall performance of community involvement. All these factors can be a facilitating as well as a challenging factor for community involvement. Thus these factors are discussed collectively.

1. Political commitment

One of the important factors that influence performance of community involvement or community participation in public health sector is the political commitment of the government. Therefore it is the political commitment and local institutional support which is critical for the successful functioning of such community involvement.

The literature suggests that a significant determinant of the success of such partnerships appear to be linked to the level and type of support that is provided at district level (15). Baez & Barron have indicated where such necessary political and material support was provided at district level, the National Health Committees in Zambia flourished. Unfortunately this was not the case in the Free State province in South Africa and in Zimbabwe, where the necessary district level support was missing; it resulted in a failure to incorporate community voices at district and provincial planning meetings(15).

While broad political support is important in creating an on overall supportive context and in providing stewardship, it is at the district and local levels that community participation is operationalised. So District level support or lack thereof is a crucial determinant of the success of community participation initiatives (15;40).

2. Capacity of communities to participate in health care & adequate training for community members to enable participation

Community members may be reluctant to participate in health services due to a perceived lack of skills, knowledge and confidence to engage with health facility staff.

As indicated by Loewenson that communities often lack the information, language, cohesion, organizational structures and capacities for engaging effectively and become disempowered and distrustful in the process (41). Programmes therefore, should include community education and capacity building as a key component in planning for health services (13).

Interestingly Ngulube and colleagues (42) found that some of the weaknesses in the performance of health centre committees (HCC) included the fact that members had an inherent fear of talking to educated people, were unclear about their roles and lacked the resources to fulfill their responsibilities. The same aspect of confusion about roles was reported from Clinic Committees in South Africa which showed that confusion and uncertainty around roles and responsibilities are potentially the most enduring problems facing community participatory initiatives(43).

Similar finding about not having capacity of communities was reported as a factor influencing the performance of Facility Health Committees in Nigeria *Partnership for Transforming Health Systems (PATHS)*. A need was felt for considerable mentoring for the FHCs to be performing well(37). Where it is important to build capacity of the communities for such initiatives, it is equally important to take into consideration the training needs of the community. In the Free State in South Africa, Baez and Barron(15) indicated that while the clinic committee had received training, this had not been determined or planned in conjunction with the community, or had taken into account their training needs.

3. Attitudes of health workers to community involvement in health care

Health professionals can act as important catalysts for successful community participation initiatives. They often are not recognized for their efforts in promoting community participation and often get little support from the health services (14).

Loewenson suggests that constraints to community participation include poor health worker appreciation of the value of their participation. In addition, to this non appreciation, there are few incentives for health care workers to work in partnerships; and they seldom have the benefits of doing so explained to them(41).

Ngulube and colleagues for example found that while health committees were an accepted feature of the Zambian health infrastructure, there was still evidence of resentment from health workers towards these committees(42).

Thus a positive attitude of the health workers towards the communities an important influencing factor for the performance of committees. Ngwenya and Friedman found that one of the most important factors contributing to the success of community involvement was the motivation and encouragement of the community by the nursing staff (44).

4. Clarity of roles and responsibilities of community members

One of the potentially enduring factors that can influence the performance of community participation is the uncertainty about roles and responsibilities of the members. Where these are unclear and have not been clearly articulated, progress and contributions of community participation have been slow (22;40;45). On the other hand where there has been clarity on the expected roles of such community participation as was seen in the case of the Health Centre Committees in Zambia, these committees flourished (42).

Boulle's study of Community Health Committees (CHCs) in the Nelson Mandela Bay Municipality confirmed the reduced efficacy of community participation in the absence of clearly defined roles and responsibilities. It was further reported in the study that older and more experienced members of CHCs expressed concern that the roles and responsibilities of CHCs had "diminished over time and that the health services were not fully conversant with the CHCs roles and functions" (40).

This has also been borne out by work conducted by the Health Systems Trust in South Africa, which found that confusion regarding roles and responsibilities of the clinic committee members had sometimes resulted in strained relationships between health facility staff and clinic committee members. The study showed that, due to a lack of communication and guidance on the roles and responsibilities of clinic committees, some clinic committees had attempted to exercise an inappropriate watchdog role over health facility staff with negative impacts (45).

5. Heterogeneous community representativeness in the participatory forums

Since communities are a heterogeneous group of people belonging to different races, ethnicities, classes and gender. This diversity inherently poses the danger that in creating participatory forums like health committees, due the difference of status among groups, people whose interests and views are most needed are not represented. It is thus important to ensure that all interest groups in the community including the extremely poor and marginalized are represented.

In Jamaica, for example, it was noted that such participatory forums did not traditionally involve the local elites or the very poor and marginalized (14). Similarly Zackus and Lysack in Nepal found that the minorities in the communities preferred not to engage and preferred that professionals handle and serve on community health committees(46).

Boulle found that members of Community Health Committees were often "health volunteers" who were getting a monetary stipend for providing daily support to the health facility staff. Thus concluding that even on the Community Health Committees, the members represented the health facilities rather than

their communities and closely aligned themselves to the staff within the facilities and thus were not neutral as to community interests (40).

Similar issue of representativeness of the District Health Boards (DHBs) in Zambia was raised by Macwan'gi and Ngwengwe who found that it was mostly prominent people that served on the DHBs. These DHBs were found not to be representing the interests of the community and it was suggested that selection and appointment procedures for DHBs in Zambia should be re-orientated towards general community members and women(47).

6. Sustainability of community involvement in health care

In both instances where either the community participation is being financially supported by the government or it is functioning on the traditional voluntary basis; both carry implications on its performance.

For example the Clinic Committees in South Africa were not functioning properly due the poor socio-economic conditions and a context of poverty. The study found that a failure to attend meetings (often due to transport costs) and the lack of a stipend for clinic committee members were some of the reasons why facilities did not have Clinic Committees (43).

Similar resource constraints were seen in the District health Boards in Zambia that were causing them to function less optimally (47).

The World Health Organization's study of 1991 reported that community participation flourishes in socio-economic conditions which are conducive to development. These include adequate staff, logistics and other resources which may be difficult to secure in a resource poor country (48).

Traditionally, the voluntary nature of serving on such health committees can also affect its long term sustainability. This can have negative effects particularly in contexts of high poverty and unemployment, where serving on these health committees can actually be seen as a means of generating income.

Similar trend was seen in South Africa, that the clinic committee members felt aggrieved that members of hospital boards received stipends, while they did not. Clinic Committee members expressed interest in finding routes to being appointed on hospital boards as this was seen as a more lucrative and prestigious appointment than serving on a Clinic Committee (45)

Purpose of the current study

Pakistan launched a community participatory initiative by the name of Family Health Project (FHP) in the 90s'. It was funded by the World Bank, and was an effort to institutionalize community involvement at the District level in the form of District Health Management Teams (DHMT). As a pilot it was launched in Karachi. Due to the lack of political support, the District Health Management Teams (DHMTs) could not be institutionalized. Community participation in the DHMTs was only symbolic. Other than this the implementation model of FHP could not cater to the local socio-political scenario and thus the FHP was abandoned completely (49).

Recently Pakistan has once again seen the launch of yet another community participatory initiative by the name of Health Management Committees (funded by PRIDE/USAID) in one of the Districts of Pakistan as well as that of Azad Jammu & Kashmir. Therefore knowing Pakistan's previous experience in community participatory initiatives and the literature regarding the contributions such initiative make to the health care, we under took this study to explore how these Health Management Committees were performing and what contributions have they made.

Health Management Committees by PRIDE

The project on Primary Healthcare Revitalization, Integration and Decentralization in Earthquake-affected areas commonly known as PRIDE (a USAID-funded project working in Bagh and Mansehra districts) took up the task to revitalize the health system and Primary Health Care (PHC) in these two districts. This included supporting public health management at district and provincial level, ensuring PHC services at the health facility and provider level, engaging people in health planning and implementation at the community level and improving health behaviors at the household and individual level. Apart from this, PRIDE conceptualized and launched a collaborative partnership initiative by the name of Health Management Committees (HMCs) between the community and the Health Department at district level.

PRIDE initiated and facilitated the inception of HMCs in both the districts. This included development of Terms of References (TORs) and negotiation with the governments of Khyber Pakhtonkhawa (previously known as NWFP) & AJK for formal notification of these HMCs as 'committees of department of health.' PRIDE's efforts led to the landmark notification of HMCs being part of the health system by the District Health Dept (EDO & DHO) for 02 years (from Jan 09 to Dec 10). Simultaneously PRIDE and its implementing partners re-organized and formulated Village Organizations (VOs) in the catchment area/villages adjoining the primary health facilities (BHUs and RHCs). PRIDE and implementing partners engaged with established Village Organizations (VOs) and where necessary, activated new organizations. The VOs nominated office bearers like Chairmen, General Secretaries, Treasurers and members, for these committees. To ensure a smooth working relationship with the department of health, the co-chairpersonship of the HMC was given to the facility in-charge at every BHU. Once this process was completed, the newly formed HMCs were provided orientation regarding the TORs and their roles. Capacity building workshops were conducted to help HMCs improve managerial skills as well as develop proposals for funding projects.

PRIDE launched a small grants scheme (up to \$ 10,000) to facilitate development projects proposed by HMCs with the condition that 10% of the total budget had to be provided by the HMCs themselves to start the projects and once the projects would reach a certain level of completion only then the small grants of PRIDE would be released. PRIDE tasked the HMCs with assessing community health needs, developing and implementing activities to improve public health through improved health services and health behaviors. PRIDE established 47 HMCs in district Bagh and 69 in district Mansehra. These HMCs are on their way to complete second year of their life. The HMCs have been contributing towards improving health care at the respective health facilities and adjoining areas. To document the

experience, PRIDE commissioned Human Development Research Foundation to carry out a third party evaluation in the form of a qualitative study to capture the lessons learned from this collaborative partnership. Following were the aims and objectives of this study.

At the time when this study was carried out, 50 HMCs had been commissioned by PRIDE with small grants scheme out of the total 115 HMCs. Some had completed their first phase of projects while others were starting the first phase. Similarly the duration for which these HMCs had been functional was on an average 12 to 14 months.

Aims and Objectives of the study

The overall aim of the current study was to capture the experience of Health Management Committees. Following research questions were explored:

RQ 1: How various stakeholders viewed this experience and what were the main contributions made by the HMCs?

RQ 2: What were the facilitating factors as well as the challenges faced by the HMCs?

RQ 3: How sustainable was this initiative according to various stake holders?

METHODS

1. Study design

Owing to the character and novelty of this initiative, the number of stakeholders involved, and the likelihood of naturally occurring events during its life, a qualitative methodology was considered as appropriate for this study. A qualitative style fits more in such situations because it is flexible and can be varied during the course of the study. According to Miles & Huberman (50), a qualitative method is effective at uncovering the significance that participants/stakeholders attribute to the structure of a program, its processes, events and outcomes. The HMC initiative had various stakeholders including its conceptualizers, implementers, government and community partners, and ultimate beneficiaries i.e. patients, families and community. Knowing 'what' they felt about this initiative and 'why', was crucial and possible only through qualitative discussions.

Experts have elaborated a range of foci that qualitative studies explore during various stages of public health programs. For example, Windsor and colleagues have described four angles that qualitative studies try to capture (51). These include 1) assessing the underlying assumption of the intervention 2) assessing an organization's capacity to implement 3) assessing the reasons for the lack of outcomes and 4) assessing the unintended outcomes.

The new initiative of HMCs could have all of these pros and cons. The underlying assumption was that HMCs will build linkages between a health department that was in the re-building phase, and the community that was devastated after the earthquake. All the questions around this underlying assumption were explored qualitatively during this cross-sectional study.

2. Setting

The study was carried out in District Mansehra and District Bagh.

District Mansehra

District Mansehra is the North Eastern District of the Province of Khyber Pakhtonkhawa of Pakistan. It is spread over a total area of 4,579 sq km, with a total population of 1,152,839. It has an average annual growth rate of 2.4%.

District Mansehra has three sub-districts (Tehsils); i) Tehsil Mansehra, ii) Tehsil Oghi and iii) Tehsil Balakot. In all there are 69 Union Councils in District Mansehra.

District Bagh

District Bagh is one of the eight districts of Azad Jammu and Kashmir. The district is bound by Muzaffarabad District on the north, Poonch District on the south, and Poonch District of the Indian-administered Jammu and Kashmir on its east; it is bound by the Punjab, Rawalpindi District and Abbottabad District of Pakistan's Khyber Pakhtoonkhawa on the west.

The total area of the district is 1,368 square kilometers. The total population of the district according to the 1998 census was 395,000, which is estimated to have increased to 434,000 in 2003, with an annual growth rate of 2%.

District Bagh has also has three sub-districts (Tehsils); i) Tehsil Dhirkot, ii) Tehsil Bagh and iii) Tehsil Haveli

3. Study Population and Sampling Strategy

3.1 Study Population

We proposed that four levels of respondents should be engaged in this study. The levels included those who conceptualized and implemented the idea (PRIDE and its IPs), those who were expected to share their responsibility and authority with the community (District and Provincial Health Department) and those who represented community (HMC members). PRIDE and IPs were expected to inform about the basis of their idea, their implementation experiences and lessons learned. District and Provincial health officials shared their authority with the local community members and had a stake in this initiative. It was necessary to know their views on this experience of sharing. The HMCs were supposed to be the real change-agents battling on-ground. How they viewed this initiative was valuable to triangulate the information and develop a holistic picture.

Last but not the least, the general community or the population from which these HMCs were formulated and who would be the eventual beneficiaries of this health promotion initiative was the fourth level.

3.2 Sampling Strategy for all the proposed levels of study population:

Level one, study population comprised of all relevant staff from PRIDE and its IPs. These included members providing leadership to the project and to the HMC initiative along with community mobilization partner NGOs from both districts.

A saturation sampling technique was employed and interviews were continued till the time no new information could be retrieved.

The level two consisted of senior officials of both districts (EDO & DHO) as well as provincial health department dealing with matters of primary health care. This also included the facility in-charges of the all the HMCs. Similarly a saturation sampling technique was employed till no new information could be elicited.

However during our discussions with PRIDE officials in the proposal development phase, it was pointed out that involving only the district level official was preferable since they were the ones fully involved in this initiative and the notification of HMCs; where as the provincial health dept was more of a silent partner. Therefore officials from provincial health dept were not approached for interviewing.

The third level comprised a total of 116 Health Management Committees (69 HMCs from district Mansehra and 47 HMCs from district Bagh) forming part of the study population. Each HMC was working in and around respective health facility, serving the catchment population from that area. Each

HMC had an elected chairman, a co-chair (vice chair) who was the facility in-charge and 20-25 members who belonged to the same catchment population.

Since we aimed at getting informed about the contributions, facilitating and challenging factors for these HMCs, we devised a strategy to ensure both well functioning and poorly functioning HMCs were included in our sample.

PRIDE provided us with the information on 109 HMCs regarding their annual plan review of 2008/2009 (which included number of meetings held since June 2009 to Dec 2009, number of meetings during this period attended by women members of the HMC, their annual plan reviews and their annual plan achievements).

Based on this information, following two categories of HMCs were defined;

- 1) **Good performing HMCs:** HMCs which had achieved their annual plans or went beyond their annual plans irrespective of the number of meetings held (both with and without 33% women members attending these meetings) in the last six months.
- 2) **Poor Performing HMCs:** HMCs which were either in the process of carrying out their annual plans or had not yet started carrying out their plans or could not carry out more than two monthly meetings in the last six months.

According to the above criterion District Mansehra had 30 'good performing' and 37 'poor performing' HMCs (67 HMCs). District Bagh had 17 'good performing' and 25 'poor performing' (42 HMCs).

As a starting point we randomly selected 07 HMCs (04 good performing & 03 poor performing) from District Mansehra to be approached for interviewing. Similarly we randomly selected 05 HMCs (03 good performing & 02 poor performing) from District Bagh; with the idea that we would continue to carry out interviews till thematic saturation was achieved. Thus ensuring both types of HMCs were included in the study.

The fourth level of the study population was the general community or the population being serviced by the facility and it's respective HMC. We approached the general communities of the HMCs that were included for the interviews.

However during the course of the study we found that the HMCs had not been able to make their presence felt among the general communities for which they were working. This was due to the fact that a short time period had elapsed since the HMCs had started working on-field before this study was conducted. Therefore only three FGDs of the general communities were conducted.

3.3 Participants Interviewed during the study

We conducted a total of 30 in-depth interviews (IDIs) and 13 focus group discussions (FGDs) during the study. Out of these, 14 IDIs and 8 FGDs were carried out in district Mansehra while 9 IDIs and 5 FGDs were carried out in Bagh. In addition, 4 IDIs were conducted with PRIDE and 3 with implementation partners (IPs) of the PRIDE project at various locations. Overall 156 respondents were engaged in IDIs as well as FGDs. Out of these, 133 were male and 23 female participants.

The 14 IDIs carried out in district Mansehra (Table 1) included 6 interviews with chair of HMC, 7 interviews with co-chair, while one interview was conducted with the Executive District Officer Health (EDO-H). All the respondents to these IDIs were male. The total number of participants to FGDs was 83 out of which 14 were females. Six FGDs were conducted with 64 members of HMCs, out of which 14 were female while there were 50 male participants. Two FGDs were conducted with a total of 19 members of local community. All of them were male.

Table 1: District Mansehra IDIs & FGDs

SNo	Union Council	HMC Members (FGD)			Chairman (IDI)	Co-chair (IDI)	Community Members (FGD)
		Female	Male	Total			
1	'a'	6	10	16	1	1	-
2	'b'	2	7	9	-	1	6
3	'c'	0	7	7	1	1	-
4	'd'	0	9	9	1	1	13
5	'e'	6	9	15	1	1	-
6	'f'	-	-	-	1	1	-
7	'g'	0	8	8	1	1	-
Total	07	14	50	64	6	7	19

Note: For the sake of confidentiality, names of the Union Councils are not disclosed. Since naming Union Councils would indicate its respective HMC.

The 9 IDIs carried out in district Bagh (Table 2) included 4 interviews with chair of HMC, 4 interviews with co-chair, while one interview was conducted with the District Health Officer (DHO). All the respondents to these IDIs were male. The total number of participants to FGDs was 43 out of which 9 were females. Four FGDs were conducted with 36 members of HMCs, out of which 9 were female while there were 27 male participants. One FGD was conducted with a total of 7 members of local community. All of them were male.

Table 2: District Bagh IDIs & FGDs

SNo	Union Council	HMC Members (FGD)			Chair (IDI)	Co-chair (IDI)	Community Members (FGD)
		Female	Male	Total			
1	'a'	4	10	14	1	1	7
2	'b'	1	6	7	1	1	-
3	'c'	3	6	9	1	1	-
4	'd'	1	5	6	1	1	-
Total	04	9	27	36	4	4	7

Note: For the sake of confidentiality, names of the Union Councils are not disclosed. Since naming Union Councils would indicate its respective HMC.

4. Instruments:

We developed the study instruments in the light of the literature review, objectives of the study and detailed discussions with the PRIDE team during the development phase of this study. Separate set of guiding questions were developed to be used for interview/discussion with all the three levels of respondents. The guiding questions were accompanied by a brief study protocol that outlined how to initiate an interview/discussion, introduce the study and state the objectives, ask for consent, and carry on with asking the questions after getting due permission from all the participants. These instruments explored broader themes like experiences, success/failures, limiting and facilitating factors, challenges, and sustainability through guiding and probing questions. These instruments were translated in Urdu and then back-translated as has been recommended in the literature (52). (Questionnaires for different respondents attached as annex). Members of the research team were provided a one-day orientation on using these instruments.

5. Data Collection

A research team put together by Human Development Research Foundation interviewed all the respondents. The research team consisted of a total of 10 people. 03 senior investigators from Human Development Research Foundation had extensive experience of research both qualitative and quantitative (Dr Siham Sikander PhD, FCPS, Prof. Dr Shamsa Rizwan MSc Epidemiology, FCPS & Dr Zaeem ul Haq BCC Expert and a Fulbright PhD Scholar), 03 note-takers and 04 transcribers. All the interviews were conducted by the senior investigators.

The team carried out in-depth Interviews (IDIs) with the PRIDE officials, Implementing Partners, District Health Officers, HMC Chairmen and Co-Chairs. Focus Group Discussions (FGDs) were carried out with the HMC members. Participants to each FGD of the HMC members comprised 7-12 members including the female members. Chairmen and Co-Chairs; and HMC members were interviewed separately to

ensure that all of them express their views openly and do not hold back their opinion in the presence of each other. The team carried out the interviews and group discussions, and tape-recorded these with the consent of the respondents. Simultaneous note-taking was also done. The team of researchers included trained note-takers who took detailed notes under headings in accordance with the questions being asked and the responses being given.

6. Data Analysis

A team of professionals transcribed all the interviews and FGDs. The transcripts were read and coded by members of the research team. Data from two districts was separately transcribed, coded and analyzed as a first step. A continuous comparative method of generating the themes/categories was used. The team developed a systematic coding method to mark the responses and highlighted the text in the transcript. These coded responses were tabulated and also compared with the note-takers drafted tables to address any discrepancies, ensuring accuracy of the theme/category. This exercise was carried out to generate HMCs experience from each district at three levels including PRIDE and its IPS, Health Department and the HMCs level. The synthesized data from two districts was then compared and combined to finalize the overall themes emerging from the study.

7. Limitations of the study

Before presenting the findings results, some limitations of this study are discussed below.

Firstly, this study had only 14% (23 out of the total 156 respondents interviewed) women as respondents. We had hoped to get more but many of the women members of the HMCs or the communities were not available for interviewing.

Secondly, senior health officials from state and province level were not approached for interviewing. However retrospectively we feel this was a limitation as their views on the sustainability of HMCs would have been invaluable.

Last but not the least; we had originally planned at least 12 FGDs with the general communities served by the HMCs. However we had to stop after doing only 03 FGDs since the general community was still unaware of this initiative and the interviews could not provide any substantial data. Thus this study does not report the views of the general communities.

RESULTS

The following section presents the findings under four broad categories; Contributions made by HMCs, Facilitating factors, Challenges faced and Views on sustainability.

1. Contributions made by HMCs

1.1 Development of a collaborative partnership with Health Department

Developing a collaborative partnership between the community representatives and health dept through these committees was one of the key objectives of PRIDE. It appears that the HMCs and the health department were able to build the foundations of a two way partnership. This collaboration materialized due to the realization of each others role and a sense of ownership on part of both the stakeholders. It appears that HMCs comprising of members from the local community, started recognizing the facilities and its problems as their own; and felt a sense of responsibility towards solving these problems. A facility in-charge in district Mansehra shared that *HMC is becoming a public-private partnership. They (HMC members) don't see the hospital as something alien to them, but as something established for the community, and therefore realize a responsibility towards its improvement.* As a project that sowed the first seeds of this initiative, PRIDE feels that a sense of partnership is one of the important achievements. According to PRIDE, *HMCs have become champions of their facilities and key ambassadors of their facility needs which is a landmark achievement.*

The HMCs have been developing annual action plans in consultation with the staff of health facilities through regular meetings. These meetings facilitated the identification of problems faced by the facilities and helped prioritizing them accordingly. HMCs, working in tandem with the facility staff, have been addressing these problems one by one over a period of time. According to the implementation partners in district Mansehra, *there were some HMCs that had identified 7 to 8 problems to be solved in the first year, they solved those and are now drawing new action plans for the second year to address other problems.* This prioritization of problems while working as partners was endorsed by the health department as well when a facility in-charge in Bagh shared: *we put our problems at the facilities in front of the HMCs in the meetings and they try and help address them.*

This partnership had an additional dimension of providing the leverage for the facility staff to talk about facility problems with their higher officials, and advocate for increased and appropriate resource allocation at their hospitals. Facility staff especially the officers' in-charge from both districts shared that *Certain issues could not be discussed directly with our DHO/EDO in the past. After HMCs, we were able to discuss these issues in reference to the HMCs and ask for favorable decisions.* Describing their satisfaction on the assistance they received from HMCs, these officers said *HMC members have been very cooperative and helpful and we are very satisfied with them.* The members of HMCs also realize this partnership and the responsibility that comes to them through this. According to members of

HMCs in district Bagh, *We have become more aware of our health issues compared to the past, and the role we can play in improving the health situation.*

However it is important to note here that this vibrant partnership was not present across all the HMCs included in the study. At places it was thriving, while in other places it was minimal thus rendering the HMCs almost non-functional.

The HMCs with a vibrant partnership had certain attributes that helped in developing this partnership. For one, these HMCs had a dynamic set of members who were motivated to make a change. These members had a background of teaching or social work and getting such members in the HMCs was in turn attributable to the selection process. This selection process of HMC members will be discussed further in the sections below.

At the same time the facility in-charges took interest and played a very supportive role in developing this partnership. The facility in-charges were motivated and guided the HMCs to become more productive, thus helping the partnership.

Apart from these two important attributes, the regular meetings also helped bringing the two partners closer and helped the overall process of building the partnership. Thus where these attributes were missing the process of building the partnership suffered causing the HMCs to be less functional.

1.2. Improvement in physical environment of health facilities

It appears from the discussions and interviews that the HMCs were able to contribute towards improving the physical environment and infrastructure of the facilities. This was done in the form of getting water supply to the facilities, constructing boundary walls or getting link roads made to the facilities. A facility in-charge from district Bagh said *Water is a basic need and very important for hygiene at the facility; HMC members have helped solving this years-old problem by getting water supply from adjacent village.* This was reiterated by another in district Mansehra: *One of our prime needs was water, and now with the hand pump installed in our facility through our HMC, we can rest easy.* Similarly access to the facilities was also one of the problems faced by some facilities. This issue was also addressed by

Text Box 1

Installation of a transformer at Khawari Health Facility through donations made by HMC Khawari (District Mansehra)

Khawari Health Facility was faced with the problem of electricity for the last two years due to a faulty transformer.

This issue was related to another government organization called Water & Power Development Authority (WAPDA). Despite repeated requests made by the facility in-charge to WAPDA, the transformer was not being replaced. As a consequence the facility's dental unit & lab had become redundant and no vaccines could be stored as well.

This issue was brought to the HMCs meeting and Khawari HMC prioritized this as an issue and took the initiative to gather donations from the community and approached the SDO themselves and pressurized the department to install the new transformer on immediate bases.

the HMCs. This was affirmed by a facility in-charge from district Bagh saying, *we have constructed almost a kilometer long link road leading to our facility, this was essential as many delivery cases could not come up into the facility.*

Similar views were shared by a facility in-charge from Mansehra when he shared *our facility was cut-off from the main road and we needed a link road for easy access; land owners were not giving us permission to build a link road going through their fields. HMCs not only convinced the land owners to give us passage but they also got the link road built.* Helping facilities have their boundary wall to block trespassing and administrative issues was another contribution made by these committees. These improvements in infrastructure were realized through the small grants scheme and mobilizing the community resources. Through meetings and consultations between the members and the facility in-charges the HMCs prioritized their issues and made project proposals and implemented these projects by receiving funds from the small grants scheme.

1.3. Facilitation in health service delivery

The discussions and interviews revealed that HMCs were successful in creating an environment of improved health service delivery. This was achieved through deployment of staff at health facilities, ensuring their regular attendance, setting up availability of services for 24 hours, improved procurement of supplies and medicines, and facilitation in the National Immunization Days (NIDs).

HMCs recognized that improving services at facilities required having adequate staff at their facilities. Special need was felt about the availability of Lady Health Visitors (LHVs) and Female Medical Technicians (FMTs) who could provide services to the women folk. Such needs were identified and put up in annual plan meetings. Using the forum of HMCs, the chairman and the members approached the District Health Officers to formally ask for staff to be deployed at their facilities. As a result of repeated applications, many of the HMCs were able to get staff for their facilities. The chairman of one HMC in district Mansehra shared: *We had been repeatedly asking for a doctor for our facility. Since I have my connections and through the support of all the HMC members we were able to get a medical doctor for our facility. Since his arrival, the turnover of our OPD has increased. We have put up beds for indoor treatment as well.* This deployment of staff by HMCs in turn led to increased turn over of patients, thus further facilitating provision of health services for the communities.

There have been examples where there was no suitable residential place for the new staff to house, so HMCs first made residence available for staff members. *We didn't have a doctor or a medical technician in our facility. Without a place for them to lodge in, nobody would stay here for more than a month. So first we put up a place for the doctor, and then approached the District Health Officer for a doctor. Now we have a medical technician that stays here in the facility* said the Chairman and members of an HMC from district Bagh. Thus getting staff deployed and providing an enabling environment for the facility staff actually facilitated provision of better facilities to the community; which is a contribution of these HMCs in improving health services.

Another aspect of contributing towards service delivery by the HMCs was through improved attendance of facility staff.

The HMCs ensured regular attendance of the staff at the facilities. According to respondents, the staff members especially the technicians and vaccinators regularly attend to their duties now as compared to the past. However this has not been without resistance and frictions. *The HMC members come here and interfere with our routine working. They start checking the attendance registers and if they find someone absent they start making noises* said a facility in-charge from district Bagh. A facility in-charge from Mansehra shared: *Members on their own reported some people directly to the EDO. Sometimes they (HMC members) reported some staff members in the newspapers. This does not help anyone.* It appears that in the beginning, the HMCs were relatively inexperienced and they also faced resistance from the facility staff.

With gradual building of mutual confidence and relationship, this friction decreased and concerns were minimized over time. A facility in-charge of HMC Mansehra said *I suggested to my HMC that if you see some staff being regularly absent, instead of reporting this directly to the EDO or going to the newspaper we should bring him/her to the HMC meeting and inquire about it. If that person has a problem we should help and if that person still remains absent from work, then I'll personally report this to the EDO.*

As discussed above, with the building of a mutual partnership over time, the commitment on part of both the partners and suggestions from facility in-charges this early period of friction was addressed and the attendance of facility staff regularized.

The HMCs of some Rural Health Centers (RHCs) in District Bagh, report that they established 24-hour maternity services in their facilities. Some HMCs reported that they were able to get Lady Health Visitors posted at their centers; and supply the necessary equipment which has been pivotal to getting the service going. A facility in-charge from district Bagh said: *We now have maternity services round the clock. The HMCs helped in raising awareness in the community that our facility had maternity services and trained personnel and women should get their deliveries at the centre. Our facility has seen an increased turnover of deliveries through the efforts of the HMC members.*

Text Box: 2

HMC plays an important role in NID activities in District Mansehra

"Since the formulation of our HMC, we conduct a special meeting prior to the beginning of every Polio Campaign. All the members help identify any areas that were not covered in the previous campaign and arrange for transport and a chaperone for the LHW. They also get announcements made from the mosques for the community and the importance of polio vaccination".

"Now I rest easy as my HMC takes care of the arrangements. I would say that they (HMC Chairman & Members) have become my hands and feet. Facility In-charge

It is worth mentioning that a simultaneous intervention in the form of social marketing and branding was undertaken by PRIDE for certain facilities in District Bagh only, especially RHCs for maternity services. PRIDE also took the initiative to get trained female staff for deliveries deployed at these facilities and run the Emergency Obstetric Care (EOC) trainings in these facilities that were branded. Therefore it is difficult to ascertain whether it was the HMC's role in getting the 24 hour maternity services set up at RHC's or it was PRIDE's intervention independent of HMC's role that led to the 24-hour services and a subsequent increase in the overall turnover at OPDs.

One facility in district Mansehra have been able to advocate the need of a maternity centre at their facility in front of the EDO Mansehra and PRIDE and have gotten funding for a maternity centre which is almost ready. They have also established 24- hour services at their Basic Health Unit. In case of an emergency, the facility in-charge is called over the mobile phone and he informs his female staff and other staff members to get to the center and if needed, they also arrange for transportation for the patient using their mobile phones to coordinate this. This is an exceptional case, and shows the commitment of the facility in-charge and HMC members support for such a service at a Basic Health Unit. And this commitment has led to an increased turnover of patients at that facility.

HMCs also facilitated service delivery through their supportive role in Government's Polio Campaigns. HMCs have been forth coming in their support by not only identifying any uncovered areas in their community, but also providing transport and chaperones to accompany the Lady Health Workers in far flung areas. HMCs assisted the campaign by getting the Imams (Clerics) of the mosques to make announcements about the time and place of immunization in the respective areas.

Another contribution of the HMCs in service delivery has been by getting the quota of medicines re-appropriated because of the increased requirement at the respective facilities. A facility in-charge from district Bagh shared: *Last year we attended 4000 patients in our outpatient department but the number rose to over 5000 this year because of the HMCs awareness raising campaigns in their communities. I had to ask for an increase in the quota of medicines. The HMCs has played their part in this due to their presence and pressure on the health department.* Some of the HMCs have not only contributed in getting the set quota of medicines increased but were also able to help expedite the process and avoid procedural delays in procurement of medicines. The need to increase the quota has been reported to be secondary to the increase in the turnover of the OPDs. *HMC has helped speed up the procurement procedures at the health dept, now it takes much less time to get medicines supplies due to the forum of HMCs* shared a facility In-charge from Mansehra.

In summary the HMCs contributed by getting a dynamic two way partnership going which was the key milestone. This in itself caused other contributions to get materialized. This partnership developed a voice that could communicate directly to the District level health officers for deployment of necessary staff. Or address certain procedural delays in procuring medicines or getting the quota increased by the health department. Similarly the HMCs could advocate to their community to help address the need of building link roads by giving passage through their lands. It was this partnership that helped identify and prioritize the needs of the facility and address them one by one.

The other very important contribution of these HMCs has been in improving health service delivery. As mentioned above this was done by getting staff deployed, ensuring regular staff attendance, timely procurement of medicines, directly supporting the health department in NID activities as well as establishing 24 hr services at some places. Thus some of the HMCs contributed to one of the prime objectives of such initiatives and that is improving health service delivery.

2. Factors that facilitated the HMCs

Number of factors facilitated the overall performance and effectiveness of the HMCs. We describe those factors as 'facilitating' that helped in formulating these committees, assisted in the functioning, or played a role in achieving the objectives of these committees. The nurturing of these committees by PRIDE, representation of community within the HMCs, collaborative nature of the initiative, acceptance of these committees by the health department, and the local leadership that seems to have maximally availed the opportunity are some of the factors that facilitated these HMCs.

2.1. Fostering the leadership

Most important among the facilitating factors is role of conceptualizing and nurturing these committees played by PRIDE. PRIDE had a clear conceptual and operational framework for the development of this initiative. So conducting orientation workshops, workshops on how to develop and implement projects were part of the operational framework. All this in turn helped the development of leadership within the HMCs. This leadership took this initiative to the next level where the HMCs identified their needs and prioritized their issues. As representatives of PRIDE explained, *they conducted a lot of workshops for the committees on how to develop annual plans, how to look at the public health issues and service issues, how to determine activities, how to determine responsibilities and timeline resources.....so a number of trainings were carried out.* This capacity building helped the committees take care of their affairs independently during the course of the project. A partner organization shared: *HMCs were provided with a template for developing proposals after their trainings; they have been putting up proposals ever since on their own without our guidance.*

The committees developed action plans, identified community resources (both in the form of human resource and financial resource), developed project proposals, got funding secured and successfully completed the projects. According to chairpersons of committees from both the study districts, *PRDIE made us aware and showed us the way through the training workshops; and we were able to develop proposals, get funding and complete projects.* It seems the activities in the form of orientation and capacity building workshops for the HMCs successfully achieved their objectives. There was a conscious effort on the part of PRIDE to develop the capacity of these HMCs and to enable them in running these committees efficiently. In their own words: *People are already aware of what they need, and can prioritize their issues; so there is plenty of leadership out there we don't have to develop it, all that we did was perhaps get the focus of communities on how to get to the outcomes.*

2.2. Community representation in HMCs

Part of the conceptual framework that PRIDE had for this initiative was to have representation of the community in the HMCs. This was done by a two step process. The first was forming or in certain places, merely re-activating Village Organizations (VOs). These VOs were formed in 10 to 12 villages that were in the catchment area of the facilities. This process of forming or re-activating VOs was facilitated by the implementing partners of PRIDE in both the districts. Once the VOs were established, each nominated two members from their VO to be sent to the forum of HMCs. As the next step in the formulation, this group of 20 to 25 people elected the most appropriate person as the Chairman, General Secretary and rest of the members of the HMC. Thus this two step approach was carried out for the formulation of the HMCs thereby having representation from the entire catchment villages that a particular facility served. As one of the PRIDE senior officials narrated that *In order to have community representation in the HMCs, we developed a strategy of having VOs in all the villages of the catchment area. We wanted to have an exclusively inclusive approach in ensuring community representation at HMC level.*

Commenting on the process of electing the members of HMCs, a participant from Bagh narrated: *We had a gathering of about 40 people; all senior respected people had come from villages. The Councilor and Nazim were also present. We elected a person through a show of hands (voting) in favor and not in favor of a particular person.*

The process of choosing the office bearers of a committee was left to the members of the committee and they adopted the method that suited the most according to the local situation. A committee chairman from district Mansehra shared: *Once all the people nominated at VO level were present, the IP asked us to elect members and chairman for the HMC. We thought we will not elect but instead we'll select our members through consensus, and we need more time. We picked only those people who were motivated and active and were educated and well known in their communities. Today we have only active and hard working people who can spare time for the HMCs.* Leaving this process of decision making to the committee members helped build the confidence of its members and they did not feel as if they were being directed by pre-contemplated decisions. Chairpersons of committees from both the districts shared: *Either selection or election of the members which is backed and supported by the community should be done.*

Text Box: 3

Selection of the members and chairs of HMCs- views from both Bagh and mansehra districts

“Selection of the members and chairs is very important. It should be through consensus and people who are activists and can give time should be nominated from the VOs” – Chairman & Members HMC Mansehra and Bagh”

Our discussions with various stakeholders revealed that the process of ensuring representation within the committees was crucial. From the outset the people coming from the VOs wanted only those people in the HMCs that were activists and motivated to give time to the HMCs. This motivation and commitment among the HMC members or chairmen made a difference in the overall performance of HMCs. The committees included all the castes or clans when the HMC was formed. They also had people from the villages that the community perceived ought to have been present and part of the HMCs. This level of representation in the HMCs made a difference in the overall effectiveness of some of the HMCs.

2.3. Collaborative nature

The collaborative partnership between the community and the health facilities became a facilitating factor for both the partners. This collaboration which in turn developed into an enabling working environment helped the HMCs achieve many of the targets that they set for themselves. These targets were developed through regular meetings and having discussions among the facility in-charges and the HMCs to make decisions in prioritizing the goals. Thus these meetings led to developing action plans and finding solutions to issues. This process was further helped by the developing sense of pride and ownership among the HMCs regarding their role in health system and the things they had done through small grants scheme. Officers' in-charge in both the districts commented on the process of making decisions in the HMCs by sharing: *We bring our problems to the HMCs; we discuss it, if two thirds of the members agree to some issue it is passed as a resolution.*

It was the ongoing collaboration that helped HMCs implement small grants projects effectively, help the facility staff in polio campaigns and help other areas of service delivery as mentioned above. This partnership got staff deployed at facilities and helped voice the needs of the community at the facility, and in front of the District Health Officers. The element of mutual respect and trust that developed as the sense of partnership increased; this brought the facility and other staff closer to the community. A chairman of a committee from Mansehra described this mutual confidence: *We have a very good environment and the facility in-charge takes a lot of interest in HMCs and guides us how to be more productive and achieve our targets.*

Similarly a facility in-charge from Manshera commented on the sort of trust he had for his HMC through this collaborative nature of partnership, *now I rest easy, as my HMC takes care of the arrangements for the polio days. I would say that they (HMC Chairman & Members) have become my hands and feet.*

2.4. Small Grants Scheme

The small grants scheme introduced by PRIDE also helped HMCs materialize the goals and targets that they set in their annual plans. This small grants scheme provided HMCs an amount up to \$ 10000 for development projects. However the HMCs were asked to share 10% of the total budget in any of the proposed projects. PRIDE through their capacity building workshops for the HMCs helped HMCs to develop proposals and develop their skills to manage the funds and implement projects.

Although the small grants helped the HMCs to materialize their projects, it did other very important things for the growth of the HMCs. This gave the HMCs the opportunity not only to develop proposals but actually get funded and implement projects. So in our opinion this was a valuable experience for the HMCs. Apart from this the HMCs had to mobilize 10% of financial resources of their total budget. So they went to the communities to look for donations. This too in our opinion was a valuable experience for the growth of the HMCs that did manage to get funded; as this would have increased their advocacy skills.

And it was this experience that gave confidence to these HMCs in thinking that now they could sustain themselves even when PRIDE leaves. This view of the HMCs that they can sustain in the long term will be discussed in the section on views about sustainability.

Regarding the small grants scheme, HMCs from both the Districts shared: *Through meetings we prioritized our goals and then developed proposals for which we were funded. In order to have it supervised and monitored we constituted sub-committees to oversee our projects during implementation phase. We knew we could get the best possible outcome in the least amount of money.. So we wanted to ensure monitoring and transparency through the sub-committees. We appointed the most suitable people with relevant experience from amongst us to supervise and monitor these projects on ground.*

This launch of small grants scheme however was not free of the initial problems. According to PRIDE officials, *At first a lot of people were not interested when HMCs started developing plans, but when HMCs were given funds amounting to \$ 10,000:00 all kinds of people suddenly became interested. They started interfering in the HMCs, they pushed to get into the HMCs and to add to it, they wanted to chair the committees. They even approached ministers and members of the parliament for this purpose. They even started pressuring the EDO/DHO to get the composition of the committees changed.* So while this small grant scheme provided the initial seed money for a cause, it also brought political interference from outside just to influence and control the HMCs and the funds that were being allocated for projects.

It appears that the small grants scheme did pose some issues or challenges. Yet it infused a powerful element into the functioning of HMCs. The grants motivated and catalyzed the process while helped the overall growth and maturity of the HMCs at the same time. The grants and the process of grant making developed the capacity of HMCs to put up project proposal and implement them. This in turn helped develop a sense of ownership, commitment and pride among the HMCs that they can continue to play their parts as effectively as possible. A facility in-charge from district Mansehra stated: *We had a lot of negative minds trying to hijack the committee for their political interests. We had to struggle and fend them off, and both I and the HMCs members agreed not to let such people take charge of the HMCs. After a while these gradually lost interest and one year down the line, we have enough motivated people in the HMCs.*

2.5. Notification of HMCs by the District Health Department

With successful establishing of the HMCs, the consistent negotiations of the project with district health department brought results and HMCs were notified as official committees by the district health department. This was a strategic step that helped committees earn legitimacy and credibility. HMCs from both the districts shared that *with the notification of HMCs as part of the health dept, we felt confident that now the facilities will treat us differently and will acknowledge us.* According to PRIDE officials, *we wanted to institutionalize community participation in the health system which became possible through this notification.* This notification proved a factor that facilitated the further processes and helped committees achieve their objectives. The notification facilitated the process of community participation at the facility level. All the facility in-charges were briefed by the District Health Officers (both Mansehra & Bagh) about this initiative and were advised to facilitate the health committees.

This notification made the HMCs an entity endorsed by the health system. The sense of ownership on the part of committees and partnership on the part of health department increased with this notification. The communities now had an officially acknowledged access to the matters of their health facilities. The notification coming from the offices of the senior most health officer in the district was binding on the facility staff including the officer in-charge. According to a facility in-charge from Mansehra, *we were called at the District Health Office and briefed by the EDO about the HMCs and our roles in HMCs and that's why it was important to work with these committees.*

In summary PRIDE had a clear conceptual and an operational framework for the development of HMCs. This framework had the provision of fostering local leadership through a number of capacity building workshops for the HMCs and this fostering of leadership took the HMCs to the next level of performance. PRIDE was also cognizant of the importance of having representative HMCs so the process of formulating HMCs with representatives of the community also facilitated the functioning of the HMCs.

Apart from these important factors the collaborative nature of the partnership between the facilities and the HMCs also became a facilitating factor and helped setting the priorities by making mutual decisions.

Similarly the small grants scheme helped the HMCs to materialize their targets and goals that the HMCs had set in their annual plans.

Last but not the least, notification of HMCs from the district health office further facilitated the functioning of the HMCs as this was binding for the facilities to cooperate with the HMCs and the HMCs felt more confident.

3. Challenges faced by HMCs

Number of factors hindered the overall performance and effectiveness of the HMCs. We describe these factors as 'challenges' that were faced either in formulating these committees, during the course of their functioning, or factors that played a role in hindering these committees to achieve their objectives. Therefore not being able to have representation within the HMCs, initial conflicts with the health facilities, low level of motivation of HMCs or conflicts within the HMCs were some of the challenges that HMCs have faced. One other challenge that HMCs did struggle with was the active participation of women in decision making.

3.1. Lack of community representativeness in some HMCs

As discussed above, PRIDE had a clear strategy for the formulation of HMCs. This strategy ensured that the HMCs that were eventually formed were representative of their communities. And this in fact became one of the facilitating factors for the HMCs; since these had all the representatives from the villages in the catchment area. However, during the course of our study, we found that some of the HMCs were not representative of their communities.

PRIDE had tasked their IPs to carry out forming VOs in the catchment villages and this process of forming VOs is a time consuming and effort demanding task. It requires having all the key people from the villages fully on board before going ahead with such initiatives. There have been time constraints on part of the IPs to carry this task out and in the words of an IP in Mansehra: *We carried out the task of getting VOs formed and in some places re-activated in just a years time which was actually a task of at least three years.*

These time constraints led to not having all the key members or influential families on board prior to the forming of the VOs. This in turn led to not having important members of the communities' part of the VOs and eventually a missed opportunity for them to be nominated for the HMCs.

A facility in-charge from Mansehra HMC said: *Initially when the HMC was being formed, in our area, a village was missed and when that village came to know that they did not have their representation in the HMC they strongly protested against this.* He further narrated the current dynamics that had set in their HMC due to this: *That village had protested very strongly and important elders from that village thought that others were preferred over them and were upset because of this. So it took a lot of effort to bring them on board. Now the current situation is that we do have people from that village in our HMC but some of the other members don't want them in the meetings and vice versa. And as a result these people (HMC members) don't come and attend the meetings regularly*

This same issue of not having included some of the important villages during the formulation phase was indicated by a facility in-charge of Bagh HMC who thought some important villages were left out. He said: *I had suggested them (PRIDE) to have 20-25 villages surrounding our facility to be included for the selection of our HMC; not just the big villages around our facility.*

We know through our discussions with PRIDE & IPs that approximately 10 to 15 villages in the catchment area of the facility were included in the formulation phase of VOs and HMCs. However the above mentioned facility in-charge's suggestion does point to the need of having more representation at VO and HMCs level.

In the opinion of an other facility in-charge from Mansehra who him self has been a very active social worker and a resident of the locality commented on the same aspect of representativeness of the HMCs and said that *they (Implementing Partner of PRIDE) came to me with a list of the members of the HMC. I told them that I know a lot of people who are very active and motivated from many villages in the catchment area and they are not on your list. I asked them (IP) to verify if those people were part of the process and if they were not then I will not accept this list of members.* He further reported that *some how some important people were missed from some villages and due to my insistence those people had to be included and as a result this process took another two months. I know PRIDE would not have liked this but having right people in the process is important..*

Chairman of the same HMC from Mansehra said: *People approached us and protested when they came to know that their villages were not included in the HMC. We assured them that their issues will also be addressed.*

Similarly, the members of an HMC from Bagh commented on the same aspect and said: *We had to include some villages that were originally not included in the HMC as those villages wanted to be part of the process.*

This and the above mentioned examples/quotes suggest the importance of taking the important community members on board and perhaps at places including more villages may be needed if the situation warrants so. And all of this needs time and considerable effort.

It is also important to keep in mind that the IPs had a mammoth task of forming a huge number of VOs in a very restricted time period. And due to the time constraints, at some places the HMCs were not representative of their communities and this did pose a challenge.

We observed the HMCs that did not have community representation were also facing the challenge of having chairs and members that were less committed, less motivated and did not give time to their HMCs. This was not the case where the HMCs had representation from the community. In fact the HMCs which did not raise the issue of representativeness had a dynamic set of members led by a motivated chairman. Perhaps for the HMCs that did not have community representation, had missed the opportunity to bring forth committed, motivated and time giving people.

One of the Chairmen HMC from Mansehra said: *Getting these (HMC members) together regularly for our meetings is challenging. People don't have time to give to the HMCs.*

The facility in-charge of the same HMC said: *I alone cannot do everything; they (HMC members) have to take the initiative. They don't take interest, don't come to the meetings.*

One similar HMC from Bagh reported that *it is very difficult for us to give time to the HMC as we are not paid for this and we have to earn a livelihood too.*

Or as the members from another HMC of Mansehra shared that *our chairman is not here as usual, perhaps he has had a good yield of wheat from his land and has gone to the market to sell it and make money.*

Since this initiative is based on voluntary work so it is understandable that people would also have to make a livelihood for their families. So as a result they may not have had time to give solely to the activities of HMC. Nevertheless this concern of members or chairs not having time to give to the HMCs due to any reason was not raised by the HMCs that had representation of the community.

3.2. Conflicts and frictions between health dept & HMCs:

The other challenge that came out during our discussions with PRIDE, facility in-charges and the HMCs was this element of friction between health dept and the HMCs in early days of this initiative.

As with any other collaboration, it takes time for the partners to develop a certain level of confidence and comfort before they can actually start working towards their mutual goals.

Before the beginning of this initiative some concerns and reservations from the health dept were flagged up.

One of the senior PRIDE team members in our discussions pointed this out and said that *the district health officers deliberately opposed this idea of health management committees. They were apprehensive that this will eventually pose more problems for them and will become a forum for rioting and agitating.*

Despite these reservations from the health dept, the HMCs eventually did get notified and the facilities were informed and briefed by the district health officers of this initiative. The facility in-charges too had some reservations of their own. As one of the in-charges from Mansehra reported his concerns and said *I had reservations about this initiative. I thought that this was a tactic to impose monitors on our facilities.*

Now with this mind set of the health department and the fact that the HMCs did get notified and it became binding for the facilities to accommodate and cooperate with the HMCs; thus the health facilities took time to adjust to this new situation. This slow, hesitant start was reported by chairmen and members of HMCs from Mansehra and Bagh: *In the initial few months we used to go to the facilities and would just sit around and come back. The facility in-charges would not engage with us.* Coupled with this mind set of the health dept and a hesitant start was the fact that HMCs were notified and PRIDE conducted orientation workshops for the HMCs regarding how they can contribute in health issues ; so they wanted to exercise their powers and tried to dominate the facilities. On the other hand facilities were just given a briefing by the EDO/DHO that HMCs have been notified as part of the health facility. So the facilities were not entirely clear about the exact role of the HMCs. Therefore such dynamics did lead to some frictions in the early days. .

The HMCs wanted to keep a close check on the facility staff's daily attendance and wanted to keep a track of daily activities of the facilities. One of the facility in-charges from Bagh voiced this aspect out and said, *HMC members think that their sole duty is to see who has come who hasn't, check which facility vehicle left and when did it come back? We know what we are doing and what our duty is. They don't know what their role is?*

Similar views were shared by a facility in-charge from Mansehra and said *a person would come into the health facility take a chair and sit in front of me and starts asking me to show the attendance register. Ask me who have come on duty and who haven't? And then expects that I'll answer him.*

In two instances this escalated into conflicts between the two, and eventually affected the overall performance of the HMC as the partnership did not get of to a good start. And as a result the HMC was viewed by the facility in-charge as something negative and non productive. As one of the facility in-charges from Mansehra HMC said: *If you ask me this HMC has zero output in fact negative output. All they do is give problems to me. I am not a local resident and if I get late they question me whereas there are other staff members too who get late or are even absent. They have also reported me to the EDO. As a result now I don't take much interest as I too am human with feelings..*

Similarly one of the facility in-charges in Bagh commented on such an incident and said, *I asked the Chairman, if somebody from the HMC is shouting, using foul language or beating the staff members inside the facility then it is your duty to stop that HMC member. We have our dignity we are government employees after all.* Similarly an HMC from Mansehra, which had connections with the print media even reported some irregular staff in the newspapers.

It seems that the early days of this initiative were a period of some turbulence which for a very few HMCs continued to be perpetual and did not manage to over come and as a result the collaborative partnership did not take root.

However, there were HMCs that even with a turbulent start to their relations, managed to strike a balance between their roles and managed to tide over these initial conflicts. One of the facility in-charges of Mansehra indicated defining roles for both the partners to make this work as *both the sides (Health Facilities & HMCs) should be clear on their limits and where not to cross these limits. This is a good initiative and they (PRIDE) have done well. HMC is a good forum. I am not afraid of being accountable or being asked questions but please ask in a non-threatening and polite way.* Thus suggesting the HMC how to approach such matters and expressing the worth of this initiative plus showing the commitment to carry the partnership forwards.

Similarly another facility in-charge guided the HMC to overcome this friction by suggesting: *Not to report absent staff either in the newspaper or directly to the EDO. Rather call that person to the HMC meeting and if that person has a genuine problem we should all help him. If even then he/she doesn't comply I will personally report it to the EDO.*

So some good suggestions from the facility in-charges, their belief in the worthiness of this initiative and the realization on part of the HMCs helped both the partners to get over these frictions.

And eventually both moved towards a partnership which did make important contributions as mentioned under the section on contributions made by HMCs.

3.3. Pressures from within and from outside the HMCs:

Another challenge that the HMCs had to face was conflicts and frictions amongst the HMC members themselves. These were the pressures from within the HMCs and were due to the dynamics between the members. Our discussions with them also revealed that they also had to face some pressures/interferences from outside the HMCs.

These conflicts between the HMC members or the members and the chairman have been due to a number of reasons. For example one group (a particular clan or a particular sect) wanted to dominate and take charge of the HMC or if during the formulation phase, some important villages were not included or were not approached for this initiative that too posed some internal problem for the HMCs; since the villages protested and pressurized the HMC for them to be included through the existing members.

As the chairman from Bagh reports of the type of pressure he had to face due to certain family dynamics in there settings, he said, *a very senior and respected elder of our village came to me and said, "I see him (a member of HMC) sitting in the HMC, he is just a blacksmith by profession (Iohaar) and you neglected me who is a Syed (a very pious family linked directly to the Prophet Mohammad's family) and who is not in this HMC*

Similarly PRIDE also reported such pressures that were faced by the HMCs, *we have had severe problems due to Shia Sunni (two sects of Islam with traditional rivalry) members of the HMC to the point of their breaking down the HMC*

The fact that these family or religious influences can overwhelm the scenario is a reality and one of the HMCs actually had to dissolve the elected members and re-do the elections. This was reported by a chairman from Mansehra in these words, *we had to dissolve our HMC and get it re-elected because some of the families from some villages were not included.*

Similarly the HMCs have also faced a lot of outside interference from politically motivated influential people and have caused initial problems for the HMCs. This political interference was seen especially with the launch of the small grants scheme and some politically motivated people saw this as an opportunity to get control of the HMC and the money. With the result that a lot of political pressure came on the district officers to change the composition of the HMCs.

This point was elaborated by one of the senior PRIDE officials as *political interference was definitely an issue. Political interference was a key issue for postings and transfers. It is part of the system and I think that was an issue six seven months ago, we have been able to ride through along that.*

The above mentioned challenge of having pressures from within and outside the HMCs was also something that the HMCs faced in the early days. We observed during our study that over time these

internal and external pressures were addressed in a number of ways. Thus majority of the HMCs addressed these issues and moved on.

For example one HMC had to re-elect their members to settle the internal dynamics of one group wanting to dominate and control the HMC. At another place the facility in-charge being committed to the initiative, reiterated to the members to be positive and work out differences amongst themselves and also to ward off outside interference. This was communicated by both the facility in-charge and the chairman as: *We did have our differences, but we all developed the resolve to use this opportunity to do positive things. We also had some negative interference from outside but due to this resolve of being positive, we were able to resist and keep away those negative influences from outside and have moved on.* In other instances the HMCs had to go back and include people from the villages that were demanding to be included to help address this sort of external pressure.

3.4. Participation of women in HMCs:

Our discussions with PRIDE, health dept and the HMCs revealed that women's participation in HMCs could be described in terms of three levels. Level one was women just attending the meetings, level two was taking part in discussions during meetings and the level three being their role in decision making process. Indicating these three levels, a PRIDE Official shared with us: *I would say we have gotten women attendance, we have some level of participation but we are a long way to develop a shared leadership.*

For the sake of describing our findings regarding the different levels of women's participation in HMCs and the challenges involved; we use the terms "attendance" referring to level one participation and "active participation" referring to levels two and three mentioned above.

The TORs that were developed for this initiative had the mandatory rule of having 33% of women as members of the HMCs. This was achieved by all the HMCs that were formed and notified.

All the HMCs interviewed reported having 33% of women members in both the districts. And all the HMCs that were interviewed reported the challenge of getting women out of the houses and attending meetings. They also reported that active participation of women was also a challenge.

Regarding getting women to attend HMC meetings regularly and have them as active participants one of the facility in-charges from Bagh commented: *these women member of our HMC still do not have that much awareness in them. And apart from the women of this village (which has the facility) none of the women from other villages come to attend the HMC meetings.*

The reason for women not being able to regularly attend meetings was attributed to our cultural and traditional values which restrict the mobility of women in our society. Commenting on this the facility in-charges from both the districts said, *we have our customs and traditions, and having women participating like this and going out of their houses is quite difficult for us.*

Similarly this aspect of our traditional values was reiterated by another facility in-charge from Mansehra as: *these are Pathaans; they have their local customs and say "our women will not go out of the house like this.*

Thus having the women merely attend the meetings was shared as a challenge and its reason being attributed to our traditions. Furthermore having active participation of women was also shared as a challenge.

Through our discussions we found out that the reason behind this was related to perhaps the woman's background. That is if she was merely a housewife then she struggled to actively participate.

As one of the members and chairman from Bagh shared their views and said: *what would house bound women know about issues of the world.*

Similar views were shared by a facility in-charge from Mansehra who commented: *in my opinion a house wife will never be able to play an effective role in the HMC. This needs vision and perhaps a more educated woman compared to a housewife will have better thinking. A housewife made to sit here will never open up and talk freely.*

However if the women had a background of either being social workers or teachers or being a LHW, this seemed to have helped them be more active in participation as suggested by many male members of the HMCs both in Mansehra and Bagh during our discussions with them.

One of the HMCs of Mansehra, however has been an exception to this challenge where not only women regularly attended the monthly meetings but were active participants. They were given an opportunity by the male members to convene and conduct meetings.

We present this as an example of 'good practice' in the text box (4) to not only have attendance but also ensure active participation of women in other HMCs.

3.5. Procedural delays in commissioning projects through the small grants scheme:

Our discussions revealed another challenge that was faced by HMCs and it was due to the procedural delays regarding the small grants scheme of PRIDE.

At the time of this study about 50 HMCs had received the small grants and were in different phases of their projects being implemented. Some had successfully finished their first phase of implementing the projects and were going on to the second phase. While

Text Box: 4

An example of 'good practice' for ensuring women active participation in one of the HMCs of Mansehra

We have 33% of women as members in our HMC. They come from varied backgrounds, some are housewives and some are school teachers and others have the background of social work. They not only attend our monthly meetings, but we have made it a practice that we ask the women to convene and conduct the proceedings of every other monthly HMC meeting. In these meetings they make presentations, discuss issues and record minutes of the meeting. This helps their confidence and makes them feel part of the HMC even more.

We send our women members to attend any workshop or training organized by PRDIE to further their capacity and to interact with people outside their villages. They even presented our HMC proposal for a project to PRIDE's senior most official - Chairman & Facility In-Charge & Members HMC Mansehra

others were just beginning to get started with the first phase. And there were other HMCs that still were developing their project proposals.

As the small grants scheme was launched to facilitate HMCs, some delays in commissioning the approved projects or delays in disbursing installments of finished projects did cause some challenges for a few HMCs

These few HMCs reported that they didn't completely understand what caused the delays in either commissioning an approved proposal or release of installments of completed/implemented projects.

In one of the HMCs this waiting led to a certain level of de-motivation among the members thinking that this was a waste of their time and efforts. On the other hand the Chairman found it difficult to keep holding meetings with the members and not having the answer to this delay. One of such HMCs which had their proposal approved by PRIDE for the small grants scheme were waiting for their installment and said, *we come here take time out for these meetings and constantly come to know that another month has passed and we haven't received the funds despite being approved. So what is the use of wasting time like this talking about the same thing over and over again?*

Similarly the chairman of the same HMC Mansehra reported how difficult his position had gotten in front of his members due to this delay. He said, *all this waiting and no progress has been counterproductive for us. The members keep hearing about other HMCs doing well and completing their projects and ask me why don't we get the funds? My integrity is being questioned. The members have started thinking that I have made some deal with PRIDE or I have taken the money and not telling the truth to the members. I am de-motivated by this so naturally the members will feel the same.*

The other aspect of delays in commissioning approved projects was that it posed some financial burden on one of the HMCs. The chair of HMC Mansehra said that *when we budgeted the project and quoted the prices of materials to be used was different to when we actually got the funds due to a delay by PRDIE. The market has jumped prices but we were committed to getting the best materials for our BHU and did not compromise on the quality and completed the project out of our own pockets.*

Similar delay was reported by another set of HMC members from Mansehra who said, *I am a resident of this place; people know me and have known my forefathers. We are respected in the community. I was able to get a lot of materials like bricks, cement etc on credit just because of my family's credibility. Now due to PRDIE's delay in releasing installments, those people come and knock at my door. I have never had people knocking at my door asking back for their money. I feel embarrassed and ashamed.*

Another aspect that was shared by one of the HMCs from Bagh regarding the small grants scheme was the criterion for approving the proposals. The members of this HMC shared that they were not made clear as to what was the exact criterion of approving projects and shared their frustration by saying that *PRIDE says one thing then goes back on its word. They agree to our proposal then disagree. Then they start suggesting something new which we don't feel is our need or priority. When we protest*

and say that you people are imposing/dictating your agenda they confuse the issue further by talking about “hardware & software” and their ‘policy issues’. Then why was this HMC made if they did not intend listening to our needs. Then they start talking about the DHO and what he wants. Nobody wants to listen to our needs? Perhaps the health dept (DHO) and PRIDE are in on it together and this is just a cover up like many other NGOs.

It is important to note here that PRIDE had to process a lot of proposals and having 50 or so HMCs commissioned in different phases of their projects would have been a challenge in itself for PRIDE. Therefore some delays in this process would be natural and as we saw this was limited to just a few of the HMCs that we interviewed.

In summary the HMCs faced some challenges like not having representation of their respective communities due to time constraints posed on the IPs. Importantly this issue was resolved by taking onboard the communities that were missed and wanted to become part of this initiative.

The other challenge which was only limited to the early days of this initiative was some frictions between the Health Dept and the HMCs. As with any other partnership it takes time for the partners to start feeling comfortable and the trust to build. It is noteworthy that this initial challenge was also addressed by the resolve and commitment shown by both the sides. Once this was addressed it was this partnership that eventually delivered.

Similarly when groups of people engage, there are bound to be some difference of opinion amongst the groups. This is a natural phenomenon and if addressed helps the partnership to grow. There were some frictions that surfaced amongst the members of the HMCs or at times the HMCs faced having external interference from people with vested interests to take over the HMCs. This challenge, too, was addressed by the commitment and the level of resolve of the HMCs to settle their differences and not let outside influences override their agenda of making positive contributions.

The participation of women also was one of the challenges. Due to our traditional values and cultural norms it is difficult for women to participate in such initiatives especially if they are solely housewives. However amidst these norms and traditional values we did see an example of good practice from an HMC which was encouraging women to actively participate.

Then there were a few instances where delays regarding disbursement of funds by PRIDE came up. This was limited to a very small number of HMCs, nevertheless did pose as a challenge.

Overall despite these challenges, the HMCs managed rising above these and eventually became the agent of change on the ground. The important thing is that the larger outcome of addressing issues was done even with all these challenges.

4. Views of all the stake holders on the sustainability of HMCs:

One of the important long term aspects of any initiative or health program is related to its sustainability. Sustainability involves two main areas based on the initiative's effectiveness and the other is based on the capacity of people running the initiative.

If an initiative shows to be effective, then it stands more chances of been sustainable. Similarly if the people involved show that they have both the financial and human resource capacity to run the program or the initiative, then this too helps in assuring sustainability.

Our discussions with PRIDE revealed that they, from the outset, wanted this initiative to be institutionalized in the main stream health system. And for this they developed the TORs along side of the health dept and eventually these HMCs were notified by both the district for two years. Then they did orientation and training workshops to build capacity of HMCs and fostered local leadership. It was also realized by PRIDE team that eventually it is the state and province level policy people that will matter if these HMCs have to carry on beyond the two years mark. This point was explained by of the PRIDE officials as *one is capacity building of HMCs, the other thing is the TORs, this is the kind of documents needed at state and province policy level. Most of the officials at district and provincial level are aware of those documents. I think we need to and plan to do kind of National Forums, but need to advocate more to get some legislation. Legislative cover is the key.*

PRIDE having been able to foster leadership among the HMCs and then further facilitating them through the small grants scheme made HMCs effective in the sense that they successfully implemented projects. The HMCs also showed their capacity to mobilize resources as 10% of the project money was funded by the HMCs. One of the PRIDE officials commented by saying that *we were mindful from the beginning that eventually the HMCs will have to do resource mobilization. There was a conscious decision not to involve international implementing partners but have national networks like existing rural support programs and initiatives like Pakistan Poverty Alleviation Funds (PPAF) as implementing partners and training the HMCs to network and mobilize resources from these organizations.*

So regarding the capacity of HMCs, PRIDE did considerable trainings and plans to do more to further instill capacity. This was reported by PRIDE that *we have done lots of training of HMCs, but we need to do more. They need more mentoring and training in conflict resolution on their own without outside help. We plan to train the trainers form HMCs in the next 6-months of the remaining project time*

In terms of HMCs having the capacity, our research shows that the HMCs were able to develop mutual partnerships with the facilities, prioritized their problems and through leadership addressed these one by one. They were able to get funding for their proposals, did resource mobilization and successfully implemented projects.

This capacity do get things mobilized was also felt by the HMCs and during our discussions HMCs of both the districts said, *PRIDE has shown us the way, now we can carry on doing this.* Similarly the

chairs of from both the districts said *Inshallah (God willing) we have the resolve, motivation and awareness what to do. So we will carry this on.*

However, having reported the resolve and the capacity to carry on, the HMCs did mention their reservations surrounding the issue of their notification being extended or not. They viewed this notification very important for their long term functioning. This aspect of uncertainty did come out in our discussions with them. Both the HMCs at Mansehra and Bagh voiced their concerns regarding this by saying that *we feel if our notification is not extended, the health dept will not let us in the facilities. This attention that we are getting from the facilities and the health dept will disappear once the notification ends.*

Our discussions with the facility in-charges from both the districts revealed that all were in the favor of this initiative and all of them thought this was a useful initiative. In-charges from both the district said, *I think it is a good initiative and it should be there.* One of the facility in-charges from Bagh said *we are trying that it carries on. Inshallah (God willing) it will carry on.* However, some of the facility in-charges from Mansehra did say that eventually it is up to the state and province level to decide for the future of the HMCs. One of the facility in-charges commented *how to get HMCs into mainstream health system is for the state/province to decide. They make the policy we are just part of the system.*

This aspect was also revealed by one of the district level officers and he commented that *sustainability will be ensured only if state and provincial cover is given to HMCs. How long will I hold this office and when will I get transferred is not known and that can happen even tomorrow. And if the next health officer does not see these HMCs useful he will not extend the notification. What will then become of the HMCs? To ensure that it is not just the discretionary power of the district health officer to notify or extend HMCs, PRIDE has to get it legislated at the state and province levels*

However the other district level officer had slightly different view to share with us and he said *this was a one time activity. The people of HMCs are not mature and don't have the capacity to carry this on. They have caused more problems than solve. They have become political. We (Health Dept) are concerned with public health and there are many things that are linked to over all public health like education, poverty, clean water, proper sanitation etc which are actually the responsibilities of other state depts. It is not our duty/work to address the problems of sanitation etc. I feel that HMC is a good initiative but the people are not ready for it.*

Nevertheless both the district level officers did see this as an initiative with some potential although one of them thought that the people at this point in time were not ready for this empowerment.

Our discussions with all the stake holders has brought forth that it is eventually the state or provincial level that will make this decision about mainstreaming HMCs into the health system. PRIDE has shown that this initiative can be implemented and does show some promise, the HMCs themselves think and believe that they can carry on if they have a legal cover and the health dept at the district level also thinks that this initiative has some worth. Since the district health system is the implementer of the

policies made at state and province level, so they will implement this initiative provided it comes from the state or province level.

So the next step forward for PRIDE in terms of HMCs being sustained and legalized is by doing more advocacy at the state and province level. And this was communicated by one of the senior PRIDE officials who said that *I would say that we need to continue in Pakistan to foster an appreciation of the importance of people involvement in service delivery. And I think we have been able to demonstrate it is possible to involve people, not only you get people supporting you but you can actually get better services and that can lead to improved health outcomes. These positive experiences should be documented so there is greater appreciation.*

DISCUSSION & CONCLUSIONS

Involving communities into the health care delivery through HMCs is a new experiment in Pakistan. The formulation of these committees by PRIDE project, their existence for last two years, regular meetings and implementation of some innovative ideas are important contributions. These contributions appear more significant when we look at them in the context of an environment devastated by earthquake, and a culture dominated by indifference and apathy. The committees were able to develop collaborative partnerships, foster leadership and improve service delivery through commitment and implementation of innovative ideas. At the same time, they also faced some challenges and seemed to be grappling with the issue of sustainability beyond the life of PRIDE project.

The collaborative nature of the partnership facilitated many contributions both towards the improvement of service delivery as well as addressing the infrastructural needs of the facilities like link roads, water supply and electricity.

Regarding the contributions HMCs made to help improve service delivery at the facilities being supervised by them, were considerable. They influenced the increase in the number of staff appointed at the facility and also improved their attendance. It seems that this change is attributable to the HMCs being able to develop a voice at the District level and some form of accountability at the facility level. As the literature suggests that V&A is an important aspect of contributions that such community involvements make(36;37). Thus we saw that it was this voice and accountability (V&A) at the District level that had to acknowledge the needs of the community in deploying essential staff at facilities. On the other hand absenteeism of the facility staff was addressed through some level of accountability that the HMCs were able to pose upon the facilities.

Linked with this V&A is the aspect of responsiveness (53). Meaning the health system accommodates the needs that are being demanded by the community. So we saw that the HMCs made the health system more responsive not only in getting the staff deployed but also getting the medicines procured timely; and in some places getting the set quota of medicines increased.

The HMCs were able to contribute to the coverage aspect of service delivery. We saw that the HMCs directly supported the Lady Health Workers (LHWs) in polio campaigns in uncovered areas. Similarly setting up 24 hour services at facilities by some HMCs in Bagh is also a contribution to service delivery. Although PRIDE simultaneously was intervening for establishing these services; still the role of HMCs cannot entirely be negated. One example in this regards is important to mention. We saw that a basic health facility in Mansehra was able to establish 24 hours service. The facility and the HMC went beyond their roles and responsibility to get this materialized. Having clarity of roles is an established factor for facilitating the performance of such initiatives (42). But this facility in charge and the HMC members were not only clear about their roles but their collaboration helped them to go beyond and develop social capital. In this instance, this initiative seemed to have harnessed and developed the social capital within its partners. Social capital refers to: *those features of social relationships such as interpersonal trust, norms of reciprocity and membership of civic organizations which act as resources*

for individuals and facilitate collective action for mutual benefit (54). Thus we see that the partners went beyond their set roles when a primary health facility took the initiative and established 24hrs services.

HMCs have also been addressing the infrastructural needs of their facilities. It was through this mutual reciprocal partnership that helped needs like water supply, putting up residential places for the staff, and electricity at the facilities to be addressed. More importantly building link roads to facilities was done by the HMCs. There are examples of such committees providing for the facilities thus indicating ownership on part of the communities towards their facilities (14).

Building link roads was not a simple matter as this required getting passage through the lands of the communities. The health department had not been able to do this and as result some facilities did not have access, leading to considerable difficulties, for the patients.

It is worth mentioning here that it was the HMCs that advocated to their communities to give passage through their land for link roads. Again we see that using their voice they were able to harness the spirit of social capital even in their communities. This is a unique example of result orientated advocacy that the HMCs did; that is they convinced people to give passage through their land for link roads. In our setup land is a treasured asset and giving up even small piece of land is a big gesture on part of the community. To our knowledge the existing literature does not report this particular type of contribution where health committees were able to advocate to their communities to give up land for free to ensure easy access to facilities.

In conclusion, it appears that this community participation initiative is well on its way to addressing the intermediate outcomes of environmental and systems change which in turn help in addressing the long term (distant) population health outcomes (7;55). This initiative was able to get the health service delivery more efficient and helped in its coverage as well. Both of which are one of the fore most aims of such initiatives (14).

Many factors helped the overall performance of the HMCs. One of the factors was the nurturing role played by PRIDE. This nurturing role was in the form of trainings to orientate HMCs on their roles as well as trainings to build the capacity of the HMCs. So this helped the HMCs like the Zambian committees which flourished as they were trained and were clear regarding their roles and responsibility (42). So PRIDE did trainings keeping in line with what Grubb and colleagues have recommended. They recommend that programmes should include community education and capacity building as a key component of their budgeting and planning (13). Thus it was this training that the HMCs were able to develop projects and secure funding and then implement the projects successfully. This training eventually helped fostering leadership within the HMCs. Leadership has also been identified as a factor promoting performance and an attribute that helps sustain such committees (39).

One of the other factors that helped the performance was the notification from the District Health Offices. It took much advocating and convincing on part of PRIDE to get the notification from the districts. Therefore this notification by the District Health Officers, eventually, was an expression of their willingness to support this initiative. We have seen that such support and political commitment at the district and higher levels have been a facilitating factor for the Zambian committees (42) and has also

been suggested by Baez and Barron (15) that institutional support at the district level is critical for the committees to perform.

In conclusion PRIDE as a program did capacity building of the HMCs, this led to fostering of leadership amongst the HMCs, and the HMCs were supported by the districts through the notification, thus helping HMCs to perform and contribute. .

While these committees made contributions and were facilitated by some factors, they also had some limitations as well as challenges.

One of the challenges, in the early days of the initiative was the friction between the health facilities and the committees. In our opinion it was due to a number of reasons. One of the foremost reasons that came to light was that the facility staff was not orientated regarding this initiative as much as the committees were. And this uncertainty about the initiative and the roles each carried on part of the facilities played some part. Similar reason of friction has been reported from South Africa's clinic committee's initiative where the health facilities were uncertain about the roles of their committees (45).

The other reason of this friction in the early days was that the HMCs feeling confident due to their notification and wanting to get on with things ended up dominating the health staff. These sorts of dynamics were also at play in the above mentioned South African clinic committee's initiative. They have further reported that it was more of inappropriate power struggles between the two partners that escalated into frictions(45).

However it is important to note that this friction in majority of the HMCs was restricted to the early days of the initiative only. Both the partners resolved this and did manage to move on and eventually developed into a productive entity that contributed a lot as mentioned above.

It is very natural for groups to encounter some turbulence in the early stages of their development. And it appears that this initiative went through the stages of group development, which are forming, storming, norming and performing (56). However this challenge could have been addressed if PRIDE had put more emphasis on conflict resolution and conflict management trainings for the HMCs as well as for the facility staff.

Similarly there were some frictions and conflicts between the HMC members. Apart from this the HMCs also had to face some external pressures. We found that these internal and external pressures were due to not having representativeness within the HMCs. There are similar examples from Kenya, Zambia and Nepal where representation of all important groups was missed, and this non representativeness of the committees became a challenge (46;47;57).

Another challenge that the HMCs faced was the active participation of women in their committees. This was reported by all of the HMCs. In fact getting women to attend the meetings regularly was also difficult. However, attendance was comparatively a lesser challenge than having active participation of women. This was reported to be due to our cultural and traditional norms that restrict women's mobility within our society. And in our opinion what ever level of women attendance the HMCs managed is in itself quite an achievement for now. It will take time for our culture to evolve

till it permits women to attain that level where they can start actively participating in such productive initiatives. Provided such chances are constantly available for women to participate in.

Sustainability of this initiative is an important aspect that we explored during this study. Our discussions revolved around the conceptual sustainability i.e. whether the initiative is replicable and can be up-scaled, and financial sustainability i.e. whether HMCs can work without the support of projects like PRIDE. Mixed opinions were shared by all the respondents on both categories.

The project (PRIDE) itself thought sustainability could be possible if higher authorities legitimized it through formal legislation either at state or provincial level. Similar views were shared by one of the two District Level Health Officers. While the other District level Health Officer thought that for now HMCs were more of a one time activity and perhaps people were not ready yet to embrace it in its true spirit.

However the local facility staff thought it was a very useful initiative as majority of them felt supported by their HMCs. Similarly the HMCs themselves were very positive that they could carry on beyond the project life of PRIDE, provided they had their notification extended.

It is important to have the international perspective regarding the issue of sustainability surrounding community involvement in the health care.

Resource poor countries of the developing world recognize the importance of having community participation in their health care. So for example countries like Zambia, Kenya and South Africa already have community participation part of their health care system. So we see for example South Africa, in their Health Act of 2003 has legitimized community participation as part of their health care setup; thus showing commitment to this cause.

However due to resource constraints of such countries, despite having community involvement part of their health systems, they cannot continue to support such initiatives (14;40;47). At times one of the other constraints that have challenged sustainability in such resource poor countries has been the lack of political commitment on part of the governments. As Baez and Barron report that it was the lack of support at district and province level that constrained the initiatives in the Free States of South Africa as well in Zimbabwe. However in Zambia the community participation flourished due to the district and provincial support and political commitment (15).

The issue of sustainability is linked with resources and political commitment and as the 1991 WHO study reports that community participation flourishes in socio-economic conditions which are conducive to development. These include adequate staff, logistics and other resources which may be difficult to secure in a resource poor country (48).

Regarding the issue of sustainability of community involvement in our setup, the HMCs believed that they could carry on provided they were given some ownership at the District level in the form of extending their notification. The reason that the HMCs believed so strongly about their future was because they felt that they had the capacity and the leadership to do so. And these two attributes have been considered as important factors that help such initiatives to sustain themselves (39). The other factor that had strengthened this view was their ability to mobilize community resources. This ability to

not only to identify but also to mobilize community resources is an attribute that has been linked to sustainability as well (39). Working on purely voluntary basis the HMCs have demonstrated they can contribute to the health care and have shown the ability to mobilize community resources. Thus in poor resource settings, having a voluntary model of working, having the capacity to materialize contributions and the ability to mobilize community resources are some attributes of the HMCs that in our opinion, provides a unique opportunity for the policy makers to explore the potential of HMCs further.

The other aspect to be considered, in our setup, is that as an implementation model of community participation in health care, PRIDE was able to get the Health Management Committees institutionalized at the District level. Through its conceptual and operational framework it was able to take the local socio-political context into account. In comparison to the Family Health Project (FHP) (1992–1999), funded by the World Bank, which was also an effort to have community participation institutionalized at the District level in the form of District Health Management Teams (DHMTs). Due to the lack of political support, the District Health Management Teams (DHMTs) could not be institutionalized. Community participation in the DHMTs was only symbolic. Other than this the implementation model of FHP could not cater to the local socio-political scenario and thus the FHP was abandoned completely (49).

Now it is up to the policy makers at the state and province level to take the next step keeping in view the previous example of Family Health Project and the existing experience of HMCs with the view that Pakistan has been showing its commitment to the Declaration of Alma Atta and the Ottawa Charter, of promoting health and believing in Health for All. While advocating the case of HMCs with higher authorities is the only next step that should be considered by PRIDE.

Recommendations

Following are the main recommendations in light of the findings of our research. These recommendations can help improve the current level of the HMC's performance as well as help in replicating this initiative at other places.

1 Ensuring representativeness of HMCs

A representative HMC is very important for their overall effectiveness. This alone can address many of the internal conflicts and frictions faced by the members. As discussed, these internal conflicts can render such initiatives unproductive. It should have representation of every clan and sect of the community.

This representativeness is a process and starts at the grass root levels. Representativeness can be ensured if more time and effort is invested in forming VOs. People who form the VOs should preferably be from a background of teaching or social activism. These people should be well known to and backed by the community. Such are the people that bring added strength to such initiatives. Similarly these people with such backgrounds should get nominated to form HMCs.

2 Orientation of Health Department along side of the community:

Since eventually it is the health dept and the communities that would be working together. Therefore it is important to orientate the health dept as well as the community on such initiatives eg TORs etc.

When the health dept and the community will get orientated at the same time in the same forum (not separately) the process of collaboration will start from that point. This will help define roles and limits, dos and dont's for both the partners and can help avoid a lot of conflicts and frictions that can decrease the productivity of such collaborations.

3 Capacity building of HMCs

More capacity building of HMCs should be done. This process of building capacity should start upfront prior to the actual launch of the initiative. There should be the provision of some refresher trainings as well during the course of such initiatives. More emphasis should be given in training the HMCs to resolve and address conflicts both internal and external with the health dept.

Similarly more training should be given on identifying community resources and strategies of mobilizing such resources. Meaning they should be trained in fund raising strategies.

4 Developing better mechanisms for disbursement of funding

Funding agencies launching funding schemes like the small grants scheme should ensure swifter mechanisms of disbursing funds and installments. Procedural delays can affect the internal dynamics of such initiatives.

5 Ensuring active participation of women:

Mechanisms/strategies should be developed to ensure that women not only attend but actively participate in such initiatives. Women should be part of the training process from the outset of such initiatives. As an example of 'good practice' quoted above, should be exercised by all the HMCs. It will take a lot of effort and time to help women to learn to voice up their suggestions in the presence of men. Similarly it will take a lot of time and effort for the men to be sensitive enough to ask for suggestions from women.

6 More advocacy campaigns are needed at state and provincial level for a legislative cover for HMCs:

Last but not the least of the recommendations is the need of advocacy targeting the provincial and state level health policy people. It is imperative that a legislative cover from such levels is needed for the sustainability of such initiatives.

This can be in a number of forms, like doing National Forums, documenting positive aspects of such initiatives, documenting how these are helping the facilities to carry out service delivery eg facilitation of HMCs in polio campaigns etc.

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Terms of Reference

Health Management Committees (HMCs)

Role

The Health Management Committees will enable community participation in the planning and management of the health units. The Health Management Committees will be established for Basic Health Units (BHUs) and Rural Health Centers (RHCs). The HMCs will take direction from and report to the District Health Officer (DHO).

Principles

Health Management Committees will function in accordance with these principles:

1. People have a right to basic health services
2. People in communities have the capacity to identify and help solve their health issues and problems;
3. Communities and governments need to collaborate to improve health and health services
4. Health can improve when women and men in communities actively participate in the management of health services.
5. Participation in the management of health services is non-partisan and non-political.
6. Collaboration between community representatives, health care providers and government for the management of health services is done in a spirit of cooperation, problem solving, and mutual respect.

Responsibilities

With the Department of Health, the HMC will:

1. Review the current situation of health issues and health provision in the unit and the area served by the unit.
2. Encourage participation by the community to provide necessary support to the health unit the health providers and the users.
3. Identify gaps in health services and establish priorities for service provision.
4. Determine ways and means for responding to the priorities including obtaining resources required from government and support required from the community.

5. Liaise with the responsible local government bodies on priorities and resources requirement from government.
6. Monitor government and community responses to requirements and advocate as necessary for required action in support of health needs and priorities.
7. For new health unit construction, to:
 - help facilitate the design and construction of the new health unit and,
 - solve and prevent community problems related to the construction.
8. Share responsibility with the DHO for long term management and maintenance of the health unit.

Composition

1. As Bagh has far fewer community-based organizations than NWFP, part of the Bagh HMC is to be comprised of representatives selected by beneficiary villages of the catchment area. These representatives are to be selected by those villagers in a general meeting of each of these villages.
2. The beneficiary villages are to choose up to twelve local leaders/influentials including one Headmaster and one Headmistress, men and women representatives ; If there are more than 12 villages in the catchment area, the villages should be prioritized as to their likelihood of using the particular BHU and the main 12 villages chosen to provide representatives.
3. In the cases where construction of a new health facility is to be carried out, the HMC may strike a special, temporary sub-committee to concentrate solely on facilitating the design and construction. This sub-committee, to be selected by the HMC, is to be comprised of up to seven people, drawn mainly from residents living in close proximity to the construction site. This sub-committee will end when construction is finished.
4. One private health practitioner
5. Officer-in-charge of the health unit
6. One Lady Health Visitor/Lady Health Worker
7. The Health Education Officer or other Officer designated by the DHO.

Office Bearers

1. Patron (a Medical Doctor recognized for leadership in the community or district).

2. Chair (from among the community or village representatives and selected by the committee)
3. Vice Chair (Officer-in-Charge)
4. Secretary Treasurer (a technical person from among the community or health facility)

Responsibilities of Office Bearers and General Members

Patron

1. Will provide general guidance and advice.

Chair

1. Will preside over each meeting
2. Will have each meeting called, taking into account member wishes for when to have meetings
3. Ensure that members participate in discussions, are free to express opinions and offer suggestions, and cooperate with each other.
4. Together with other office bearers, the chair will, for each meeting:
 - prepare the agenda for each meeting
 - in each meeting report on actions taken on the issues decided in the previous meeting
 - raise new issues and problems and open discussion and decision-making on them
 - ensure that at least 50% plus one¹ of HMC members attend each meeting
 - ensure activities of HMC are managed effectively
 - encourage participation by both women and men in the HMC
5. If and when the HMC begins to have cash income or opportunities for it, the HMC will set up financial management (bank accounts, financial records, etc.) according to generally accepted financial rules and regulations.
6. Will represent the HMC to those outside the health unit and for official business with the EDO Health/DHO and others.

Vice Chair:

¹ For example, if a committee is comprised of 15 members, at least 8 should be at every meeting

1. To carry out duties of Chair in the absence of the Chair.
2. Along with the Chairman, will act as one of the two HMC signatories
3. To assist in other HMC duties as requested by the HMC or DOH

Secretary/Treasurer:

1. Under the direction of the Chair the Secretary/Treasurer will call the meetings, ensuring that all members receive notice of the meeting.
2. The Secretary/Treasurer will record minutes and attendance at the meeting, keeping these in an official meeting records book
3. Record minutes of the meetings on the same day and circulate these within three days to HMC members and the Department of Health (including the DHO and the Director General Health)
4. Present the minutes and get endorsement of the minutes of the previous meeting in every meeting
5. Prepare correspondence and keep files, documents, official stamps, pads, etc.
6. Prepare a six month progress report for the Secretary Health AJK.

If and when the HMC begins to have some cash income or opportunities for cash income, The Secretary Treasurer will:

- Maintain all financial records: records of income and expenditure, banking documents, official financial stamps, and other financial papers
- Maintain accounts and ledger books, keeping all records up to date
- Carry out all financial activities, e.g. Oversee HMC money coming in, collecting money owed or being contributed, paying bills, etc. Will also carry out purchasing, as directed by the HMC
- For each meeting prepare and present an income and expenditure statement, show the financial records and get approval for the statement. Financial records are to be open for members to see at any time
- Hand over these records for an annual audit or as required
- Carry out banking business as required
- Maintain the financial documents in a safe place.

General Members

1. Provide advice and guidance to the HMC, helping to promote the principles and meet the HMC responsibilities, prevent and solve problems
2. Assist in building outside linkages and resources.
3. Assist in disseminating information about the health unit and HMC, HMC objectives.
4. Attend HMC meetings as an active member
5. Participate in HMC discussion to support the planning and managing of the health unit.
6. Promote the services of the health unit within the community.

Elections and Terms of Office

1. The term of office of each HMC member is 2 years.
2. HMC representatives are to be selected every two years in a general meeting of the beneficiary villages or community-based organizations operating within the catchment area of the health unit.
3. The HMC will seek representation from one private health practitioner to serve for each two year period.
4. The LHV/LHW will be nominated by the Officer in Charge of the Health Unit and will be confirmed by the HMC.
5. Those selected as representatives by beneficiary villages and community based organizations are to select from amongst them, the HMC office bearers (except for Vice-Chair which is a fixed position for the Officer-in-Charge of the health unit).
6. For any HMC member, absence from three consecutive meetings of the HMC, without permission, will automatically dissolve the membership. When this happens, the Committee will select a new member by mutual consent and the absent member will be informed about the decision. Wherever possible the replacement should be from the same beneficiary locale.

Meetings of HMCs

1. Regular meetings of the HMC will be called, at least once a month. The meetings will take place on decided dates and times.
2. Meetings will generally be held at the health unit.
3. An emergency meeting may be called by one-third of the members, upon written notice to members.

4. Actions will only be taken on decisions made in meetings where member attendance is 50% plus one.
5. Agenda for each meeting will be in this format:
 - opening according to local customs (recitation, prayer, welcomes, etc.)
 - approval of agenda (or additions, changes)
 - presentation and endorsement of previous meeting minutes
 - summary of actions taken on decisions made in the previous meetings
 - financial report and planning
 - review of present situation, identifying problems, choosing solutions and deciding what to do
 - new issues
 - Other subjects of interest
 - closing

Record Keeping

The HMC needs to keep the following kinds of records:

Minutes and attendance of meetings

- Minutes and attendance register book
- Resolutions register
- Correspondence

Financial Records:

- Income and Expenditure Book
- Stock Register
- Bank books
- Budget

Annual Health Unit Management and Maintenance (M&M) Plans

Every year the HMC will make or up-date an M&M plan for the year to show for the building and in support of health promotion activities:

- regular and special events
- duties to be carried out
- Resources needed for each activity and how the resources will be found.
- Costs for each activity need to be estimated and a plan made for how to raise or find the money.
- who is responsible to do each part of the plan
- a schedule for each event or duty
- Planning should start first by identifying the problems, needs, strengths and opportunities of the health unit. Then make plans that will help eliminate or reduce the problems and increase the strengths and opportunities.
- Plan for, enforce, and support the maintenance and upkeep of the health unit.

Monitoring and Evaluation

Every 4 months, the HMC should:

1. Review its own performance and decide on how to make things better and continue what is good
2. Review plans to see if they are being achieved, and bring plans up to date
3. Results of this monitoring and evaluation should be recorded in minutes of the meeting where it occurred.

INSTRUMENTS

In depth Interview with PRIDE/IPs

Name-----	Date-----
Designation-----	Interviewer/Facilitator -----
Location-----	-----

<ul style="list-style-type: none">• Thanks• Intro• Purpose• Confidentiality• Duration• Tape/Notes• Clarifications• Consent	<p>I want to thank you for taking time to meet with me/us today.</p> <p>We are _____ and would like to talk to you about your experiences on HMCs initiative.</p> <p>Specifically, as one of the components of our overall HMC evaluation, we are assessing HMC effectiveness in order to capture lessons that can be used in future interventions.</p> <p>All responses will be kept confidential. This means that your interview responses will be part of the findings but we will ensure that any information we include in our report does not identify you as the respondent.</p> <p>The interview should take less than an hour.</p> <p>We will be taping the session because we don't want to miss any of your comments. Simultaneous note-taking will also be done but possibly we cannot write fast enough to get it all down. And because we're on tape, please be sure to speak up so that we don't miss your comments.</p> <p>Are there any questions about what I have just explained?</p> <p>Are you willing to participate in this interview?</p>
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No.	Question	Probe	Response
1	Tell us something about the experience of Health Management Committees (HMCs)?	<ol style="list-style-type: none"> 1. Previous h/o similar initiatives? 2. Learning from international /regional experiences? 	
2	In your views, what were the main objectives of these HMCs?	<ol style="list-style-type: none"> 1. Were/How local organizations involved? 2. Was the scope limited to health facility? 	
3	Did the Project achieve these objectives? If yes, how?	<ol style="list-style-type: none"> 1. Any M&E mechanisms/indicators? 2. Any data against it? 	
4	What steps were taken for the formulation and performance of these HMCs?	<ol style="list-style-type: none"> 1. Any revisiting of plans done in the light of community's feedback? 	
5	What were the main successes attributable to HMCs?	<ol style="list-style-type: none"> 1. How local leadership was fostered? (trainings, conflict management etc) 2. Any efforts to develop systems? 	
6	What were the challenges?	<ol style="list-style-type: none"> 1. How the DOH was taken on-board? 2. Any resistance on the part of the community? 	
7	What would you like to improve/change in future?		
8	Your views on sustainability of these HMCs?	<ol style="list-style-type: none"> 1. Did you have a vision for sustainability from the beginning? 2. Did you document with guides and tools? 3. Did you diversify the funding base? 	
9	What are strengths of initiatives like HMCs?		
10	What are the weaknesses of such initiatives?		

IDI HMC Chairman

Name of Chair -----	Date-----
Location -----	Note taker -----
Interviewer/Facilitator -----	

<ul style="list-style-type: none"> • Thanks • Intro • Purpose • Confidentiality • Duration • Tape/Notes • Clarifications • Consent 	<p>I want to thank you for taking time to meet with me/us today.</p> <p>We are _____ and would like to talk to you about your experiences on HMCs initiative.</p> <p>Specifically, as one of the components of our overall HMC evaluation, we are assessing HMC effectiveness in order to capture lessons that can be used in future interventions.</p> <p>All responses will be kept confidential. This means that your interview responses will be part of the findings but we will ensure that any information we include in our report does not identify you as the respondent.</p> <p>The interview should take less than an hour.</p> <p>We will be taping the session because we don't want to miss any of your comments. Simultaneous note-taking will also be done but possibly we cannot write fast enough to get it all down. And because we're on tape, please be sure to speak up so that we don't miss your comments.</p> <p>Are there any questions about what I have just explained?</p> <p>Are you willing to participate in this interview?</p>
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No.	Question	Probe	Response
1	Tell us something about the experience of Health Management Committees (HMCs)?	3. Did you have any previous experience of similar initiatives?	
2	In your views, what were the main objectives of these HMCs?	3. Were/How local organizations involved? 4. What was the focus; providing service delivery or involving the community?	
3	Did the Project achieve these objectives? If yes, how?	3. Any M&E mechanisms/indicators? 4. Any data against it?	
4	What steps were taken for the formulation and performance of these HMCs?	2. Any revisiting of plans done in the light of community's feedback?	
5	What were the main successes attributable to HMCs?	1. Sustainable local leadership? 2. Any efforts to develop systems? 3. Gender mainstreaming?	
6	What were the challenges?	3. From the DOH? 4. From the community?	
7	What would you like to improve/change in future?		
8	Your views on sustainability of these HMCs?	4. Did you have a vision for sustainability from the beginning? 5. Did you document with guides and tools? 6. Did you diversify the funding base?	
9	What are strengths of initiatives like HMCs?		
10	What are the weaknesses of such initiatives?		

In depth Interview with Officials from Health Department (Co-Chair HMCs)

Name-----	Date-----
Designation-----	Interviewer/Facilitator -----
Location-----	-----

<ul style="list-style-type: none"> • Thanks • Intro • Purpose • Confidentiality • Duration • Tape/Notes • Clarifications • Consent 	<p>I want to thank you for taking time to meet with me/us today.</p> <p>We are _____ and would like to talk to you about your experiences on HMCs initiative.</p> <p>Specifically, as one of the components of our overall HMC evaluation, we are assessing HMC effectiveness in order to capture lessons that can be used in future interventions.</p> <p>All responses will be kept confidential. This means that your interview responses will be part of the findings but we will ensure that any information we include in our report does not identify you as the respondent.</p> <p>The interview should take less than an hour.</p> <p>We will be taping the session because we don't want to miss any of your comments. Simultaneous note-taking will also be done but possibly we cannot write fast enough to get it all down. And because we're on tape, please be sure to speak up so that we don't miss your comments.</p> <p>Are there any questions about what I have just explained?</p> <p>Are you willing to participate in this interview?</p>
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No.	Question	Probe	Response
1	Are you aware of the Health Management Committees (HMC) initiative in your area?		
2	What are your views on the implementation experience of HMCs in your area?	4. How health department viewed such initiatives in the light of previous experiences?	
3	In your views, what were the main objectives of these HMCs?	5. Were you on-board when these HMCs and their objectives were being laid?	
4	Did the HMCs achieve these objectives? If yes, how?	5. Any M&E mechanisms/indicators? 6. Any data against it?	
5	In your view what were the main contributions of these HMCs?	1. Civil works? 2. Improved services? 3. Improved access? 4. Systems development? 5. Referral and ensuring client satisfaction? 6. Fostering leadership?	
6	What were the shortcomings in the idea and its implementation?	5. Financial resources? 6. Involving local people? 7. Implementation of work plans? 8. Weak planning?	
7	In your views, did/how these HMCs bring special benefits to the marginalized?	1. Was special emphasis given to women's /children's needs?	
8	What would you like to improve/change for the next phase?		
9	How can such committees become part of the mainstream healthcare?	1. What steps should be taken at conceptualization, implementation and concluding stage?	

FGD with HMC members

HMC -----	Date-----
Facilitator -----	Note taker -----
Names of Members-----	

<ul style="list-style-type: none"> • Thanks • Intro • Purpose • Confidentiality • Duration • Tape/Notes • Clarifications • Consent 	<p>I want to thank you for taking time to meet with me/us today.</p> <p>We are _____ and would like to talk to you about your experiences on HMCs initiative.</p> <p>Specifically, as one of the components of our overall HMC evaluation, we are assessing HMC effectiveness in order to capture lessons that can be used in future interventions.</p> <p>All responses will be kept confidential. This means that your interview responses will be part of the findings but we will ensure that any information we include in our report does not identify you as the respondent.</p> <p>The interview should take less than an hour.</p> <p>We will be taping the session because we don't want to miss any of your comments. Simultaneous note-taking will also be done but possibly we cannot write fast enough to get it all down. And because we're on tape, please be sure to speak up so that we don't miss your comments.</p> <p>Are there any questions about what I have just explained?</p> <p>Are you willing to participate in this interview?</p>
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No.	Question	Probe	Response
1	Tell us something about the experience of Health Management Committees (HMCs)?	5. Did you have any previous experience of similar initiatives?	
2	In your views, what were the main objectives of these HMCs?	6. Were/How local organizations involved? 7. What was the focus; providing service delivery or involving the community?	
3	Did the Project achieve these objectives? If yes, how?	7. Any M&E mechanisms/indicators? 8. Any data against it?	
4	What steps were taken for the formulation and performance of these HMCs?	3. Any revisiting of plans done in the light of community's feedback?	
5	What were the main successes attributable to HMCs?	4. Sustainable local leadership? 5. Any efforts to develop systems? 6. Gender mainstreaming?	
6	What were the challenges?	9. From the DOH? 10. From the community?	
7	What would you like to improve/change in future?		
8	Your views on sustainability of these HMCs?	7. Did you have a vision for sustainability from the beginning? 8. Did you document with guides and tools? 9. Did you diversify the funding base?	
9	What are strengths of initiatives like HMCs?		
10	What are the weaknesses of such initiatives?		

In depth Interview with Officials from Health Department (EDO/DHO)

Name-----	Date-----
Designation-----	Interviewer/Facilitator -----
Location-----	-----

<ul style="list-style-type: none"> • Thanks • Intro • Purpose • Confidentiality • Duration • Tape/Notes • Clarifications • Consent 	<p>I want to thank you for taking time to meet with me/us today.</p> <p>We are _____ and would like to talk to you about your experiences on HMCs initiative.</p> <p>Specifically, as one of the components of our overall HMC evaluation, we are assessing HMC effectiveness in order to capture lessons that can be used in future interventions.</p> <p>All responses will be kept confidential. This means that your interview responses will be part of the findings but we will ensure that any information we include in our report does not identify you as the respondent.</p> <p>The interview should take less than an hour.</p> <p>We will be taping the session because we don't want to miss any of your comments. Simultaneous note-taking will also be done but possibly we cannot write fast enough to get it all down. And because we're on tape, please be sure to speak up so that we don't miss your comments.</p> <p>Are there any questions about what I have just explained?</p> <p>Are you willing to participate in this interview?</p>
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No.	Question	Probe	Response
1	Are you aware of the Health Management Committees (HMC) initiative in your area?		
2	What are your views on the implementation experience of HMCs in your area?	6. How health department viewed such initiatives in the light of previous experiences?	
3	In your views, what were the main objectives of these HMCs?	8. Were you on-board when these HMCs and their objectives were being laid?	
4	Did the HMCs achieve these objectives? If yes, how?	9. Any M&E mechanisms/indicators? 10. Any data against it?	
5	In your view what were the main contributions of these HMCs?	7. Civil works? 8. Improved services? 9. Improved access? 10. Systems development? 11. Referral and ensuring client satisfaction? 12. Fostering leadership?	
6	What were the shortcomings in the idea and its implementation?	11. Financial resources? 12. Involving local people? 13. Implementation of work plans? 14. Weak planning?	
7	In your views, did/how these HMCs bring special benefits to the marginalized?	2. Was special emphasis given to women's /children's needs?	
8	What would you like to improve/change for the next phase?		
9	How can such committees become part of the mainstream healthcare?	2. What steps should be taken at conceptualization, implementation and concluding stage?	

FGD with Community members

Names of Participants----- ----- ----- # of Men _____ # of Women _____	Date----- Location----- Interviewer/Facilitator ----- -----
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<ul style="list-style-type: none"> • Thanks • Intro • Purpose • Confidentiality • Duration • Tape/Notes • Clarifications • Consent 	<p>I want to thank you for taking time to meet with me/us today.</p> <p>We are _____ and would like to talk to you about your experiences on HMCs initiative.</p> <p>Specifically, as one of the components of our overall HMC evaluation, we are assessing HMC effectiveness in order to capture lessons that can be used in future interventions.</p> <p>All responses will be kept confidential. This means that your interview responses will be part of the findings but we will ensure that any information we include in our report does not identify you as the respondent.</p> <p>The interview should take less than an hour.</p> <p>We will be taping the session because we don't want to miss any of your comments. Simultaneous note-taking will also be done but possibly we cannot write fast enough to get it all down. And because we're on tape, please be sure to speak up so that we don't miss your comments.</p> <p>Are there any questions about what I have just explained?</p> <p>Are you willing to participate in this interview?</p>
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No.	Question	Probe	Response
1	Have you heard of HMCs ?		
2	How did you come to know about these HMC's ?	<ol style="list-style-type: none"> 1. Through your local facility (BHU)? 2. Through your LHW? 	
3	What do you think these HMC's do for you?	<ol style="list-style-type: none"> 1. As you aware of their objectives? (like improving conditions at your facility?) 	
4	Do you or your family members visit the BHU/ RHC for health issues?	<ol style="list-style-type: none"> 1. What are the main reasons of visiting your BHU/RHC? 	
5	Have you observed any change in the products/ services provided at this facility during last 2 years?	<ol style="list-style-type: none"> 1. Civil works? 2. Water supply? 3. Staff? 4. Medicines? 	
6	Any differences in the health services prior to and after the Oct 2005 earthquake?		
7	Would you recommend others to use the facility?		
8	Any suggestions to improve services provided at you facility(BHU/RHC) ?		