Towards a basic health-sector information system for municipal actors

Jurrien Toonen, Dramane Dao et Thea Hilhorst

Draft

Foreword

According to a Bambara adage, 'He who knows all will not die.' By sharing with readers some of the experience and learning from 'the evident desire, in all our countries which have launched decentralisation reforms since the 1990s, to try out new approaches and new methods of cooperation to build local monitoring and evaluation capacity', [1] the aim is to make a modest contribution to the knowledge available on this subject.

This publication is for all actors in development, working in the field of decentralisation and local governance, especially practitioners and policymakers working on issues connected with capacity building in the area of monitoring, evaluation and democratic control of local governance structures.

The case studies presented in this document have been prepared in the context of an exercise that aimed to document, analyse and learn from experiences with different approaches/methods and instruments for building the capacities of different actors in decentralisation and local governance, and in particular, the capacities of local government to monitor and evaluate the outcomes of these complex reform processes.

This learning exercise started in Mali. It has been a joint initiative by the *Réseau de Réflexion et d'Echange sur le Développement Local* (REDL)[2] (a Malian network of development organisations and programmes working in the field of decentralisation and local development), the Netherlands Development Organization (SNV-Mali), the Malian Ministry of Territorial Administration and Local Government (MATCL) and the European Centre for Development Policy Management, an independent foundation based in Maastricht in the Netherlands.

The purpose of this exercise has been to jointly map and document relevant experiences in the West African region and share 'good practice' and lessons learned. A total of 11 case studies from different countries of the West African region were prepared during this exercise, and a seminar held under the auspices of the MATCL in Bamako on 17 and 18 May 2006 provided a forum for a structured exchange of experiences.

This study, 'Towards a basic health-sector information system for municipal actors', has been prepared by Jurrien Toonen, Dramane Dao and Thea Hilhorst.

Jurrien Toonen is a doctor working for the Royal Tropical Institute (KIT), in Amsterdam, coordinating a number of health-systems development projects and activities. These include institutional aspects, human resources, financing of health, monitoring and evaluation, and community participation. Since 1992, he has

---

[1] Taken from the welcome speech given by Mr Ibrahima Sylla, decentralisation adviser at the Ministry of Territorial Administration and Local Government (MATCL) of Mali, at the sub-regional seminar 'Building capacities for monitoring and evaluation of decentralisation and local governance in West Africa: exchange of experience and learning'.

[2] For more details see http://www.snvmali.org/actus/redlinfo0606.pdf. The REDL members taking part in this learning exercise were SNV-Mali; the Programme d'Appui aux Collectivités Territoriales (PACT), a project in support of local government run by German Technical Cooperation (GTZ); l'Aide de l'Eglise Norvégienne (AEN), Norwegian Church Aid; CARE International in Mali; the Programme d'Appui aux Acteurs de la Décentralisation (PAAD), a development programme of HELVETAS-Mali; the Swiss Association for International Cooperation; 'Solidarité, Union, Coopération' (SUCO), a Canadian NGO; the Association of French Volunteers (AFVP); and the Programme Gouvernance Partagée (PGP), a programme financed by the US Agency for International Development (USAID).

contributed to the development of the public-health sector in Mali, in particular when a national policy on human resources was being drawn up and the national health programme (PRODESS-I) was being evaluated.

Dramane Dao has a degree in finance and accounting and is an adviser at the Netherlands Development Organisation (SNV), responsible for the issues raised by the transfer of powers and resources to local authorities. In the past he has worked for various health organisations: as an SNV adviser to the Regional Directorates for Health and Social Development in the context of Mali's Health and Social Development Programme (PRODESS) and as a manager of a number of local and regional health programmes for government departments.

Thea Hilhorst also works at KIT, but for the economic development section. She has specialised for a number of years in rural decentralisation and local governance. She coordinates research projects throughout West Africa for SNV. In particular, she initiated the project to develop tools facilitating partnership work in the area of public health, along with a potential strategy to promote synergies between projects in municipal areas.

This study capitalises on the experiences of a research project to test a tool for monitoring and managing basic information on public health at a decentralised level. The approach taken by this research project was to provide a basic package of information for the various key public-health actors at local government level (including elected officers, community health associations and technical departments). This project is known as the 'Système d'Information Essentielle pour la Commune dans le secteur de Santé' (SIEC-S) (Basic Health-Sector Information for Municipalities).

In this study, the authors show that joint collection, sharing and analysis of health information and indicators may help to enhance cooperation between the actors concerned and improve their understanding of public-health challenges and therefore their capacity for action. It is for this reason that this research project is also a very practical experiment that paves the way for the transfer of health-sector powers to local governments.

The facilitators of this joint documentation, analysis and learning exercise would like to thank the members of the Malian REDL network and the organisations working in other West African countries that have supported and co-financed the preparation of the different case studies. Through the generous support of these organisations and the Swedish International Development Agency/Swedish Ministry of Foreign Affairs, these case studies are being published in both French and English and will also be included in a more comprehensive publication, bringing together all the case studies and the results of the regional seminar held in May 2006.

We would also like to express our gratitude to Mr. Ibrahima Sylla, senior advisor on decentralisation in the Malian Ministry of Territorial Administration and Local Government, for his indefatigable support for the success of this joint initiative. Last but not least, we would like to thank Kathleen Sheridan for her language editing work and David Harris for translating this document to English.

Sonia Le Bay (SNV) and Christiane Loquai (ECDPM)

Contents

Introduction

In Mali, health indicators are still at worrying levels, and the public sector's performance in supplying basic services has to improve if poverty is to be reduced. The challenge for the various actors involved with health at the municipal level is to work effectively together in order to provide public-health services that are tailored to local needs, including those of the most vulnerable groups.

After the municipalities were established in 1999, the way in which public health was organised institutionally was completely overhauled. The municipalities are now responsible for certain basic services, which means that roles and responsibilities must be redefined, particularly between local government, the Ministry of Health and the community health associations. As municipal representatives are to be increasingly involved in health management, it is becoming essential for everyone to have access to appropriate information on priorities and to be able to monitor progress, so that they are in a position to take informed decisions.

This report describes our experience developing a minimum health-information package to enable local government and the community health associations (ASACOs) to assume their new responsibilities and to be actively involved in managing public health. Known as the 'Système d'Information Essentielle pour la Commune dans le secteur de la Santé' (SIEC-S) (Basic Health-Sector Information System for Municipalities) this package is based on data collected by the Ministry of Health. It aims to provide municipalities and ASACOs with access to data from the National Health Information System (SNIS). SIEC-S is not so much about introducing a new data-collection system, as it is about building on existing health services.

The SIEC-S forms part of a programme of activities and tools developed to support the transfer of responsibilities from ministries in various sectors to local government. The whole approach is designed to improve coordination and cooperation between the various actors.

We will begin by describing the general context, the research project itself and the problems associated with health information. We will then look at the approach developed for the SIEC-S, the first experiences of applying it in the field and, finally, the lessons learnt.

1. Background

1.1 National decentralisation policy

The collapse of the one-party state and the military dictatorship in 1991 was a decisive turning point in Mali's political development. One consequence was that all the state institutions were called into question. At the national conference in 1991, decentralisation was regarded as a strategic priority in the construction of the future Malian state and it was therefore enshrined in the new Constitution. The process of devolving powers paved the way for a fundamental change in relations between the state and ordinary citizens and for bringing public services closer to the people.

Framework Law No 93-008 lays down the conditions for the independent administration of local government through legislative and executive bodies. It provides for the introduction of four types of local government: municipalities (703), rural districts[3] (49), regions (8) and the district of Bamako. These have no hierarchical relationship and are managed by elected councils. The municipal elections in 1999 marked the start of the implementation of this institutional reform. The various local authorities then became the appropriate statutory areas for local development and are now responsible for developing and implementing economic, social and cultural development programmes in their territory.

[3] The English term 'district' is used for the second tier of local government in rural areas, i.e. the 'cercles'. It should however be noted that the mandate and administrative structure of the 'cercle' is not strictly comparable to those of the district in Anglophone West African countries and that the district of Bamako has a special status, comparable to that of a region.

1.2 Health-sector policy

In 1990, the Mali government adopted a comprehensive framework for action in the health field. This new policy is mainly based on the devolution of certain responsibilities from the Ministry of Health to the ASACOs (which are legally recognised entities authorised to recruit staff, manage financial reserves and own buildings). In order to increase the area covered by the health services, the Ministry of Health adopted a policy promoting the setting up of ASACOs and giving them a greater role in mobilising resources and managing the community health centres (CSCOMs).

Le PROgramme de DEveloppement Sanitaire et Social (PRODESS) (Health and Social Development Programme) started in 1998, before the new administrative divisions were in place, so its planning system and procedures did not take the new local government responsibilities into account. Investment continued to be managed directly by the Health Ministry's administrative and financial directorate, including investments made on behalf of the municipalities, districts and regions. In 2004, the PRODESS was revised (PRODESS-II) to include the responsibilities of local government. The Ministry of Health is currently adapting the SNIS indicators to provide the information needed by PRODESS II. For instance, special emphasis is now being placed on quality of care from the users' point of view.

1.3 Transfer of powers

In June 2002 the government signed decrees transferring powers in the health, education and water sectors,[4] spelling out the powers, resources, funding and assets to be transferred from the State to the local authorities. The municipalities can then delegate management to specialised bodies such as the ASACOs.

Box 1: Activities Resulting from the Transfer of Powers in the Health Field to the Municipalities

- Developing and implementing the health-development plan;
- Creating and maintaining infrastructure;
- Issuing licences to set up community health centres;
- Drawing up mutual assistance agreement with ASACOs;
- Funding ASACOs;
- Recruiting staff;
- Establishing initial turnover stock of essential medicines;
- Combating the black-market trade in medicines;
- Providing health information, education and communication;
- Implementing national policies and strategies to prevent and combat disease;
- Encouraging local support for social and health objectives.

The transfer of certain powers from the Ministry of Health to local government also offers the following potential benefits:

- national resources (financial and human) in the health field can be allocated more appropriately and fairly if planning is based on local needs and if there are specific allocation criteria;
- health experts can concentrate on health services once the financial and administrative tasks involved in constructing and managing the infrastructure have been transferred to local government;
- the involvement of local government makes it easier to have an inter-sectoral approach to public health and better coordination with sectors such as drinking water supply and sewage disposal, nutrition and education, and the prevention of HIV/AIDS and other diseases;

[4] The transfer of powers was automatic in the case of public records, among other things. Preparations for transferring powers related to the management of natural resources and state-owned property are not yet very advanced.

- the involvement and engagement of the municipalities in public health could increase the mobilisation of resources and encourage local support for prevention campaigns in the health field;
- if local government and the ASACOs are more actively involved in public-health decision-making, it could strengthen the idea of 'accountability' between users and health services and thus bring about an improvement in the quality of care.

Progress is slow, however. During this phase, a degree of mistrust has arisen between the technical staff and the municipal authorities. Moves towards a more concrete transfer of powers are being held back by the negative views held by some of the staff already 'decentralised' by the Ministry of Health, stemming largely from bad experiences of this staff with this reform process and working with the ASACOs.

The Ministry departments in question also have a number of reservations, mainly about the fact that local government does not have the human resources and technical capacity to cope with the responsibilities that are to be transferred. However, as far as financial management is concerned, a number of local authorities have proved themselves capable of managing the funding earmarked for infrastructure (ANICT, 2004).

Nevertheless, the Ministry of Health is increasingly coming to realise the opportunity that decentralisation offers for implementing its policies and strategies more effectively by involving new actors, and it is trying to harmonise them with decentralisation policy. The decentralisation support unit in the Ministry has been working on this since 2006.

2. Approach used in the research project

The legislation on the transfer of powers does not make it clear how the various actors are to work together. Furthermore, if local government is to participate effectively, tools will be needed to allow non-specialists to take part in policy discussions and to monitor the health system's performance.

This is why, since 2004, SNV-Mali and the Royal Tropical Institute (KIT) have been working with the actors involved to develop approaches and practices that will make it easier to establish effective local partnerships in the public-health field, which will improve the actors' performance and increase their empowerment (Hilhorst et al., 2005). This has involved a series of discussions and exchanges of opinion and experience between the key actors, linked to practical, functional proposals to ensure that activities are in line with resources.

2.1 Actors

In the rural environment, the Community Health Centre, the ASACO and the municipality are the main actors involved in running public health, though some municipalities also have non-governmental organisations (NGOs) working in this field. There are very few private doctors working in rural areas and often only traditional healers. Some pharmacies have been opened and itinerant salesmen sell medicines on the market. In towns, the private sector plays an important role in providing health care.

Each of the actors has a relationship with the authorities at the circle, regional and central level. The community health centre has hierarchical relations with the reference centre at circle level. The ASACOs are organised as a federation at circle, regional and national levels. The municipalities are represented in the circle council, even though there is no hierarchical link between the municipality and the circle.

2.2 Phases involved in building an effective partnership

The following phases are important for building effective partnerships between the Ministry of Health, local government and the civil organisations involved with the community health centres:

1. Establish **a basis of trust** between the various partners. This means, for instance, ensuring that all the actors are **equally well informed**, particularly about decentralisation and health policy.
2. Accept that certain **powers** are to be **transferred** from the Ministry of Health to local government, as required under the relevant legislation, and develop effective working relationships.
3. Design a **consultation framework that encourages** discussion and negotiation. This can start off informally, but should subsequently be given a formal basis.
4. Help **local government to have a better understanding** of public-health activities from a multi-sector point of view. The challenge is to improve skills in municipalities so that councillors and their staff can understand, monitor and, if necessary, act on performance indicators.
5. **Identify activities that act as catalysts**. Although establishing functional working relationships is a long-term process, it is important to begin with activities that are priorities for all actors, that are achievable in the short term and that are unlikely to create conflicts of interest. In Mali this cooperation could start with the organisation of immunisation campaigns and health activities funded by the municipality, before moving on to more complex and difficult issues, such as transferring responsibility for health-sector investment and human resources to local government, which is required by law.
6. Drawing up **tripartite performance contracts** could prove useful since discussing the contracts could enable the partners to define what they expect from each other.
7. Encourage **greater empowerment at grass-roots level** so that more weight and importance is given to ordinary people, particularly the poor, thereby encouraging all actors to take account of local needs and customer satisfaction.

Our research project seeks to develop approaches and tools that are likely to promote effective cooperation. Relationships will be studied and analysed as they develop and conclusions drawn about the problems and opportunities presented, along with possible solutions to them.

Box 2: Tools Produced during the Research Project

Information and communication tools:

Health-policy information guide for councillors and their partners

Information guide for local actors on decentralisation and the transfer of powers in the health field

Partnership tools:

Basic health-sector information system for municipalities

Annual micro-planning guide for health measures in the municipality

3. Information as a prerequisite for active involvement

3.1 The national health-information system

The Ministry of Health runs a national health-information system in order to monitor progress on the 'minimum package of activities' defined in the PRODESS.

Data are collected regularly on the performance of community health centres as regards developments in their geographical accessibility, use of their services and their coverage. At village level, data are also collected on certain things such as latrines, coverage of iodine-enriched salt, level of membership of the ASACO, collection of contributions, monitoring of certain preventive medical consultations (immunisations, antenatal examinations) and distribution of impregnated mosquito nets. The community health centre's financial management, management of stocks of medicine, proper holding of meetings (including keeping of minutes), action plans, fulfilment of commitments and communication of results to beneficiaries are also regularly monitored by the Ministry.

The main data-collection document is prepared at the national level. In the community health centre, the data are collected by the nurse (who keeps a copy, in theory), forwarded to the circle authorities and then on to higher levels, where they are collated and published in a regional statistical yearbook.

The circle's health technicians use these municipal data when they visit community health centres to assess progress on targets set at the start of the year. The ASACO sometimes attends these quarterly inspections. The ASACOs and the municipalities also receive a copy of the quarterly reports, which are huge documents, containing extremely detailed information, and are very cumbersome to use.

Data in the National Health-Information System are fairly inaccessible for non-specialists in the form in which they are currently presented. Moreover, municipal councillors have many other fields to deal with, with limited staff and resources. It is therefore much more efficient to concentrate on priorities and to assemble a minimum package of basic information (the SIEC-S) that will allow them to understand and take decisions on public health.

Lastly, the SIEC-S can help the municipal council to make the results of its support more tangible and visible. Help in supplying health services could thus become just as visible as investments in buildings and equipment.

3.2 Municipal councils' growing need for health data

It used to be the case that the ASACO had a mutual-assistance agreement with the Ministry of Health for the running of the community health centre, but since the new local authorities were set up, the ASACO now has to sign such an agreement with the mayor of its municipality. Up to now, however, councillors have generally failed to get to grips with the content of these mutual-assistance agreements, and their role often remains a passive one. Talks are currently being held about this, mainly involving the ASACO federation (FENASCOM). A system like the SIEC-S could make it easier for all actors to play a more active part, since it takes account of the challenges and substance of the commitments given and makes it easier to monitor progress.

The Ministry of Health is trying harder to be more dynamic in bringing municipal planning (in the form of Economic, Social and Cultural Development Plans [PDESCs]) into line with the health-sector programme at the circle level. The chairman of the circle council already chairs meetings of the reference health-centre management council. All mayors are members of this management council but their involvement is often passive because they do not have access to the relevant information.

Clearly, if the municipal council is to have effective dialogue with the Ministry of Health and if it is to have greater responsibilities, it needs regular access to reliable information on the public-health situation in its own municipality. The local authorities and the ASACOs have voiced this need at a number of meetings and workshops organised as part of the research project. As a result, the municipal councils and ASACOs have been increasingly involved in the supervisory visits by the circle's health technicians. This has been a huge step forward

in strengthening partnership in the public-health field, showing once again just how necessary it is for reliable and comprehensible data to be circulated regularly by all actors.

3.3 Monitoring micro-planning and performance contracts

Micro-planning was introduced as part of the Accelerated Strategy for Child Survival and Development (SASDE), supported by UNICEF, in order to encourage active involvement in improving indicators within the community health centre areas. It is carried out every six months following a meeting to monitor community health centre activities attended by all the relevant actors.

Micro-planning has become a national practice, but municipalities do not feel engaged in the process because they are not involved in many of the phases, most of which involve meetings between the community health centre and the reference health centre. Some community health centres currently invite the municipal council to attend these meetings, but nothing is done to make their involvement more dynamic: councillors are not prepared in advance about the state of play and the factors involved, and there are no tools to help them to understand and therefore to participate.

One way of giving micro-planning greater weight is to follow it up by signing performance contracts. The Ministry of Health is currently developing 'standard' contracts at various levels (municipality, circle, region). Two types of performance contracts are planned: one between the Ministry and local government, and the other between the Ministry and NGOs. The contracts set out expectations and responsibilities and define the performance indicators to be used for monitoring purposes. This practice, which is a monitoring tool in itself, could also be used with the SIEC-S.

During the research project, discussions with the municipal actors (ASACOs, community health centres, municipal councils) produced an annual health micro-plan to be used as a reference for the commitments undertaken by all the parties involved. The commitments are to be set out in a performance contract for their implementation. Supervisory meetings will be held to monitor performance, attended by all the actors concerned, which is why the SIEC-S is important in the process.

4. The SIEC-S: starting point and structure

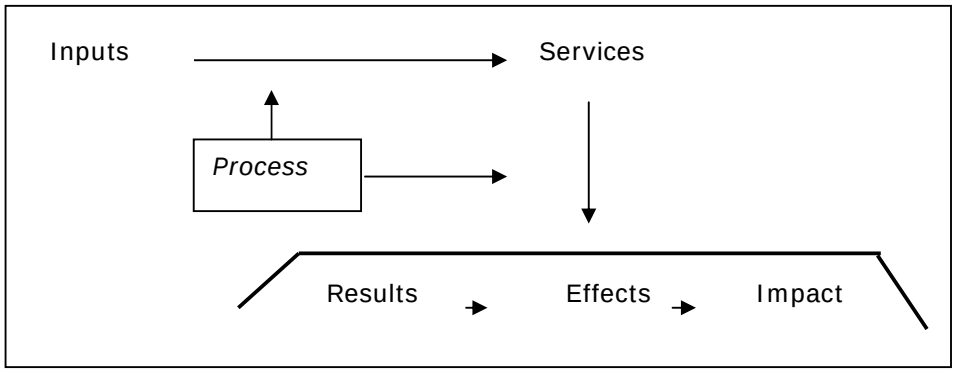
4.1 Approach used

The purpose of the SIEC-S is to enable representatives of the municipal councils and the ASACOs to monitor the state of public health, to identify priorities for their municipality, to take an active part in discussions with the Ministry of Health and to monitor the progress of the community health centres, micro-plans, performance contracts and mutual-assistance agreements. The SIEC-S also serves as a basis for dialogue in the context of tripartite cooperation.

The SIEC-S research project aims to develop an approach that enables priority data to be selected in a given municipality and presented in a format that local actors can understand. The SIEC-S mainly uses data from the existing SNIS and does not alter either the way in which information circulates within the Ministry of Health or the monitoring and advisory system. The Ministry of Health is fully involved in developing the SIEC-S.

The data provided by the SIEC-S should provide a sound basis for identifying priorities when joint health plans are developed within the municipality. The SIEC-S should make it possible to manage the municipal resources available (financial, human and material) efficiently and effectively.

Box 3: Impact chain in a programme monitoring providing health services



To illustrate the principle, let us take the example of a programme to monitor diarrhoeal diseases in a municipality that has decided that one of its priorities is to reduce infant mortality. A diagram can be drawn up showing how different elements interlink, and certain indicators relating to *inputs* or *services* can then be identified, which allow the performance of the system to be monitored. Of course, other diseases also contribute to infant mortality, such as malaria, acute respiratory diseases, malnutrition, etc., and identical diagrams can be drawn up for these.

Box 4: Example of a Programme to Monitor Diarrhoeal Diseases

	Indicators	**Examples**
↓	*Input indicator*	Resources invested in construction, information, education and communication (IEC)/training services and activities
	Activity indicator (process)	Latrines, awareness-raising IEC, distribution of oral rehydration salts (ORS)
	Service indicator	Number of latrines, number of trained mothers, availability of ORS
	Result indicator	Incidence of diarrhoea and number of dehydrated children
	Effect indicator	Proportion of children who have died of diarrhoea
	Impact indicator	Infant mortality rate

4.2 Criteria for choosing SIEC-S indicators

It is essential for the SIEC-S to focus on a small number of indicators for planning and monitoring the performances of services in order to avoid overwhelming users with a mass of data and creating a system that is unwieldy in terms of workload and cost. It therefore needs to be limited to providing basic data with which to plan services and monitor their performance. A procedure is required that will first allow users to prioritise their information needs and then allow indicators to be selected on an informed basis.

The data provided by the SIEC-S must do the following:

- satisfy municipalities' information needs;
- inform municipalities about performances and results in the health sector (quality and productivity);
- cover aspects of the sector that the municipality can influence, and encourage it to take action;
- enable the municipality to take decisions about the joint management of the health sector on the basis of reliable data;
- be flexible in order to be able to fulfil the specific needs of different municipalities.

In 2005 a meeting was held with representatives of the municipalities and the ASACOs to define their information needs. The SNV/KIT technical team then used this as a basis for

proposing indicators (see Annex IV for a full list), which were adopted by the representatives after modification. Each pilot municipality and its ASACO, working with the health services, then selected the indicators that corresponded to their specific information needs from this list.[5]

A form for identifying and analysing the chosen indicators was then drawn up as a reference and the following details were requested:

- information user;
- type of indicator;
- significance and use;
- frequency of indicator;
- method of calculating indicator;
- classification (green, orange, red [see section 4.5]).

Box 4: Examples of Indicators

Classification	Field of interest	Examples of indicators
Productivity and quality of care	Principal diseases	Use of curative services Expanded programme on immunisation (EPI) Malaria
	Coverage of preventive services	Immunisation coverage Antenatal checks Assisted births
	Health promotion	Accelerated Strategy for Child Survival and Development (SASDE) Drinking water and latrines Vitamin A coverage Financial coverage for AIDS sufferers
	Perception of quality of services	Reception given and respect shown by staff
Management	Management of financial and human resources and medicines	Community health centre operating accounts Average cost per case Average cost per prescription Staff availability
Consultation	Operation of bodies involved	Membership rate Proportion of women in ASACO decision-making bodies
	Involvement of villages in activities of community health centre	Proportion of villages having benefited from immunisation campaigns

4.3 Local actors' understanding of indicators

The first challenge was to check whether all the actors involved understood the indicators, so we tested the SIEC-S in two municipalities in the circle of Dioïla (Wacoro and Nangola).

In January 2006, we analysed to what extent local actors in the municipality of Wacoro understood certain SNIS indicators. Representatives from the Ministry of Health also attended these meetings. Our discussions with the municipal council and the ASACO covered what the indicators meant, how to analyse them and how they could be useful for the measures to be taken. The test showed that they understood the indicators very well,

[5] A municipality may have priorities that are not covered by the Ministry's regular monitoring system. Where that is the case, new indicators must be developed, together with a system for collecting and analysing the data.

and once we had overcome a few problems, some even wanted to go into them in more detail. Representatives from the Ministry of Health also attended these meetings.

The first indicator considered was that for antenatal examinations (ANE), which play an important role in reducing maternal mortality. Pregnant women are recommended to have three ANEs. The indicator was presented in a descriptive form rather than as a percentage: 'Out of 100 women, 90 attended the community health centre once for an antenatal check and 37 attended the community health centre three times for antenatal checks.' The corresponding results were ANE-1: 90% and ANE-3: 37%. The local actors clearly understood this indicator.

The ANE-trend chart drawn up during the supervisory visits is already up on the wall of one of the community health centre offices. It was presented to the local actors, but although they understood the meaning of the ANE indicator and the rates in their municipality, they were initially unable to interpret the chart. However, once the principles behind the graph and the chart were explained, it seemed that a whole new world opened up before their eyes. One person said: 'We thought the pictures on the wall were meant to make the community health centre look nicer. We didn't realise they were technical figures that we could understand.'

We immediately started a discussion about the graph, the target for the municipality and the results obtained. The participants concluded that the ANE-3 rate was too low. In analysing why this was the case, general explanations (not always correct) were first put forward, such as 'the women are ashamed to let people see they are pregnant.' In the end, more detailed explanations added substance to the debate. One of the municipal councillors suggested that one problem might be that husbands refused to let their wives attend the examination. In that case, the participants themselves concluded, rather than focusing awareness-raising solely on women, men also needed to be made more aware, in order to overcome the economic and social problems preventing women from deciding for themselves. Clearly, only detailed analysis will generate relevant comments and suggestions.

The second indicator discussed with the municipal actors was the rate of use of curative care, which was 0.25% for Wacoro. This indicator was explained as 'if everyone attends the centre just once, the figure is 1, but a person may visit the centre more than once.' The participants agreed that almost everyone in the municipality would fall ill at least once a year. So a figure of less than one would mean that some patients did not come to the community health centre, either because they sought treatment elsewhere or because they just stayed at home. A further discussion was then held about why this should be: 'Why are not all villages are covered?.' 'Who are the other health-care providers?' and 'What should be done to change this?'

The third indicator chosen was coverage of impregnated mosquito nets. In the municipality of Wacoro, 35% of the population have an impregnated net. This indicator was clear and the participants asked for more details: 'Impregnated mosquito nets for women or children?'

The municipal actors genuinely welcomed this working meeting. Because relevant indicators were presented in a comprehensible form, they were able to analyse them on the basis of results. This gave them a better understanding of the problem and made it easier for them to identify appropriate and feasible measures. The chairman of the mayors' association said: 'This is great. It's just what we needed. Now we can get a better idea of the state of health in our municipality. Before, we thought we were making good progress because we weren't analysing the figures properly, but now we can also find out where the problems lie.'

The Ministry of Health representatives also welcomed the discussions and realised that even unspecialised and sometimes illiterate actors can follow data provided by the SNIS. This should get municipalities more involved in tackling health problems — if the indicators are clearly explained and presented in an appropriate way. They thus realised the importance of the SIEC-S and its usefulness for the Ministry.

4.4 Presentation and analysis of information

The second challenge was to develop a way of presenting the data to make them accessible and comprehensible to local actors (municipalities and ASACOs), who were not health specialists.

It is important to take account of the municipal councils' objectives and the way they communicate with local people. First of all, the language used must not be technical. Since councillors are elected for five years and usually seek re-election, a five-yearly presentation usually suits them best, particularly if it means that, at election time, they can show local people what has been done and what results have been achieved. They are primarily interested in the results, not how the value of the indicators has been calculated. In addition, since many of them are illiterate, it is vital to present the information in visual form.

In order to be able to estimate the value of an indicator, it is important to compare it with figures from previous years for the community health centre concerned and/or the results for neighbouring centres (see Figure 1). Such a comparison allows the municipal council and the ASACO to judge the results for their community health centre. The actors can choose from three options for comparing the data collected in their municipality:

- compare indicators for the municipality with the average for the circle;
- compare indicators for the municipality with the national or regional norm;
- compare indicators for the municipality with a target set when the SIEC-S started.

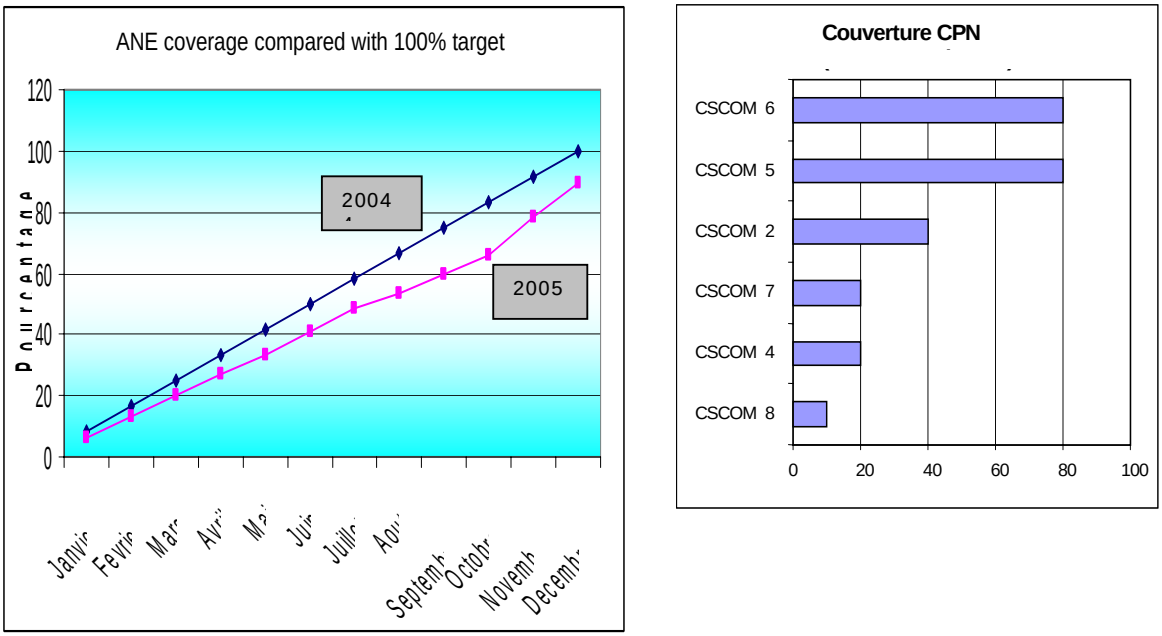


Figure 1: Sample graphs comparing data on antenatal checks

4.5 Stages involved in the SIEC-S

The starting point for the SIEC-S is a tripartite agreement between the municipal council, the ASACO and the Ministry of Health in which they identify priorities, choose indicators and determine the 'standards for comparison'.

Before beginning to put together the SIEC-S, an information and training meeting in the local language is held with all the participants and with representatives of the other local associations working in the public-health field. The participants must first understand the objectives and principles of the monitoring system and the meaning of the list of indicators. They need to know how to measure and interpret the graphs.

Special forms have been developed for the SIEC-S (see Figure 2).

Field of interest	Indicateur	Year			
		Q1	Q2	Q3	Q4
Principales maladies	Utilisation des services curatifs				
	Pourcentage des cas référés:				
	▶du village au CSCOM				
	▶du CSCOM au CsRéf				
	exacerbation d'une maladie à prévenir par le PEV				
	Proportion des enfants malades				
	- infections respiratoires aiguës				
	- syndromes diarrhéiques				

Key:
Far left: principal diseases
Second column, top to bottom: indicator; use of curative services; percentage of cases referred from the village to the community health centre; from the community health centre to the reference health centre; exacerbation of an EPI-preventable disease; proportion of sick children; acute respiratory infections; diarrhoeal syndromes

Figure 2: Sample SIEC-S form for a municipality

The indicator form must be filled in every three months by representatives of the municipal council and the ASACO on the basis of the information supplied by the community health centre's technical team. It is filled in in colour, either green, orange or red, depending on the target set when the SIEC-S starts. These colours or 'traffic lights' mean the following:

- **green**: when the results are as desired;
- **orange**: when the results suggest less progress than anticipated;
- **red**: when the results are declining or negative.

The data needed for the indicators chosen are supplied by the community health centre's technical team and are among the data already collected for the SNIS. With the ASACO's help they are calculated and recorded on special forms and given to the mayor. The municipal and ASACO representatives then analyse the data and decide which colour to give for each indicator. Then, before the circle team arrives for its inspection, they fill in the tables with the appropriate colours. The indicators are also presented in graph form by the municipality's medical officer, helped (if necessary) by the circle's health-information system (SIS) officer.[6]

The results of the SIEC-S and the graphs are presented and discussed during the Ministry of Health supervisory visit.[7] It is important for the circle officials to check, by asking detailed questions, that the municipal actors have understood the significance of the results. They can only take appropriate measures once they have understood the source of the problems. At the end of this joint analysis, an action plan is drawn up, including how responsibilities are divided, and progress is checked at the next visit.

[6] During the research project we worked with some SIS officers to make this information easier to read rather than merely providing a table full of figures. Their first reaction was usually to be doubtful and unenthusiastic. However, when they saw at the meetings how much their work was appreciated and the effect it had on the quality of the discussions, they recognised the importance of this type of presentation.

[7] As we said earlier, quarterly inspections of the community health centres form a regular part of the monitoring system.

The results of the SIEC-S are also used at municipal planning meetings. With the SIEC-S, it is possible to evaluate work carried out in the public-health field and the results obtained. It provides a basis for the municipality's annual planning. The council can also use the SIEC-S to show local people what the municipality is doing about public health and what it has achieved.

5. Conclusions and prospects

The approach for drawing up the SIEC-S is now fixed, and parts of it have been tested in two municipalities. Training in using the guide is to be provided during 2006. Although the provision of funding to complete the testing is behind schedule, it will be applied in other municipalities in order to validate the approach.

To their great surprise, the municipal representatives have proved quite skilful in understanding and analysing the indicators, discussing their significance with the devolved departments and identifying priority measures to be taken. They have shown enthusiasm for taking part in these activities. This shows that municipal councils have little involvement in public health not because they are not interested, but because they have not known how to talk about it.

The great strength of the SIEC-S is that it does not involve setting up a new data-collection system, since it uses only information already collected and available from the community health centre. What is new is the way in which information is made accessible to local people and officers in the municipality, and the SIS officer can play an important part in supervising the community health centre's technical team and local actors.

The SIEC-S allows non-specialists, including those who are illiterate, to take part in discussions on health-system results, progress and the reasons for failures or successes. Local actors and the Ministry of Health have welcomed the practical approach of the SIEC-S and recognised its importance for bolstering public health in municipalities. Setting up a basic information system for municipalities in this field could make it easier to create similar systems in other sectors, such as education, for instance.

One effect of the SIEC-S is that discussions between municipalities, ASACOs and the decentralised Ministry of Health departments are no longer limited to health funding, as they used to be. Now, they also look at 'public health'. The SIEC-S makes it easier to analyse and talk about the current situation, priorities, progress made and work to be done in the health field, and it thus encourages the various stakeholders to discuss and work together. The joint analysis encourages the actors to pool ideas in seeking solutions and discussing how tasks should be distributed.

The SIEC-S thus helps to improve consultation and increase mutual trust, because each partner is better informed. Experience has shown that actively involving local actors in monitoring can be an important way of improving cooperation in the health sector and system performance at the local level.

To be continued…

Annex I: Acronyms

ANE:	antenatal examination
ANICT:	Agence Nationale d'Investissements des Collectivités Territoriales / National Agency for Local Government Investment
ASACO:	association de santé communautaire / community health association
CSCOM:	centre de santé communautaire / community health centre
EPI:	expanded programme on immunisation
FENASCOM:	FEdération Nationale des Associations de Santé COMmunautaire / National Federation of Community Health Associations
HIV/AIDS:	human immunodeficiency virus/acquired immune deficiency syndrome
IEC:	Information, education and communication
KIT:	Royal Tropical Institute
NGO:	non-governmental organisation
ORS:	oral rehydration salts
PDESC:	Plan de Développement Social, Économique et Culturel / Economic, Social and Cultural Development Plan
PRODESS:	Programme de Développement Sanitaire et Social / Health and Social Development Programme
SASDE:	Accelerated Strategy for Child Survival and Development
SIEC-S:	Système d'Information Essentielle pour la Commune dans le secteur de la Santé / Basic Health-Sector Information System for Municipalities
SIS:	système d'information sanitaire / health-information system
SNIS:	Système National d'Information Sanitaire / National Health-Information System
SNV:	Netherlands Development Organisation

Annex II: Bibliography

ANICT. 2004. FICT 2001-2003, rapport de fin d'exercice. Bamako: Agence Nationale d'Investissements des Collectivités Territoriales (ANICT). 23p.

Hilhorst, T., D. Bagayoko, D. Dao, E. Lodenstein and J. Toonen. 2005. Dynamiser la santé communale - construire des partenariats efficaces dans l'espace communal pour améliorer la qualité des services de santé. Bamako: Netherlands Development Organisation (SNV) and Royal Tropical Institute (KIT). 44p.

Annex III: Resource persons, online documents and useful addresses

Resource persons:

Jurrien Toonen (KIT), e-mail: j.toonen@kit.nl

Thea Hilhorst (KIT), e-mail: t.hilhorst@kit.nl

Dramane Dao (SNV), e-mail: ddao@snvworld.org

Documents and links for consultation:

Hilhorst, T., D. Bagayoko, D. Dao, E. Lodenstein and J. Toonen. 2005. Dynamiser la santé communale - construire des partenariats efficaces dans l'espace communal pour améliorer la qualité des services de santé. Bamako: Netherlands Development Organisation (SNV) and Royal Tropical Institute (KIT). 44p. Available on-line: (http://www.snvmali.org/publications/brochuresante.pdf)

Online resources: www.kit.nl

www.snvmali.org

Useful addresses:

Royal Tropical Institute

Mauritskade 63, Amsterdam

BP.95001

1090 HA Amsterdam, Netherlands

Tel: (+31) 20 5688 272

Fax: (+31) 20 5688 286

SNV-Koulikoro

BP. 20, Koulikoro, Mali

Tel: (+223) 226 24 71

Fax: (+223) 226 20 92

Annex IV: Basic indicators

Classification	Field of interest	Indicators	Quarterly monitoring	Annual monitoring
Productivity and quality of care	Principal diseases	Use of curative services	x	
		% of cases referred	x	
		Priority diseases	x	
		Number HIV-positive (prevalence)		x
	Coverage of preventive services	Immunisation coverage (<1 year fully immunised)	x	
		Antenatal examination	x	
		Family planning	x	
		Proportion of children malnourished	x	
	Health promotion	Integrated advanced immunisation strategy carried out in X% of villages in the area		x
		Coverage: drinking water		x
		Coverage: latrines		x
		Coverage: impregnated mosquito nets		x
	Perception of quality of services	Reception given and respect shown by staff		
Management	Management of financial, material and human resources	Operating account: medical treatment	x	
		Operating account: essential generic medicines		x
		Average cost per prescription	x	
		Staff availability for treatment	x	
		Condition of buildings, equipment and transport		x
Consultation	Operation of bodies involved	Involvement of bodies in consultation meetings		x
		Compliance with regulations and internal rules		x
	Villages' participation in activities of community health centre	Proportion of villages that took part in immunisation campaigns	x	
		Proportion of villages regularly represented in community health centre management		x