

5

Community-based information systems

Francesca Moneti

• Introduction

During the 1980s, the government of Italy provided UNICEF very substantial support for a number of global programmes in the areas of health and nutrition, namely the Extended Programme of Immunization, the Essential Drugs Programme and the Joint WHO/UNICEF Nutrition Support Programme. As the programmes were meant to provide the greatest benefit to the countries in greatest need, the majority of resources were directed to countries in sub-Saharan Africa.

Perhaps the most important lesson that emerged from the implementation of these programmes is that achievement of health and nutrition goals can only be attained by strengthening the capacity of the population to address their health situation. It also requires effective decentralisation of the services, with greater participation of the population. This process must include both the retention of resources (organisational, human and financial) at peripheral level and an increased capacity, at that level, to take decisions on the allocation of the resources in line with the priority needs of women and children. The process of decentralization thus goes hand in hand with the push for greater democratization which is growing in strength, particularly in Africa.

• Background

The Joint WHO/UNICEF Nutrition Support Programme (JNSP) played a key role in bringing about a greater consensus on what constitutes a viable approach to address the problem of malnutrition. The approach, which provides the basis of the nutrition strategy now promoted by UNICEF, is based on the recognition that significant human and economic resources can be better focused on

the needs of women and children by increasing people's awareness and understanding of their health and nutrition situation, and by strengthening their capacity to take action.

The major methodological lessons emerging from the JNSP experience, outlined during the course of the JNSP evaluation done under the leadership of the Istituto Superiore di Sanita' in Rome, were as follows:

- The various JNSP programmes were originally quite different in their approach and strategy even though they shared similar overall objectives. Over the course of the life of the programmes, the differences have decreased and there is an emerging JNSP approach which is community-based, multisectoral and uses nutrition as a focus. **It emphasizes the need to create awareness about the nutrition situation and to empower the community to handle their own health and nutrition problems.**
- Experience has shown the usefulness and need to generate nutrition data. **The regular collection of information regarding the nutritional status of children under five years of age has shown to be a powerful mobilization tool.** This is because the information is obtained through a system of community-based growth monitoring, where the data is analysed by the community before being sent to higher levels. The use of nutrition data also seems to have made intersectoral coordination more achievable and convergence more possible.

The community-based methodology is applicable to all development activities in so far as it aims at increasing people's awareness of

their situation, helping them to deepen the analysis both of their problems and of the available resources so as to take appropriate action.

At the final meeting of the JNSP Steering Committee, held on 7 February 1990, it was agreed that a portion of the uncommitted JNSP Global funds would be used by UNICEF to further develop the methodology and accelerate its adoption 'beyond nutrition'. Due to a series of bureaucratic obstacles, there has been a delay in the development of the proposal for the utilisation of these resources.

The delay has enabled UNICEF to better evaluate how to situate the activities. Specifically, it has enabled it to place the resources strategically, taking into account past experience as well as the challenge of the WHO/UNICEF Goals of the 1990s endorsed by Heads of State at the World Summit for Children in September 1990.

Since the resources available for the development of community-based information systems are limited, they must be used as 'seed' funds to influence other programme activities supported by UNICEF that are endowed with greater resources. The Bamako Initiative has emerged as the most promising approach for achieving the health goals of the 1990s, exactly because of its emphasis on strengthening management capacity with more direct control of resources by the population. It has therefore been deemed appropriate to link the development of community-based information system to the development and implementation of Bamako Initiative programmes covering all of sub-Saharan Africa. Presently, a group of 12 countries is well into full scale implementation of the Initiative and it is expected that, by the end of 1992, an additional dozen will have begun implementation.

• Programme goal

Within the context of Bamako Initiative programmes already established or being developed, strengthen the capacity of communities and government staff at district and peripheral levels to manage the health and nutrition situation and more effectively contribute to decreases in morbidity and mortality of women and children.

• Programme objectives

The general objectives of the programme are:

- identify and strengthen existing community-based systems which generate and spread information on the health and nutrition of the population so as to enable households and communities to better quantify their health and nutrition problems;
- increase people's understanding of the immediate and underlying causes of death and disease by strengthening their capacity to analyse the information on the health and nutrition status, relating it to how resources are presently used, both at household level and collectively; and,
- increase the quantity and effectiveness of resources being used to promote the health and nutrition of women and children.

In order to achieve these objectives, it will be necessary to:

- accelerate the establishment and functioning of development committees at village or neighbourhood level;
- ensure that, through the community representatives serving on health centre committees, information on the health and nutrition situation of villages is shared with health centre staff so that appropriate decisions can be made about the allocation of resources available at the health centre; and,
- similarly, ensure an effective flow of information to district level to enable a better allocation of resources at that level.

• The Bamako initiative and development of community-based information systems

The challenge presented by the goals of the 1990s is to capitalize on the substantial progress made during the last decade in the pursuit of Universal Child Immunization and shift from specific coverage goals to the overarching impact goals such as the decrease in infant,

child and maternal mortality. Achievement of these goals is deemed impossible without a strengthening and extension of the health care delivery system. This is the main objective of the Bamako Initiative. Adopted by the African Ministers of Health in 1987, it has the following main elements:

- community participation, with a view to fostering self-reliance;
- strengthening management systems at community and district levels with a view to making them more supportive of each other;
- constant availability, rational prescription and use of good quality essential drugs; and,
- community financing.

Emphasising MCH, the Initiative integrates a wide range of individual health interventions such as immunisation, CDD, pre- and post-natal care, the prevention and control of malaria, ARI and AIDS. What characterises the Bamako Initiative is that the revival and strengthening of these basic health services is subject to people's greater participation and control. Local ownership, with finances that are generated by the health system being maintained under community management, has shown to be effective in making services more appropriate to local conditions.

Community-based management of resources requires information with respect to the health and nutrition situation and with respect to the present availability and utilization of resources. The development of community-based information systems, when linked to the direct control of resources, will therefore be of crucial importance in increasing people's ability to make decisions aimed at improving their health and nutrition situation. It will also enable communities to monitor the progress being made locally in the achievement of health and nutrition goals.

In countries that have begun to implement the Bamako Initiative, a central element of the effort to strengthen the peripheral health delivery system has been the greater direct participation of the population in the decisions relating to the use of resources generated by the health facilities. Concretely, this has meant supporting the establishment of health centre

committees composed of health staff and community representatives. While the exact responsibilities of the committees vary from country to country, their role generally includes:

- participation in, and oversight of, the accounting of resources (most specifically the proceeds from the sale of services and drugs);
- decisions about the allocation of resources generated locally;
- decisions to ensure access to services, including criteria for exemptions, reduced payments or credit arrangements; and,
- representation in the health management process at district level, through participation in district health committees.

Community representation in health centre committees is a necessary but insufficient condition for ensuring that the resources available at health centre level are used for the priority health problems of the population. In order to effectively carry out their role, the committees need to have specific information about the health situation of the population falling within the catchment area of the centre. Such information is necessary at the outset to determine the priority health needs of the population, to agree on specific targets and, based on these, to take decisions regarding the allocation of the resources available at the health centre. Subsequently, information on the health situation is necessary in order to monitor and evaluate the effectiveness of the allocation of resources.

The central issue here is that of the **accountability of the health system**, not only in terms of financial management but in terms of its ability to fulfil its mandate of serving the health needs of the population. In order to facilitate accountability, specific targets relating to the health of the population need to be established and regularly monitored. For these to be set, and to enable communities to monitor the progress being made toward their achievement, there must be a simple system which provides key information about the health status of the population. The more this information is public and shared widely, the greater the potential for increasing the accountability of the health system.

There is another, perhaps more fundamental reason why the information should be generated, analysed and used at village or neighbourhood level. The highest proportion of resources to promote the well-being of women and children come from the household and the community level. These include not only financial resources, but also people's time, knowledge, land and infrastructure. Greater consciousness at local level of the health and nutrition situation and of the resources available to address the problems can serve as an important stimulus for development activities at local level.

Thus, simple data on, for example, child births, deaths and nutritional status, when collected and analysed regularly at the level of the community, can be a powerful tool for decision-making. In addition, information on women's health, such as the outcome of pregnancies, should be included in order to focus more attention on the situation of women. The decisions taken at local level can relate to specific actions to be undertaken directly by households or collectively. Examples include organisation of feeding posts to ensure that young children receive at least three meals per day or lightening of women's workload during the last months of pregnancy. At household level, the increased awareness and understanding can lead to decisions on child spacing. Other actions, such as increasing the number of children immunized, need to be undertaken with the collaboration of the health system.

In this context, the establishment and functioning of a community-based information system can help to strengthen the role of the community representatives in health centre committees. If the targets set locally are shared with the health centres through the community representatives, the resources at the health centre can be more effectively mobilised toward the achievement of the targets. Another important implication is that an element of accountability is also introduced with regard to the individuals serving on health centre committees; they will be the direct linkage between the health system and the population and will be responsible for explaining how

resources were used by the peripheral health system and why.

To facilitate the collection, analysis and use of health and nutrition information both at community and at health centre levels, particular attention must be placed on the inclusion of women in health centre committees since, typically, they are most knowledgeable and directly responsible for the health and nutrition of the family.

• **Strategy**

To promote the development of community-based information systems within the programmes being supported by UNICEF, activities are carried out at two levels:

- A number of countries will be given direct support for the development of health and nutrition information systems that are community-based. This will be done in the context of the Bamako Initiative programmes. In some cases, the inputs will only consist of technical support, in others, they may be coupled with some financial support. The countries to be selected will include some where the Bamako Initiative is already well established and some where it is being developed.
- At Headquarters level, work will be undertaken directly with the Bamako Initiative Management Unit (BIMU), to ensure that community-based information systems are part of the Bamako Initiative programmes being developed at country level. The experience gained through the focused activities in a few countries will help to refine the overall programme development. This type of direct collaboration has already been effectively established between BIMU and the Essential Drugs Programme, with the Advised, Essential Drugs, working as part of the 'extended' BIMU team and having direct responsibility for backstopping Bamako Initiative programmes in countries that are also receiving support through the EDP.

- **Additional comments**

The Bamako initiative

UNICEF views the Bamako Initiative as a means of empowerment for villages.

Information collection plays a crucial role in the activity of health centres.

Initially those health committees involved were very worried about having enough money on hand to buy their drugs. But once they could see that they did have enough money coming back in through charges, they then started asking what to do with the extra money. Some committees hoarded it, others thought about how to work at community level. There is a triangular relationship between the utilisation of the centre, which drugs are bought and sold and the income/expenditure levels of the centre. The question was how to encourage these committees to move on from concentrating on the financial aspects of the centre to a consideration of the health aspects of the community. In Guinea, for instance, there were initially no catchment areas for health centres. No pro-active community work was carried out. It should be said here that P/RRA would make a very valuable contribution as an initial participatory base-line study.

Accountability and control of resources would then be built into the system, for instance in the recording of new births. Questions could be addressed such as: "*How do health centre resources reach new babies? How can villagers save to pay for those resources?*". Of course the health centre would have to be responsible for EPI, for instance. Yet at the community level some things can be done. Nutrition work, for instance, is an area which could very much be focused at community level, through information generated by the community.

Growth monitoring in Tanzania is a good example. This was a large scale issue of this last decade. In Tanzania there was a focus on making it a village-based activity. Village-level data collection and analysis took place. Only then was information passed on to district level. Village growth charts were generated, with locally set targets. This was a process that emerged independently when the weighing was

done. No one had previously asked the communities to set themselves targets.

Some said this could only be done in Tanzania. However UNICEF decided to try it in Mali, Peru and a richer area of Ethiopia. These ventures were all supported by government staff, not by UNICEF. In Ethiopia, local health workers initially resisted the idea. They did not believe that villagers could do the weighing themselves. However at the first weighing session, there was a recognition that 40% of children were underweight in food surplus area.

In Mali literacy training took place alongside the village based monitoring. But maybe this was not necessary. The third round of weighing was after the harvest (the children were weighed every three months). The villagers expected that their children would weigh more, because of the food availability. But the children turned out to be worse off. The villagers then asked themselves why this was so. They then realised that, although there was food in the house, the women were out harvesting groundnuts and therefore were not available to feed their children. Thus they realised that women's work loads were a problem which had to be addressed if children's nutritional status were to improve. (This realisation then also indirectly offered the possibility of improving life for women). In such ways, rapid assessments allow for a local analysis which can be continued over time. Villagers can themselves monitor the health process and make the health system accountable.

In the Peruvian Andes men reacted very violently when they realised the low nutritional status of their children. They said it was because they were landless. They wanted to reclaim their land, which was of course a big issue. But there were also some more immediate smaller solutions which could be addressed. Over time their analysis of the problems grew deeper and they appreciated that they had a combination of immediate, underlying and basic causes governing their poverty. On the immediate level, there was a problem of infections and lack of food. At the more underlying level, there was a lack of health services, food security and land. At a basic level were such questions as who controls the resources and so on. Thus, through the

process of village involvement in growth monitoring, the community were able to develop their appreciation of their needs. Thus as a basis for general community awareness raising, community involvement in such activities has proved to be an effective process.

- **Francesca Moneti**, UNICEF, 3 United Nations Plaza, New York, NY 10017, USA.