

PN-ACC-411  
97466

**PROCESS EVALUATION  
OF THE COMMUNITY PARTNERS  
FOR HEALTH PROGRAM OF  
BASICS/NIGERIA**

September-December 1997

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BASICS Technical Directive 000 NI 58 012  
USAID Contract Number HRN-C-00-93-00031-00

The BASICS project in Nigeria was given the mandate to find innovative ways for meeting the child health needs of poor urban communities in 1994. In 1995, BASICS undertook the Urban Private Sector Inventory (UPSI) in 13 communities within the Lagos metropolitan area in order to identify community-based organization (CBOS) and health facilities that could form local partnerships or coalitions that could not only advocate for, but also plan and deliver child and family health services themselves.

Using the results of the UPSI, BASICS chose six communities where organizational efforts began through community fora where issues of child and community health were discussed and the idea of the CPH (community partnerships for health) was put forth. In 1997, with CPHs in both Lagos and Kano, two BASICS consultants undertook the exercise of documenting the Nigeria CPH program. The following appendix is their documentation report.

## **APPENDIX**

DOCUMENTATION EXERCISE  
A PROCESS EVALUATION OF THE  
COMMUNITY PARTNERS FOR HEALTH PROGRAMME  
OF BASICS, NIGERIA

by

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September-December 1997

*DRAFT 12 January 1998*

## EXECUTIVE SUMMARY

Basic Support for Institutionalizing Child Survival (BASICS) in Nigeria was given the mandate to find innovative ways for meeting the child health needs of poor urban communities in 1994. In 1995, BASICS undertook the Urban Private Sector Inventory (UPSI) in 13 communities within the Lagos metropolitan area in order to identify community based organizations (CBOs) and health facilities (both indigenous and western) that could form local partnerships or coalitions that could not only advocate for but plan and deliver child and family health services such as immunization and prompt treatment themselves. In the process, these community partnerships for health (CPHs) would learn basic principles of democracy and governance that included an increased role for women as decision makers.

Using the results of the UPSI, BASICS chose six communities where organizational efforts began through community fora where issues of child and community health were discussed and the idea of the CPH was put forth. By the end of 1995, six CPHs that resulted from this process, Lagos Island (Ward E), Ajegunle, Amukoko, Mushin, Lawanson (in Surulere), and Makoko. In the next two years BASICS staff have provided assistance in organizational development, technical training and minimal supplies and equipment to enable the CPHs to undertake action in line with the objectives of their work plans. Efforts are currently underway to develop 5 CPHs in the northern Nigerian city of Kano.

At this point, two years into the life of CPHs in Lagos, the need to document the progress and processes of CPH formation and functioning was actualized. Some of the documentation activities have begun in Kano, and will serve as a baseline for future process evaluation there. Between September and December 1997, two consultants worked with BASICS staff to answer the following questions through review of documents, interviews with CPH and member group leaders, discussions with CBO members and analysis of CPH Board meeting minutes.

1. What is the CPH Approach purpose, steps, processes, core activities and participants?
2. What does the CPH approach produce organizational structures, community action, awareness, spin-offs? (An ETIC perspective)
3. How is the CPH approach perceived benefits, results, community efficacy? (An EMIC perspective)
4. How does the CPH approach achieve its results organization, management, inputs/resources (internal & external) decisions?
5. Is the CPH approach sustainable and replicable?

Records revealed a series of core activities that were undertaken to build the CPHs. For example, governance of the CPHs evolved with the formation of a governing Board, formalization of relationships within the CPHs and between the CPHs and BASICS through memoranda of understanding (MOU), drafting of a constitution, and eventual registration with the Federal Government of Nigeria as NGOs.

The majority membership of the CPHs at present rests with the CBOs, although during the UPSI large numbers of both CBOs and HFs were identified. Proportionately fewer Health Facilities expressed interest in the concept, especially as the CPH approach requires the guarantee of affordable and timely care to prevent death from childhood diseases. Among those groups that did join, there is a stronger perception of community efficacy (identity, cohesion and social control) than among groups that did not become part. Leadership of the CPHs and their member CBOs and HFs reflect the ethnic diversity of Lagos, but it was found that ethnicity could also be a source of tension within some CPHs.

CPH leadership in Lagos has involved women, who make up one-third of Board members. Since the MOU forms the basic foundation of individual group commitment to the CPH, it was important to see that most CPH, CBO and HF leaders were aware of the document and understood its purpose in defining roles and responsibilities. Unfortunately there was a fair number who had not seen the document or did not know what it was about. CPH Boards were asked to undertake self-study rating of their current levels of basic organizational structure, management mechanisms and programming efforts. As expected, the CPHs rated themselves strongest in having established an organizational structure and weakest in the area of programming. The validity of the self-study guide was seen in the fact that the newest dyads to join the CPHs in Ajegunle and Lawanson ranked themselves low on organizational Structure (Dyads are sub-groups within a CPH that consist of a minimum of two partners, one CBO and one HF).

All CPHs developed a work plan, and while the initial efforts reflected some individuality in prioritization of needs, later versions of the plans included overall USAID country objectives such as family planning and HIV/AIDS control. Not surprisingly awareness that these issues were CPH priorities was low among CPH leaders. All groups have undertaken programmatic activities including linking with local government vaccine stores to guarantee regular immunization of children, environmental clean-up to address the causes of malaria and diarrhoeal diseases, and awareness campaigns to alert the public on the dangers of HIV/AIDS. The latter has become an important focal issue for the youth wings that have formed in most of the CPHs.

CPHs have developed three main mechanisms for financial sustainability, 1) collection of dues and donations, 2) fundraising activities like raffles and launchings, and 3) income generating projects. The latter was facilitated quite by chance by USAID when used furniture and vehicles were given to the CPHs. Lawanson sold its vehicle while JAS/Mushin chose to turn theirs into an ambulance for hire. Both of these CPHs have started Cooperative and Thrift Societies that not only aid individual members but also generate a small annual profit for the CPH.

On the organizational side of sustainability, CPHs have started reaching out to other agencies, both governmental and non-governmental to access both resources and technical assistance. They have also been calling on each other more and more to get assistance and advice in starting new projects and solving problems. This augers well for future independent action and sustainability, and BASICS staff themselves have been promoting inter-CPH communication and activities within both Lagos and Kano.

Preliminary information from Kano shows a major role for patent medicine vendors

and indigenous healers in those CPHs. Unfortunately, but not unexpectedly, female leadership is only about 5% of Board members. This may not be unconnected with the low level of female literacy, a priority issue that all five Kano CPHs wish to tackle.

### **Recommendations**

- 1 Clarify the structure and functioning of dyads within the overall governing process of the CPHs to ensure not only a viable, meaningful and participatory intermediate level structure, but also to guarantee that in the process, individual CBOs and HFs will not feel left out of CPH governance
- 2 Ensure that all current and new CBO/HF members not only have copies of the MOU but have actually signed it. A system by which new members formally sign the MOU soon after joining needs to be instituted in each CPH
- 3 An intra-city CPH management or facilitative Board needs to come formally into being within the next few months as this is the main mechanism through which continued CPH activity in Lagos can be ensured and by which the formation of new CPHs can be stimulated. This intra-city Board can also be a “court of last resort” to settle conflicts within individual CPHs
- 4 Particular attention needs to be paid to Makoko CPH in order to identify active Health Facility partners who can and will handle basic services such as immunization on a regular basis. The need to form strong dyads around these health facilities and the subsequent restructuring of the CPH to encourage wider participation will be necessary to overcome perceptions that the current leadership is authoritarian
- 5 At this point, the Surulere/Lawanson area and Ajegunle are the farthest along in terms of dyad formation. There is need to ensure that the transition is both amicable and constitutional when it comes time to reformulating the CPH structure and leadership. All parties must be involved in restructuring decisions
- 6 In the longer term, there is need to experiment with more rapid, focused and cheaper mechanisms for identifying future partner organizations, as it is unlikely that local NGOs would have the time or resources to conduct a full UPSI
- 7 The upcoming process of elections and potential change of leadership in the CPHs must be monitored and fully documented as an indicator of organizational maturity and sustainability,
- 8 Proper and timely filing needs to be introduced at the BASICS Lagos office so that all information concerning a particular CPH is kept together in chronological fashion. Effort must be made to obtain promptly and to read through thoroughly the minutes of Board and committee meetings in order to grasp CPH developments and make timely intervention to resolve conflicts and solve problems

## ACKNOWLEDGEMENTS

The consultants wish to express their gratitude for the high level of cooperation and collaboration received from BASICS Nigeria staff, especially, but not limited to, Dr J O Ayodele, the Country Advisor, Mr Sam Orisasona, the Community Development Program Officer (CDPO), Mrs Ayo Iroko, Assistant CDPO, and Mr I Bebeji, CDPO for Kano, who ensured that field work ran smoothly

CPH and CBO/HF leader interviews and CBO member focus group discussions were conducted with the help of the following research assistants in Lagos Mr I A O Ogunbiyi (supervisor), Mr J Ogunlade, Mrs E O Adebayo, Mrs R Ogunjimi, Mr P.E Adejo, Mr R O Oginni, Mr O.P Ejidiran, A A Adetoro, and Mrs D O Ahehomen They are to be commended for their maturity Mr Ogunbiyi and Mrs Ogunjimi also helped conduct the in-depth interviews with community leaders Mrs Ogunjimi, because of her fluency in Hausa, and R O Oginni, because of their experience gained on the field in Lagos, assisted Mr Bola Ogunlade supervising the interviewers in Kano Those interviews were ably conducted by

# CONTENTS

	<u>page</u>
Title Page	1
Executive Summary	ii
Acknowledgements	v
Contents	vi
List of Abbreviations and Acronyms	ix
<b>1 BACKGROUND</b>	<b>1 1</b>
1 2 African Urbanization	1 2
1 2 1 Voluntary Associations	1 2
1.2 2 Participation in Urban Life	1 3
1 2 3 Urban Administration and Services	1 5
1 2 4 The Private Health Sector	1 6
1 3 The Lagos Metropolis	1 8
1 4 Urban Child Health Issues	1 11
1 5 Community Organization and Coalitions	1 12
<b>2 METHODS</b>	<b>2 1</b>
2 1 Leadership and Membership Inventories	2 3
2 2 CPH and CBO Leadership Survey	2.3
2 3 CPH Management Self-Study Guide	2 5
2 4 BASICS Staff and CPH Chair Essential Activities Rating	2 7
2.5 Textual Analysis of Board Meeting Minutes	2 8
2.6 CBO Member Focus Group Discussions	2.9
2 7 Community Leader and Agency Staff In-depth Interviews	2 10
2 8 Review and Updating of CPH Filing System	2 10
<b>3 CORE PROCESSES &amp; ACTIVITIES</b>	<b>3 1</b>
3 1 Ranking	3.2
3 2 Perceived Differences	3.4
<b>4 MEMBERSHIP</b>	<b>4 1</b>
4 1 The Urban Private Sector Inventory	4 1
4.2 Community Fora	4 3
4 2 1 Organizing the Fora	4 3
4 2 2 Summary of Fora	4 4
4.3 Partnership Formation	4 5
4 4 Membership Changes	4 7

	<u>page</u>
4 5 Current Membership	4 11
4 5 1 Reasons for Joining	4 12
4 5 2 Reasons for Not Joining	4 14
4 6 Overview of the Communities	4 17
4 6 1 Ethnic Mix	4 17
4 6 2 Religion	4 18
4.6.3 Community Efficacy	4.19
4.6.4 Violence	4 21
5. GOVERNANCE	5 1
5 1 Memorandum of Understanding	5 1
5 2 Constitution	5 7
5 3 Dyads and Clusters	5 8
5.3 1 Lawanson	5 9
5 3.2 Ajegunle	5 12
5 3 3 Nascent Dyads	5 14
5 4 Leaders, Boards, Committees and Wings	5 15
5 5 Perceived Benefits	5 17
5 6 Organizational Development and Functioning	5 18
5 6 1 Self-Study Guide	5 18
5 6 2 Attitude toward CPH Functioning	5 18
5 7 Board Representation	5 21
5 8 Summary of CPH Organizational Achievement	5.24
6 WORK PLAN and ACTIVITIES	6 1
6.1 Evidence of Action	6 3
6.2 Perceptions of Achievements	6 10
6 2 1 Leader Perceptions of Achievements	6 10
6 2 2 Reasons for Success	6 12
6 2 3 Perceived Benefits of CPH	6 13
6 3 Views from the Outside	6 13
6 4 Summary of Progress towards Goals	6 14
6 5 Capacity to Monitor	6 15
7 SUSTAINABILITY and RECOMMENDATIONS	7.1
7.1 Financial Sustainability	7 1
7.2 Reaching out to Other Agencies	7 5
7.3 Inter-CPH Contact and Organization	7 7
7 4 Recommendations	7 10
8 PRELIMINARY FINDINGS FROM KANO	8 1
8 1 The Ancient City of Kano	8 1

	<u>page</u>
8 2 Organizational Steps	8 2
8 2 1 UPSI	8 3
8 2 2 Community Fora	8 4
8 2 3 Partnership Formation	8 5
8 3 Membership	8 7
8 4 Leadership	8 8
8 4 1 Leadership	8 8
8 4 2 Self-Study Guide/Organizational Development	8 9
8 5 Programming	8 9
 9 REFERENCES	 9 1
 APPENDIX - INSTRUMENTATION	 A 1
Leadership/Membership Inventories	A 2
CPH Leadership Interview	A 3
CBO/HF Leadership Interview	A 13
Core Activities Ranking	A 19
Focus Group Discussion Guide	A 21
In-Depth Interviews with Community Leaders	A 23
Management Self-Study Guide	A 26
 DOCUMENTS	 D 1
Sample Memorandum of Understanding	D 2
MOU Between CBO and HF Partners	D.2
MOU Between CPH and BASICS	D 8
Sample Constitution	D 13

## LIST OF ABBREVIATIONS AND ACRONYMS

AJ2	Ajgunle area new dyads
AJE	Ajgunle original CPH at Rikky Hospital
AMU	Amukoko
BASICS	Basic Support for Institutionalizing Child Survival
CBO	Community Based Organization
CDPO	Community Development Program Officer
CPH	Community Partners for Health
HF	Health Facility
IP	(USAID) Implementing Partner
JAS	JAS Medical Services, JAS CPH Mushin
LAI	Lagos Island
LAW	Lawanson
MAK	Makoko
MOU	Memorandum of Understanding
OJU	Ojuelegba area of Surulere, new dyad of LAW CPH
SPP	Sub-project Proposal
SUR	Surulere (containing Lawanson and Ojuelegba)
UPSI	Urban Private Sector Inventory
USAID	United States Agency for International Development

## 1. BACKGROUND

The Basic Support for Institutionalizing Child Survival (BASICS) Project of the U S Agency for International Development began work on the Urban Private Sector Integrated Health Project in mid-1994 in Lagos, Nigeria. BASICS pioneered a model known as the Community Partners for Health (CPH) in six low income communities in Lagos that was based on coalitions between community based organizations (CBOs) such as resident associations, religious groups, social clubs, and trade associations and private or non-governmental health facilities (HFs) which could either offer western medicine or indigenous health care. The broad goals of these coalitions were to promote child and maternal health, make health care accessible and affordable, and to empower community members, especially women, to take responsibility for their own lives. Specific activities arising from these goals included childhood immunization, reduced cost health care, environmental sanitation and community health education campaigns. By the end of 1995, six CPHs had been formed in Lagos.

In late 1996, the CPH model was taken to the city of Kano in northern Nigeria. During 1997 five CPHs were organized in Kano. This report will focus primarily on the Lagos experience, since the CPHs there have had two full years to develop their leadership, management and programmes. A brief section is devoted to preliminary findings from Kano, but a subsequent report will provide more detailed information on the CPH start-up activities in Kano.

Now that the Lagos CPHs have been functioning for two years, the BASICS Project staff deemed it necessary to document the process and progress of CPH formation. In this way immediate lessons can be learned and applied to programme activities in Kano and be made available for expansion to other parts of Nigeria and Africa. The documentation exercise took place between September and December 1997. Two external consultants were engaged with experience in social research and programme evaluation in order to provide an objective overview of the CPH development process. They received guidance and logistical support from the BASICS staff based in Lagos. The major questions to be addressed in the exercise were as follows:

1. What is the CPH Approach: purpose, steps, processes, core activities and participants?
2. What does the CPH approach produce: organizational structures, community action, awareness, spin-offs? (An ETIC perspective)
3. How is the CPH approach perceived: benefits, results, community efficacy? (An EMIC perspective)
4. How does the CPH approach achieve its results: organization, management, inputs/ resources (internal & external) decisions?
5. Is the CPH approach sustainable and replicable?

Answers to these questions can be found, not only by collecting data directly from the

CPHs, the BASICS staff and the local communities themselves, but also by reviewing the effort to build community coalitions in Lagos in the context of the African urbanization process, the role of local government administration, factors that promote community participation in the African metropolis and the principles on which coalitions are founded. This introductory section is devoted to this broader African urban context.

## **1.2 AFRICAN URBANIZATION**

Africa may be one of the least urbanized areas of the world, but it is experiencing the most rapid rate of urban growth (Mabogunje, 1976). The West African region is characterized by both indigenous pre-industrial cities, like Kano and Ibadan, as well as modern urban industrial complexes like Lagos (Mabogunje, 1976). The role of the modern industrial city is one of transformation - economic, social - and is the point from which innovations diffuse throughout the country. This transforming and innovating nature of cities attracts the relatively poorer rural populations, resulting in rural to urban migration and urban growth rates often twice or more the national population growth rates. While initial migrants may have been drawn to cities because of work in large scale industries, others soon follow to undertake supportive trading and small scale manufactures such as tailoring, bakeries and electronics repair (Mabogunje, 1976).

While the urban environment has advantages in terms of education and amenities, it also suffers from unique health and environmental problems. Lack of adequate housing means that most urban families are crowded into one room, and housing densities can average more than 3 persons per room in urban Nigeria generally, and over 4 per room in Lagos (Adegbola, 1987). Under these conditions, sanitation and waste disposal are major problems creating opportunities for the spread of faeco-oral diseases and breeding sites for disease-carrying vectors such as mosquitoes. Many areas are not served by regular electric power, and the subsequent reliance on wood and kerosine for cooking in these congested residential environments produce air pollution and higher rates of respiratory diseases.

### **1.2.1 Voluntary Associations**

When these migrants enter the city, they stimulate the development of new social institutions and organizations to meet their needs in the absence of the traditional extended family. In the public and formal sectors, this gives rise to institutions that protect and promote life, such as schools, hospitals, and social amenities such as water, sewage, electricity and refuse disposal. On the informal side, various voluntary associations are created to aid the newcomer to integrate into urban life. These include religious societies, trade unions, recreation clubs, and perhaps the most important, ethnic or home town associations (Mabogunje, 1976). Mayo (1969) identified three functions of West African urban voluntary associations to include substituting the function of the rural extended family, functioning as an agent of social control, and assisting in the adaptation of rural migrants to urban life.

In his study of 113 of the approximately 300 voluntary associations in Benin City, Nigeria, Enabulele (1987) found that the average membership was 30-60 persons and that most (80%) had membership fees. Although a few (19.5%) served external, instrumental functions (i.e. addressed issues in or provided services to the larger society), most focused

on the internal expressive needs of members by providing financial assistance, settling disputes, enhancing knowledge and skills, making business contacts, and maintaining cultural norms and practices. Likewise, Barnes (1975) identified five types of voluntary associations in metropolitan Lagos: religious groups (which were most prevalent), primary or ethnic associations, work related groups (including unions and market associations), recreational groups (e.g. involving sports, hobbies), and *esusu* or revolving credit and savings associations.

Among the 'modern' urban associations of most significance are branches of Christian churches. While their explicit aims are propagation of their faiths, they also serve important social adaptation functions. Members may gain from mutual benefit schemes and enroll in guilds and fellowship groups that are concerned about the economic, social and educational needs of members, as well as their spiritual concerns (Little, 1970). Other associations that have grown on urban soil also reflect western education and culture and include societies of old students of urban secondary schools, football clubs, and social clubs that feature debate and discussion in English, but even these 'modern' urban associations may reflect ethnic and religious divisions in the larger society (Little, 1970).

In a northern Ghanaian town from about 1930-1969, the Baptist Church provided the Yoruba migrants from Nigeria a not only a familiar way to worship, but also a social structure that substituted for extended families and social groups from their home towns such as Ogbomosho, Igbeti and Igboho (Eades, 1977). The church provided an opportunity to reinforce group norms far from home. Not only did the church provide an outlet for leadership aspirations among leading businessmen, but by the formation of two congregations, mirrored the social class differences in the migrant population.

As can be seen above, voluntary associations in urban Africa also serve political functions (Wheeldon, 1969). Low income, minority and disenfranchised groups, may, through their voluntary associations maintain and promote their rights vis-a-vis other groups. Wheeldon (1969) outlines three functions of these associations: expressing of their specific interests within their communities, providing a platform from which community needs may be made known to the larger society, and providing a context in which local politically ambitious individuals can acquire prestige and influences.

Hausa migrants in southern Nigerian cities provide an example of the degree to which ethnic association can go beyond small voluntary associations to the re-creation of a nearly complete Hausa society in the new setting (Cohen, 1969). A concern about maintaining trade monopolies and ethnic and religious customs resulted in a network of Hausa communities in the then Western Region of Nigeria. This network held monopoly over major stages of trade, especially in kola nuts. A complex political and social structure evolved to fend off rivalry from local Yoruba traders. Not did the Hausa of the Sabo community in Ibadan maintain cultural exclusiveness from the host Yoruba society, but also appeared immune from the broader national social and cultural changes that were affecting the Yoruba in Ibadan.

### **1.2.2 Participation in Urban Life**

Although voluntary associations play a role in helping individuals and groups adapt to

urban life, they do not necessarily guarantee the creation of a broader feeling of community in urban neighborhoods. As Rifkin (1987) pointed out -

Urban dwellers often share only a common location, they have little common interest or framework for joint action. It is difficult to maintain community involvement because poor urban communities lack a common understanding and social infrastructure. The urban poor often lack land titles, knowledge of government aid, contact with social welfare agencies and, most important, confidence to overcome any or all of these barriers.

The characteristics of urban neighborhoods help explain the difficulty of involving urban dwellers in community development. Warren and Warren (1997) identified three characteristics of communities that foster success in community development:

- 1 *Interaction* How often and with what number of neighbors do people visit and interact on the average during a period of one year?
- 2 *Identity* How much do people feel they belong to a community and share a common destiny with others - a sense of consciousness about what their community is and where it is spatially and symbolically?
- 3 *Linkages* What channels exist in terms of both people with memberships in outside groups and those who bring news about the larger community back into the neighborhood?

At one extreme they describe the 'integral' community that is strong in all three characteristics, having both strong internal identity and a cosmopolitan outlook. The opposite is an 'anomic' community simple survive without social interaction and advantageous outside contacts

A study of urban communities in Ibadan, Nigeria revealed that most neighborhoods fall somewhere in between these extremes. Areas of indigenous settlement founded in the pre-industrial era could be termed 'parochial' in that they have a strong sense of identity and internal interaction (based on, for example, local festivals and leadership installation ceremonies), but few links with the 'modern' city administration from whence social welfare benefits are derived. These communities can organize small-scale internal self-help projects, but lack the external links to attract major resources to solve their chronic problems such as lack of pipe-borne water (Brieger and Adeniyi, 1981-82)

Many urban communities are 'transitory,' with strong external links to their places of work and city-wide ethnic or home town associations, but little sense of internal identity or interaction. Many such residents rent rooms in congested tenements, and many of their landlords are absentee, living in higher income sections of town. Tenants are politically weak and are reluctant to make their needs for improved services and amenities known, but may be able to come together for small-scale projects like school toilet construction through local organizations such as the Parent Teachers Association (Brieger and Adeniyi, 1981-82)

It has been found that the 'collective efficacy' of communities or neighborhoods as

defined by a high degree of social cohesion and willingness to intervene for the common good is associated with more stable, less violent places to live (Sampson, Raudenbush and Earls, 1997) Collective efficacy is also associated denser friendship and kin networks, and thus related to the concepts of identity and interaction as espoused by Warren and Warren (1997) The transitory nature of many low income African urban communities, may make it difficult to achieve the level of cohesion needed for collective action In fact, when considering the expansion of the Bamako Initiative, which is based on community financing and participation, to urban areas, Jarrett and Ojosu-Amaah (1992) commented that,

With rapid urbanization in Africa, the need to look at urban health, especially of mothers and children, cannot be ignored The same principles of equity and decentralization of management also apply to the delivery of health services in urban areas Community solidarity is, however, often much less in evidence in the younger, more fragmented urban communities than in established and traditional rural areas.

### **1.2.3 Urban Administration and Services**

In theory, urban administration should be designed to fill the gaps in services for transitory and poor urban communities Ironically, while modern welfare services, such as education, health, sanitation, markets, art and recreation, emanate from urban centers (Mabogunje, 1977), basic weaknesses in African urban administration mean that the poorest areas in these cities are inadequately served (Mabogunje, 1976) Interestingly, one of the key reasons why municipal councils have not been able to discharge their duties effectively is due to the lack of -

enlightened participation of all members of the community and on a public-spirited leadership For the majority of city-dwellers in Africa, this type of participation is a novel experience It is in sharp contrast to the traditional rule of elders and chiefs or the more recent authoritarian government of colonial administrators Most city-dwellers lack experience as to what criteria to use in selecting representatives for the council or in distinguishing between the self-centered demagogue and the public-spirited local leader (Mabogunje, 1976)

Another problem of urban administrations is that the large number of poor and unemployed residents do not contribute to the tax base, and yet they make considerable demands on urban services In some cases, national ministries take over provision of these services, but this results in fragmentation of responsibility, inefficiency and a delay in long term development (Mabogunje, 1976) In Nigeria, local councils (or Local Government Areas LGAs) depend on subvention from the Federal Government, and to some extent the states, for subventions that are required to cover their basic and recurrent expenses Although LGAs are entitled to raise local revenue from taxes, rents, licenses, and rates, this usually amounts to less than 20% of their annual budgets (Ohwona, 1990) It is usually from local revenue that LGAs are able to provide services such as primary health care, refuse disposal, management and sanitation of markets, and provision of primary school education (Adeyemo, 1990)

Not all LGAs are created equal In 1986, urban Lagos Island LGA raised 58% of its

revenue locally, compared to 9% for the more rural Epe LGA (Adeyemo, 1990) One would suspect that even in the metropolitan area, LGAs would vary in their income generating capability based on the economic status of the inhabitants

LGAs have often considered user charges to be one avenue for generating internal revenues, for example charges for market stalls, health services and transportation Unfortunately, this approach often has negative side-effects Internally, the cost of collecting the charges may outstrip the intended profits More importantly, these charges may price the cost of services beyond the reach of the very citizens for whom they are intended (Adeyemo, 1990)

Discontinuity of management of another administrative problem of the present LGA personnel system in Nigeria All staff on salary grade level 07 and above and under the authority of the state level Local Government Service Commission This includes all professional health and human service personnel (Adeyemo, 1990) While this arrangement ensures uniformity in qualifications and salary and job security for the worker, it is potentially disruptive for the health service These 'senior' staff can be transferred at will, or on the other hand, may see transfer as the only way of gaining promotion in the service This means they are not accountable to the local councils and communities in which they serve

#### **1.2.4 The Private Health Sector**

The private sector has been touted as an alternative to inefficient LGA and other government health and welfare services Recently the World Bank (1993) noted -

Greater reliance on the private sector to deliver clinical services, both those that are included by a country in its essential package and those that are discretionary, can help raise efficiency The private sector already serves a large and diverse clientele in developing countries and often delivers services of higher quality without the long lines and inadequate supplies frequently found in government facilities

One component of the Nigerian private sector is the ubiquitous patent medicine store, often referred to as the "hospital for the urban poor" (Iweze, 1987) People patronize these shops because of proximity to home, lower charges, short waiting time, friendly demeanor of shop owners, prompt attention and beliefs that shop owners are knowledgeable In addition, shops often sell medicines on credit to well known neighbors In addition, patent medicine sellers have been observed to sell customers exactly the quantity of drugs they can afford, regardless of what a prescription states (Oshiname and Brieger, 1992). Some efforts have been taken to train medicine sellers, but the orthodox health establishment is reluctant to support any activity that might legitimize the role of medicine sellers as 'doctors' (Oshiname and Brieger, 1992)

The role of private or 'entrepreneurial' medical care is growing in Nigeria, and nowhere faster than in urban centers Alubo (1990) documented that in Nigeria in 1985, 13.2% of all forms of health establishment were privately owned, a growth of 8.4% over 1982. In that same year 16.5% of all hospital beds were in private hands This was a

growth rate of 8.8% in private hospital beds over 1982. It should be noted that these figures were based on officially registered private facilities only.

While the disparity in allocation of medical doctors between rural and urban areas is well known, little attention has been placed on intra-metropolitan distribution of physicians. As Ojo (1990) explained -

It has been noted that the same factors identified for rural-urban preference can be used to explain the uneven distribution of medical care within the major urban centres of Nigeria. In the traditional cities, such as Ibadan, Kano and Benin, similar socio-economic factors contribute to the concentration of most facilities in the new residential areas - where most of the middle- and upper-income households are situated - whereas the indigenous residential neighborhoods, characterized by poor housing and low-income families, rarely attract the placement of medical facilities and services. In Lagos, Port Harcourt, Maiduguri and Kaduna, for example, physicians not only prefer to locate their practices near the middle- and high-income residential areas, but also in some of these cities, they congregate in 'physician clusters', often near the area of the teaching hospital. In general, economic factors are of increasing importance to physicians even when they decide to locate in the most populous area of a city, the desire to maximize incomes appears to be a major consideration.

Alubo (1990) describes private facilities as sparsely equipped, often housed in residential buildings, thus resembling more such local businesses as beer parlors and provisions stores than health care establishments. In a similar way, he observed that these facilities advertise themselves with street-side signboards that often reveal the specialty of the clinic operators and other special services available. Charges in these private clinics are 100-300 per cent higher than in the public system. Even so, the consumers are said to prefer private services in order to avoid the long queues and insults for which public health care is notorious. The fall in the value of the Naira is blamed for the increase cost of equipment and subsequent increased cost of services, but with the introduction of fees in the public sector, these differences may eventually be eliminated, increasing the impact on the poor (Alubo, 1990).

One of the BASICS baseline survey instruments, known as the Urban Private Sector Inventory (UPSI), not surprisingly confirmed the widespread nature of medicine shops in Lagos. In the 13 communities surveyed in 5 LGAs, 414 chemists, pharmacists and patent medicine vendors were identified (Silimperi, Ayodele, Orisasona and Macauley, 1997). The UPSI also identified 330 private health facilities in those areas. Interviews were completed with 279, of whom 255 completed the full-length questionnaire. The most common kind of clinic was classified as 'polyclinic', small hospital or primary care clinic (67%). The majority (78%) of private facilities are small with a single practitioner or a group less than five. Nearly all (98%) operate as for-profit practices. About half (51%) had a fixed fee arrangement, while 46% had a sliding scale, and the rest either bartered, accepted in-kind payment, or provided some charity services. Many (72%) offered family planning services, and 65% provided some type of immunization service. Most (76%) who offered immunization bought their vaccines from a local pharmacy, and consequently 84% who gave

vaccinations charged a fee Few (17%) facilities procured their vaccines from and reported their immunizations to the LGA Health Department, meaning that “the vast amount of private facility immunization services are not included in national statistics” (Silimperi, Ayodele, Orisasona and Macauley, 1997)

One can conclude that while the private sector appears to be a growing resource for promoting the health of urban residents, many questions about quality and type of services and access by the poor remain to be answered

### 1.3 THE LAGOS METROPOLIS

Lagos, deriving its name from Portuguese contact in the 17th Century, has grown from a small Yoruba farming settlement to the most populous metropolis in Black Africa (Mabogunje, 1976) In 1800, the population was estimated to be 5,000, although this took account only of the settlement on Lagos Island itself (Mabogunje, 1968) Until 1861, Lagos was a major slave trading centre, but the British took possession of the island to put an end to the trade and eventually declared Lagos the capital of the colonial territory in 1901, when its population was estimated at 39,387 Being a port city where many major routes converged (including the railroad which was commissioned in 1895), Lagos grew to 250,000 by 1950, and was estimated at near one million by 1975, when it accounted for 40% of the country's industrial capacity and industrial employment (Mabogunje, 1976) Lagos also grew from less than 2 square miles in 1891 to over 27 (or over 70 square kilometers) in 1950 (Mabogunje, 1968)

The Lagos metropolitan area consists of four islands (Lagos, Ikoyi, Victoria and Iddo) along the coast and numerous communities on the mainland to the north and west Numerous lagoons and swamps separate the settlements The traditional centre where the King or *Oba* lives is on Lagos Island, although the southern coast of Lagos Island, known as Marina, is also a modern commercial and bureaucratic centre The original settlers were the Aworí Yoruba, but immigration has produced a population that represents most all other Yoruba groups plus the other major ethnic groups in the country, as well as immigrants from other parts of West Africa (Mabogunje 1968)

By 1978, the metropolitan area consisted of six LGAs stretching as far west as Badagry and covering 1,140 square kilometers or about 31 per cent of the land area of Lagos State The estimated population of this greater Lagos was 5 million in 1984 (Oyekanmi, 1987) Subsequent governments have subdivided the area into more LGAs When the BASICS project in Nigeria began in 1994, a decision was made to focus on five of the most highly urbanized and lowest income of the existing LGAs These included Ojo, Somolu, Mushin, Lagos Island and Lagos Mainland (Silimperi, Ayodele, Orisasona and Macauley, 1997) Since that time, Somolu was replaced by Surulere These 5 LGAs have an approximate population of 2.5 million (Harvey, Macauley and Ayodele, 1992) Ojo LGA, since the start of the programme was divided into two LGAs, Ojo and Ajeromi

Mabogunje (1968), in his classic work, Urbanization in Nigeria, described the communities where BASICS now works Based on a sampling of rent paid per room, he was able to classify the larger Lagos metropolitan residential districts into four grades high, medium, lower medium, and low Surulere Estate fit into the medium grade area, while its

neighbor, Ojuelegba was classified as lower medium grade. Old Lagos, that is the northern and western sides of the island, fell into the low grade category along with Mushin and Ajegunle-Ajeromi (which includes Amukoko). Makoko was not mentioned by name, but would be included in Yaba East, another low grade district. Although these observations were published nearly 20 years ago, they provide a good look at the foundations of the present day communities, and as will be seen, many conditions and characteristics have not changed.

Mabogunje had the following to say about the Ajegunle area

In the extreme south-west close to Apapa, but outside the municipality, there have developed since the 1950s low grade residences to house dock-workers and factory hands. This suburb, known as Ajegunle-Ajeromi, developed on the crest of two parallel east-west sand ridges which are separated by a marshy depression. The streets are not developed, and are most inconvenient to vehicular traffic. As far as housing conditions go, this district has a status midway between Mushin and Somolu. The houses are on the whole fairly substantial as at Mushin, with many being two-storied and having 16 to 20 rooms. But as in Somolu the standard of household equipment and facilities is very low. Turnover of tenants is, however, also low due largely to the fact that there is no better suburb within a convenient distance of the Apapa Industrial Estate. As in Somolu, the non-Yoruba groups are well represented, with Ibo predominating. The region, however, attracts very few people in the higher income group.

On the other hand, Mushin, though low grade, had a very different character according to Mabogunje (1968).

Outside the municipal boundary, Mushin offers to the low income workers cheap tenements and to the higher income workers cheap land. The result has been the development of a suburb of very mixed character. The most striking feature is a layout of streets which has been incidental to the sale of regular plots of land and which the local authority has done little to improve. The main axis for this development is the Agege Motor Road. Along this road three and four-storied tenement buildings containing from 24 to 40 rooms are common. Elsewhere in the area, however, poorer houses, mainly mud-built cement plastered bungalows, are to be found. Artisans and young clerks of Yoruba (64 per cent) or Ibo (24 per cent) extraction who are attracted by the low rents and are prepared to tolerate low housing conditions predominate.

The indigenous communities of Lagos Island fall into both the lower medium and low grade districts (Mabogunje).

Lower medium grade residential districts though planned, started as slum areas. Partly for this reason, even after their new layout, they have been not completely excluded the kind of occupiers who tend to make the district return to slum conditions. A good example is provided by Isalegangan and Oko Awo districts as well as the adjacent parts of Idumagbo and Idunshagbe, all of

which were involved in the earlier slum clearance of the 1930s. These districts constitute an oasis of planned layout in a wilderness of confused housing. The main north-south through road is Idumagbo Avenue, a wide street of which the traffic flow has, however, been considerably reduced by the crowd of petty traders lining it on both sides with their movable 'counters'. Indeed it is the preponderance of petty traders in the population of these districts that has, in spite of the relatively good provision of household amenities, led to a generally lower standard of neighborhood upkeep.

Low grade residential districts are characteristic of never having been planned. It includes the oldest districts on Lagos Island with their narrow, confused lanes and generally poor housing conditions. Old Lagos comprises all the districts in the western one-third of the island which were, in the early growth of Lagos, established on the available dry spots. The Nucleus of the region is the extreme north-west in Idumagbo where is to be found the Oba's palace as well as those of his chiefs.

Old Lagos suffered most from deterioration. Being primarily an indigenous Yoruba community, it was populated by traditional extended families. Family ties made it difficult for many inhabitants to move out of the old town. Population grew and dwelling accommodation became more scarce. In north central Lagos (Epetedo and Okepopo) housing conditions are poor and population densities are quite high. Most residents are artisans and traders, though some younger members have become white-collar workers (Mabogunje)

The area labeled Yaba East was developed because of the need to provide cheap accommodation for the low-income population serving educational and other institutions around Yaba. This unplanned, low-grade suburb was, until the 1930s, considered unsuitable for development because of the threat of seasonal flooding. The street connections between the hamlets were poor. Quality of housing varied from cheap, mud bungalows to cement block storied buildings. The proximity to Yaba ensured some amenities. Initial inhabitants were largely cooks, gardeners, artisans and stewards who could not afford the rents in Yaba proper. At the time Ibos represented one-third of the inhabitants. Higher income groups started to be attracted to the area as land owners who built better designed homes (Mabogunje, 1968).

Medium grade residential areas were generally of lower density, except for the Surulere Estate, which was established in 1956. The area provided convenient accommodation for the white-collar workers of Marina on Lagos Island. The estate was originally intended to house the persons displaced by the slum clearance of the 1930s on Lagos Island, but the new inhabitants found even the subsidized rent to be too much. Subsequently these housing units were sub-let to middle-income workers, while the original inhabitants moved to cheaper residences in Mushin and Somolu. Ojuelegba, though considered part of Surulere, developed as a lower medium grade district in response to the stimulus of the nearby railway terminus in Iddo Island that also influenced growth in Ebute Metta West. These districts developed without the layout and planning of Ebute Metta itself and Yaba. Finally, about 1930, these areas were incorporated into town planning, and after World War II, witnessed the construction of large storied houses with numerous rooms to hire for the influx of immigrants arriving in Lagos at the time. Although the construction

was of better quality, the newness of the areas meant that amenities such as light, water and sewage, were not immediately available (Mabogunje, 1968) It should be noted that the larger Surulere borders on Mushin and contains areas like Ojuelegba, and thus more generally resembles these areas than that described within the Estate

#### 1.4 URBAN CHILD HEALTH ISSUES

According to Foege (1990), urban immunization campaigns should, in theory, be the show case of national immunization efforts due to access to superior transportation and communications networks In fact, he notes that urban efforts are stressful to programme planners -

Frequently, the lack of social cohesion makes it difficult to mobilize all segments of a geographic area The mobility of the population may make it difficult to determine the number to be served From the first polio campaigns in the 1950s, through the smallpox eradication programme and into the current Universal Childhood Immunization campaign, urban areas have presented special challenges Often urban areas have required such labour intensive efforts that the expenditure per person is prohibitive

The urban immunization programme experience in Bangladesh offers some suggestions for tackling the problems outlined above (Ralph, 1990) The involvement of NGOs was seen as crucial for strengthening the relatively weak municipal health services Start-up may be slow because of the need to establish fixed centres, but the wait is worthwhile, as these centres form the nuclei for expansion into the neighborhoods Lessons from the Philippines included the need to conceptualize a unique urban immunization strategy with focus on, for example, congested slum areas where disease transmission is relatively more rapid, use of multiple communication media, and the necessity of holding more frequent immunization sessions (at least weekly) (Galvez-Tan, 1990)

The REACH (Resources for Child Health) project of USAID also was a source of important lessons on urban immunization (Claquin, 1991) These included the fact of the essential, though not fully recognized role of private providers, the importance of tailoring campaigns to the unique ethnic and social mix of different urban neighborhoods, the importance of NGO partnerships, and the need to prevent dropping out The latter is a major difference between rural and urban efforts Physical accessibility is not as much a problem in the urban setting, but what causes dropping out there is the quality of services provided in the health facilities (Claquin, 1991)

In 1990, immunization coverage in Nigeria for most of the childhood antigens approached the African target of 80% (FMOHSS, CDC and USAID, 1993) Since 1991, immunization efforts have decreased such that in 1993, only 37% of children had received all antigens by their first birthday (FMOHSS and WHO 1994) The REACH Project of USAID in Nigeria conducted a childhood immunization coverage survey in 1992 in all of the then 15 LGAs in Lagos State They documented that only 37% of children in 1991 and 29% in 1992 had 'valid' full immunization coverage by 12 months of age compared to a 'crude' full immunization coverage of 44% and 32% respectively The gap between crude and valid was attributable to health staff giving immunizations at the wrong time and to the lack of cards

given to mothers, making it impossible to verify contacts except verbally (Harvey, Macauley and Ayodele, 1992)

Although the REACH report found that full immunization coverage was lowest in the two rural LGAs of Lagos State, it concluded that -

it is important to consider the comparatively greater impact of disease on densely and highly populated areas. For example, in the rural area of Ibeju-Lekki - which has a population of 24,825, valid measles coverage by 12 months of age of 15%, and a measles vaccine efficacy rate of 80% - 872 cases of measles would be expected annually. However, in Oshodi-Isolo - which has one of the highest rates of access to service and the highest valid measles coverage by 12 months of age (51.7%) in the survey, but a much larger population (497,476) than Ibeju-Lekki - 11,669 measles cases would be expected. It would therefore make sense to give higher priority to increasing valid measles coverage in Oshodi-Isolo than in Ibeju-Lekki because disease incidence and disease transmission are greater. Also the average age of infection is younger in crowded areas, which increases the risk of dying from measles.

Valid full immunization coverage in the 5 BASICS LGAs in 1992 was pegged at 20.5% in Mushin, 35.7% in Surulere, 22.5% in Lagos Island, 34.6% in Ojo, and 40.9% in Lagos Mainland (Harvey, Macauley and Ayodele, 1992). None of these, of course, approach the 80% target mentioned earlier.

Concerning the adequacy of LGA health facilities to meet the needs of sick children, a 1992 survey by the Combatting Childhood Communicable Diseases (CCCD) Project of USAID documented that in Ojo LGA 71.4% of 14 LGA health facilities had sufficient stocks of all vaccines, 85.7% had ORS packets available, and 78.6% had oral chloroquine (FMOHSS, CDC, and USAID, 1993). Those these figures were better than in some rural LGAs (e.g. Egbeda in Oyo State 18.2%, 18.2% and 36.4% respectively), they still indicate that clients may not be fully served in LGA health facilities. It is these problems of service delivery and adequacy of facilities that led to the development of the BASICS urban health focus in Lagos and efforts to build community coalitions to promote child health.

## **1.5 COMMUNITY ORGANIZATION AND COALITIONS**

The concept of national level coalitions is taking root in Nigeria. In 1989, the Nigerian Association of Non-Governmental Organizations on Health (NANGO) was formed, growing out of efforts by the Federal Ministry of Health to involve NGOs in the national immunization programme. On 8th December 1994, the inaugural meeting of the Nigerian Association for the Promotion of Adolescent Health and Development (NAPAHD) took place. NAPAHD is a coalition of several youth serving organizations from all sections of Nigeria. Recently the Coalition of Nigerian Non-Governmental Organizations on Health, Population and Development (CONNOHPD) launched a book that advocates for social integration and development from the grassroots. What is new about the BASICS approach is the formation of community-level coalitions of voluntary associations and private health care providers, known as Community Partners for Health (CPHs), that "engender a sense of

community responsibility for health and overall empowerment by finding feasible solutions to local problems using local resources” (Silimperi, Ayodele, Orisasona, Williams and Macauley, 1997)

Butterfoss, Goodman and Wandersman (1993) recently reviewed the important role that coalitions are assuming in health promotion programmes in the United States. They noted that while coalitions have been a major form of health promotion intervention over the past three decades, little systematic work has been done to understand the nature and process of coalition formation, development and maintenance. They justified the need for the coalition strategy to augment traditional individual-oriented behaviour change strategies because, “The current wisdom in health promotion holds that targeting the behavior of individuals, without also intervening at these other social levels that shape behavior, will not have as great an impact on health status.” Thus coalition building is a strategy aimed at “strengthening the social fabric.”

Two definitions of coalition were used by Butterfoss *et al* (1993) “an organization of individuals representing diverse organizations, factions or constituencies who agree to work together in order to achieve a common goal” (Feighery and Rogers, 1989), and “an organization of diverse interest groups that combine their human and material resources to effect a specific change the members are unable to bring about independently” (Brown 1984). By being united for a purpose, coalitions, according to Butterfoss *et al* (1993) can achieve the following:

1. Enable organizations to become involved in new and broader issues without having the sole responsibility for managing or developing those issues,
2. Demonstrate and develop widespread public support for issues, actions or unmet needs,
3. Maximize the power of individuals and groups through joint action, i.e. increase the critical mass behind a community effort by helping individuals achieve objectives beyond the scope of any one individual or organization,
4. Minimize duplication of effort and services, resulting in improved communication and trust among partners,
5. Help mobilize more talents, resources and approaches to influence an issue than any single organization could achieve alone,
6. Provide an avenue for recruiting participants from diverse constituencies, such as political, business, human service, social and religious groups and individuals, and
7. Exploit new resources in changing situations because of their flexible nature.

Furthermore, three different types of coalitions were identified -

- *Grassroots Coalitions* organized by volunteers in times of crisis to pressure policy makers to act
- *Professional Coalitions* that bring professional organizations together for a crisis or longer term action when their combined power and influence is needed
- *Community-based Coalitions* that bring professionals and grassroots leaders together to influence more long-term health and welfare practices for their communities.

The CPH approach is clearly a *Community-based Coalition*. The question to be addressed at this point, two years after formation of the 6 Lagos-based CPHs, is how they have developed and are they sustainable for achieving the “more long-term health and welfare practices of their communities ” In this respect, Butterfoss *et al* (1993) outline four stages in the development of coalitions: formation, implementation, maintenance and accomplishment of goals

Successful formation of a coalition is said to depend on three factors (Butterfoss *et al* , 1993) exchange of resources among member organizations that lead to inter-organizational cooperation, payoffs (benefits) that the coalition members receive by joining, and minimum size to make the coalition effective. Other important issues that prompt the formation of coalitions are a clear recognition and clear articulation of a mutual need or concern, the failure of previous programmes to solve a problem, history of previous collaboration and joint efforts, compatibility among potential partners, and a determination to work together.

Implementation and maintenance, according to Butterfoss *et al* (1993), are influenced by having formalized rules, roles and procedures, strong central leadership, a diversity of members who bring a wide range of skills and resources, an organizational climate that fosters good relations among members, and external supports that facilitate resource exchange and community linkages. Finally, achievement of goals is required for the coalition to stay together. In this light there is need to accomplishing some quick, short-term successes “to increase member motivation and pride and to enhance the credibility of the coalition ” There also need to be observable indicators of progress toward the more long-term goals of the coalition. These ideas provide a backdrop for documenting the development and successes of the CPH programme in Lagos

## 2. METHODS

By design, this documentation exercise constituted a process evaluation. Other methods, such as USAID's Integrated Baseline Health Survey, will be used to determine progress toward the program's longer-term health indicators. The scope of work was stated clearly when BASICS requested the consultant's services -

*The process evaluation will be a systematic investigation by both the partners of the CPH and BASICS to understand how the approach was implemented. The process evaluation will tell the "story of the CPHs" and the "ingredients of success". This will review the process of CPH formation in depth and relate it to an analytical framework (What was done? Why was it important or not important? How did it fit with everything else? Who did it? etc.)*

*The process consultation will provide detailed information for people and organizations who want to establish new CPHs both in Nigeria and other countries. It will also be an opportunity for the CPH members to review their own work and make modifications for the future.*

The Community Partners for Health (CPH) group forms the primary unit of interest and analysis, and therefore, this exercise does resemble a case study as indicated above. In addition, leaders of the CPHs and the member Community Based Organizations (CBOs) and Health Facilities (HFs) were interviewed to learn their roles in and perspectives on CPH formation. Also, leaders of non member CBOs and HFs were contacted as were community leaders in the political and health sectors.

The initial focus of the documentation exercise has been on the six CPHs organized by BASICS in the Lagos metropolitan area. These have been functioning for two years, and therefore, it should be possible to learn lessons about sustainability from their experiences. Five CPHs have been organized in Kano, in the northern part of Nigeria, in recent months. Some information was gathered from and about these CPHs, and will be presented in more detail in a subsequent report. Data from Kano will serve as a baseline for those CPHs.

The five major questions that drove the documentation exercise have been enumerated in the first section of this report. They appear again in the chart on the next page that outlines the overall design and methods used for the process evaluation. Overall, the design incorporated both qualitative and quantitative methods, as well as both participatory and external evaluation. All instruments are appended. The work spanned the period between 1st September and 20th December 1997, a time coinciding with the second anniversary of the formation of the six CPHs in Lagos. Additional time may be needed for more fieldwork in Kano.

## BASICS DOCUMENTATION DESIGN

INSTRUMENTS and DOCUMENTS	RESEARCH QUESTIONS				
	1 What is the CPH approach purpose steps, core activities, processes, and participants?	2 What does the CPH approach produce organization, community action, awareness, spin-offs? (ETIC)	3 How is the CPH approach perceived benefits, results, community efficacy? (EMIC)	4 How does the CPH approach achieve its results organization, management, inputs/resources (internal & external) decisions?	5 Is the CPH approach sustainable and replicable?
1 CPH Leader and CBO/HF Member Inventory	✓	✓			
2 CPH and CBO Leader Survey	✓	✓	✓	✓	✓
3 CPH Management Self-Study Guide		✓		✓	✓
4 BASICS Staff and CPH Chair Essential Activity Rating	✓			✓	✓
5 Textual Analysis of CPH Board Meeting Minutes	✓	✓		✓	
6 CBO Member Focus Group Discussions		✓	✓		
7 Community Leader and Agency Staff In-depth Interviews		✓	✓		
8 Review and Updating of CPH Filing System	✓	✓		✓	

## **2.1 LEADERSHIP AND MEMBERSHIP INVENTORIES**

One of the first steps taken was the conduct of leadership and membership inventories for each CPH in both Lagos and Kano. Three ruled forms were sent to each CPH Board. The first form asked for a listing of all current CPH members, their affiliation (Health or CBO) and the date on which they became a partner of the organization. Two copies of the second form were provided that requested a listing of CPH leaders/board members at the formation of the CPH and as of September 1997. In addition to the leaders' positions, information was provided on their affiliation (Health or CBO) and gender. A third form was used to record CPH committees by name and membership.

Information obtained from these forms provided part of a sampling frame for identifying leaders and member organizations who would be interviewed. Additional information from BASICS files were used to identify non-member groups.

## **2.2 CPH AND CBO LEADER SURVEY**

This survey covered both CPH leaders, leaders of member CBO/HF groups (including those who had dropped out) and leaders of groups that had never joined. Non-member CBO/HF names were culled from the files kept by BASICS on each CPH. Within these were lists of organizations that met the criteria for CPH membership who were to have been invited to attend introductory fora in each community. The exception to such a list was Lawanson, which was a carry over project from the USAID Initiatives Program. In that case, CPH leaders were asked to recall any neighborhood groups that had been contacted by themselves, but that had not yet joined.

The leadership survey began with a section on demographic data and affiliation. CBO/HF leaders were asked for reasons why their organization either did or did not join the CPH. All respondents were asked to comment on the strengths and weaknesses of the CPH approach and the achievements and problems of the particular CPH in their community. CPH leaders were asked to indicate the reasons for successes and problems and also mentioned their own particular roles in promoting the achievements and solving the problems.

Questions about personal benefits (CPH leadership) and group/CBO benefits were asked for those who had joined the CPH. Awareness of the Memorandum of Understanding that established the CPHs was ascertained for all leaders, while details about the CPH's work plan were asked from the CPH leaders. Outreach efforts were also documented.

Four attitudinal scales were constructed. The first was a self-efficacy scale for CPH leaders only to learn about their perceived confidence in handling role demands such as resolving conflicts, seeking resources and running programmes (Bandura, 1986). Five items with scores from 0-4 points comprised the self-efficacy scales, and scores could range from a high level of self-efficacy of 20 points to a low of 0 points.

The second was a community efficacy scale that looked at indicators of community social control, identity and cohesion (Warren and Warren, 1997, Sampson, Raudenbush, and Earls, 1997). Both CPH and CBO/HF leaders were asked such items as whether people in

their communities would intervene if a child threw rubbish on the street or abused an elder, how well people in the community trusted each other, and the degree to which they socialized with one another. This scale was constructed of 14 0-4 point items, yielding a potential range of 0-56 points. Certain items were reversed scored for analysis, e.g. "People in this community generally do not get along with each other."

The community efficacy scale of Sampson *et al.* (1997) (with additional concepts from Warren and Warren, 1977, on community identity and cohesion) was used in a study of Chicago neighborhoods, where the score was found to be negatively correlated with measures of community violence (both perceived and as determined from police records). Although their violence scale was adapted for the Lagos setting, the purpose of either scale in this documentation exercise was not to test social theory but determine leader perceptions. The Chicago study included a very large random sample of individual community members, and therefore the leadership survey in Lagos would not serve that purpose of determining community-wide perceptions. Instead the purpose of using the community efficacy scale in Nigeria was to compare perceptions among leaders of different CPHs against a background of other case study information concerning the relative level of functioning of the different CPHs.

The violence scale, consisting of eight items scored from 0-4 points, sought information on how often events such as fights, robberies and assault occurred in the CPH neighborhoods. Both CPH and CBO/HF leaders were asked about the level of community violence. A particularly Nigerian item on harassment from government officials was added. Again, the purpose of this scale was not specifically to compare with perceived community efficacy, but as a means of learning about an important characteristic of each community for comparison among communities.

Questions on a CPH functioning scale were asked on CPH leaders and CBO/HF member leaders. The seven items, again with a score of 0-4 points, focused on such concerns as perceived favoritism, levels of commitment and maturity of the CPH. Here it was possible to compare the different CPHs as well as the perceptions of CPH leaders versus leaders of constituent CBO/HF groups.

Finally, CPH leaders only were asked questions about the performance of BASICS. They commented on the perceived mission, activities of the staff, and possible deficiencies. In closing these leaders were asked to indicate any links they had made with other CPHs and other organizations in the community and city.

Seven research assistants were employed for the leadership survey in Lagos. One served as supervisor. They were trained by the consultants and BASICS staff in the field at Lawanson CPH. Effort was made by the BASICS staff not to become too closely involved in the daily management of the interviewing so as not to introduce bias in the responses. Thus, the survey was an element of external evaluation. Between 3-4 days were spent at each CPH, and a call-back was made for missing interviewees at all sites. In addition to the membership and leadership inventory lists, CPH leaders helped the research assistants locate member and non-member groups. The table below indicates the rate of coverage of each leadership group.

Interview	Leadership Category		
	CPH Leaders	Constituent CBO/HF Leaders	Non-member CBO/HF Leaders
Number Interviewed	81	168	68
Percent of Total	90	82	54
Estimated Total Number	90	204	124

There were actually 174 CBO/HF constituent interviews, but there were cases where two leaders from the same CBO/HF were interviewed. As explained in a subsequent section, a few CBO/HF members disbanded. The poorest rate of interviewing was among the non-member groups, and the interviewers indicated that this group was the hardest to locate. There were a few refusals, but the main problem was in locating the groups. This is not surprising because on the original invitation lists in the BASICS files were notes that a fair number of CBOs and HFs could not be located or reached. Still, this is a limitation.

### 2.3 CPH MANAGEMENT SELF-STUDY GUIDE

An important part of the documentation process was not only to obtain information from the BASICS Lagos files and the CPH records but also to encourage the CPHs themselves to consider how far they themselves had developed. Based on experiences with the West African Youth Initiative that worked with community based youth serving organizations (Brieger, 1997), the PACT program in Ethiopia (Booth and Morin, 1996), and BASICS staff (D Pyle, personal notes), a guideline was constructed for CPH Boards to review and rate their own progress in implementing structural, management and programming processes and indicators. CPH Boards were asked to discuss and record whether, "In our CPH we have fully achieved, partially achieved, just started, or not yet undertaken" the following:

#### A Organizational Structure

1. a written constitution, bye-laws or charter
2. a memorandum of understanding among member CBOs/HFs that includes all current members to-date
3. a clear policy statement that tells our purpose/mission
4. officers who all have clearly defined titles, responsibilities, and duties
5. committees that are appropriate for getting our work done
6. regular board meetings
7. regular general meetings
8. set realistic and achievable goals
9. Involved all members in programme planning
10. a reliable system for communicating and sharing information among our members
11. a concrete way of ensuring that women play a central role in the CPH

- 12 A concrete way to ensure that youth play a central role in the CPH
- 13 made necessary or timely changes in leadership as required

## **B Management and Logistics**

- 1 a secretariat
- 2 a well kept system of minutes, records and documentation
- 3 adequate furniture for our secretariat
- 4 Adequate space for meetings (either at secretariat or with CBOs)
5. minimal essential equipment for our secretariat (bought or loaned)
- 6 appropriate volunteer or paid staff to run the secretariat
7. adequate volunteers any time we run a programme
8. an organized in-service training programme for our leaders and members
9. been able to organize successful fundraising
10. a clearly defined catchment, service or membership area
11. involved the general community in contributing resources to ensure our long term success
- 12 Established links with other organizations, associations and agencies (governmental, non-governmental and voluntary) within and outside the community to help promote our goals
- 13 Established standard referral links with other health services as necessary
- 14 Established lasting links with various donor agencies
- 15 Set up and maintained a bank account
- 16 Established an accounting/auditing system with regular reporting to the CPH
- 17 Developed an annual budget for overall organizational management
18. Actual expenditures and income that match in our budget
19. Set up regular sources on income from dues, membership, etc.
20. Developed other income generation activities for the sustaining the organization
- 21 Set up a monitoring system to get feedback about progress toward our goals  
- e.g immunization coverage
- 22 Have a plan for expansion of the CBO/HF membership of the CPH
- 23 Have actually recruited new CBO/HF members into the CPH within the past year

## **C Programming**

1. A written overall plan of action that has been revised/updated as needed
2. A specific plan of activities for the current quarter (3-month period)
3. A specific budget for each plan of action or activity
- 4 Expenditures that match the budget for each programme
- 5 A system for reviewing progress on plans and activities
6. Written reports on each specific activity on an annual basis and when the activity was completed
- 7 A health education component of each of our major activities and programmes
8. Developed locally appropriate health educational materials and activities (e.g posters, drama)
9. Engaged in advocacy to ensure that local policy makers are aware of the needs of children, youth, women, mothers and poor people

- 10 Planned a comprehensive programme of activities that address all aspects of primary health care
- 11 Adequately trained personnel and volunteers to undertake each programme and activity
12. Established a good working relationship with the local media TV, radio, newspapers, magazines
- 13 Maintained a regular, standard and reliable childhood immunization programme for the community

The BASICS CDPO was asked to undertake an independent rating of each CPH using the same guide. It is hoped that the CPH's review this guide at least twice a year to determine how far they have progressed toward sustainability. They may also wish to add to the list of indicators in order to update the programming activities and organizational processes

#### **2.4 ESSENTIAL ACTIVITY RATING**

Through review of reports and files, a list of core and supplemental activities was compiled. These were the steps and processes used in the creation and development of the CPHs and ranged from holding community discussions (fora) to the provision of gifts of office furniture for CPH secretariats from USAID. These items represented the technical and material support provided by BASICS to get the project off the ground and running. The question remained as to how many and which of these steps or core activities were feasible and necessary to replicate the CPH system in other communities in the future when the current level of donor support would not be available.

A list of 27 activities was developed and presented to the BASICS staff most directly involved in CPH formation and supervision. The same list was also presented to the chairpersons of the CPHs. All were asked to rank the relative importance of each activity for future replication as follows:

- 3 = absolutely essential/required for CPH success and sustainability
- 2 = highly recommended
- 1 = complementary to the programme goals, but not essential/required
- 0 = would not recommend for future programmes

The following 27 activities/processes were ranked:

Urban Private Sector Inventory	Youth Wing Formation
Community Fora	Management Training
Work Plan Workshop/SPP	D&G Training
Memorandum of Understanding	Distribution of Megaphones
Constitution	Capacity Building Exercise
Registration	Establishment of Local Secretariat
Gifts of Furniture	Micro-Credit Training & Activities
Provision of Office Supplies	Cooperative Society Activities
Provision of Environmental Equipment	Subsidized Health Care Scheme
Provision of Cold Chain Equipment	Technical Training in ORT, etc.
Gift of Vehicle	City-wide CPH Sharing Meetings
Having Logo, Letterhead and Brochure	Community Awareness Campaigns
TBA Training	IEC Material Development
Women Empowerment Com. Formation	

Feedback was received from 4 BASICS staff and 7 Lagos area CPH chairpersons. The items were ordered according to the summation of the individual ranks to provide an idea from those directly involved in sustaining the CPHs which activities should comprise the strategy for promoting CPHs elsewhere in Lagos and the country.

## **2.5 TEXTUAL ANALYSIS OF CPH BOARD MEETING MINUTES**

The CPH Boards met at least once a month, some starting as early as January 1996. Photocopies of these minutes were supposed to be forwarded and filed with BASICS Lagos office. It was expected that these minutes would document the development of CPH development and be somewhat more valid than in recall of individual board members. In particular, these minutes were read for the purpose of documenting the following processes

- ◇ Finance and Sustainability
- ◇ Membership and Community Relations
- ◇ Conflict Resolution
- ◇ Management
- ◇ Programming

First, it was necessary to obtain all minutes. It was found that the CPHs had stopped forwarding their Broad Meeting minutes after the first year. Requests for these minutes were honored by all by Makoko CPH. These minutes had never been typed on computer, and some were in handwritten form. The second step was simultaneously reading, sorting and typing the minutes into a format bearing the process headings listed below. In this way it was possible to go back and complete the third step, which was constructing the stories of each CPH concerning, for example, how JAS CPH turned the gift of a used vehicle from USAID into an ambulance or how Lawanson developed their environmental sanitation program.

## 2.6 CBO MEMBER FOCUS GROUP DISCUSSIONS

Focus group discussions were organized to learn the views of the beneficiaries of the program, the members of the partner CBOs. Effort was made to hold one male and one female FGD in each CPH at the end of the 2-3 days used for leader interviews. A minimum of 3 CBOs were selected for recruiting female participants and 3 different CBOs for males. Each selected CBO was asked to send two members to a designated meeting site in each community. The same staff who conducted the leadership interviews were involved in the FGD sessions. Pairs of moderator and recorder were appointed. The recorder wrote all FGD responses and reviewed and revised the final transcript with the help of the moderator. The questions used are found below.

- 1 First, please tell us what you know about the Community Partners for Health programme  
*Probe* What is the purpose of the CPH?  
*Probe* What are some of the activities/programmes undertaken by the CPH in your community?
- 2 What do people in your CBO think about the programmes of the CPH?  
*Probe* How have the programmes been helpful?  
*Probe* How has the programme been of value to women?  
*Probe* What are some of the needs/problems that the CPH has not been able to address fully so far?  
*Probe* Do people have any complaints about the way the CPH has functioned?
- 3 Please share with us your personal experiences with the CPH?  
*Probe* Have you or your family members personally benefitted from the CPH?  
*Probe* Do you or your family members personally have any complaints with the CPH?
- 4 The CPH has engaged in many activities in the community as we discussed above, such environmental sanitation, awareness campaigns against some deadly diseases, and the like. Please let us know to what extent members of your CBO have actively participated in these activities.  
*Probe* What activities were popular with members of your CBO, that is the activities in which they participated fully?  
*Probe* What specific contributions (time, funds, labor, etc ) did your CBO members make towards the success of these activities?  
*Probe* Which activities did not interest your CBO members and why?
- 5 Have you noticed any changes in this community since the CPH got started? If yes, please describe these changes.  
*Probe* Did any of these changes have anything to do with health?  
*Probe* Did any of these changes have anything to do with the way people relate to each other in the community and the level to which they participate in community activities?
- 6 There are many CBOs in this community in addition to those who joined this CPH?
  - a Are you aware of any of these who now want to join the CPH?  
Which ones? Why do they want to join?
  - b Are you aware of any of these who do not want to join the CPH?  
Which ones? Why do they not want to join?
- 7 Please offer your suggestions on
  - a) what additional work the CPH should undertake,
  - b) how the running of the CPH could be improved, and
  - c) what more could your own CBO do to make the CPH stronger?

The transcripts were reviewed for major themes and a summary of common responses was produced

## **2.7 COMMUNITY LEADER AND AGENCY STAFF IN-DEPTH INTERVIEWS**

It was expected that should the CPHs be successful in their programming they would have come into contact with leaders in the community (indigenous and political) as well as local health department heads. The former may have been important in awareness campaigns, fundraising activities, and membership recruitment. The latter may have provided assistance in acquiring resources such as vaccines or given technical assistance in areas such as essential drug supplies. Interviews with such leaders were intended to document the extent to which broader community awareness and involvement had been created in the 2-year history of the CPHs and nearly 3 years of BASICS activities at the sites.

The following persons/positions were identified as the population for in-depth interviews

- LGA Chairman
- Supervisory Councillor for Health
- PHC Department Head
- MCH Services Head, PHC Department
- *Baale* (indigenous chief of a Yoruba community)
- *Iyalode* (indigenous women's leader in a Yoruba community)
- Head of other ethnic sub-communities (e.g. Seriki Hausa)

The primary purpose of the interview was to determine whether the particular leader was aware of the CPH and its activities and accomplishments. The interview began with a general question about the needs of the community and what groups were active in trying to address those needs. Follow-up probes asked what had been done about 1) environmental sanitation, 2) immunization, 3) improving the status of women, and 4) making health care more accessible and affordable, and then which organizations and groups had worked on these issues. The foregoing gave the leaders an opportunity to mention the CPH spontaneously. Additional questions asked specifically about the activities of the CPH and whether the particular leader had contact with the CPH. A total of 31 leaders were interviewed in the 6 communities.

## **2.8 REVIEW AND UPDATING OF BASICS FILING SYSTEM**

Since this was a documentation exercise, it was important to locate, collate and mine all available written information on the project. This included, but was not limited to annual reports, individual staff reports, minutes of CPH meetings (as noted separately above), outlines of plans and progress, reports on capacity building exercises, sub-project proposals, copies of MOUs and constitutions, certificates of registration as NGOs, and correspondence between the CPHs and BASICS.

Much of the information was filed according to CPH in the office of the CDPO, but other information was located with other staff, e.g. the capacity building exercise reports. There were also what were known as the "primitive files," file folders kept safely in a closet

that contained documents from the very beginning of the project before the CPHs were formed. These files were a very important source of information on names and addresses of the CBOs and HFs that were culled from the UPSI and eligible for invitation to the community fora where the CPH idea was introduced to potential partnership members.

These files and documents were read and excerpted to provide information throughout this report to support an understanding of 1) membership development, 2) governance, 3) program planning and implementation and 4) efforts at sustainability. It had been hoped that the primitive and current filing system could have been integrated and that some redundancy could also have been possible such that topic files (e.g. MOU, SPP) and CPH files could have been created. This could not be completed and will require special secretarial support to be accomplished.

### 3. CORE PROCESSES AND ACTIVITIES

The first two research questions formulated for the documentation process addressed the issues of 1) processes and core activities, and 2) organizational structure. As noted in Section 1 of this report, the successful maintenance of coalitions such as CPHs, requires formalized rules, roles and procedures, strong central leadership, a diversity of members who bring a wide range of skills and resources, an organizational climate that fosters good relations among members, and external supports that facilitate resource exchange and community linkages (Butterfoss *et al.*, 1993) These issues are operationalized in this section on core processes and activities.

Silimperi *et al.* (1997b) identified the following core steps in the development, implementation and functioning of CPHs:

1. Conduct of an inventory of community based organizations (CBOs) and private sector health facilities (HFs: indigenous and western health care providers) in the target communities (April-May 1995),
2. Determine appropriate CBO and HF partners for inclusion in CPHs based on membership orientation, service strengths and potential reach (June-July 1995),
3. Hold community partnership fora among appropriate and interested CBOs and HFs to explain the partnership concept and invite them to form a local CPH (August-November, 1995),
4. Form the 6 Lagos CPHs (December 1995-January 1996),
5. Evolve governance mechanisms and organizational structure for the partnerships (February-March 1996),
6. Develop an action plan to delineate specific partnership activities and interventions, (with submission of sub-project proposals to USAID) (February-April 1996), and
7. Organize capacity building exercises to enable partners to better undertake defined activities, use local area data in planning and advocacy, and assess how their services are viewed in their catchment areas (from December 1996)

During the actual intervention process, additional activities and steps were undertaken, either to strengthen core steps outlined above or to provide the CPHs with additional inputs and technical assistance that became available through the network of USAID Implementing Partners (IPs) in Nigeria. At a meeting of all six Lagos CPHs, BASICS' Community development Officer presented an outline of major partnership activities that had been accomplished or were ongoing. The list below shows those activities beyond the original core and indicates an expansion of work undertaken by BASICS.

- Development of CPH logo, brochure and letter headed papers (Mar/Apr 1996)
- Distribution of environmental sanitation equipment (Apr/May 1996)
- Establishment of CPH secretariats (May/Sept. 1996)
- Formation of CPH special committees (May/Aug 1996)
- Distribution of megaphones to CPHs (Jul/Aug 1996)
- Distribution of USAID vehicles and furniture (Aug 1996)

- Development of CPH constitution (Oct 1996-Jan 1997)
- establishment of documentation/information sharing corners (2 as of Sept 1996, remaining ongoing)
- CPH mobilization for pictorial/video documentation of program activities (ongoing)
- Initiation of in-house information sharing with CPH after attending workshops outside (ongoing)
- Establishment of CPH collaboration in programs (Ongoing)
- Launching of community awareness campaigns (Aug 96/ongoing)
- Fund raising activities (Mar 96/ongoing)
- mobilization of existing/formation of new CPH youth associations (Mar 96/ongoing)
- Translation of MOU to Yoruba (May 96/Feb 97)
- Translation of pathway to child survival to local languages (Oct 95)
- IEC materials development in collaboration with JHU (Mar 96/ ongoing)
- Technical training courses
  - TBA, Financial Management, Cold Chain Management
- EPI equipment distribution to the CPH (Jan. 97)
- CPH participation in the National Immunization Days (NID) campaign (Jan. 97/ongoing)
- Family Planning commodities distribution to CPH HFs by USAID through PSI (Feb /Mar 97)
- Formation of Women Empowerment Committees (Aug-Nov 1996)
- Conducted financial sustain ability/income generating activities orientation with all the CPH in collaboration with Initiatives (Oct/Nov 96)
- CPH sustain ability plan design (Nov/Dec 96)
- Formation of cooperative system (Jan.97/ongoing)
- Subsidized health scheme as per MOU (Sept 96)
- Democracy and governance fora (Sept-Nov 1997)

## 5.1 RANKING

From the foregoing, it can be seen that the CPHs have been exposed to a variety of inputs and led through a range of processes that are quite extensive. It could be assumed that in replicating such a process of CPH formation, not all of these resources would be available nor all steps possible (or even desirable) Therefore the Delphi method was used to achieve a relative ranking of these processes was undertaken among key BASICS involved in CPH formation and the CPH Board Chairpersons.

The Table that follows provides the ranking achieved with the responses of 4 BASICS staff and 7 CPH chairpersons. The following options were offered for ranking and scoring the items:

- 3 = absolutely essential/required for CPH success and sustainability,
- 2 = highly recommended,
- 1 = complementary to the programme goals, but not essential/required, and
- 0 = would not recommend for future programmes,

RANKING of CPH Processes/Activities	Overall		Separate Scores	
	Score	Centile	BASICS	CPH
1 Community Fora	3 0	100th	3 0	3 0
2 Registration with Government	2 9		2 8	3 0
3 Cold Chain Equipment Provided	2 8		2 8	2 9
4. Constitution	2.8		2 8	2 9
5. UPSI (BASICS Staff only)	2.8		2.8	n/a
6 Logo, Letterhead, Brochure	2 7	75th	2 5	2 9
7 Community Awareness Campaigns	2 7		2 5	2 9
8 Work Plan/SPP Development	2 7		2 8	2 7
9 Secretariat	2 6		2 3	2 9
10 Memorandum of Understanding	2 6		2 5	2 7
11. Management Training	2 6		2 5	2 7
12 Subsidized Health Care	2 5	50th	2.5	2 6
13 IEC Materials Development	2 4		2.8	2 3
14 Sharing Meetings Among CPHs	2 4		2.0	2 7†
15 Women Empowerment Committee	2.4		2.3	2 6
16. Technical Training	2.4		2 3	2 6
17 Democracy & Govern Training	2.4		2 3	2 5
18 Youth Committee/Wing	2.3		2 3	2 4
19 TBA Training	2.3	25th	2.3	2 4
20. Gift of Megaphones	2.2		1.8	2 6†
21. Capacity Building Exercise	2.2		2.0	2 4
22. Environmental Sanitation Tools	2.2		2.0	2 4
23. Micro Credit Scheme	2.1		1.2	2 6*
24. Cooperative Society*	2 1		2.0	2 1
25. Gift of Vehicle from USAID	2 0		1.0	2 6*
26. Provision of Office Supplies	1 9		1.5	2 1
27 Gift of Furniture	1 7	1 0	2 1*	

\*t test p value < 0.05, † p < 0.10

No one chose to rank any item as “not recommended.” It should be noted that only the 4 BASICS staff were asked to comment on the UPSI. Also only two CPHs (JAS and Lawanson) appear to have embarked on Cooperative societies and the micro-credit scheme is still on the drawing board.

Three of the top five ranking activities correspond with the original seven steps/core activities conceptualized at the beginning of the CPH process. The UPSI formed the foundation for identifying the future partners/members, the constitution embodied the evolution of a governing mechanism, and the community fora were the venue where the CPH concept was explained so that potential members could have adequate information on which to base their decision to join their local CPH. The high priority given to government registration can also be linked with governance because without a constitution, no organization can be registered. The high importance of cold chain equipment related to the fact that all CPHs included immunization among their priority work plan objectives.

The placement of various gifts from BASICS and USAID among the lowest scoring items overall appears at first encouraging, and might indicate that both staff and CPH chairpersons realize that for CPHs to be self sustaining, they should not depend on such donations, but find ways to generate their own resources. It is suspected that had more CPHs introduced cooperative societies, this item would have ranked higher as it provides clear membership benefits, being a well known and government sanctioned and supported means for ensuring thrift and credit among people at the grassroots. Finally, the lack of strong appreciation for the capacity building exercise could be due to its late introduction in several CPHs and the lack of follow-up to institutionalize monitoring in the CPHs where it has been held.

## **5.2 PERCEIVED DIFFERENCES**

More detailed analysis showed that BASICS staff and CPH Chairpersons did differ on several individual items. Average scores for CPH leaders (using t test) were significantly higher than BASICS staff ratings for gifts of furniture, gift of vehicle and promises of micro credit scheme, and marginally higher for gift of megaphone and information sharing meetings. Seeing as how four of these 5 items were material provisions by BASICS, it was decided to construct two scales, one combining the seven items that entailed transfer of materials or funds from BASICS to the CPHs (furniture, office supplies, vehicle, megaphone, micro credit capital, cold chain equipment, environmental sanitation tools) and the remaining 20 that concerned organizational processes.

The mean overall score for process items was 48.5, with CPH leaders averaging 50.0 and BASICS staff 46.0 ( $p > 0.20$ ). The average score for the 20 process items was 2.3 points per item for BASICS staff and 2.5 for CPH leaders. On the other hand, the average score for material items was 15.1, with CPH leaders averaging 17.3 and BASICS staff, 11.5 ( $p < 0.001$ ). There was a similar disparity between average individual item score with 1.6 points per item as rated by BASICS staff and 2.5 by CPH leaders.

Therefore, while BASICS staff and CPH leaders view the organizational processes

with a similar degree of relative importance, they differ significantly concerning the importance of material contributions to the establishment and development of the CPHs. On 5 July 1996, the minutes of the Lagos Island CPH read as follows: "Members, after a heated deliberation, berated BASICS for not supplying enough materials and resources that could fasten the pace of activities. At this juncture, Dr Aworo stressed that it was high time the body started placing less dependence on BASICS for almost everything. Rather, he enjoined that the LICPH should also think of ways to generate funds." Similar concerns about the perceived importance of material and financial assistance were mentioned by CPH leaders during interviews as seen below.

*The resources given to us at the beginning were small, and we could not provide funds. Again, people were not willing to join then. (Lagos Island)*

*We lack of fund as we could only contribute small amounts of money for running the programmes. (Ajegunle)*

*There is not enough equipment to work with like typewriters, safe, etc. This is because the project is still new, but it is progressing. (Lawanson)*

*Financial help (from BASICS) remains to execute our programmes, especially the women's loan, which has not been carried out yet. (Lawanson)*

*We did not have take-off grants to start the CPH initially. (JAS/Mushin)*

*The people complain about money/credit facilities that BASICS has promised to give. Some CBOs are eager to get monetary reward through credit facilities, and this made them to be grumbling when money was not forthcoming. They believe that BASICS has disbursed some money and that the Board members have collected and shared it (among themselves). (JAS/Mushin)*

When asked what were the main difficulties facing the CPH, 73% of 81 leaders mentioned financial problems. This was the single most highly mentioned problem, with the next most frequent concern being lack of understanding among members at 30%. These findings are not meant to imply that BASICS should provide more material assistance to CPHs, as that would raise problems with long term sustainability and future replication, but this situation does show that guaranteeing financial sustainability should be an essential activity for organizing local NGOs/PVOs like the CPHs.

More information about sustainability is found in Section 7 of this report. In sections that follow, more details the other core activities are provided. The next section on "Membership" looks at the role of the UPSI and Community Fora. The Memorandum of Understanding, Constitution and leadership issues are examined in Section 5. Planning, intervention and monitoring are addressed in Section 6.

## 4. MEMBERSHIP

This section describes the process through which potential partner Community Based Organizations (CBOs) and Health Facilities (HFs) were identified and recruited into the CPHs. Reasons for joining, or not joining in the case of groups that were eligible but did not become part of the CPH, are reported. Characteristics of the member and non-member organizations are presented and compared. Finally, some characteristics and perceptions of the CBO/HF leaders are outlined.

### 4.1 THE URBAN PRIVATE SECTOR INVENTORY

Silimperi *et al* (1997a) provide a quite detailed account of the purpose, conduct and results of the Urban Private Sector Inventory (UPSI) which was used to identify the potential partners for the Community Partners for Health. The purpose of the survey, which was conducted in 13 communities within five LGAs in early 1995, was “*to better define the, size, and basic service capacity (specifically in the area of immunization) of the Lagos urban private health sector*”. Service providers were broadly defined as private for-profit and non-profit allopathic and indigenous providers, chemist shops/pharmacies and patent medicine vendors (PMVs). CBOs included local religious, social, occupational/trade, service and other voluntary associations.

In essence the UPSI was first and foremost a census of CBOs and HFs. Concerning the CBOs, the survey questionnaire attempted to document their membership type and size, duration of existence (as a marker of sustainability) and their previous involvement in community health outreach programs. Information gathered about the HFs included type of practitioners, range of services offered (with particular attention to previous involvement in childhood immunization), size of client/service population, level of current management capacity, and evidence of sustainability. Since there was no complete registry of CBOs or HFs, the trained interviewers contacted community leaders and key informants to supplement what ever list of organizations existed in any professional registries. They also conducted “rapid street assessments,” a visual survey of the areas.

Over 1,000 potential partners were identified including 395 CBOs, 330 HFs, and 414 Chemists/PMVs. The overall refusal rate (including incomplete questionnaires) was 18%. Of the 279 HF interviews completed, 14% were indigenous providers. Ninety (25%) of the CBOs interviewed reported any involvement in health activities, of which 71 specifically mentioned immunization. Over 65% of HFs provided some level of immunization service.

Those conducting the UPSI consider that it, “*can play a pivotal role in identifying the composition, size, location, and general functional capacity of the urban private health sector. This information is vital for the selection of private sector partners, target communities, and the development of operational frameworks for programme implementation. It can also be useful for ongoing program monitoring, public sector policy development and municipal health system planning*” (Silimperi *et al*, 1997a). These benefits must be viewed in the context of the costs. The UPSI in Lagos was estimated to cost \$US 15,000, or \$1,153 per community, \$12.80 per organization identified, and \$15.60 per completed interview. As will be seen below, 137 groups joined the CPHS within the first two years (excluding the recent expansion in Ajegunle and Ojuelegba). This fact means that the cost of the UPSI per resulting member

was \$109 50 (approximately N8,759) Annual membership dues in most CPHs are approximately N500 The implication is that without major donor input, it might be difficult for local NGOs or government agencies to conduct an UPSI in the manner and on the scale used for this program BASICS staff did indicate that the process was easier and less costly when undertaken the second time in Kano

GROUP/ ORGANIZATION	UPSI Coverage and Findings		
	Number Identified	Number Interviewed	(%)Involved in Immunization
CBOs	395	358 (91%)	71 (20%)
Health Facilities (allopathic & indigenous)	330	279 (85%)	181 (65%)
Pharmacies and PMVs*	414	324 (78%)	52 (16%)
<b>TOTAL</b>	<b>1169</b>	<b>961 (82%)</b>	<b>304 (32%)</b>

\*involvement in immunization = sales

It was decided not to include Pharmacies and PMVs in the Lagos CPH scheme in part because there was some concern about the ability for the partners to exert control or influence over the highly business/profit oriented nature of these shops, and possibly because most private allopathic health facilities operate their own pharmacies As will be discussed in a subsequent report, PMVs comprised major partners in the Kano CPH experience The UPSI results were used to select 6 of the 13 communities for intervention based on the following criteria

- absolute number of CBOs and Health Facilities in the community
- types of CBOs and HFs in the community (i.e. service, gender orientation)
- number of CBOs/HFs with large potential impact (membership, clientele)
- networking potential based on the range and type of potential partners

Using these criteria, the staff chose the following communities. Ajegunle and Amukoko in Ojo LGA (which was later divided into 2 LGAs), Mushin in Mushin LGA, Alapere in Shomolu LGA, Ward E on Lagos Island, and Makoko in Mainland LGA These communities contained an estimated population of 1 million inhabitants, of whom approximately 183,000 would have been under the age of 5 years These six communities also contained 144 HFs (or 52% of those interviewed) and 241 CBOS (67% of those interviewed)

Prior to the actual community organization process that established the CPHs, BASICS and USAID decided to substitute the Lawanson community within Surulere for the Alapere community of Shomolu This occurred because Lawanson had already participated in the

USAID Initiatives program and had a network of four allopathic health facilities who were working together with community associations to provide a health care financing scheme. The consultants from Initiatives commented that the original Lawson proposal, *“is one of the most innovative proposals coming out of the Nigerian LIGs (Local Initiatives Groups) It focused on primary healthcare for the appropriate target group. If Nigeria is selected as an Initiatives country, this LIG should be seriously considered, if only because of the experimental nature of the proposed model ”* (Pattison, Hare and Huff-Rouselle, 1993)

The inclusion of Lawson means that the baseline data from the UPSI and is not completely applicable to calculations concerning the evolution of partnerships/membership over the next two years. An assumption is therefore made, that Lawson community and Surulere LGA are a rough numerical substitute for Alapere community and Somolu LGA

## 4.2 COMMUNITY FORA

### 4.2.1 Organizing the Fora

The following Table summarizes the major and minor criteria by which organizations were judged eligible to receive invitations to the community fora where the CPH concept would be discussed and from where the eventual initial membership of the CPHs would be drawn

CBO/HF Selection Criteria	Community Based Organizations	Health Facilities
Major	<ul style="list-style-type: none"> <li>▪ established network or networking potential</li> <li>▪ existing or potential linkage with health facility</li> <li>▪ established or potential outreach capacity</li> <li>▪ interest and enthusiasm</li> <li>▪ established ability to participate in immunization programmes</li> <li>▪ evidence of effective management</li> <li>▪ evidence of sustainability - resource base, membership size</li> <li>▪ minimum of 50 members</li> <li>▪ nonpolitical orientation</li> <li>▪ priority toward those oriented to of involving women</li> <li>▪ reputation for achievement</li> </ul>	<ul style="list-style-type: none"> <li>▪ networking potential</li> <li>▪ existing or potential linkage with CBOs/outreach capacity</li> <li>▪ interest and enthusiasm</li> <li>▪ established ability to provide health services (or great potential)</li> <li>▪ evidence of effective management systems including administration, records</li> <li>▪ registration with government as evidence of credibility and quality</li> <li>▪ minimum of 5 paid staff with training or potential to be trained in immunization</li> </ul>
Minor	<ul style="list-style-type: none"> <li>▪ range in types (religious, women’s, social, trade)</li> <li>▪ community based members</li> </ul>	<ul style="list-style-type: none"> <li>▪ minimum 50 children &lt;5 years of age served per month, or minimum of 50 pregnant women seen/deliveries per month</li> </ul>

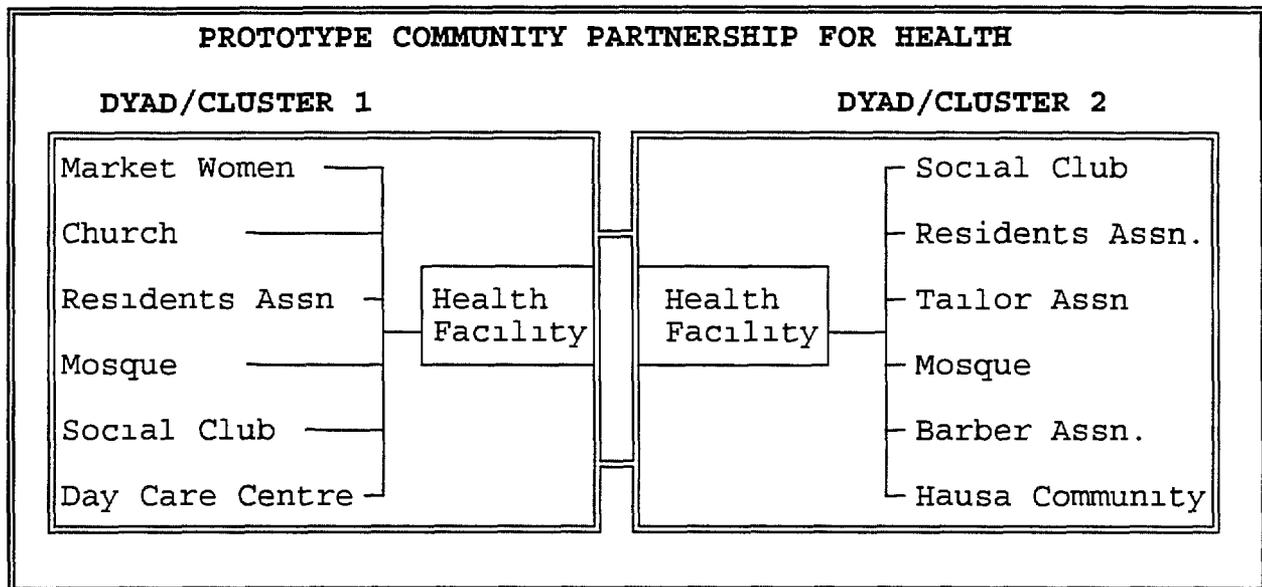
According to Silimperi *et al* (1997b), a total of 164 potential partners were identified from the UPSI and invited to the Community Fora. These included 90 CBOs out of the 358 interviewed (25%) and 74 of the 279 Health Facilities seen during the UPSI (27%). The Alapere/Somolu groups were eventually dropped from the programme and Lawson

45

substituted, but according to minutes of the Mushin Cluster 1 forum of 10th October 1995, Alapere was still under consideration during the conduct of the fora. Furthermore, it was noted that -

*The week before each fora, BASICS staff hand-delivered invitations and discussed the purpose of the meeting with the invited participants. Such personal outreach may have contributed to high attendance - an average of ten people per session, not including BASICS staff. The recent UPSI also increased interest and participation, since everyone had participated in the inventory, and hence had some recent exposure to BASICS.*

The meetings were organized around potential clusters of CBOs and HFs that might eventually form dyadic partnerships (i.e. a minimum of 1 CBO and 1 HF making a dyad) within the larger CPH (see sample in Figure below). Two fora were held with each cluster, and took place in community meeting halls, religious buildings, schools and offices of potential member organizations.



#### **4.2.2 Summary of Fora**

The first of two fora in each cluster/community had the following points as a general agenda (Silimperi *et al*, 1997a)

- Introduction to BASICS Urban Integrated Private Health Project facilitators, project mission, goals and objectives
- Discussion of common community health problems
- Presentation of the concept of private partnerships for health
- Exploration of the feasibility of the partnership concept challenges and suggestions for success
- Examination of potential community partners in dyad or cluster formations
- Identification of next steps for BASICS, participating health facilities and CBOs

Likewise, the second session, held a few weeks after the first, had a focus as follows

- Review of key content from Session 1
- Presentation of progress on assignments
- Clarification of roles and responsibilities of each partner type CBO, HF and BASICS itself
- Suggestions for additional partners that built on existing relationships or collaborations
- Steps to form partnerships
- Operational guidelines for partnerships
- Common questions about partnerships
- Development of Action plans and future steps
- Discussion of common health problems in the community

The discussions during the second fora were instructive of how different potential CBO and HF members reacted to the idea. This difference was most clear at JAS/Mushin where one cluster floundered and never became part of the partnership, while the other did. When asked what had been done since the last forum, participants in Cluster 1 were recorded in the meeting minutes of 10 October 1995, as saying -

*Phrontline Hospital had actually not done anything since last meeting but have been eagerly awaiting to commence the project. However the representative was anxious about the absence of the CBOs the Hospital had intended to be in partnership with - the Women Association of Christ the King Catholic Church, who were absent at the meeting. She was then encouraged to pay some of the members a visit and to let them know of the intention of the Hospital as they too were aware of the BASICS project. The 2 CBOs (in attendance) apart from informing their Church members, were awaiting technical support from BASICS on how to effectively mobilize their members and training for health education.*

In contrast, the response at the second fora in Mushin Cluster 2 showed more initiative by those who had attended the first meeting -

*The Medical Director, JAS Medical Services, recalled that he had introduced the BASICS project to community leaders, some of whom he brought with him to the meeting. Two elderly men both of them chairmen of Landlord/Tenant Associations in Mushin, were introduced to the other participants.*

Interestingly, none of the groups attending Cluster 1 fora in Mushin joined the CPH, while JAS Medical Services became the hub of the new CPH as reflected in the name, JAS CPH. The BASICS CDPO confirmed that the other groups in Mushin continued to express interest whenever he saw them, but none took initiative to attend JAS meetings or come to BASICS office, as was done by the newly formed dyads in Ajegunle and Surulere, to turn their interest into action.

#### **4.3 PARTNERSHIP FORMATION**

Partnership formation consisted of a third community meeting wherein those who had

been convinced of the value of the program during the preceding 2 community fora in their area/cluster came together to formally declare their intention to create the CPH

On 12 December 1995, at the first partnership meeting in JAS/Mushin, for example, the 12 assembled members representing 10 organizations, reviewed some of the problems facing the community including poor roads, lack of pipe borne water, thieves, health problems and poor drainage. They discussed what had been done about these problems to date and what could be accomplished through community action in the future. The group, with the guidance of BASICS' Community Development Programme Officer (CDPO) reviewed roles and responsibilities of partners and were told that a formal memorandum of understanding would be prepared to delineate these more clearly. Priority child survival problems were also outlined including malnutrition, cough, ring worm, chicken pox, immunization for preventable diseases and water-borne diseases like typhoid. The next lines of action as spelled out in the minutes of that meeting were reviewed as follows

- *BASICS would report on the meeting as early as possible in 1996*
- *Meeting time was still considered as appropriate after a debate, but it was suggested that members needed to be mobilized the more.*
- *Participants would need to disseminate the information discussed to members*
- *For each item under number three on the agenda dealing with the characteristics of partnership, members are to produce mini write-ups on this, a guideline format would be handed over to JAS Hospital for distribution later, before the end of the year (note this is the foundation for the MOU)*
- *Next meeting would be in 1996, at the instance of the partnership summoning the meeting to discuss some concrete terms and programmatic issues*

In JAS, 26 CBOs and 14 HFs identified during the UPSI met membership criteria. Of these, 17 neither attended any fora nor joined the CPH. Seven of these had not been reached with an invitation. Sixteen groups who attended fora did not join. At the first partnership meeting in December 1995, 9 CBOs and one HF joined. Eight of these had attended the fora. The two who did not attend the fora plus one other who did, did not appear on the "invitation list" drawn from CBOs surveyed during the UPSI who met partnership criteria. Also, of the four of the groups that joined later, one had attended a fora, but three neither attended the fora nor were they on the list of CBOs that were culled from the UPSI. In summary, of 40 groups eligible, 33 were contacted. Of those contacted 23 attended fora, and among these, 8 eventually joined. Six CBOs who do not appear to have been identified by the UPSI, or if they were, were not invited to join, did hear about the programme and eventually joined. These included one church, one ethnic women's group and 4 residents associations.

The forgoing depicts a relatively low yield for the UPSI (20%). In addition 29% of JAS CPH members were not identified by the UPSI. This experience indicates that a less arduous and costly means could be found for identifying future partnership members in new communities.

According to the Membership Inventories completed by each CPH leadership, the following number of CBOs/HFs joined each CPH in the beginning - i.e. late 1995, early 1996. These numbers differ slightly from those reported by Silimperi *et al* (1997a) because

of clarification For example, in Lawanson, it was eventually realized that the Hairdresser Association never joined, that the person attending had never informed or involved her group Another anomaly, as noted by Silimperi *et al* (1997a) is the uncertain status of CBOs that also offer community health services For example, was Holy Trinity Church in Mushin a CBO or was the volunteer Clinic run by the church a HF member? The same question pertained to the Catholic Church in Amukoko Also there may have been some minor discrepancy in defining what was the beginning date for the CPH and how many months later was still considered "joining at the beginning " In Makoko, Silimperi *et al* (1997a) reported that 13 partners started the CPH, but only 11 were listed as joining in 1995 by the CPH leadership on their Membership Inventory sheet

CPH/Community	Groups Joining at the Beginning		Total
	CBOs	HFs	
Ajgunle	10	1	11
Amukoko	2*	2	4
JAS/Mushin	9	1	10
Lagos Island	9	2	11
Lawanson	8	4	12
Makoko	9	2	11
Total	47	12	59

\* The original CBO membership at Amukoko was considered as only the two broad market associations (Amukoko and Muritala) Later, as described below, they accorded membership to each trade association within the larger markets, bringing the membership total to 16 CBOs

#### 4.4 MEMBERSHIP CHANGES

As seen from the Table below, all CPHs added new members after the initial formation meetings in later 1995/early 1996, according to the membership inventory forms filled out by the CPH leadership at the start of the documentation exercise in September 1997 Ajgunle increased its membership most (62% of members joined after January 1996), while Amukoko increased the least (7%)

When Joined	Community Partners for Health Membership						TOTAL
	AJE*	AMU	JAS	LAI	LAW*	MAK	
Beginning	11	17	10	11	12	11	72
Later	18 (62%)	3 (7%)	6 (12%)	8 (19%)	15 (38%)	15 (45%)	65 (47%)
Total	29	20	16	19	27	26	137

\*Status in September 1997, before new dyads formally recognized

Amukoko originally completed the inventory form listing only 2 CBOs and 2 HFs. The 2 CBOs were the Amukoko Market and the Muritala Market. Minutes of the CPH Board meetings revealed that this arrangement made the CPH more difficult to function as seen below

<b>Amukoko CPH Board Meeting Minutes</b>	
12/03/96	<i>Mrs Iyabo Olurebi suggested that each partner must have one or two more representatives in order to make the constitution of the sub-committee possible</i>
26/03/96	<i>On discussion of special committee, Mrs Abokoye said this could not be possible unless the numbers of the partnerships were increased. She suggested that each partner should increase their representatives, the HF by 2 and the CBO by 4 at least</i>
02/07/96	<i>The chairman advised the CBOs to increase their representatives to at least 20 members so that appointing committee would be made easy</i>

Eventually, it was decided that each trade association within the two markets that expressed interest should be recognized as an independent CBO member of the CPH. These new members are listed below -

Amukoko Market

Chicken Sellers Association  
Fish Sellers Association  
Grinders Association  
Hausa Community  
Oporoko (Stockfish) Assn  
Pepper Sellers Association  
Provision Sellers Assn.

Muritala Market

Fish Sellers Association  
Food Sellers Association  
Meat Sellers Association  
Pepper Grinders Association  
Tomato Sellers Association  
Vegetable Sellers Association

During the process of interviewing CBO/HF leaders, only two CBOs specifically stated that they had dropped out, that is the Goldsmith Association in Lawanson and the Catholic Church in Amukoko. The Goldsmith representative said that he was the main person interested, and when he was not longer able to attend meetings frequently, no one else was willing to take up the task. This was not the first group to be less than active at Lawanson, but the board was able to maintain participation by the photographers as seen from the board meeting minutes extracted below

<b>Lawanson Clarifies CBO Membership -</b>	
17/06/96	<i>(Disciplinary Committee Report) The secretary read a copy of a letter dated 06/06/96 served to the photographers Assn for a proper representative, based on nonchalant attitude of Mr Olawuyi. The chair of the Assn denied his representative and never give a feedback from meetings attended said by Mr Ogundipe, a vice-chair of the photographers Assn</i>
25/07/96	<i>A reply from the photographers Assn has not been received</i>
30/08/96	<i>In response to the letters to the photographers Assn, they replaced Mr Olawuyi with another member of their association to be assisted by Mr. Olawuyi.</i>

The Catholics in Amukoko went through a change in leadership, and when the new sister-in-charge of their health project assumed duty, she decided that the CPH was no longer in their interest. The official excuse given was that they could not associate with the CPH because it was linked with the U S government. It was also noted that the Catholics perceived that the CPH was viewed as a duplication of the type of work their community health project was undertaking.

Some names on membership lists, as it turned out, were misrepresentations. The Hairdressers Association in Lawanson never really joined, although a hairdresser attended many meetings in Lawanson and claimed to represent the group, her association never officially joined. Finally, some CBOs/HFs disbanded or left the community. In JAS, Kayode Native Doctor disappeared from the area due to some alleged improprieties, and also, the Kingdom Christ Ministry moved its church to another section of town.

Although all CPHs showed that new members joined, the climate for welcoming new members varied. Although the Table above shows an increase in membership at Makoko, some CBO and CPH leaders there had the impression that new members were not welcome, as seen from their comments below

*There is no opportunity for new members to join because they were not allowed to know the real purpose. The chairman will not take time to explain. People (outside) complain that we are not well organized, that instead of telling us the truth, our leaders hide facts (CBO Leader)*

*I have not tried to recruit new members because of the instruction given to us that we should not bring in new members until we are told to do so (CBO Leader)*

*The chairman does not seem to be favorably disposed towards admitting new members because of personal reason (CPH Leader)*

*I have not tried to recruit new members because of what BASICS told us at the initial stage that we should not admit new members, but now the embargo has been lifted. (CPH Leader)*

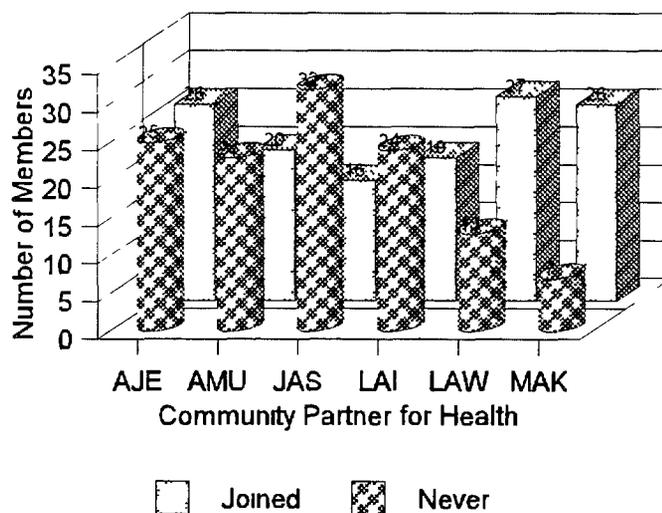
*I have tried to recruit new CBOs into the CPH, but the chairman refused their entry He will not welcome new members, and we are quarreling with him on this (CPH Leader)*

Overall, 57 CPH leaders interviewed (70%) indicated that they had tried to recruit new members into the CPH Two-thirds of these said that the groups they approached had agreed to join Likewise, 57% of CBO/HF leaders said they had tried to bring in new groups, and of those two-thirds were also said to have joined Reasons for not joining included "They are still discussing", "They do not fully understand", "They have no time", "They think it will not profit them", "The dues are too high", "They are not interested", "They have their own internal problems", and "They heard about our problems "

A summary of the membership process in the six original Lagos CPHs shows that out of approximately 258 organizations that were eligible to join, 27% joined at the foundation of the CPHs Another 25% joined later, over the next two years, while 48% never joined The highest proportion of never joiners was in JAS/Mushin (67%), and the lowest was in Makoko (21%).

Also the type of organizations that joined were different than the broader list of eligible groups Overall 28% of the baseline organizations were health facilities/services (65 western and 7 indigenous providers) Only 13% of those who ever joined were health care providers (18 western and 4 indigenous) This contrasts to 45% service providers among those who were designated as "potential partners" from the UPSI results It appears that there is an ideal proportion or ratio of CBOs to HFs, with more of the former required to strike a balance There is also the likelihood that fewer HFs would agree to the ideals of the CPH, that is providing reduced price health care.

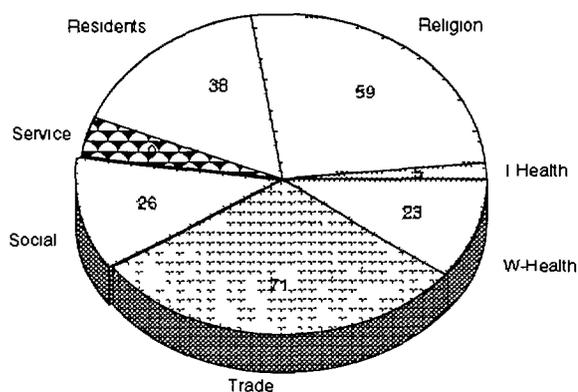
Status of CBO/HF Joining CPH



#### 4.5 CURRENT MEMBERSHIP

Overall, 203 (88%) of the reported 231 current Lagos CBO/HF member organizations are CBOs according to the membership inventories. Of the remaining members 10% are western health facilities and 2% are indigenous healers. A further breakdown of the CBOs and HFs is seen in the table below and includes religious groups (churches and mosques), resident (or landlord) associations, service groups (e.g. Red Cross, Boy Scouts, day care centres), social clubs, and trade associations (market women, tailors).

*Types of CBO/HF Members*



Type of Member	LAGOS Community Partners for Health						TOTAL
	AJE	AMU	JAS	LAI	MAK	SUR*	
Indigenous Health Provider	1	0	1	0	3	0	5 (2%)
Religious Society	27	0	5	3	4	20	59 (26%)
Resident Associations	17	1	3	0	5	12	38 (17%)
Service (e.g. Day Care Red Cross, Boy Scouts)	2	0	1	0	2	4	9 (4%)
Social Clubs	6	2	2	6	2	8	26 (11%)
Trade Associations	6	15	2	8	4	36	71 (31%)
Western Health Providers	4	2	2	2	6	7	23 (10%)
TOTAL (9/97)	63	20	16	19	26	87	231

\*SUR = Lawson and Ojuelegba combined  
Note AJE combined all old and new dyads

#### **4.5.1 Reasons for Joining CPHs**

The Table below provides an insight into why CBOs and HFs decided to join their CPH. The most common reason was probably the most obvious, because the programme promotes the health and survival of children (36%). The second most common reason included the perceived benefits in terms of health (34%). As seen below, other common reasons for joining included the opportunity to promote community health, because of the convincing information received, because the idea was seen as noble or worthwhile, the opportunity to promote the interests and needs of women.

REASON FOR JOINING CPH	NUMBER	PERCENT
Promote child health/survival	62	36
Benefits like improved health care	62	36
Convincing information received	45	26
Promotion of community health	26	15
Opportunity for women empowerment	19	11
Noble, worthwhile ideal	17	10
Progress and unity of community	17	10
Knowledge to be gained	12	7
Opportunity to contribute, help	12	7
Interest, in line with our goals	10	6
Benefit our organization	9	5
Improve environmental sanitation	5	3
Learn about our rights	4	2
Help our youth	4	2
NUMBER	174	

Some of the actual comments made by CBO and HF members are listed below. Some of the reasons are altruistic while others recognize the material benefits possible from the programme. Some even envisioned projects, like tap water, that were outside the mission of the programme.

*We joined because we saw it as a better alternative to the inefficient government hospitals. We are also in love with its lofty objectives like the credit facilities, reduced health cost, etc.* (Ojuelegba, new dyad)

*This programme came to me at a point when I was thinking about what I should do for my community. Thus when I got to know about the CPH, I was eager to join them.* (Ojuelegba, new dyad)

*We joined because of the facility that would be available to the school in which I am a proprietor. I need treatment for the children in the school.* (Ajegunle, new dyads)

*As a voluntary organization whose mission is to help the women, we saw the idea of the CPH as an additional way of realizing our goal of improving our women.* (Ajegunle, new dyads)

*We joined because our hospital shared in the objective of the programme, which is to give qualitative health care to the people around us (Ajegunle, new dyads)*

*We want the health situation of our congregation to improve We want people to become more aware of health related issues I want my members to benefit (Ajegunle, new dyads)*

*We were introduced to us as an association for health, especially for women and children Because I am a leader in the community, I see it as an opportunity (Makoko)*

*I heard of the development in some places BASICS gave vehicle and furniture to us That convinces me that it is a good plan to join them (Makoko)*

*They explained to me that there is a way that our child will not die and how to know our right in the community That is why we joined (Lagos Island)*

*To gain more knowledge and patronage in our health facility and to participate in the child survival programmes (Lagos Island)*

*We joined so as to contribute our quota to child survival within the community and Nigeria as a whole Also to create health awareness in the community (Lagos Island)*

*We joined because the philosophy and objectives of the CPH idea conform with ours here, and that is serving the people at reduced cost (Lagos Island)*

*The CPH promised to give us amenities such as tap water and other social amenities (Amukoko)*

*There were a large number of our people with health problems We reported to our pastor about the large amount of money involved in health care So, any medium of help is welcome.(Ajegunle)*

#### **4.5.2 Reasons for Not Joining**

The most common reason given among the 68 CBOs and HFs leaders interviewed who did not join the CPHs was that although they attended the community fora, there was not proper follow-up about subsequent meetings and activities (22%) A fair number said there were not aware of the programme at all (19%) even though their names were culled from lists of organizations that met the criteria for CPH membership, implying that they were likely to have been invited to the fora Several (19%) complained that they were not invited or properly informed Six said they were too busy, and another 6 said they did not understand what the program was all about Other reasons seen in the table below included internal problems (e.g. change of leadership) precluded them from joining at the time Three said they could not abide

by the process, for example because the venue for meetings was in a church, or because they were against working with TBAs

REASON FOR NOT JOINING CPH	NUMBER	PERCENT
Attended fora, but no follow-up	15	22
Not aware at all	13	19
Not invited, properly informed	13	19
Did not understand the programme	7	10
Too busy, no time	6	9
Internal problems to CBO at the time	5	7
Not aware before, but interested now	5	7
Could not abide by venue, program	4	6
Disenchanted with CPH leadership	1	1
Fear U S involvement	1	1
NUMBER	68	

Both BASICS staff and CPH leaders made comments that the reason why CBOs and HFs did not join was that they were skeptical and wanted to wait to see how the programme evolved before making a commitment to join. From the responses above, it appears that there might also be a case to be made that more personalized contact prior to the fora and follow-up afterwards could have netted a larger membership. Additional comments from non-joining groups follow.

*We were put off by the administrative laxities of the former CPH, so we did not join them (Ajegunle)*

*We did not join earlier because it did not appear to be open to other tribes. It seemed limited to people of the Igbo race alone. It does not seem to be properly organized - no secretariat (Ajegunle)*

*BASICS forgot about us for whatever reasons we do not know. We were among the first people to accept the programme. They used us as a guinea pig. I identified with the project because one of the BASICS*

*staff is known personally to me. I still have a file with correspondence from BASICS. We are still unable to rationalize what criteria BASICS used to choose Roland Hospital as the secretariat of the CPH. We are still interested (Lagos Island)*

*At the initial stage we had been coming, but along the line, the information stopped reaching us. Thus, I cannot say whether we are a member or not. We are still very much interested in being a member (Lagos Island)*

*I (the matron) never heard of it before My MD is out of the country, but he may be favorably disposed to the idea, if there is a follow-up to explain the programme better to him (Lagos Island)*

*I don't even have knowledge about the CPH We would like to join if invited now.(Lagos Island)*

*I am interested to join We would have joined, but our chairman died last year, while I am very old (85+) I would like another of our members (landlords) to be contacted to know if he would be interested, too (Amukoko)*

*The location they are using is against my religion (Islam) I expected us to go to a neutral place I am willing to join if they can remove the secretariat from the Catholic church.(Amukoko)*

*We did not count it to be important We did not think that it could be of benefit (Amukoko)*

*There was a break in communication from Shammah Hospital Then we thought that the Nigerian Government would be annoyed with us for joining a U.S programme (Amukoko)*

*I am not aware of the programme currently They came to explain a long time ago and never showed up again (Amukoko)*

*Our facility was mismanaged at the time We are just trying to recoup again (Amukoko)*

*We did not know the next line of action after the first few meetings (fora) with BASICS. There was no follow-up information as to what to do next We were supposed to be affiliated to Saint Mary's Clinic (Cardoso), but after a few*

*unfruitful visits to the clinic, we forgot about the whole thing We are still interested in a partnership, but we need more information on the next steps (Ajegunle)*

*There was no further information about the programme (after the fora) We do not clearly understand the whole thing and need further explanation There was no follow-up We had no idea that the CPH took off at all (Ajegunle)*

*We were never invited. If we receive a proper invitation we will surely show up The goal sounds interesting (Ajegunle)*

*We are hearing about it for the first time, but would like to know more about the purpose of BASICS We are interested in joining (Ajegunle)*

*Because of time I'm very busy at my clinic, but now am interested to join I was also afraid of loaning Nigerians money It was this fear that inundated me off originally I advised Dr Sowande not to get herself involved in loaning money, although she refused In view of her persuasion, I may be active soon.(Lawanson)*

*There was no official invitation to my organization to join. A friend merely mentioned it to me as an individual (LAW)*

*The information or invitation for meetings always came late, and we have not been given the opportunity to attend (JAS)*

*BASICS came to mobilize us and asked us to get the TBAs and other CBOs involved, which we couldn't do So we lost contact with the programme (JAS)*

*We attended a couple of meetings (fora), but somehow the meetings stopped and everybody seemed to forget about the whole*

thing Our health staff were quite interested from the outset, but were discouraged when the meetings stopped Again, the idea of treatment terms of the partnership, which included treating people on credit sometimes, did not seem profitable (JAS)

Although invited, we could not join because we did not understand in clear terms the motives or objectives of the scheme, and there was nobody to explain these to us There was no personal contact (JAS)

I have no time for meetings because of the nature of my job (JAS)

#### 4.6 OVERVIEW OF THE COMMUNITIES

The leaders survey also provided an overview of the six communities From data on leader characteristics, one might get a hint of such issues as ethnic and religious mix Also results from the various scales provide an insight, from the leaders' perspective of community efficacy (social control, identity, cohesion) and violence

##### 4.6.1 Ethnic Mix

The table below shows the ethnic mix of CPH, CBO and HF leaders interviewed in the six communities Overall, 75% of all 323 leaders interviewed were Yoruba, but this ranged from a high of 90% on Lagos Island to a low of 54% in Ajegunle The breakdown of other groups include 12% Igbo, 1% Hausa and 11% others (particularly from Midwestern states of Edo and Delta)

Ethnic Group	Ethnic Mix of CPH, CBO and HF Leaders Community Partners for Health						TOTAL
	AJE	AMU	JAS	LAI	LAW	MAK	
Yoruba (%)	54	77	83	90	82	80	75
Other (%)	46	23	17	10	18	20	24
Number	76	43	41	38	84	41	323
$X^2 = 26.9440$ 28, d.f = 57, p = 0.00005856							

It is important to note that there were some ethnic differences among leaders between the two new dyads and the existing CPH as seen below The older groups in the two sets had significantly more non-Yoruba leaders Although the new Ajegunle group has a greater proportion of Yoruba leaders, it still has more people from other ethnic backgrounds than the other CPHs aside from the original Ajegunle

Ethnic Group	Ethnic Mix of Leaders: Community Partners for Health with New Dyads			
	Ajegunle		Surulere	
	AJE (old)	AJ2 (new)	LAW (old)	OJU (new)
Yoruba (%)	41	72	74	92
Other (%)	59	28	26	8
Number	32	44	46	38
Fisher's exact p value	0.0104		0 0441	

The next table looks only at the 81 CPH leaders who were interviewed. The combined Ajegunle and Surulere (Lawanson/Ojuelegba) CPHs have the highest percentage of non-Yoruba leaders, 24% and 28% respectively. In both the old Ajegunle dyad and Lawanson, 36% of the leaders were non-Yoruba. Only Yoruba leaders held posts in the CPH Board in Makoko, one each in Amukoko and Lagos Island, and three at JAS.

Ethnic Group	Ethnic Mix of CPH Leaders Community Partners for Health						TOTAL
	AJE	AMU	JAS	LAI	LAW	MAK	
Yoruba (%)	14	17	21	9	28	0	17
Other (%)	76	83	79	91	72	100	83
Number Interviewed	17	6	14	11	18	15	81
$X^2 = 5.67, d.f = 5; p > 0.14$							

#### 4.6.2 Religion

Overall, 320 of the leaders interviewed stated a religion: 66% Christian, 32% Moslem and 2% other (e.g. indigenous). Amukoko and Lagos Island had the highest proportion of Moslem CPH, CBO and HF leaders (51% each), while Christians predominated in the other communities as seen in the table below.

Religious Affiliation	Religious Mix of CPH, CBO and HF Leaders: Community Partners for Health						TOTAL
	AJE	AMU	JAS	LAI	LAW	MAK	
Christian (%)	67	44	95	49	68	68	66
Moslem (%)	31	51	5	51	30	32	32
Other (%)	3	5	0	0	2	0	2
Number Interviewed	75	43	41	37	83	41	320

#### 4.6.3 Community Efficacy

The community efficacy score was calculated for 315 leaders who responded to all questions. The lowest score was 10 points, while the maximum possible of 56 was achieved. The average was 45 with a median of 47. There was significant variation in scores among the various CPHs and dyads. It was highest for the newest dyads - new Ajegunle (48) and Ojuelegba (47) and lowest for Rikky Dyad-Ajegunle, Lagos Island and Amukoko (42 points average). The other original CPHs scored well also - JAS (47), Makoko (46) and Lawanson (45). This difference is significant ( $p = 0.0003$ ). If the new dyads were left out, the difference in mean community efficacy scores was still significant as seen in the Table below ( $p = 0.012$ ).

COMMUNITY EFFICACY SCORES FOR EACH CPH						
CPH	Obs	Total	Mean	Variance	Std Dev	
AJ2	32	1542	48.188	37.706	6.140	
AJE	42	1771	42.167	79.459	8.914	
AMU	42	1781	42.405	61.905	7.868	
JAS	39	1824	46.769	43.393	6.587	
LAI	35	1477	42.200	90.576	9.517	
LAW	46	2076	45.130	53.138	7.290	
MAK	40	1857	46.425	54.661	7.393	
OJU	38	1803	47.447	47.173	6.868	
<u>ANOVA</u>						
Variation	SS	df	MS	F statistic	p-value	
Between	1651.259	7	235.894	4.019	0.000316	
Within	17961.738	306	58.698			
Total	19612.997	313				
<u>ANOVA (without new dyads)</u>						
Variation	SS	df	MS	F statistic	p-value	
Between	944.286	5	188.857	2.987	0.012336	
Within	15047.468	238	63.225			
Total	15991.754	243				

Two other major factors were associated with community efficacy scores. Leaders' status was significantly associated with the score. CPH Board members/leaders scored highest on average (46.1 points), followed by leaders of member CBO/HF groups (45.6). Those leaders of non-member groups scored lowest (41.7) ( $p = 0.0014$ ). When CPH and CBO/HF leaders were compared alone, the difference was not significant ( $p = 0.66$ ).

Perceptions of community efficacy also varied by ethnic group of the respondent. The 238 Yoruba respondents scored highest (45.8), followed by those 34 belonging to other groups like Ishan and Edo (45.0). These others came primarily from the old "mid-west" which was actually part of the primarily Yoruba Western region of Nigeria for many years. The 39 Igbo respondents scored 40.6 points on average, while the 3 Hausa leaders scored 38.3 points. The difference in scores between the Yoruba and the mid-westerners was not significant ( $p = 0.54$ ), but the overall difference among groups was significant ( $p = 0.0007$ ).

This survey was cross-sectional, so it is not possible to say that any particular factor "caused" community efficacy perceptions to vary, but some implications seem evident. Ethnicity does appear to be an important factor in perceptive community cohesion, control and identity. The fact that Ajegunle leaders perceived a low level of community efficacy and that Igbos, who also perceived low community efficacy wherever they live, were more common in Ajegunle, indicate that ethnic diversity may work against community cohesion in some places. Lawanson had a fair ethnic mix, but on the other hand, the wider Surulere community of which it is part is a longer established community with more lower middle class residents. The ethnic mix in Lawanson, by the way, was more of mid-westerners. As will be seen in the section on Governance, with the exception of Makoko, the two original CPHs with the higher community efficacy scores also appeared to function better.

This raises the issue of whether perceived community efficacy influenced joining a CPH, or whether joining had an influence on perceived community efficacy. In other words, do the lower scores of non-members reflect a pessimism that kept them from joining, or did joining increase the optimism of the members? The very high scores of the two new dyads (AJ2 and OJU) imply that some level of enthusiasm about community problem solving capacity may be engendered by the formation of a CPH. This might reduce after some time dealing with the realities of group dynamics and the stubbornness of some community problems, but if the CPH is making some progress, as in JAS, the perception that the community is strong and can overcome its problems might persist. The benefit of conducting the survey among the new Lagos dyads and the new Kano CPHs will mean that there will be a baseline from which these hypotheses can be tested in the future. Some comments during the interview from the CBO leaders shed light on the scores as seen below -

**Makoko:**

- ▶ *There is no unity in Makoko. People relate among people from the same tribe.*
- ▶ *People are more prone to cooperate on ceremony and not on community progress.*

**Amukoko**

- ▶ *There is ethnic distrust. (a Hausa community representative)*
- ▶ *People only agree in their own compounds.*
- ▶ *Ethnicity is high.*

**Ajegunle** ▶ *People in this community know each other well, but I do not think that they cooperate*  
 ▶ *One should not trust people in this community*

**Lagos Island** ▶ *No quick action and Islanders want quick action for them to be mostly interested*  
 ▶ *Lagos Islanders are the most terrible and sensitive They rely on cost-benefit efforts*

One of the interviewers added these comments to the end of the questionnaire of one Makoko respondent

*My respondent is the chief of the Ogu Community, and his responses seem to be highly influenced by what appears to be a long standing mistrust or even misunderstanding between Yoruba and Egun people He complained of intense marginalization of his people both within the CPH and by the Yoruba generally.*

#### 4.6.4 Violence

Perceived levels of community violence varied among the CPHs Since the scores did not vary within the dyads of Lawanson/Surulere and Ajegunle, their scores were combined The table below shows that Lagos Island leaders perceive their community to be the most violent If their scores are withdrawn, the difference among the remaining 5 CPHs is not significant

MEAN VIOLENCE SCORES FOR EACH CPH						
CPH	Obs	Total	Mean	Variance	Std Dev	
AJE	74	630	8.514	41.870	6.471	
AMU	42	305	7.262	31.222	5.588	
JAS	40	272	6.800	13.446	3.667	
LAI	35	432	12.343	31.055	5.573	
LAW	84	709	8.440	23.984	4.897	
MAK	40	247	6.175	31.430	5.606	
ANOVA						
Variation	SS	df	MS	F statistic	p-value	
Between	891.774	5	178.355	6.034	0.000024	
Within	9133.369	309	29.558			
Total	10025.143	314				
The variances in the samples differ						
Kruskal-Wallis H (equivalent to Chi square) =					28.726	
Degrees of freedom =					5	
p value =					0.000026	

Violence was a problem mentioned at some of the community fora, and it can inhibit community development and work like that of the CPHs The problem in Lagos Island was

witnessed firsthand by the interviewers, one of who recorded the following on the back of a questionnaire

*In the course of this interview, a commotion ensued among some groups, in a twinkle of an eye, more than one thousand area boys/Lagos Islanders were out Broken bottles, knives were used as weapons to fight Cars were damaged, windows were damaged Efforts to quench the commotion by community heads failed, but the quick intervention of the Nigeria Police Force quenched it There is a high level of community violence here.*

This section has shown that although the same processes were followed in organizing the CPHs in the 6 communities, historical, ethnic and other differences resulted in a different foundation for CPH formation It was also seen that CBOs were more likely to join the CPHs Although the initial proportion of eligible CBO to HF partners was 1 2, the proportion of CBOs to HFs among current members in Lagos is 7 3 Subsequent sections will permit one to see if these differences among communities and in membership might explain some of the observed differences in performance among the CPHs

## 5. GOVERNANCE AND MANAGEMENT

Governance of the CPH was attended to early in the formation stages on the organizations. This section looks at the development of the memorandum of understanding (MOU), the constitution, leadership structure, committee formation and dyad structure

### 5.1 MEMORANDUM OF UNDERSTANDING

Partnerships developed individual Memoranda of Understanding (MOUs) between each member organization and the partnership as the implementing mechanism for their action plans. In addition, an MOU was developed between each partnership and BASICS (Silimperi *et al* , 1997b). The core components of the MOU among members were four

- 1 The names and addresses of all partner members, both CBOs and HFs,
- 2 The objectives of the partnership, especially health concerns (e.g. malaria, immunization, acute respiratory infections, diarrhoeal diseases), the need for sustainability, and the enhancement of women's decision making,
3. Governance of the partnership, with emphasis on being non-discriminatory, formation of a Management Board, income generation, special committees, banking and accounts, female leadership, and admission of new members, and
- 4 Roles and responsibilities of partners including willingness to serve on the Management Board, ensure that members receive prompt treatment for illness, promote/provide immunization, proper record keeping and ensuring the ability of all to pay for health services

The MOU was framed in a standard format wherein the names of each CPH were inserted. This was not presented as a *fait accompli* by BASICS, but developed and discussed over time as can be seen at from excerpts and notes from meeting minutes of the JAS CPH at the right.

<i>Developing the MOU at JAS CPH</i>	
16/11/95	At the second community forum in cluster one, the issue of Roles and Responsibilities of partnership members was raised using the example of diarrhoeal diseases, the same discussion took place at the forum for cluster two on 24/11/95
12/12/95	At the inaugural CPH partnership formation meeting it was explained that " a formal memorandum of understanding would be prepared later to incorporate some of the things discussed as roles and responsibilities "
14/02/96	The group was informed by the chairman on the need to deliberate on the MOU
13/03/97	A draft MOU was produced
01/04/96	"The chairman showed to the seated members the MOU which is a product of the various meetings held after the workshop "
May 1996	The MOU was signed

At the Amukoko CPH Board Meeting of 7 March 1996, the Board debated the draft MOU and noted that, "On the MOU issue of the risk bearing by the CBO was finalized that any patient who was unable to pay up his/her bill within the stipulated period of two weeks should be the responsibility of the CBO in which the patient belongs. We agreed to different color of patient card for each CBO. The card should carry a logo and be designed in such a way that only HF partners will identify them."

The issue of a standard format came into question during the debate on the MOU at Lagos Island CPH on 23 May 1996, as seen below

*Dr Aworo sought the opinion from other members of the dyad in respect to the roles and responsibilities of partners (BASICS, HF, CBO) as stated in the proposed MOU. Mr. Adebimpe of Happy Klub referred members to part 4 section B1 of the proposed MOU where 15 days maximum was allowed for clients who are not able to pay the health facility on the spot, whereas, it had been agreed by the partners in a previous meeting in the dyad that the maximum credit period is one month. Dr Aworo assured the member of his compliance with the one-month grace period but the section should be left as stated in the proposed MOU due to other dyads who might have agreed in 15 days.*

Much earlier in the process in March 1996, a local consultant meeting with the Board of the Ajegunle CPH shared the following with the group:

*I informed the meeting that there is a great need for them to finalize their Memorandum of Understanding (MOU), failure of which would hinder their project implementation and will create room for confusions, e.g. the Dyad Secretary's status. The participants requested that BASICS should give them a prototype MOU to work on. I advised that we had already given them insights into this from the cluster formation meetings up to the dyad workshop but that we are not going to write the MOU for them. I then went through the roles and responsibilities of each partner.*

*A member of the meeting said that he had already done his homework on this. He briefed the meeting of this and suggested an organogram for the dyad. I then requested that he should put his ideas on paper so that other members of the dyad can discuss it. BASICS will give technical inputs to the development of the MOU, but that the dyad should originate the ideas. (A.A Adetoro, 1st March 1996)*

During the regular Ajegunle CPH meeting of 22 April 1996, the CDPO visited as the following observations were recorded in the Board meeting minutes: "Mr. Sam . confirmed their mission, issued the Dyad a set of different documents comprising the MOU, subproject programme, Time line, Logo and Disbursement Term "

From the foregoing, it would appear that ultimately, BASICS did play a stronger role in developing the MOU format. This appears to be a natural response to the guidance sought CPHs in such a new endeavor. On the other hand, there may be concern that a unified

format may detract from the sense of ownership of the process by individual CPHs, and may have contributed to the problem of lack of awareness by some CPH/CBO leaders of the document as described later.

The actual chairpeople of the CPHs, as well as BASICS field staff did appreciate the value of the MOU, as registered by the ratings they gave this core activity during the Documentation Exercise. Feedback from BASICS staff and CPH Chairpersons ranked the MOU with a mean score of 2.6 as presented earlier, and thus viewed it as an essential CPH formation activity. As will be seen in comments below, some people considered the MOU to be equivalent to a constitution, and the development of a constitution itself ranked higher at 2.9 points.

During the Leadership interviews, it was learned that not all CBO and CPH leaders were fully familiar with the MOU. Nearly half (45.6%) of the 173 CBO leaders interviewed had not heard of the MOU, while 7.5% were uncertain. Although 81 (46.9%) had heard of the MOU, 11 of these could not say what its purpose was. All 81 CPH leaders interviewed had heard of the MOU, but here also, 12 (14.8%) could not explain its purpose (see Table).

Heard of MOU	CBO Leader		CPH Leader	
	No.	%	No.	%
YES, and purpose	70	40.5	69	85.2
Yes, don't know purpose	11	6.4	12	14.8
Uncertain	13	7.5	0	
NO	79	46.5	0	
Total	173	100.0	81	100.0

Hearing about the MOU by CBO leaders varied by CPH. It was highest in the original Ajegunle Dyad and Lawanson (65.2% at each) and lowest at Amukoko (23.5%) as seen in the Table below. The low level of awareness in Amukoko could be explained by their recent restructuring to recognize as CPH members each of the distinct associations that comprised the two larger market associations that originally came together to form the CPH.

At the Lawanson CPH board meeting of 6 May 1996, it was recorded in the minutes that, *"The Memorandum of Understanding was read through. The groups (CBOs/HFs) demanded for copies and the chairman promised to get them ready for collection by the next day."* Lawanson was the only CPH that began with 4 dyads, and the subsequent discussions among members about their rights and relationships could have increased reference to and thereby heightened awareness of the MOU. At a subsequent meeting on 20 May 1996, a day before the official signing, the following was recorded in the LCPH board meeting minutes:

*Mr. Agunbaka said that the handout given to him on MOU and Partnership for*

*Child Survival, when he presented to his members, some of his members could not understand. The chairman advised that initially not everybody would understand, but we the leaders have to lecture them, that what we have to do is to explain the aims and objectives of this programme, what they would benefit. Even though you don't have money to pay at the spot, what is paramount is that we make sure quality treatment is given to your child and you give guarantee that within two weeks money would be paid at affordable price.*

Concerning Ajegunle, contentions about lack of representativeness in that large CPH and the subsequent development of additional dyads there in recent months could also have been responsible for increased awareness of the MOU among CBOs there. The problem was summed up by a CBO member that switched to the new dyads:

*We were part of AJCPH before, but decided not to have anything to do with it after the delegation we sent to one of the meetings was walked out. We are now associated with LAJCPH. The CPH idea is quite good, but the AJCPH was poorly run. There were ethnic tendencies, dishonesty and a lack of transparency.*

This level of awareness of the MOU in Ajegunle does not necessarily correspond to full understanding. As one former member of the Rikky Dyad noted, *"This is an agreement between the CBOs and the CPH, and we are supposed to have a copy to know our right. Because we don't have a copy, we don't even know what to do."* A member that stayed on commented that, *"It has been long I can't really remember. If we have not benefitted much, it is because of our inability to play our own part well."*

Heard of MOU	Community Partner for Health (% Heard of MOU)							
	AJ2	AJE	AMU	JAS	LAI	LAW	MAK	OJU
No	53.8	26.1	76.5	53.8	33.3	17.4	52.0	54.8
Uncertain	0.0	8.7	0.0	7.7	20.0	17.4	4.0	6.5
Yes	46.2	65.2	23.5	38.5	46.7	65.2	44.0	38.7
Number	26	23	17	13	15	23	25	31

Chi square = 27.15, Degrees of freedom = 14; p value = 0.01840173 <---

For those who had heard about the MOU and knew its purpose, the next Table shows their ideas about the purpose of the MOU. The most common response (78 respondents) was that the MOU serves as a guidelines for the smooth running and management of the CPH as stated by 52.8% of CBO leaders and 59.4% of CPH leaders. Second to this was the response by 72 people that the MOU defines roles, relationships and expectations, as mentioned by 62.8% of CBO leaders and 40.6% of CPH leaders. Other responses, including containing the organization's objectives, giving legitimacy to the CPH and serving like a constitution are seen in the next Table.

Purpose of MOU	CBO Leaders		CPH Leaders	
	No	%	No	%
Guidelines for running CPH	37	52.8	41	59.4
Spells out roles, relationships and expectations	44	62.8	28	40.6
States CPH objectives	21	30.0	4	5.8
Gives legitimacy	3	4.3	4	5.8
Helps achieve goals	2	2.8	3	4.3
Like a constitution	0	0.0	4	5.8
Gives sense of democracy	1	1.4	2	2.9
Brings us together	0	0.0	3	4.3
Promotes understanding	0	0.0	2	2.9
Other	4	5.7	3	4.3
No Benefit	5	7.1	3	4.3
Number	70		69	

Specific positive comments made by CPH leaders during the questionnaire interview about the MOU are seen below.

From Lawanson: *It has reduced true price of health care. It gives us guidelines on how to operate and what are our responsibilities. Helps us know how to function*

From JAS: *The CPH would probably have disintegrated if not for the MOU. It's more like a constitution and has provided a guide to the CPH.*

From Makoko: *It is the agreement, and we used it because it outlined the duty of every party. It is our bible.*

From JAS: *At intervals we go back to the MOU and look at the roles of the chairman and others to guide us in our activities or deliberations. It has been very beneficial.*

From Lagos Island: *Through the MOU we have been able to involve the health facilities, and we know more of the subsidized health scheme.*

From Lawanson: *Without it they can't bring us together. It gives us a sense of belonging, working together.*

From Lagos Island: *It served as an instrument for conflict resolution. It has served to smoothen our relationships.*

From Amukoko. *We tried to work within the articles It guides us in making decisions It clears the role confusion*

From JAS *It has sharpened everyone's awareness It has given us a guideline about democracy Accountability is entrenched in the organization. Everything is orderly and tenure is clear.*

From Ajegunle *If not for the MOU, the CPH would have been down*

From Lawanson: *It makes the CPH an authentic body. It gives us the confidence that the American Government recognized the problems we are facing here and they are working on it.*

On the other hand, some CPH leaders have not been impressed with the role of the MOU as seen below.

From Ajegunle: *It hasn't been followed, so I wouldn't know the usefulness Up till today, we haven't got a solid bank account, which we ought to have*

From Makoko: *I just know it exists, but can't say anything about it.*

From Lawanson *It could have been useful but for the lack of finance to execute the programmes.*

From Lawanson: *It does not work according to its original plan.*

From JAS: *I have got no copy I cannot therefore, say anything about its usefulness Please let me have a copy*

From the foregoing, it can be seen that the MOU has played an important role in establishing the CPHs in Lagos Key leaders rank its importance in the future promotion of new CPHs quite high. Many leaders can explain fully the purpose of the MOU and value its role in providing identity, cohesiveness and guidelines to the emerging organizations The MOU fulfills one of the criteria for coalition implementation and maintenance. *having formalized rules, roles and procedures* (Butterfoss *et al* , 1993), but there are two concerns for why the MOU may not achieve its desired effect First, most (59.5%) CBO leaders are not fully aware of the document. In fact, since the MOUs were originally signed in May 1996, none of the subsequently joined CBO/HFs in any CPH has signed this agreement

It certainly was the intention of BASICS staff that all CPH member groups be fully aware of and particulate fully in the deliberations concerning the MOU and other governance issues as evidenced in an excerpt from the Ajegunle CPH Board meeting minutes of 22 April 1996

*Mr. Sam advised CBO member organization to endeavor to photocopy each of these documents to enable them do a thorough perusal. Adding that the potential impact in this programme if properly utilized/directed is great He added that by the year 1998, that death rate shall be reduced to certain minimal, particularly children and mothers; are the main objective of BASICS*

*In their conclusion the CBO were asked to appoint a committee who will revise the said document and send their report a day after the revision There-in-after a 5-member committee was set to review the documents Before Mr Sam handed over the documents to us, he warned that forthwith no individual shall reach on any decision on behalf of the CBO or else such decision stands on owners risk Adding that it is necessary that the community have to meet together before decision and execution be taking*

The second concern is that even when aware of the existence of the MOU, some members do not have access to the document It appears that the request that CPH leaders photocopy and distribute the MOU widely may not have been followed Also some CBO members have limited or no English language skills in order to read the document Even a few of those CBO and CPH leaders who are aware of the MOU are skeptical about its usefulness, especially if it is seen that the CPH leaders do not follow its principles (e.g. in the way finances and banking are managed). Clearly more work is needed by CPH leaders and BASICS staff to educate people about the MOU, especially in local languages, and to ensure that new CBO members understand the document and sign it

## **5.2 CONSTITUTION**

All CPHs have developed a standard constitution, which was one of the requirements for registering with the Federal Government The constitutions bear close resemblance with the MOUs especially in the area of objectives and the role of women As noted under the discussion of core activities in the Section 3, leaders ranked constitution higher than MOU It is probably the requirement of the Constitution for registration that increased its perceived importance as a step in CPH development.

Basic components of the CPH constitutions included the following sections

- 1 Supremacy of the Constitution
- 2 Aims and Objectives (which mirrored the MOU)
- 3 Finance and Management
- 4 Membership
- 5 Admission of Members
- 6 Duties and Responsibilities of Members
- 7 Composition and Duties of Board of Trustees
- 8 Removal of Trustees
- 9 Corporate Seal
- 10 Legal Adviser
- 11 Procedure for Election
- 12 Miscellaneous (e.g amendments, quorum)

A sample constitution is attached The document was signed and dated by the Chairman and Secretary of each CPH after it had been adopted during a Board meeting Although the constitution is more detailed than the MOU, and although it rated higher among the core activities than the MOU, it had the weakness that each member CBO/HF was not required to append the signature of its representative, and thus may appear less binding than the MOU

### 5.3 DYADS AND CLUSTERS

The concept of dyads or clusters was central to the original formulation of the CPHs. According to Silimperi *et al.* (1997b), "The schematic mapping of potential partners revealed groupings of geographically proximal CBOs and health facilities that might function as 'clusters' within each community." The term dyad was also used and defined as a "cooperative partnership between at least one health facility and one or more neighboring CBOs."

CPH	HEALTH FACILITIES Reported as of mid-1997	New Additions	Dropped out
Ajgunle	Rikky Hospital	BeeBat All Souls Ola-Abi	
Amukoko	Shammah Hospital Catholic Community Health Project		Catholic Health Project
JAS	JAS Medical Services Holy Trinity Clinic (affiliated with Holy Trinity Church)		Holy Trinity Clinic (not an active provider)
Lagos Island	Roland Hospital Salvation Army Hospital		
Lawanson	Anthmie Clinic Pine Hospital Rock of Ages Hospital Royal Health Care, Ltd.	Logos Clinic	
Makoko	Bolutife Hospital Elizar Clinic & Maternity Home Makoko Medical Centre Halleluya Clinic St Daniel Hospital Oshoffa Spiritual Clinic & Maternity		Elizar (access and leadership problems)

Although the cluster or dyad concept had strong management and access implications, there was no original formulation about how dyads would fit into the governing structures of the CPHs. All CPHs, except Ajgunle, started out with more than one western health facility member, as listed above, but none of these had developed a distinct dyad-level management structure through the end of 1997.

### 5.3.1 Lawanson

Only in Lawanson had there been a conscious effort to have functioning dyads/clusters, though the details of partnerships are still being worked out. Efforts are underway now to develop the cluster structure in all CPHs, spurred in large part by the situation in Ajegunle. It appears that there were other CBOs and health facilities in the community who had interest in the CPH concept, but who were reluctant to join with Rikky Hospital and the other CPH members due to what they perceived as "tribalism" and "mismanagement." The key figure from neighboring All Souls Hospital approached BASICS with the desire to form a new CPH. This was not feasible on both geographic and programmatic groups. BASICS was mandated to work with only six CPHs in the Lagos area. The solution was to convince the "All Souls Group" to form a new dyad within the AJCPH. In fact, a more politically astute solution was proposed by BASICS staff, which was to form three new dyads among the three new health facilities that were part of the All Souls Group. In the process, it was realized that the dyad concept was not thoroughly developed in the other CPHs, and that it would definitely come to the forefront if new HFs and CBOs joined these CPHs.

When the new clusters were formed at Ajegunle and Lawanson, the question arose about how they would be integrated into the larger CPH Boards. Fortunately, CPH Board elections are coming up within the next few months. What is more important is the need to work out a cluster/dyad governing structure and then specify how the dyads/clusters will relate to the larger CPH, especially in terms of representation and participation.

It should be noted that the dyad concept has been greeted with mixed feelings. At the time of the CPH leader survey, as mentioned, only Lawanson officially had the dyad/cluster structure. Eighteen respondents gave their opinions about the functioning of dyads. Of the 22 multiple responses, 14 were definitely positive. "*We work together well,*" "*It runs smoothly,*" "*There is good leadership,*" and "*All have representatives on the Board*" Three comments imply problems: "*The doctors are not cordial to each other,*" "*There are different levels of commitment,*" and "*Health facilities prefer independence.*" The remaining responses were of intermediate nature. "*It was not easy at first,*" "*It is a good idea in principle,*" "*Some are stronger than others,*" and "*I can't say.*"

One respondent gave a little more detail of the problems he observed. "*There are personal problems due to the different approaches people have. There are 4 health facilities and 4 different doctors. This brings fears, animosities against each other. There is nothing wrong with the idea, but each health facility would like its own CPH. Each wants to be number 1. They don't like being under another health facility.*" Another CPH leader stated that, "*It was not easy at the beginning. It was difficult for the CBOs to know which Health Facility they belonged to. But know things are alright.*"

The ambiguities in relationships among 4 facilities and their surrounding CBOs in Lawanson necessitated conflict resolution by the BASICS Community Development Program Officer (CDPO) in May 1997. He summarized the origin of the problem in his report as follows:

*The Initiatives-inherited Lawanson Health Plan by BASICS has not been*

*without problems as the network of the four Health Facility Doctors which formed a cluster dyad under the BASICS' concept of "Community Partnership for Child Health" program have not been operating well Under the first dispensation of the Initiatives-Managed Health Care, the doctors-perceived benefit was well, and time-defined, but under the new dispensation, the perceived doctors' benefit needed a lot of time, commitment, and grassroots integration with the CBOs, before any benefit could be accrued There has been a subconscious carry-over of expectations, and operational mechanisms to the later, thereby affecting smooth collaboration amongst the doctors of the CPH*

*Again, each of the Health Facilities is supposed to be a potential dyad with recognizable CBOs, under the umbrella cluster dyad, but unfortunately, three of them are not, this has tended to weaken the base, as well as threatening the survival of the experimental cluster dyad, which BASICS has been nurturing Sometime in 1996, these issues were discussed with all the doctors with the hope that the situation would improve, but it has been worsening ever since*

*Recently, there was need to identify the real problems and address them once and for all with each of the doctor individually, and later collectively in order to move the CPH forward*

Some of the doctors' views are illustrative Dr. Ali of Rock of Ages Hospital complained that, "There is no forum for doctors to informally discuss issues, deliberate efforts have been made to prevent such an opportunity by the Chairman." For example, Dr Ali did not know how much the vehicle donated to the CPH was sold for. He was interested in how the money could be used to start the drug revolving scheme. He also was concerned that, "The WEC Leader at the Rock of Ages Hospital has not been reporting to the house whenever she attends the meeting of the CPH," and "Up till now, I have not seen the CPH Constitution." He suggested that the composition of the Governing Board of the CPH has to be reviewed to accommodate the interest of the other dyads within the cluster dyad Also, the MOU has to be reviewed to accommodate the interest of the other dyads as well. It should reflect the clustering of dyads as opposed to single dyads.

Dr. Shoga of Pine Hospital observed that, "A personality clash exists between doctors, particularly between Dr Mrs Showande and Dr. Ali, which if not resolved, will prevent the CPH from moving any forward." Furthermore, he observed that, "The Secretariat located in a single place does not reflect the clustering nature of the dyad, hence there is limited effective communication to other health facilities on crucial matters." He complained that, "The CBOs expect a lot of monthly contribution by the doctors, but the doctors have not been allowed to have a say on this." He also remarked that, "The Governing Board have not been properly constituted "

The following suggestions for resolving the conflict arose from all 4 doctors.

- Including all doctors on the management board
- Holding regular informal meetings among the doctors to forge a team spirit
- Updating the MOU to reflect dyad structure and participation

- The CDO should work with the doctors to strengthen each dyad
- There should be equal sharing of all resources

Logos Clinic along the busy Western Avenue in the Ojuelegba section of Surulere became another nucleus for CPH interest in mid-1997. Coincidentally, Logos Clinic had the retainer for health care of BASICS staff, and the physician in-charge always asked staff what BASICS was about. Based on these conversations, and his inquiry with people in the nearby Lawanson section of Surulere, the physician realized that the CPH program could benefit people in the southeast corner of Surulere also. The group had a series of meetings at which the attendance steadily grew.

Eventually, the group had to determine who was attending as an interested individual and who was representing a CBO. At this point in October 1997, a CPH executive was elected. Again, BASICS had to inform the group that it could not support additional CPHs in the same community. A resolution occurred by including the new group as a dyad within the Lawanson CPH. Extracts of some of the early meeting minutes from Ojuelegba, as seen below, show their intentions and evolution.

During the Leader interviews, fear was expressed by many that the new dyad would be suffocated by the existing partners. Therefore, there is need by BASICS staff to bring all parties together in Lawanson/Surulere to guarantee that the public recriminations that have occurred in Ajegunle, as described below, do not surface in LCPH.

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### Ojuelegba Becomes a Dyad

27/05/97 The purpose of (this first) meeting was briefly explained. This type of program is already going on in different locations in Lagos. But (this community) has never been privileged to have such an association. This was the challenge Dr Owoye took up.

10/06/97 *The representatives from BASICS were introduced. They explained that the goal was to improve child health services and home practices in underserved high risk urban communities.*

15/07/97, *The partnership guidelines were outlined. We have to determine the participating partners, e.g. how many CBO, HF that have been constant. We need to develop a MOU. Action for the next meeting included ordering problems in priority and dissemination of the information we have discussed.*

07/08/97 (a general meeting was held first wherein 7 Governing Board members were elected. Following this the Board met). *The chairman implored us to work hard and be aggressive in mobilizing of CBOs. By doing so the community would feel the impact of the organization. Dr. Mustapha is to contact the Hausa community at Tejuosho. Mr Awoleye is to contact the Hausa community at Idi-Araba. Chief Role is to contact the market women at Ojuelegba. Prince Ademisoje is to contact the Road Transport Employers Association at Ojuelegba. Everybody is to liaise with several CBOs and report their activities at the next meeting. The last Thursday of every month is adopted for the Governing Board Meeting.*

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### 5.3.2 Ajegunle

The largest and most dynamic CPH membership increase was seen within the past six months as new dyads/clusters came into being in Ajegunle and Lawanson (Surulere). The circumstances were quite different. At Ajegunle there was dissatisfaction by some CBOs with the existing set up which they termed “tribalized” and “mismanaged”. At the same time, three additional health facilities became interested in the CPH idea on seeing how Rikky Hospital gained through the programme. This combination of dissent and interest coalesced in the attempt around mid-1997 to form the Layeni-Ajeromi CPH based in All Souls Clinic, located, ironically, a few doors away from Rikky Clinic on Ojo Road in Ajegunle. There was a complete geographical overlap among the CBOs of the two competing groups. The problem was addressed in a politically astute way when BASICS staff, having notified the Ajegunle area people that they could not support more than one CPH in the community, suggested the formation of four dyads/clusters in the CPH because 4 HFs were now involved. This appeared to diffuse the tension as it was intended to prevent the new set up from becoming dichotomized as “old versus new” or “us versus them”.

Unfortunately this solution to the “Ajegunle Crisis” has not been fully welcomed by the original Dyad based at Rikky Hospital. A recent article in a local newspaper gave voice to these concerns.

#### Trouble Brew at AJCPH

The Commoners Newspaper, 4-17 December 1997, page 14

There are strong indications that a silent war, which might tear the Ajegunle community partners for Health (AJCPH) is rearing its ugly face.

Pointers to this, according to a source is the desire of Basic Nigeria to bring expansion without consulting the constitution of AJCPH. The source told our reporter that, there is nothing wrong with expansion, but Dr. Ayodele, the country

adviser for Basics Nigeria should do it constitutionally.

Continued, the source said, “There are elements of tribalism in the whole thing, because when Dr. Omeziri started financing AJCPH in 1995, nobody saw the need to support him, but now that it has been incorporated, Dr. Ayodele is now trying to cause confusion by asking other DYADS to come in just like that.”

“At least, decency demands that they should

come in through the right channel, the constitution is clear on this” he stated. Revealing, he said”

Article 5 of the AJCPH constitution stipulates condition of membership. So they should apply to the Trustees of AJCPH.

All efforts to seek the views of Dr. Ayodele proved abortive.

*We intend to do a specialized report on the genesis of the trouble in AJCPH - Editor.*

In fact, the constitution does state that a group who “*desired to join shall apply in writing to the Trustees.*” Also the applicant should “*face an interview panel.*” Finally, a successful applicant CBO/HF must “*be given an admission upon payment of a non-refundable ₦500.00 admission fee.*” Regardless of the seeming political expediency of the 4-dyad

solution proposed by BASICS, CBO/HF participants apparently feel imposed upon and may not easily accept the suggested mode of co-existence

An additional irony in the above article is that the unrevealed "source" from the Rikky Dyad, which had a majority of Igbo members, and was accused by those who dropped out of being tribalistic, is now using the label of tribal against the primarily Yoruba new dyads. The issue of expansion and dyads will not be resolved finally until early 1998 when new CPH elections are scheduled. Until that time, BASICS is viewing the old CPH Board and the newly formed group as dyad leadership structures

The concerns within the original AJCPH leadership and membership about how the new dyads were evolving in Ajegunle was no secret, as they were clearly enunciated in a letter to the BASICS Country Adviser dated 3rd September 1997. The newspaper article implies that the members of Rikky Dyad were still not satisfied three months later with how the expansion was being effected. In the 25 signatories representing about 15 CBOs listed several examples of what they thought were discriminatory practices by BASICS including 1) changing the name of the CPH from Rikky to Ajegunle "unilaterally," and 2) not providing the CPH with family planning kits when other CPHs were supposedly provided. But the main bone of contention in the letter,

*. and perhaps more worrisome is the continued threat by some medical practitioners within our cluster (community) to use their privileged positions as 'Sons of the soil,' to take over control of the affairs of AJCPH. This threat, some of which have been made to the hearing of your staff over the last one year, is sadly being given impetus by the recent attempts to force this same group of people on us*

*It is noteworthy to point out this same group of people were contacted at the inception of this programme but for no obvious reason than a simple unwillingness to invest in an unknown venture, they jettisoned the call only to turn around in the usual Nigerian way to reap where they did not sow.*

*It is also instructive to mention that past attempts by these group of people to embarrass us by barging into our meetings and/or whipping up tribal sentiments by misinforming traditional rulers and leading figures in the community regarding the activities of AJCPH have always failed after a careful explanation of the situation to these leaders. Yet they will not relent.*

*Our stance on this issue should not be misconstrued to mean that we are averse to others joining out fold - far from it, what we detest and strongly rebuff is the obvious attempt to hijack our association without a recourse to the due process of civilized norm*

The Ajegunle situation provides an example of the conflict between 1) the need to confine activities within limitations of the program, i.e. the focus of USAID subproject proposal funding on only six communities/CPHs, and 2) the guiding principle of encouraging communities to participate actively in governing their own organizations and solving their own problems. In all likelihood the Ajegunle crisis could have been solved constitutionally,

but the way forward was not always clear. The idea of donor agencies working at the grassroots level promoting community coalitions is new in Nigeria. There are concerns about what is feasible and what is permitted, and guidelines are not explicit. At times staff must feel their way along in the dark. The experience in Ajegunle should provide lessons for a smoother transition from a single more amorphous collection of members to dyad formation in the remaining 4 CPHs. The need for involvement of all parties in direct dialogue is one of those lessons.

### 5.3.3 Nascent Dyads

The interview responses of those leaders of CPHs where the dyad/cluster idea had not been formalized were asked how the formation or addition of new clusters would be accepted, and they were generally supportive. Among the 64 who gave an opinion, 38 were definitely positive, giving responses such as, *“It would be good because the community is large,”* *“We need to expand,”* *“Dyads will allow facilities to share the workload,”* *“It will work because we have a good foundation,”* *“We can reach more people with more dyads,”* and *“The MOU will make it possible.”* Another 12 simply said, *“It will be no problem.”* Three said they did not know what would happen, and seven gave a conditional response, *“It will work only if there is common interest,”* or *“...mutual understanding.”* Thirteen were outright negative about the idea claiming that, *“It will cause rivalry,”* *“There will be confusion,”* *“I am not optimistic,”* *“There is no need now, we are sufficient,”* *“It is not an issue.”* *“There will be administrative and communications problems.”* More detailed positive comments included,

*We were even trying to reach out to more HFs to join the CPH because for now the work is certainly too much for the health facilities, so additional dyads will pose no problems.* (Amukoko)

*It is welcome, and it will make people to achieve their aims and be satisfied.* (Makoko)

*We need to expand, so we will do well with other dyads in future.* (Ajegunle)

*There will be no problem because of good foundation and effective leadership that we enjoy.* (JAS)

The skeptics were also in evidence, especially in JAS CPH -

*I don't see any need for it now. The existing one is underutilized. But if another dyad springs up, there is likely to be competition and disunity.* (JAS)

*There will too many people who are “too know” and that can lead to quarrel* (JAS)

*The news we have been hearing about CPHs that have more than one dyad is not encouraging because of rivalry and competition between the health facilities. The issue should be addressed before BASICS leaves. The doctors tend to clash with one another over petty issues. We have heard of cases where*

*doctors fight over drugs and other things donated to the CPH We have also heard of personality clashes (JAS)*

Recently, BASICS staff have had meetings with the CPHs concerning expansion within their communities. From the foregoing, it appears that there is much interest and some resistance. What is important to resolve before major membership drives are undertaken is the appropriate internal structures (clusters/dyads) needed to accommodate and cope with the workload implied by additional CBOs on the HFs. Also, new membership needs to be legitimized quickly, and new members need to feel that they are welcome officially. The Ajegunle experience underscores the need for BASICS staff to adhere to principles of the constitutions they themselves helped draft. Obviously there is pressure to ensure that all CPHs are functioning fully before the project draws to a close in 1998, but the need to involve the CPHs themselves in resolving these issues is a necessary part of guaranteeing the sustainability of the programme in each community.

#### 5.4 LEADERS, BOARDS, COMMITTEES AND WINGS

Information on Board composition was obtained from the 6 original Lagos CPHs and the new group of dyads in Ajegunle as of September 1997. These seven groups had an average of 11.5 people on their boards. Most (68%) were male, and 27% were health professionals. The MOU requires that "At least one or two women must be members of the management/trustee board." On average, each CPH Board has 3.7 female members. The largest female representation was at Makoko (6) and the smallest at the original Ajegunle CPH (2) as seen in the Table below.

Board Member Characteristics	COMMUNITY PARTNER FOR HEALTH (in %)							Total (%)
	AJ2	AJE	AMU	JAS	LAI	LAW	MAK	
Female	23	18	57	40	33	27	35	32
Male	77	82	43	60	67	73	65	68
Health Worker	31	9	43	40	42	27	12	27
Non-Health	69	91	57	60	58	73	88	73
NUMBER	12	11	7	10	12	11	17	81

Although Lawanson and Makoko had the largest number of HF members, they had among the lowest proportions of health professional board members (27% and 11% respectively). Details are seen in the Table above.

In terms of officers, all CPHs had the following: chairperson, deputy chair, secretary, treasurer, and women empowerment committee representative. Six each had a financial secretary and a public relations officer. The most of the female board member positions were either ex-officio/trustee (31% of women members) or WEC representative (27%). Only one chairperson was a woman, and two were deputy chairs. Two were PROs, 3 were

treasurers and one each were assistant secretary, auditor and financial secretary

Five chairpersons and 4 deputy chairs were health professionals Six health workers were ex-officio members, in part to ensure that most facilities (and potential) dyads were represented on the boards. One health worker was an auditor, 2 were treasurers, one was a secretary, two were WEC representatives and one was a youth representative

Although formal Board elections were not due until late 1997 or early 1998, there had been a few leadership changes. The example of JAS is illustrative as extracted in minutes from their Board meeting minutes seen in the box to the right.

Committee or Sub-Group	Community Partner for Health						
	AJE	AJ2	AMU	JAS	LAI	LAW	MAK
Women Empowerment Committee	✓	✓	✓	✓	✓	✓	✓
Youth Wing		✓		✓	✓	✓	✓
Finance/Budget Committee					✓	✓	✓
Cooperative Society				✓			
Ambulance Committee				✓			
Proposal Writing				✓			
Container Committee				✓			
Revolving Drug Scheme						✓	
Managed Care/Hospital Harmonization	✓					✓	
Fund Raising/Projects		✓			✓	✓	✓
Environmental Sanitation Committee						✓	
Welfare Committee							✓
Public Relations					✓		
Constitution Committee	✓						
<b>TOTAL</b>	<b>3</b>	<b>3</b>	<b>1</b>	<b>6</b>	<b>5</b>	<b>7</b>	<b>5</b>

The Table above indicates the special committees and sub-groups within the Lagos CPHs (including the new Ajegunle dyads but not Ojuelegba) as of September 1997 All seven groups had a Women Empowerment Committee, and most (5) had a youth wing Committees for fundraising/special projects (4) and finance/budget (3) Other committees

reflect unique concerns or situations JAS has the most well established Cooperative Society, and being new the additional Aggegunle dyads are busy writing a constitution. The average number of committees is four, but Lawanson has seven and Amukoko only one As noted under membership issues, Amukoko has difficulty forming committees until it redefined its membership to include all interested associations in the two major CBO members, the two big markets

### 5.5 PERCEIVED BENEFITS

Butterfoss *et al* (1993) indicated that one of the factors that maintains a person's commitment to a coalition is the perceived benefit of participation. CPH leaders were asked to list the personal benefits they had gained from their involvement in the CPH Top on the list of the 81 leaders was opportunity to interact with others/enhanced relationships (60.5%), followed closely by ideas/knowledge gained (53.1%). Other commonly perceived benefits included reduced health care costs (29.6%), health care available when needed (29.6%), training opportunities (23.5%) and improved health status (13.6%) Other thoughts included popularity, ideas to help run my business, opportunity to attend conferences and ability to solve problems All respondents perceived at least one personal benefit, and on average they mentioned 2.8 benefits with 77% mentioning at least two.

There was no difference in perceived benefit between female (2.8) and male (2.9) leaders Those who belonged to CBOs perceived slightly more benefits (3.0 on average) than those from HFs (2.4), but the difference was not significant On the other hand, there was a significant difference in the number of perceived benefits mentioned among the different foundation CPHs with the most benefits mentioned by leaders from JAS/Mushin and Lagos Island and the least at Makoko, as seen below

MEANS OF PERCEIVED BENEFITS FOR LEADERS OF EACH CPH						
CPH	Obs	Total	Mean	Variance	Std Dev	
AJE	11	34	3.091	1.891	1.375	
AMU	6	16	2.667	1.467	1.211	
JAS	14	49	3.500	2.115	1.454	
LAI	11	39	3.545	0.673	0.820	
LAW	11	27	2.455	1.673	1.293	
MAK	15	34	2.267	1.210	1.100	
<b>ANOVA</b>						
Variation	SS	df	MS	F statistic	p-value	
Between	18.502	5	3.700	2.437	0.044198	
Within	94.130	62	1.518			
Total	112.632	67				
Kruskal-Wallis H (equivalent to Chi square) =				12.319		
Degrees of freedom =				5		
p value =				0.030665		

Concerning training, all but 7 CPH leaders (8.6%) reported that they had attended a training workshop On average, leaders reported having attended 2.6 workshops each Democracy and Governance workshops were most commonly mentioned (73%). Others reported having attended workshops on sustainability (37%), planning (32%), financial

management (26%), immunization/cold chain (21%), TBA/CHW TOT (18%), childhood diseases (17%), HIV/AIDS (12%) and drug revolving scheme (6%), emergency preparedness/cholera (5%) and capacity building (4%)

There was no difference in workshop attendance by affiliation (CBO = 2.5, HF = 2.8) When the new dyads were excluded, there were no differences in workshop attendance by leaders among the foundation CPHs Also gender differences in workshop attendance were not significant (women = 2.9, men = 2.4)

## 5.6 ORGANIZATIONAL DEVELOPMENT & FUNCTIONING

### 5.6.1 Self-Study Guide

The CPHs were asked to review their own progress and development through the self-study guide (or organizational development checklist) during a Board meeting Also the BASICS Community Development Officer was asked to make an independent assessment of the CPHs, having not seen the CPHs' own self-rankings The Table below provides information on a summary score of indicators in three broad categories, Organizational Structure, Management Activities and Programming The column to the right indicates whether the Assessment was performed by the CPH (C), by BASICS (B), or by both It is intended that the CPHs undertake this self-assessment at least twice a year and that in future the BASICS staff also review the scores with the CPHs and guide them toward strengthening their organizations

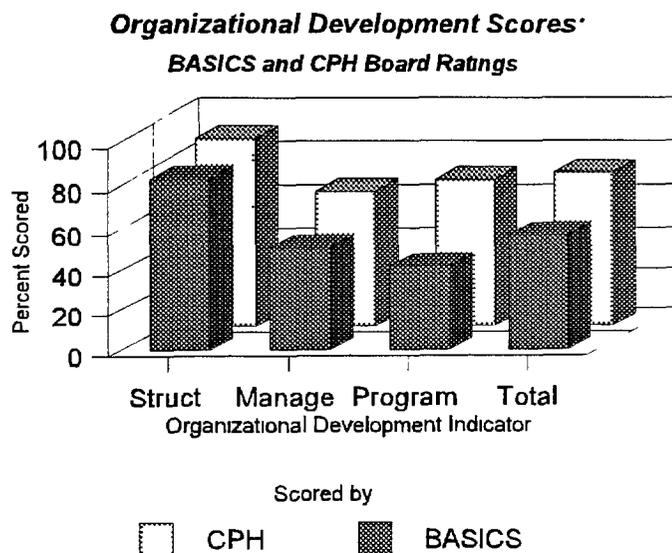
Community Partner for Health	Management Self-Study Summary Indicator				
	Structure	Management	Programs	Total Score	Who Responded
Ajgunle (Rikky Dyad)	86	66	78	75	B,C
Ajgunle (New Dyads)	56	33	26	37	B,C
Amukoko	67	28	28	38	B
JAS (Mushin)	97	69	59	74	B,C
Lagos Island	85	57	54	64	B,C
Lawanson	99	74	49	74	B,C
Ojuelegba (New Lawanson Dyad)	42	9	4	17	B,C
Makoko	74	39	51	52	B,C
Overall Averages	75	47	40	53	

To some extent the validity of the scoring can be seen in the fact that the newest clusters/dyads, Ojuelegba in southeastern Surulere LGA and those in Ajegunle, scored lowest on all measures. The fact that they are have recently formed and could not have been expected to achieve much was expressed in comments during questionnaire interviews where 12 leaders responded that there were, "no benefits yet because we are new "

Relative higher scores on organizational structure is not unexpected. Most items in that portion of the checklist correspond with core steps in CPH development as promoted by BASICS including writing the constitution, signing the MOU, setting up committees, holding regular Board meetings, setting goals, and involving women.

The validity of the programming scores will be explored in more detail in the next section of the report. The fact that the new Ajegunle dyads scored a bit higher than Ojuelegba on programming derives from the fact that they undertook free eye screening, which attracted much public attention, as well as started their immunization programmes right away. The moderate programming scores for most of the older CPHs is reasonable considering the need to develop an organizational infrastructure prior to engaging in active programming.

The previous Table provided an averaging of scores from the CPHs and from BASICS. The Chart above shows that overall, the CPHs rated themselves higher than did the BASICS CDPO. In the Table below one can see a concurrence between the CPH Board and BASICS CDPO in both JAS/Mushin and Lawanson. In the other 4 CPHs, their boards rated themselves as much as 20 points higher than the CDPO thought was appropriate for their level of progress in late 1997. The differences were most pronounced in the area of programming, as seen in the chart. The gap was between BASICS and the CPH was 28 points for Ajegunle (Rikky Dyad) and 62 points for Makoko. These gaps combined with other performance problems in the two CPHs, call into question the validity of their self-ratings and require that the CDPO sit down with these Boards and review their strengths and weaknesses using the self-study guide to provide a structure for dialogue.



Community Partner for Health	Management Self-Study Scores		
	Scored by		
	CPH	BASICS	Average
Ajgunle (Rikky Dyad)	85	65	75
Amukoko		38	
JAS (Mushin)	72	76	74
Lagos Island	76	52	64
Lawanson	70	78	74
Makoko	67	37	52
Overall Averages	74	57	65

### 5.6.2 Attitude Toward CPH Functioning

The following seven items formed the opinion scale concerning CPH and CBO/HF leader views on how well their own CPH was functioning

- 1 \* Some member groups of this CPH are more important than others
- 2 Board members are willing to commit their personal time and resources to the success of the CPH
- 3 \* New members would **NOT** be welcome in this CPH
- 4 All members in this CPH are treated as equals
- 5 \* Some members work harder for the success of this CPH than do others
6. This CPH is mature and ready to stand on its own now
- 7.\* Most members are **NOT** satisfied with the progress of this CPH

Items were scored from 0-4 ranging from "strongly disagree" to "strongly agree." Those items marked with an asterix were reverse-scored. The total CPH Function score thus ranged from 0-28. The overall average was 18 points with a range of 5-28. The 81 CPH Board members, with an average score of 19.4 points, rated the level of CPH functioning significantly higher ( $p < 0.003$ ) than did the 162 CBO/HF leaders (17.7 points). The difference between CPH Board Members and CBO/HF leaders was consistent across all CPHs (and clusters, i.e. including the newly formed Ojuelegba and new Ajgunle clusters/dyads), but the gap was highest at Amukoko (4.6 points).

There were also marked differences in perceived CPH functioning among the different CPHs/clusters. The newest clusters in Ojuelegba and Ajgunle rated their CPH functioning highest (20.6 points each). The lowest levels of perceived functioning was recorded at Amukoko (15.9 points) and Ajgunle (Rikky dyad) (16.7 points). The Table below shows that

among the older CPHs, Lagos Island (19 3), JAS (18 3) and Lawsonson (18 3) scored highest. The perceived low level of CPH functioning at Amukoko derived from averaging individual responses corresponds with the low collective scoring by the Board of Amukoko CPH on the organizational development checklist

From the foregoing, one can see that on various measures, Lawsonson and JAS CPHs appear to be functioning best Makoko has minimal health facility involvement, and there also appears to be problems with a centralized leadership, making some other members feel unwanted or peripheral Ajegunle, an ethnically mixed community, was the scene of accusations that ethnicity influenced Board decisions Ironically, the solution devised within the community was also ethnically biased toward another group Although there are complaints that in Lagos Island people do not respect time, or actually prefer to spent their time on profit making activities, there appears to be little fault with the actual governance of the CPH Finally Amukoko appears to suffer from being too small, with a heavy base in busy trader affiliated CBOs Efforts by BASICS staff to expand the CPHs should prove beneficial to Amukoko

CPH FUNCTION SCORE FOR EACH CPH						
CPH	Obs	Total	Mean	Variance	Std Dev	
AJ2	32	658	20.563	6.190	2.488	
AJE	33	552	16.727	13.642	3.694	
AMU	20	319	15.950	12.997	3.605	
JAS	27	495	18.333	15.154	3.893	
LAI	26	501	19.269	11.965	3.459	
LAW	29	529	18.241	18.261	4.273	
MAK	40	648	16.200	20.574	4.536	
OJU	36	740	20.556	13.625	3.691	

ANOVA						
Variation	SS	df	MS	F statistic	p-value	
Between	739.886	7	105.698	7.395	0.000000	
Within	3359.085	235	14.294			
Total	4098.971	242				

## 5.7 BOARD REPRESENTATION

While the foundation CPHs have an average of 11.5 persons on their Governing

Boards, they also have an average of 22.8 CBO/HF member organizations. Obviously, it is not possible to include all member organizations on a Board without making it unwieldy. This raises an important question of how CPHs can guarantee that all member organizations play an active part in the CPH and feel that they actually belong. Of the 168 CBO/HF leaders who answered the question, 54% said that their organization had a representative on their CPH's Governing Board.

Those who had members on the Boards said that the major benefit gained from this position was keeping abreast of current information about the CPH (71%). Other ways by which their organization was perceived to gain included getting benefits like training ahead of others (21%) and feeling more involved (11%). A variety of other ideas were mentioned including increased patronage for our Health Facility, equipment, we can express our needs, and recognition. Some (9%) said membership on the board does not help or gives no special benefit, while 3 people did not express an idea. The comments below give fuller expression of the perceived benefits.

*Our pastor being the treasurer has been a source of encouragement to the members of the church to respond to the CPH. Being on the board has also made the task of mobilizing the church easier.* (CBO - Ojuelegba)

*We are able to disseminate necessary information as and when due. For example, when we were asked to tell the house to make voluntary donations, I had to report back as a representative of our CBO, and we complied immediately.* (CBO - new Ajegunle)

*We have not expected anything. We want to be treated on merit.* (CBO - new Ajegunle)

*We were able to attend trainings/workshops. The immunization programme also came to our hospital.* (HF - new Ajegunle)

*That afforded me the opportunity to attend the seminar organized by BASICS. We also receive prompt information on the activities of the CPH and other benefits do not pass us by.* (CBO - Makoko)

*It gives our CBO an international recognition. Some members enjoyed health at reduced cost. Our (youth) members were able to attend international conferences in Ghana and Ethiopia.* (CBO - Lagos Island)

*It brings about adequate cooperation.* (CBO - Amukoko)

*Our representative brought us information regularly, and some of our members attended workshops on immunization and women empowerment.* (CBO - Amukoko)

*It has brought about adequate links between us and the CPH.* (CBO - Ajegunle)

*They are well informed about the programme and enjoying all the benefits, too.* (CBO - Ajegunle)

*Our representative disseminates information as and when due It makes us to be united with the CPH (CBO - Ajegunle)*

Most of those 78 who had no member on the boards (61 %) said this was no problem, and nine did not respond The rest perceived problems including delay in or poor communications (23 %), feeling edged out/not carried along (8 %), not sharing fully in the benefits (5 %) and not being able to contribute fully (4 %) Five of those who said there was no specific problem went on to say that it would be beneficial if their organization was included It should be noted that one way Lawanson CPH resolved the conflict among the four doctors/HFs was to make sure each doctor was on the board if only in an ex-officio capacity Examples of the comments made by those who saw no problem by being on the Board follow

*Actually we don't have any problem now, and I do not envisage any because a CBO very close to us has a member in the Governing Board, and he feeds us back regularly (CBO - Ojuelegba)*

*For now there is no problem, and to us it is not necessary for every CBO to be represented on the CPH Board (CBO - new Ajegunle)*

*So far it has not affected us, but becoming a member of the governing board will definitely strengthen us (CBO - new Ajegunle)*

*It does not affect us We can't be cheated (CBO - Makoko)*

*It does not affect us in any way since there is a regular communication between me and the chairman and from me to the other members of my CBO (CBO - Makoko)*

*We can't really say it affects us negatively because there is cooperation between us We receive information as and when due. (CBO - Ajegunle)*

*It has little or no effect because every information that is supposed to get to us does so promptly (CBO- Ajegunle)*

The problems experienced by those whose organizations are not on the Boards are expressed below -

*Most of the things that we were supposed to be given were not given us (HF - Makoko)*

*We are sidetracked We don't know what is going on The chairman will never invite us He has his own people (CBO - Makoko)*

*We do not know much about the CPH We are only called to programmes they deem fit I feel the executive should be decentralized to cover all CBOs in the CPH (CBO - Makoko)*

*Most of the decisions taken by the executive do not reach my CBO well We are not well informed and carried along as it should be (CBO - Makoko)*

*There is always the misunderstanding of intention on outcome of meeting before clarification is sought (CBO - Makoko)*

*This has affected us adversely in that we know next to nothing about the activities of the CPH and are hardly communicated about its programmes We have been edged out so to say (CBO - Makoko)*

*Our problems are not presented because there is no one who is a member Communication is not adequate. (CBO - Lagos Island)*

*We do not know anything about the CPH probably as a result of the fact that we are not represented on the board The CPH does not seem to be carrying the group along (CBO - Amukoko)*

*Adequate representation would guarantee ability to harness the resources It would also afford opportunity to contribute to the progress This is not so in our case (CBO - Ajegunle)*

*It affects us obviously in the area of getting feedback from the meetings (CBO - Ajegunle)*

*Because they are not represented in the Board, the Union could not do much or contribute much to the progress of the CPH (CBO - Lawanson)*

*It does not allow us full participation on sharing grants from BASICS, and we have to wait for general meetings before we know what is happening (CBO - Lawanson)*

*It steps down the pace of action in our midst because we are not aware of any steps taken unless we get to the meeting (CBO - Lawanson)*

*It affects us because sometimes when they share something, it does not reach us, and the information also does not reach us on time (CBO - Lawanson)*

It may not be unexpected that many complaints came from Makoko, since it has one of the largest memberships, making it less likely for each CBO/HF to be represented, and from Lawanson, which is widespread over 4 dyads The impending development of dyads governing systems affords the opportunity, with smaller entities, to ensure that each CBO/HF is represented on a dyad Governing Board The issue of how to ensure adequate representation of dyads and their CBOs/HFs on CPH Governing Boards needs to be resolved

## **5.8 Summary of CPH Organizational Achievement**

The Tables that follow summarize the forgoing information Results from six different indicators of organizational functioning and achievement are listed for each of the six foundation CPHs in the first Table In the second Table, each CPH is ranked for each indicator, with 6 points given for being the highest achiever on a particular score or value and 1 point for being the lowest These are added, giving a possible range of 6-36 points JAS/

Mushin scored the highest with 29 points, and Amukoko the lowest with 13. Lagos Island (26) and Lawanson (25) performed well also. Despite the turmoil facing Ajegunle, its score was fair (22), while Makoko (16) was in the same range as Amukoko.

The main weakness of Makoko has been its inability to involve fully the health facilities in the community. This is ironic because at least 4 facilities are nominally members of the CPH. The problem arises in part because most of the physicians at these facilities are not working at their clinics full time, but are also staff in a government or parastatal agency health service. Without strong HF leadership in the CPH there is doubtful commitment to the ideals of low cost and accessible health care. Also there is no designation of providers to provide regular immunization, further reducing the benefits to CBO members.

The problem at Amukoko is the opposite, with only one HF fully involved. Also there is a narrow base of CBOs, all of which are associated with the two major markets in the area and subject to intra-market political squabbles that carry over into CPH functioning. Religious groups, resident associations and social clubs are notably absent from Amukoko CPH, so that when the Catholic Church and Health Project pulled out recently, a major gap was created. Worries about low levels of membership have been expressed by AMCPH leaders from the inception of the CPH and continue to plague this organization.

These two CPHs are the weakest and require immediate attention if they are to survive past September 1998, when the current BASICS project draws to a close.

Summary of Governance Indicators	Foundation CPHs					
	AJE	AMU	JAS	LAI	LAW	MAK
CBOs Heard of MOU (%)	65.2	23.5	38.5	46.7	65.2	44.0
CPH Leaders' Perceived Benefits of Board membership	3.1	2.7	3.5	3.5	2.5	2.3
CPH Management Self-Study Guide Achievement (%)	75.0	38.0	74.0	64.0	74.0	52.0
CPH Function Level Score	16.7	15.9	18.3	19.3	18.3	16.2
Female Board Representation (%)	18.0	57.0	40.0	33.0	27.0	35.0
Number Special Committees	3	1	6	5	7	5

Relative Order of Governance Indicators	Foundation CPHs					
	AJE	AMU	JAS	LAI	LAW	MAK
CBOs Heard of MOU (%)	6	1	2	4	6	3
CPH Leaders' Perceived Benefits of Board membership	4	3	6	6	2	1
CPH Management Self-Study Guide Achievement (%)	6	1	5	3	5	2
CPH Function Level Score	3	1	5	6	5	2
Female Board Representation (%)	1	6	5	3	2	4
Number Special Committees	2	1	5	4	6	4
Total Order Score	22	13	28	26	26	16

## 6. PROGRAMMING, WORK PLANS & ACTION

Each CPH developed a work plan quite soon after the group was formed. These were developed into formal "Sub-project Proposals" (SPPs) to meet USAID funding requirements. Each Plan had a set of objectives within which were reflected priority child health concerns and other management/development issues of interest to CPH members. This section focuses on the 6 CPHs who developed SPPs, not the 2 new dyads that have arisen in 1997.

The plan development process consisted of three workshops where members of 2 CPHs at a time came together in February 1996, to define priority health needs, develop objectives for each of those needs and set out strategies for achieving those needs within a time frame that stretched about 2 years until the end of 1998. On average 15 people attended from each CPH ranging from 9 from Amukoko (the smallest CPH) to 20 from Ajegunle. Samples of the objectives developed and printed in the SPPs are seen below.

### *By the end of 1998 ...*

1. Reduce the number of children under 5 years getting sick from watery diarrhoea in (the community), and/or among the organizational members of the CPH, and the number dying from dehydration or dysentery despite treatment in a partner health facility
2. Reduce the number of children and pregnant mothers getting sick from malaria in (the community), and/or among the organizational members of the CPH, and the number dying despite contact with partner health facilities.
3. Increase immunization coverage of children of organizational members and ensure the availability of effective, quality vaccines to reduce the number of children getting sick or dying from these childhood diseases  
  
(alternatively: increase measles immunization coverage rates in [the community] and/or among the organizational members, and ensure the availability of effective, quality vaccines to reduce the number of children getting sick or dying from measles.)
4. Reduce the number of children under 5 years getting sick from cough (ARI) in (the community), and/or among the organizational members of the CPH, and the number dying from acute respiratory infections (ARI) despite treatment in a partner health facility
5. Increase the demand for and availability of modern child spacing/family planning services among the CPH organizational members and health facilities
6. Increase the awareness of partner organizations on the epidemiology and control of HIV/AIDS and STDs.
7. the CPH is functionally self-sustaining, no longer requiring BASICS' support to maintain its improved capacity and services. Especially in the area of

management, financial capability and revenue generation capacity

- 8 Strengthen/expand the role of female decision making within the CPH and in (the community).

It is interesting to note that these objectives are not quantifiable. It is not clear whether the results of the Integrated Baseline Health Survey, reported in 1995 (c f. USAID, 1995 a-c), were made available to the work plan workshop participants to aid in their setting objectives. They definitely did engage in brainstorming and priority setting.

During CPH leader interviews, respondents were asked to list at least 4 of the priority health issues that were chosen for emphasis in the work plans. The Table below shows that there was disparity among the CPHs in terms of the awareness of leaders about these priorities. Interestingly, in all CPHs (who have a SPP) at least one-quarter of leaders mentioned environmental sanitation as a priority, though it did not appear as such in any of the plans. It should be noted that environmental sanitation was one of the key strategies for malaria and diarrhoeal diseases control adopted by the CPHs, and that BASICS provided each CPH with equipment for use in community clean-up exercises. In contrast, family planning was mentioned as a priority by only one among all the CPH leaders. Also, in only Ajegunle, were over half of the leaders aware that HIV/AIDS control was a priority. If HIV and Family Planning are excluded, one can see that most (i.e. over half) of the leaders of an individual CPH are aware of at least 3 of the child health priority issues in their plans.

Priority Health Issues in Work Plan	Awareness by Leader [CPH: per cent mentioning issue]*					
	AJE	AMU	JAS	LAI	LAW	MAK
Malaria	46	83	86	100	64	73
Cough/ARI	18	33	50	27	54	33
Diarrhoea/ORT	90	83	71	91	27	67
HIV/AIDS	54	0	14	46	18	20
Immunization	73	83	71	64	54	67
Environmental Sanitation	36	83	28	73	46	53
Family Planning/Child Spacing	9	0	0	0	0	0
Others	45	33	7	0	54	53
Knew None	0	0	14	0	18	13
Number of CPH Leaders Interviewed	11	6	14	11	11	15

\*shaded area denotes priorities in objectives of work plan

The inclusion of HIV and Family Planning as objectives in every CPH SPP seems at odds with the desire to have plans reflect local interests and needs. In fact an early version (February 1996) version of the JAS CPH's SPP did not include these two objectives. Interestingly, it was noted at the end of that document that,

*As noted, additional objectives and associated interventions will be developed in later phases, including those related to the two remaining USAID strategic objectives: family planning and STD/HIV/AIDS.*

Minutes of a board meeting on 23 May 1996 at Lagos Island also reflected concern about additional issues and objectives: "Reference was also made to the inclusion of other ailments in the objectives of the MOU such as HIV/AIDS STDS and family planning which were not budgeted for in the work plan book." From these experiences, it appears that pressure to conform with USAID objectives eventually took precedence when SPPs were revised. Therefore, lack of awareness of priorities which the CPHs themselves did not originally and independently choose, is not surprising.

The concern expressed by Lagos Island CPH are understandable in light of the BASICS Nigeria Fiscal 1996 Annual Report BASICS, January 1997) where it was stated that.

*The CPH proposals outlined their four (emphasis added) priority child health issues: malaria, diarrhoeal disease, acute respiratory infections and vaccine preventable diseases. These areas will be the focus of most CPH activities.*

## 6.1 EVIDENCE OF ACTION

The Table that follows gives sample evidence from the JAS CPH Board Meeting minutes that the group was actually addressing some of the various issues in their plan (if, as one accepts that environmental sanitation was aimed at both malaria and diarrhoea prevention). In addition, the 1996 Annual Report of JAS CPH outlines their efforts at creating community awareness on some of these issues -

*Towards the first year of existence of JCPH, the Partnership decided to celebrate its first year anniversary along with the formal launching of the dyad and along with the awareness campaign. A week-long launching of activities were out, starting with Sunday 8th December 1996, with awareness campaign organized by the youth wing of the JCPH. The topic for the campaign was on the presentation of STDs, and HIV/AIDS prevention. The programme started at 2 pm from JCPH Secretariat with the mobilized youth of the community along with the youth representatives from Lawanson Community Partners for Health. Also joined in the entourage for the campaign were two Eyo (Masquerades) and the Boys' Brigade bandset. The campaign went through the pre-planned routes ... back to the secretariat.*

*At stopovers along the route ... members of (CBOs) were waiting for the youth.) Condoms were distributed free to them. Also, 1,000 leaflets containing the aims and objectives of JCPH were distributed during the*

*campaign*

*Health talks were given at the different secondary schools. The students along with the youth leaders of JCPH organized indoor games and a quiz contest. Video shows were also made on STDs, HIV/AIDS infection*

*On Thursday, a health talk was given by Dr. Williams of BASICS on exclusive breast feeding to the women empowerment (WEC) wing of the JCPH. The grand finale was on Saturday when the formal launching and fundraising activity came up. The occasion was graced with the cultural dance presentation by a CBO, and also a short play was staged the students on one of the secondary schools on STDs, HIV/AIDS prevention. The invited guests visited the JCPH conference hall where an exhibition of the JCPH activities of one year existence were displayed including the documentation centre and the environmental sanitation equipment donated to the dyad by BASICS*

<b>Sample JAS CPH Activities</b>		
<b>Environmental Sanitation</b>	<b>Immunization</b>	<b>HIV/AIDS</b>
<p>12/06/06 Mr Kayode was told to get a report ready for the <b>environmental sanitation</b> carried out by his members during last month's environmental sanitation</p> <p>04/09/96 The BASICS representatives suggested that we should start putting into use the materials provided for this dyad concerning <b>environmental sanitation</b> of our community. Deacon Olalude then promised to mobilize some people in his association to take off so as to encourage others in the community. The Board jointly agreed that we should draw a time-table involving all the associations under this dyad to rotate the sanitation on a monthly basis.</p> <p>21/05/97 A time-table for the usage of the <b>environmental sanitation</b> materials has been prepared. Any interested CBO should contact the CPH office for relevant information on the timing.</p>	<p>29/01/97 Dr Oduyoye said the immunization clinic now holds every Saturday. He said it will take a total of ₦45 to benefit from the programme.</p> <p>18/06/97 The EPI register was shown to the house and its uses were explained to the house. He said the register will assist in checking babies that are defaulting. Dr Oduyoye also informed the board of further efforts made by Dr Williams to assist the CPH on budget proposal. He intimated the board of the days for the immunization to effect. He said that immunization commences from next month being July 1997, and will run for 18 months and campaign materials such as T-shirts, face caps and other complimentary items will be made available to the health officers. He however concluded on this issue by saying that BASICS will sponsor all these items.</p>	<p>29/09/97 The coordinator of the <b>Crusaders</b> (youth wing) briefed the house. He said the Crusaders have been given the forefront of the CPH because of their unity and cooperation. He emphasized more on their activities to eradicate AIDS and other sexually transmitted diseases. He even promised to show one of the films to bring awareness of the general members on AIDS. He talked about their plans to organise seminars and workshops to enlighten the youth about things that will benefit them. The youth agreed to be meeting every Sunday now instead of twice a month.</p>

The next Table shows that environmental sanitation also occupied the time and interests of Lawanson CPH Board members. They also got involved in a number of other activities including adult education classes, revolving drug fund and a cooperative society.

### Sample Lawson CPH Activities

Environmental Sanitation	Cooperative Society (relates to Sustainability)
<p>06/01/97 The environmental sanitation chairman reported to have embarked on cleaning drainage along Lawson Road, Akinyemi Thompson Street, Asoluka Street, Obele-Onwala and part of Oseni Street. He urged members to get in touch whenever it is decided for implementation at their respective places.</p> <p>07/07/97 Environmental sanitation the general secretary raised a point that there should be a sanitation exercise. He suggested hired labour in removing refuse from the drainage. That a sign post tripod stand while working should be made. Furthermore a prior notification served the area concerned before commencement. He passed round a specimen letter for signing. Mr Okoh object money paid as suggested from community purse rather than from individual donation. The chairperson said while creating awareness cleaning of drainage we should serve a handbill educating people along. She held her breath saying that every member should go home and work the modality before the next meeting.</p> <p>01/09/97 The chairman asked the environmental sanitation chairman to enlighten the house on how far they have gone. On placing a sign post on the road during the exercise. He responded that the sign post was not printed yet, that no effort is being released on the exercise. The chairman said that the members should suggest modus operation of the exercise and its progress. Mrs Alabi suggested that the youths should be involved in the act, while the chairman said that it should be a team work whereby all the members will more out in groups after informing the people in the area they are working so that they may know and await to join them in the exercise for child survival. The house suggested that the days will be suitable for the exercise and that it should be twice a month, i.e every first and last Thursdays of a month, 8-10 am.</p> <p>06/10/97 The environmental sanitation chairman reported that heavy rainfall disturbed the last planned environmental exercise.</p>	<p>17/05/97 Mr Okoh spoke on the need to start the cooperative society that would assist more apart from funds raised by international body.</p> <p>01/09/97 The chairman remarked that we have to make our cooperative open for now. Cooperative committee (reported). There are 12 registered members already.</p> <p>22/09/97 Meeting of cooperative thrift and credit scheme (summary). Mr Okoh serving as chairman. For one to become a member, a ₦100 registration fee has to be paid. The chairman said a very good cooperative bank will be sought so as to gain a reasonable interest. They group concluded to be meeting once a month. Further explanation was to be given by a consultant from the cooperative started by JAS CPH. Mr. Lamidi explained that money can be taken at twice the value of one's savings provided there is a guarantor and the savings has been consistent. Contribution cards will be needed for each member. It was resolved that the cooperative would take off on 1st October 1997. The next meeting was fixed for 22 October 1997.</p>

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The minutes of the meeting on 28 February 1996, in Amukoko show that the Board there did pay serious attention to the priorities in their plan:

*On the first objective (diarrhoeal diseases), activity 2 (refuse collection), the HF promised to come to the next meeting with full complete costing of required materials. Under activity 3 (advocacy), the CBO were told to find out the cost of printing handbills, posters, banners and the cost of a megaphone. Also to find out the cost of hiring a bus for the full day campaign. On the second objective, activity 1, immunization, we could not understand who to provide the vaccines for the immunization, between the two groups. Mr. Salami and Mr. Luqman volunteered to go to BASICS office to invite them to our next meeting so that they can come and make clarification on provision of vaccines and revenue generation.*

Of course, not every CPH action has been focused on the work plan objectives and strategies. At a meeting of the Lawanson CPH Board Meeting of 1st July 1996, "She (the chairperson) called for members contributions/ suggestions on a project on sickle cell disease or like our contemporaries at Ajegunle on de-worming." Organizations do feel pressure to be active and produce some short term successes. Recently, the newly formed dyads in Ajegunle staged a free eye screening exercise along with the provision of low cost eye glasses. This created much enthusiasm and was mentioned by 9 of 32 CPH and CBO/HF leaders as an achievement of the newly formed group. While it is important for groups to embark on some visible, short-term activities to generate awareness, interest and support, it is important to realize that the Lawanson CPH Chairperson in the same meeting noted above said that, "Unfortunately we are not financially buoyant." This means that groups need to focus on a few manageable priorities as planned instead of distributing their energies and resources too widely.

Another issue is that it obviously took some time for CPHs to initiate action. For example, Board meetings during most of the first year of existence (1996) of Lagos Island CPH were consumed with organizational process concerns such as the following: March - membership of the governing board; April - elections; May - MOU, secretariat and logo; June - opening a bank account; July - continued deliberations on bank account, reports from workshops attended; August - the need for grants; and September - gifts from BASICS/USAID, need for fundraising.

Programming activities, for example training local volunteers and undertaking environmental sanitation, were discussed at several points, as seen in the Table below, but little action resulted in 1996. One of the basic principles of community organization is that a community group must experience some simple successes early in its life as a way not only of motivating continued interest but also for developing leadership and problem solving skills for future sustainability. Fortunately LICPH is still functioning today, but the experience in the new Ajegunle dyads provide a contrasting lesson that should be heeded when forming any new organization. Their provision of free eye screening in the community created an early and strong sense of accomplishment not only within the community, but was also favorably noticed by leaders of CBOs in other CPHs.

## Intentions for Action at Lagos Island CPH During the First Year

Workshop for Community Volunteers	Environmental Sanitation
<p>29/05/96 BASICS introduced Dr Campbell who will be training volunteers on ORT and Child Care, etc at a date to be fixed. Volunteers, both male and female, interested parties should submit their names to the secretary</p> <p>07/06/96 The filling of volunteers forms was the first to be treated. Although the distribution of the forms to various CBOs had been affected, further briefing by BASICS will be necessary to enlist interested participants. As per the duration of the training, Dr Aworo in his opinion said it might not exceed 4-5 days since the organizers know that the average Lagosian is time conscious. As to what will be the nature of training, Dr Aworo said it might basically include childhood immunization, oral rehydration therapy, how to inject, cold chain preservation, etc which normally doesn't take long in such cases</p> <p>20/06/96 The CBOs were requested to submit their trainers of trainees forms, but only United Tailoring Association could do so. That of Happy Club had been handed directly to BASICS</p> <p>08/11/96 Ms Amgilaje of Roland Hospital briefed the house on the outcome of the meeting earlier with the organizers and stressed that interested trainees should indicate their interest but should not be less and more than 30 and 50 respectively. At this point the chairman implored everyone to show more commitment to the association so as to meet up other CPHs</p>	<p>29/05/96 BASICS handed some implements to hasten our objectives</p> <p>07/06/96 Alh Yekini then suggested the need to still contact BASICS for the mentioned materials and a wheel barrow to hasten the programme, which from all evidence we are far behind schedule</p> <p>20/06/96 Mrs Akinsinde called us to remember materials promised by BASICS during our maiden workshop early this year, materials like insecticides, brooms, buckets and even money to engage the services of rubbish collectors. But what we have received so far are insufficient compared to the members of each CBO which constitutes the LICPH. Therefore BASICS increasing the materials definitely will not only hasten the field work, but also precious time saved</p> <p>05/07/96 Members, after a heated deliberation, berated BASICS for not supplying enough materials and resources that could fasten the pace of activities</p> <p>08/11/96 Also discussed was the programme to be embark upon. Dr Aworo suggested that environmental sanitation be the first as requested by BASICS. After a thought deliberation on the matter, it was generally accepted that the committee's report be presented before further deliberations can be exercised</p> <p>2/12/96 Mrs Akintayo (a consultant) took the house down memory lane as regards the need for the consultancy which she said was for financial sustainability of the CPH. The need to focus on the values, vision and goal of the CPH so as not to be directionless and activities like seminars, outreach programmes, campaign and <b>environmental sanitation</b> exercise necessary to achieve the goal of promoting the status of health care on Lagos Island. She also registered her displeasure over the level of commitment of members of the CPH</p> <p>On existing services rendered, the consultant was made to understand that .. the services would be increased in future to include immunization workshop, environmental sanitation, malaria control activities and improving health awareness through provision of ORT corner in the health facility</p> <p>27/12/96 An environmental sanitation exercise was scheduled for Saturday 28th December by 7am and members urged to report early enough for the exercise with CPH's vests on</p>

As noted in the previous section, Ajegunle ranked itself high for programming, in fact, it had the highest self-ranking score, 92% compared with 72% for JAS, 62% for Lagos Island and 49% for Lawanson. Makoko also rated itself quite high (82%), even though it has no active health facility where immunizations are provided regularly, because the cold-chain equipment have not been distributed. Concern about the high self-ranking for programming achievements by Ajegunle, led to a review of the available minutes for 1997 Board meetings (January-April) as seen in the Table below.

MONTH in 1997	AJEGUNLE CPH MINUTES: TYPE OF MATTER DISCUSSED	
	MANAGEMENT	PROGRAMMING
January	<p>The issue of the proposed membership identity card was sampled in the meeting and it was generally accepted by the house</p> <p>A letter from BASICS . (on the) women empowerment meeting to be held on the 29th (was discussed)</p> <p>The chairman of the AJCPH Dr C Omeziri convey the commendation of the USAID/ BASICS to AJCPH members, stating that they are No 1 among other CPHS in Lagos State</p> <p>The secretary was accused of not circulating meeting notice as it supposed to be</p>	<p>Dr Omeziri called on AJCPH to join other hospitals and community to carry out NID exercise. (no action reported)</p> <p>Prince, the Ejoro Youth leader, asked how do we go forward to implement our activities, equal opportunity to participate in one thing or the other, by so doing one feels a sense of belonging. Dr Omeziri reacted on the above and said that not until membership card is implemented we cannot determine who is a member by now (no action reported)</p>
February	<p>Both the chairman and his vice were dragged into introduction of people due to some group of unfamiliar faces present in the meeting This group of people were said to have come from Oyedeji Community and other elites who were unconstitutionally invited to the meeting as usual by the Fagbemi group Due to conflicts and frustration that resulted from those non-members in the house, agenda and matters arising form the most previous minutes of meeting were not tackled</p> <p>The issue of Women Empowerment election held on 4th February 1997 was revised and refuted by Mr Odjerwedje (who) declared the election illegal, he pointed that he suspected foul practice in the election and called that the election be re-visited (The women present refuted these claims and called the speaker "mad")</p> <p>The Issue of AJCPH having its secretariat separate from the health facility (Rikky Hospital) was raised . supported by 4 persons "If the AJCPH thinks they have the resources, they can move the secretariat out from here," said the Chairman of AJCPH, Dr Omeziri The chairman in addition pointed out that "Rikky is a private provider working with the community and as such should not be seen as a mandatory service to the community," he warned</p>	(no program issues discussed)

MONTH in 1997	AJCPH TYPE OF MATTER DISCUSSED (continued ..)	
	MANAGEMENT	PROGRAMMING
March	<p>The issue of who is a member of AJCPH became a focus when the Chairman, Dr Omeziri, said the only way to determine membership is by the sales of the designed membership card. A total of 375 cards have been shared among 14 CBOs</p> <p>The offices of the financial secretary and that of the treasurer who have conspicuously rendered their roles in AJCPH inefficient and dormant were momentarily replaced</p> <p>(The youth leader) called on the AJCPH on what he foresaw as a problem that most leaders in CBOs are tempted to withdraw their youths from AJCPH due to some calibre of people of CBOs that made up this CPH</p> <p>Mrs Adewumi suggested that BASICS invitation to workshops/training should be treated accordingly and equal ,</p>	(no program issues discussed)
April	<p>The Secretary, during the reading of the minutes made a very poor presentation of it. This performance was so transparent that everybody noticed it. The Secretary immensely apologized on what he described as unfortunate. This situation did not go down smoothly with the Chairman, as he hastily moved a motion to appoint an acting assistant secretary which was adopted by the house, bringing the number of secretaries in the CPH to 3 excluding the financial secretary</p> <p>The secretary distributed the authorized letter of membership determination and added that each CBO should photocopy the said letter and return to the secretariat for record purposes</p> <p>Mr Makinde, Theatre Chairman of Ayota made his first appearance in the AJCPH (and) questioned why youths wing was formed out of prejudice. He complained that Youths suppose to be drawn from all corners of the Ajegunle community. While the chairman was reacting on Mr (Makinde's) unconstituted approach, reminded (him) that "you are not yet a member of this Association, therefore you have no right whatsoever to make an open confrontation "</p> <p>The interim financial officer appointed in March, became unnecessary when the main officer indicated his willingness to return to his post .. (and) refunded the N600 of the AJCPH which has been in his possession</p>	<p>Dr Omeziri briefed the house about his trip to Ibadan workshop . on NGO sustainability. He encouraged members to develop interest in this child survival programme (no motions made/action taken)</p> <p>The issue of TBA came up . (the chairman) who presented the report said that proper discussion on this matter will be handled in the next meeting</p>

The excerpts presented in this Table give no indication that AJCPH started out the year with any actual activities let alone accomplishments in the area of programming. In fact, it appears that the Board meetings were consumed almost entirely of conflicts.

## **6.2 PERCEPTIONS OF ACHIEVEMENTS**

Both questionnaires of leaders as well as FGDs among members were used as another means to determine whether people were aware of the purposes of the CPH and any achievements that were made to date. The seven most common CPH purposes mentioned in over half of the FGDs were -

- child health and survival (11 groups)
- education, enlightenment, raising awareness about health (9 groups)
- decreasing/avoiding diseases (8 groups)
- clean environment (7 groups)
- immunization for children (7 groups)
- promoting family health (7 groups)
- women's empowerment (6 groups)

Three of these, clean environment, immunization and women's empowerment, directly reflect the priority objectives found in all of the SPPs

When asked what changes had been observed in the community since the inception of the CPH, over half of the groups mentioned the following observations:

- we are now more united, cooperative, friendlier, relate better (9 groups)
- we are now better informed; our eyes are open (8 groups)  
(Note that two of these groups mentioned awareness of AIDS specifically)
- the environment is cleaner (fewer flies, less odor, clear roads) (7 groups)
- we are now empowered, know our rights (6 groups)

Of these perceived improvements, one relates directly to programming activities (clean environment) while the others relate to the process of organizational and community growth within the CPH and bode well for attainment of the SPP objectives concerning sustainability and women's empowerment. A few FGDs did observe changes that concern other specific programme priorities: better access to immunization (3 groups) and increased effort to prevent diarrhoea through food/water safety (2 groups), but it may be early yet for the community to be aware of marked health changes implied in the programme's health objectives.

### **6.2.1 Leader Perceptions of Achievements**

CPH and CBO leaders were asked to list the 2 main achievements of the CPH so far. The table below indicates the responses mentioned by at least 30% of the leaders in each CPH. Immunization, a featured priority in all 6 SPPs was a frequently mentioned achievement among leaders in five of the CPHs, as seen in the next table. It is useful to compare the perceived achievement of immunization services with the same item of the CPH Management Self-Study Guide. Two of the six original CPHs, Ajegunle and Makoko, ranked their efforts at maintaining regular immunization programme as "fully achieved," although the BASICS Community Development Officer (CDO) ranked them as having "partially achieved" this programming indicator. The other CPHs all ranked their efforts in establishing regular immunization as "partial" in agreement with the CDO. One can

conclude that while immunization programming has started, it is not fully institutionalized in the CPHs

High level of mention of clean environment among 4 sets of CPH leaders corresponds with the fact that those are the four CPHs where leaders most frequently thought that environmental sanitation was a work plan priority. The attention paid to the cooperative and thrift society by only the JAS leaders arises from the fact that only in JAS has a cooperative successfully taken root.

Although improvement in access to health care was not a directly stated objective of the SPPs, it was a cornerstone of the MOU and also a strategy for achieving reduction in mortality from malaria, ARI and diarrhoeal diseases. Since accessible health care was at the bedrock of the MOU, one would have expected higher mention of this achievement, but it is noticeably absent from 3 CPHs.

Perceived Achievements by CPH/CBO Leaders	CPH					
	AJE	AMU	JAS	LAI	LAW	MAK
Clean Environment		✓		✓	✓	✓
Increased Immunization	✓	✓	✓	✓		✓
Reduced Health Cost	✓				✓	
Accessible Health Care	✓		✓		✓	
Timely Medical Care	✓					
Women's Empowerment			✓	✓		
Cooperative/Thrift Society			✓			
Cooperation/Unity		✓	✓			
Increased Public Awareness		✓				✓
Number Interviewed	34	23	27	26	36	40

The lack of full involvement of any of the HFs in Makoko could explain the lack of perception of health care service improvements there, although four facilities signed the MOU, none has participated actively in the CPH. One health facility member of the CPH Board in Makoko explained his frustrations as follows, "We got materials from BASICS, but because there is no generator, the materials are useless. BASICS brought only one generator, which is still with the chairman of the CPH." Staff of another facility in the area complained, "Most of the things that we were supposed to be given were not given us." When immunizations were carried out by the CPH, it was through the efforts of the chairman, the leader of a local religious community/CBO. He made contacts with the LGA PHC Department to obtain the vaccines and made the other arrangements. The health facilities that signed the MOU appeared to have a minor role.

Another Makoko health facility representative explained, "I used to be secretary of the CPH, but have stopped attending meetings a long time ago because of the pressure of work at my hospital. Releasing me to attend to board issues always left by health facility without a doctor, and this was why I stopped attending meetings." This minimal input by facilities could be partially explained by the scarcity of HFs in the community and the fact that few are run by full time resident physicians. Most of the doctors work in some government facility or parastatal, and thus have little time to devote to the facility or the CPH. In conclusion, while CPH members who attend any of the facilities that have signed the MOU are supposed to receive the benefits of affordable care, the minimal leadership role played by these facilities in the CPH may reduce the perception of their contribution to the achievements of the CPH at Makoko.

Another view on achievements in establishing a regular immunization programme was obtained through the self-study guide. Three CPHs indicated that they had "fully achieved" the indicator of "Maintaining a regular, standard and reliable childhood immunization programme for the community," namely, Ajegunle, Lagos Island and Makoko. In contrast the BASICS Community Development Officer independently ranked five of the CPHs at the "partially achieved level for this indicator, and Makoko as "just started." Considering that the cold chain has not been properly set up in Makoko, as seen in comments from HF representatives above, one could conclude that the leaders of that CPH are out of touch with the needs and realities of achieving programme objectives.

### **6.2.2 Reasons for Success**

The 81 CPH leaders who were interviewed were asked to comment on the reasons for the achievements. The most common reason cited was cooperation among all parties (37%), followed by commitment (34%). Two other common reasons were that the members/community were well informed (17%) and that there was good leadership (15%).

These CPH leaders also explained their personal roles in the CPHs' achievements. The most common role was mobilization of their own CBO members and the community at large (42%). Others (28%) put in time, labour and/or service, while 25% said they raised community awareness. Other personal inputs included communicating, advising and sharing ideas among Board members (20%), finding resources, including personal donations (17%) and providing leadership (15%).

The leaders also speculated on the factors mitigating against the attainment of CPH objectives. Topping the list at 73% was lack of finance, which was attributed in large part to the poor economic situation of the country generally and to the fact that most community residents (and CPH members) were from the poor economic class. This issue of finance will be addressed more fully in the section on sustainability. The next most common problem was lack of understanding or awareness of the purpose and functions of the CPH (30%). Several blamed this on a pervasive attitude in many communities that people are only interested in programmes where they can see immediate personal benefit or gain. Poor communications (21%) was another common difficulty, and is addressed more fully elsewhere. Although personal commitment was seen as a factor contributing to CPH achievements, the lack of commitment was also mentioned as a problem (18%).

### 6.2.3 Perceived Benefits of CPH

An additional question on the leader interview asked what, if any benefits had accrued to the CBO/HF members as a result of the organization's belonging to the CPH. Only one person mentioned "immunization". The most common response among CPH and CBO/HF leaders was having gained training and skills (72%), followed by ability to receive medical treatment in time (38%). Other commonly perceived benefits to the CBO/HF leaders generally were reduced health care costs (30%), improved health status (30%), clean environment (30%) and receipt of materials and equipment from BASICS (25%). Nine people (5%) said there was no benefit or were not aware of any.

### 6.3 VIEWS FROM THE OUTSIDE

The 68 leaders of CBOs/HFs that did not join a CPH were also ascertained concerning their perceptions of whether the CPHs had made any achievements. Many (45%) specifically said they were not aware of any achievements or did not know. No response to the question was made by 21 leaders. Only 17 (25%) could mention a perceived effect. Ironically, six of these said the major achievement of the CPH was "increased public awareness." Five noted reduced health care cost, and four each said clean environment and bringing the community together. From this it can be seen that the impact of the CPHs beyond their member organizations is weak.

In-depth interviews were conducted with 31 leaders to learn their perceptions of CPH activities and accomplishments. Twelve of these interviews were conducted with local government leaders including supervisory councilors and PHC Department heads. The remaining interviews were held with community leaders such as section heads, women's leaders and leaders of ethnic sub-communities. Over all, 21 (68%) were aware of the CPH, and most of these had been directly contacted by CPH leaders. Only in Lawanson were all (6) of the respondents aware of the CPH, while in Makoko only 2 of 4 interviewed had heard of the CPH, and in Lagos Island, only 2 of 5 respondents knew about the CPH.

Sometimes the level of awareness was vague. The *Baale* of Makoko noted that, "*I know some of their leaders. The CPH is on health issues, but they have not fully achieved much yet. I heard that they are doing something.*" The LGA PHC Coordinator in the Makoko area was even less aware. "*I only know of their existence when we disbursed vaccines to them.*" He could say nothing more about their activities. In contrast, at Mushin, the PHC Coordinator was more aware and explained that, "*Dr. Oduyayo and some people came to tell me about the CPH, and sincerely speaking, they are working for healthful living of our children and families.*"

The questioning started with general questions about community concerns and asked about the groups involved specifically with environmental sanitation, immunization, women's empowerment and making health care more accessible. Few respondents spontaneously mentioned their local CPH in connection with these activities: 19% for environmental sanitation, 19% for women's empowerment, 32% for immunization; and 32% for accessible health care. More community leaders (47%) were aware of the role of CPHs in making health care accessible than were government leaders (8%) as seen in the table below.

As a summary, it was found that only 4 of 12 government respondents associated the CPHs with any of the four activities mentioned above. In contrast nearly half (9 of 19) community leaders mentioned the CPHs in connection with at least one of those activities.

During the subsequent parts of the interview, leaders were specifically asked to enumerate the achievements of the CPHs. Fifteen (48%) could not mention any. The most common items listed included immunizations (6 people), enlightenment about health and related issues (5), reduction in disease/improvement in health (4), and environmental sanitation (4). Other achievements were stated as eye testing (3), which was a unique new project offered by the new dyads at Ajegunle, uniting the community (2) and making health care accessible and affordable (1).

Spontaneous Association of CPH with Health Issues	LEADER				TOTAL	
	Government		Community		No.	%
	No	%	No.	%		
Environmental Sanitation	1	8	5	26	6	19
Immunizations	4	33	6	32	10	32
Women's Empowerment	1	8	5	26	6	19
Accessible Health Care	1	8	9	47	10	32
Number of Respondents	12		19		31	

Three of those who mentioned immunization as an accomplishment had not earlier included the CPHs as important groups in promoting immunization. In addition, three more people mentioned that the CPHs were involved in immunization in response to other questions about contact with the CPH as evidenced from the remarks of the PHC Coordinator in Makoko quoted above. Thus overall, 16 respondents (52%) were aware that the CPHs were involved in promoting immunization. A greater proportion of government leaders (75%) were aware of the CPHs' role in immunization than community leaders (37%). This is most likely due to the fact that the CPHs needed to contact the LGA officials to secure vaccine supplies. Awareness of immunization activities was greatest in Lawanson (5 of 6 leaders interviewed) and least in Makoko (1 of 4), Lagos Island (2 of 5), and Ajegunle (3 of 7).

As noted above, community leaders were generally more likely to associate the CPHs with at least one of the four key health issues/activities. This might be explained by their being in a better position to benefit directly from these programmes, as seen in the comments by leader of the Ishan ethnic group in Mushin, *"My wife attended the Democracy and*

*Governance Workshop. My children have enjoyed lower cost health care at JAS Clinic ”* Likewise, the leader of the Igbo community in Ajegunle said that, “*My family attended the eye clinic and enjoy the immunizations ”* The *Baale* (traditional Yoruba Leader) of Lawanson mentioned that, “*We use the health facility and enjoy all the benefits there ”*

It is important to add that all CPHs have been involved in the National Immunization Days (NID) campaigns for the past two years. The most recent campaign took place on two consecutive days during both November and December 1997. Preparatory training workshops were held with health facility staff, and CPHs conducted mobilization. Of the 17 affiliated HFs, 14 participated in the campaign. It was only in Makoko where only 1 of the 4 member facilities was involved, Makoko Medical Centre. Bolutife Clinic did send one staff over to Makoko Medical to help

#### **6.4 SUMMARY OF PROGRESS TOWARDS OBJECTIVES**

From the foregoing, it appears that the primary achievements of the Lagos CPHs in the two years in which they have been functioning has focused more on process issues such as community unity, empowerment and enlightenment. Among their objectives, it appears that the CPHs have been most active in immunization programmes, followed by environmental sanitation. There is little evidence that the CPHs have directly pursued objectives like management of ARI and diarrhoeal diseases, and in fact may have embarked on activities outside their main objectives (e.g. adult education).

Another important finding is that the CPHs and their accomplishments are fairly well known among their CBO members, but among non-members and local leaders, the work of the CPHs is less known. This issue could be addressed in part through efforts to expand membership as discussed in Section 5.4, as well as continued and increased outreach to surrounding resource agencies and advocacy among local leaders. On the other hand, comparison of the self-study guide programming section with Board meeting minutes shows that some CPHs may have an overly optimistic view of what they have actually accomplished.

#### **6.5 CAPACITY TO MONITOR**

The concept of monitoring programme outcomes and indicators was built into the SPPs (BASICS, 1996). The SPP for JAS included a statement that, “The JCPH will perform local area monitoring exercises (at facility and CBO membership levels) to collect further information regarding these and other project indicators which are detailed in JCPH work plan documents.” Later in the JCPH SPP document, the need for annual monitoring was emphasized.

The need to monitor progress was also reflected in the minutes of some CPH Board meetings. In the minutes of the Lawanson CPH Board meeting of 6th May 1996 it was stated that, “*Three committees were inaugurated: 1) monitoring and evaluation, 2) fundraising, and 3) disciplinary ”* Unfortunately, this was the only mention of monitoring in their Board meeting minutes. In the JAS CPH Board meeting minutes, the only reference to monitoring concerned the performance of the USAID gift vehicle that had been transformed into an ambulance. On 12 March 1996, the Board Meeting minutes as Amukoko noted that,

*Monitoring and evaluation committee must be appointed to see to the monitoring of our activities. The monitoring must be by visiting and writing report on the activities of the governing board every 3 months. Mrs. Iyabo Olurebi suggested that each partner must have one or two more representatives in order to make the constitution of the sub-committee possible*

At the meeting of 26th March 1996, the issue of a monitoring committee was again raised. No evidence exists in the minutes of further action.

Likewise, on 15 March 1996, the Lagos Island CPH Board minutes included the following, "Work plan monitoring: Dr. Aworo suggested that somebody be put in charge as the inspector of activities and would be responsible to the whole dyad through quarterly reporting of events." The minutes did not record that anyone was so appointed, and three months (one quarter) later, there was no reference to monitoring in the minutes.

A Capacity Building Exercise (CBE) was developed to enable CPHs to monitor by themselves the progress towards their goals. Beginning in December 1996, and continuing over the next year, BASICS staff assisted CPH members to survey their communities to learn about immunization coverage, child illness management practices, utilization of antenatal care and family planning services, HIV/STD related issues and choice of health care provider.

CBEs were phased over time so that all CPHs could be covered. For example, one of the first took place at JAS CPH in December 1996, while more recently, the CBE in Amukoko was held in December 1997. Other printed CBE reports include all four of the original Lawanson CPH health facilities and the two facilities in the Lagos Island CPH. Reports from Makoko are being edited at this writing.

Generally, the intention of the CBE was to help CPHs "use the baseline data to develop educational messages and plan specific activities. BASICS and the individual partnerships will also use the data to create monitoring and evaluation plans" (Silimperi *et al.*, 1997b). The following were listed as objectives of the CBE in Lawanson (BASICS, 1997) and that of JAS (Adesina and Orisasona, 1996a):

- Obtain information from the community about: health practices, health care seeking behaviour, home management of illness, and health status of both mothers and children.
- To improve interface between clinic services and community - outreach.
- To assess work plans, interventions and measure progress made towards the set goals and objectives.
- Improving CPH intervention within the communities.

At each health facility within a CPH, 100 women within the 15-49 year age range were sampled, using a modified cluster sample based at the health facilities, and radiating out

in the four cardinal directions. Eight CPH members and 8 research assistants were trained to administer a standard questionnaire in Lawanson, and four of each type in JAS

Common problems encountered were reluctance of community members to respond because 1) some were not aware of the value of the exercise, 2) some mistook interviewers for other people like Jehovah's Witnesses, 3) some demanded gifts in return for granting an interview, 4) some complained that the questionnaire was cumbersome and boring, 3) feeling shy in responding to questions about family planning (Adesina and Orisasona, 1996a; BASICS; July 1997 a,b, BASICS, December 1997). Problems with the immunization cards (either wrong dating or cards not given), from which data was extracted, were noted.

The interviewers were involved in data analysis. Teams tallied their own questionnaire results, and these were later combined by the whole group and made into graphs. For example, it was discovered that 27% of children under five years of age had received measles vaccine in the JAS area. Measles coverage documented during the CBE in Lawanson was 43%. Of the 15 children who had diarrhoea in JAS area, 9 received SSS and 3 were given ORS. A constraint on this process is the small sample size of children having had specific illnesses. In his monthly report for January 1997, the BASICS Community Development Officer explains the CBE process as follows:

*The month started with the completion of the Capacity Building Exercise (CBE) in the four health facilities (JAS, Rikky, Salvation Army and Roland Hospitals), where the exercises were not concluded in 1996. The participants were guided in to manually analyzing the data they had collected, and into writing reports of their findings. The processes were highly stimulating to the CPHs' participants because it allowed them to discover the communities they are serving. As from the 10th of January, the four groups reports were edited, and word processed. Each report was thus banded and distributed to each of the CPHs for discussions and taking of actions. In order to get a more detailed analysis in relation to the manually analyses data, a computer analysis was performed on the aggregated data of the four health facilities. Core frequency tables were produced, and the variables were graphed for visual impressions to be gained. A stage has now been set for a report to be written.*

The CPH member interviewers also developed recommendations for action, as implied in the objectives stated above, and examples included -

- Educating mothers on the need to have adequate record about the immunization of their children
- Intensive campaign about AIDS should be carried out to emphasize the seriousness of the disease (12% of respondents in JAS and 11% in Lawanson reportedly had an STD before).
- Measures directed at improving the educational standard of mothers will invariably reduce maternal and infant mortality

It was reported that BASICS staff did meet with the JAS CPH Board in March 1997

to discuss the results of the CBE. Comparison with the SPP objectives was made, and the leaders were encouraged to think about what they should do about the findings. Other such discussions are being planned (Adesina, personal communication)

So far regular monitoring has not been institutionalized within the CPHs. Clearly the CBE was relatively simple with minimal questions and a minimal sample size. The process of analysis using simple tally sheets appears easy to replicate by the CPHs themselves, especially since some CPH members were involved in the process at each site. On the other hand, the interviewing did appear to be alien to some of the respondents and the sample size was quite low. The challenge remains to find simple but valid indicators of the main plan objectives and establishing a realistic and regular monitoring schedule.

Also, it does not appear that a comparison of the CBE with a baseline measure was done. For example, 31% reportedly received measles vaccine in Mushin as measured during the 1995 USAID Integrated Baseline Health Survey (USAID, 1995a). Common indicators from both surveys in Mushin (USAID 1995a; Adesina and Orisasona, 1996a), Amukoko (USAID, 1995b; BASICS, December 1997), and Ajegunle (USAID, 1995c, Adesina and Orisasona, 1996b) are seen in the Table below. Although these two surveys are not comparable due to different sample sizes and locations (IBHS covered a wider area, while CBE was focused around one facility), the results could have been discussed among CPH members. It does not appear that this has happened, nor is there evidence that JCPH or the other CPHs have planned or undertaken subsequent monitoring activities.

Monitoring Indicators	Location of Survey (in %)					
	JAS		Amukoko		Ajegunle	
	IBHS 1995	CBE 1996	IBHS 1995	CBE 1997	IBHS 1995	CBE 1996
DPT3 Immunization	46	33	42	46	50	50
Measles Immunization	31	27	32	21	39	39
Received chloroquine for fever*	81	47	92	53	81	52
Received SSS for diarrhoea	41	60	27	50	29	48
Women Using Family Planning	40	37	50	46	52	22

\* IBHS may not be comparable with CBE as reported whether child received "drugs" for malaria, whereas the CBO reported whether the child received "chloroquine."

## 7. SUSTAINABILITY

The main purpose of the BASICS project in Nigeria, as stated in fiscal year 1996 Annual Program Report, is to, "*Develop and test sustainable models for improving quality and coverage of child health services provided by the private sector* " Furthermore, the report stressed the need to work quickly within the limited time-frame and political constraints of the project in Nigeria -

*Since its inception, the BASICS project has undergone a number of conceptual changes as it followed USAID directives to adapt the project to the political realities of the current Nigerian situation. Congressional waivers have allowed USAID and BASICS to continue to work through non-governmental organizations. Despite the difficult working conditions in urban Lagos, the uncertain political conditions and the threat of US Congressional de-certification, BASICS has moved rapidly to establish the community partnerships and prepare them to strengthen their infrastructure and capacity to sustain the community and home-based health programs. Building sustainable community partnerships which are capable of providing improved quality and access to health care to low-income urban families will be a critical issue during the remaining months of the project.*

While the quotation above could be taken as somewhat pessimistic, more encouraging remarks were found in an undated document entitled, "Draft BASICS Documentation and Dissemination Strategy " The writers notes that -

*The project requires very little money to keep the community partners active. The results thus far have shown a lot of "bang for the buck," which increases the chances of sustainability in the poorer developing countries.*

Sustainability of the CPHs could be broadly measured in three ways, 1) their ability to generate income to support their activities on a continual basis, 2) their ability to reach out to other health and development agencies in both governmental and non-governmental spheres, not only for resources, but also for collaboration in programming and advocacy, and 3) the extent to which the CPHs are able to govern themselves including managing resources, solving conflicts and achieving goals. The third issue had been addressed in the previous two sections. The remaining two are covered below

### 7.1 FINANCIAL SUSTAINABILITY

It is quite evident from CPH Board meeting minutes that the groups were well aware of the tentative nature of BASICS presence in Nigeria due to the vagaries of U.S. Congressional funding and policies as well as the Nigerian political situation. Therefore, all groups began discussing from the beginning plans about how they could sustain their activities financially, as seen from the excerpt from the JAS CPH Board meeting minutes of 1 April 1996 -

*The dyad was asked (by BASICS representatives) of the effort put in so far with respect to funding and sustaining the program, possibly after BASICS'*

*departure. Dr Oduyoye then itemized all steps and plans put in place like the introduction of membership registration fee and the readiness of the dyad to accept voluntary donations. He said a launching may not be laudable enough, hence the registration fee as an alternative was of fund raising*

Broadly speaking, their financial sustainability activities focused on three methods 1) regular dues and donations from members, 2) fundraising activities such as launchings and raffles, and 3) income generation projects including ambulance service and drug stores.

Examples of dues and donations come from Lawanson Board meeting minutes On 20th May 1996 the minutes recorded that, *"Mr. Olawuyi asked concerning the registration fee of N500 whether is the new association to pay or the individual members The chairman replied that foundation associations are not entitled to pay but any new association that comes to join us has to pay a non-refundable fee of N500, not individuals."*

All CPHs realized that attending BASICS and USAID IP workshops not only provided them with knowledge and skills, but gave them a financial boost in the form of allowances It was generally agreed in all CPHs that a portion of this allowance received by the appointed representatives of the CPH who attended a workshop, would be donated to the CPH On 13 February 1996, the Lawanson Board meeting minutes documents that, *"Dr Sowande reported that the cluster partnership collected a donation of N1,600 after the workshop. An account would be opened at a reputable bank "* As a follow-up, on 20 May 1996, the minutes again noted that, *"The chairman said that when a member is chosen to attend a conference, some allowance would be given and that you need not consume all the allowance that part of the allowance should be paid into Lawanson CPH purse She then opened to the house to ask what percentage should be paid into the purse. The entire members agreed on 30%."*

USAID provided some impetus to the income generation process by donating used supplies and equipment, which the CPHs were free to use or sell to make a profit. All groups received some office furniture and a vehicle. In addition, Lawanson CPH was given a large shipping container, which have become popular in Nigeria as prefabricated shops and stores As will be seen, the disposal of these items was both helpful and a source of conflict and resource consumption. Fortunately, as noted above under discussion of "core activities," none of these gift items were rated by either BASICS staff or CPH leaders as essential for establishing new CPHs. In other words, these gifts were taken with the appropriate grain of salt.

The Tables below summarizes the fundraising efforts by JAS CPH related to the USAID gifts. The first illustrates how tedious the disposition of the gifts of car and container became. The second focuses on fundraising activities and the cooperative Fundraising, it can be seen, may not yield the desired cash, but can help raise awareness and foster group interaction

**FINANCIAL ACTIVITIES OF JAS CPH -1**

Ambulance	Container
<p>29/01/97 The sales of the <b>car</b> was discussed and it was agreed that a <b>car</b> dealer should be consulted Dr Oduyoye said that a friend advised him of renting the <b>vehicle</b> out for burial</p> <p>18/02/97 A motion was moved that the <b>vehicle</b> should not be sold, but converted to a hearse A <b>committee</b> to register the <b>car</b> was set up</p> <p>23/04/97 Dr Oduyoye said that the <b>car</b> under repair will be completed soon and that the <b>car</b> has been registered and that all expenses of N16,000 had been paid And necessary papers presented to the board Unfortunately the insurance coverage was a third party of N550 He explained that the should have obtained a comprehensive insurance but the cost was unaffordable for now</p> <p>21/05/97 The chairman said the car had been delivered except for a few other accessories like the siren, jack and others He said the spare tyre had been tentatively provided He went on to say that there is already a request for its usage The bill sent in by Associated Garages was shown there is still an outstanding balance of N17,400 However the comprehensive amount spent on the car is clearly stated in the invoices The total amount excluding the siren cost is now put at N38,500 It was unanimously agreed that a 5% commission is payable to anybody who brings a customer On procuring the other items for the vehicle (siren, jack, etc ), Mrs Olayinka gave the board a loan of N10,000 This effort was applauded by the house</p> <p>18/06/97 The posters for the <b>ambulance</b> were shown Dr Oduyoye gave an update and assessed it as being averagely okay He said requests has been made in the past weeks for <b>ambulance</b> hire Mrs Olayinka gave a loan of N10,000 for the purchase of items for the ambulance It was agreed that a comprehensive market survey be carried out for a proper price list The need for a driver for the <b>ambulance</b> was also discussed Suggestions were made for a permanent driver for the ambulance and he would take the ambulance for more publicity A 5-man <b>committee</b> was set up for monitoring the ambulance and draw up a code of conduct for the driver, review the operation of the ambulance, monitor the smooth operation of the ambulance</p> <p align="right">Continued</p>	<p>08/01/97 Dr Oduyoye informed the seated attendants that an empty <b>container</b> of about 40 ft has been given to the CPH by BASICS and as soon as the whole issue is finally cleared, the <b>container</b> will be brought down and partitioned into shops instead of selling it off</p> <p>29/01/97 Mr Olagbegbo gave an update on the conveyance of the container He gave a detailed analysis of all the financial commitments associated with conveying and partitioning the <b>container</b> which stood at N18,000 Dr Oduyoye and Deacon Olalude commended the <b>committee</b> for a job well done Deacon further suggested that it would be appropriate if the <b>committee</b> also helps in finalizing the partitioning costs Dr Oduyoye suggested that people interested in shops should be consulted to know how much they are paying He said also that the local government council should be contacted for a possible tax exemption He also said we should formally contact the Gbangboye family to concretize agreements on the placement of the container</p> <p>13/03/97 The <b>container committee</b> submitted their report Mr Oduyoye, said that the <b>committee</b> received quotations from some welders, . The first one quoted N53,150 and the second was N54,450 The former was voted for He said work should start on time so that BASICS will not be disappointed by seeing the <b>container</b> abandoned</p> <p>23/04/97 Pa Olagbegbo said that the <b>committee</b> have not been able to move forward because Dr Oduyoye has not been forthcoming on the names of the proposed occupants of the container Dr Oduyoye responded that two intended occupants backed out because their movement to another area, but promised that he will do something and that the <b>container</b> will be completed before then end of next month He promised a loan of N5,000, Mrs Olayinka promised to do something too, as did Mrs Orebo Ogunyinka on behalf youth wing</p> <p>21/05/97 The <b>container committee</b> said that nobody has made any payment as regards rentage The <b>committee</b> said they are still on the look out for possible customers</p> <p>18/06/97 Mr Oregbegbor said that the potential tenants for the <b>container</b> are not ready to pay for 2 years He therefore asked to see if they will agree for one year</p> <p align="right">Continued</p>

111

Ambulance continued ..	Container continued
<p>16/07/97 The <b>ambulance</b> got knocked 4 weeks ago The ½ engine is to be replaced The engine bought is N50 000 and the gasket is N10,000 Labor is N2,000, oil and all other things are needed Dr Aworo (LAI CPH) asked about use of the ambulance</p> <p>19/08/97 The bill from Associated Garages on the <b>ambulance</b> was brought during the meeting. It was agreed that a driver be employed by the committee responsible for the ambulance to resume duty first week of September 1997</p> <p>29/09/97 A driver has been seen to handle the <b>ambulance</b> The driver will start work as from 2nd October 1997 The driver will take the bus to mortuaries and casket sellers to canvas for business</p>	<p>Note as of November 1997, the containers was still sitting unused across the street from JAS Medical Services</p>

It took 9 months to get the donated car fixed and made available for hire as an ambulance or hearse. An estimated N111,050 (or about US \$1,400) was spent getting the ambulance on the road, after a setback when the engine knocked Actual price for rental was not finalized, but this may not likely exceed N5,000 per trip for funerals, but probably much less as an ambulance. A minimum driver's salary will not be less than N5,000 per month, and of course regular maintenance will continue Conceivably, the investment made so far could be recouped after a minimum of 23 trips, and with other costs, the group might come out ahead on about 4 months if two trips can be made in a week This means that it will have taken over a year for the ambulance to start generating funds for the organization.

So far it appears that only N18,000 (\$225) has actually been spent on the container, but approximately N54,000 (\$675) is estimated to be needed to partition it into shops, and again funds will be needed to move the container to its final location. One potential source of money to renovate the container would have been advance rent payment by people who might rent the completed shops This has not been forthcoming.

In contrast to the decision by JAS CPH to keep the vehicle, Lawanson CPH decided to sell it as seen in their board meeting minutes of 24 September 1996 This decision may have saved the group some headaches

*It was agreed that other doctors should attend the board meeting for briefing over the property delivered as concluded by the board members with fixed minimum prices The secretary re-read the price table of the property. He said that preference should be given the doctors before general members over the sale of property. Dr. Okwuosah condemned the idea of depositing the vehicle with motor dealers as this may delay He suggested a direct buyer would be better. He remarked that the prices are okay. A minimum price of N100,000 for the vehicle was suggested with the vehicle going to the highest bidder. All doctors expressed interest in the properties*

In Makoko, the vehicle was one of several sources of contention among the leaders as evidenced from the comments made by one CPH leader during interview

*I can't understand, they gave us a vehicle We sold it, but we don't know where the money is. The gari we sold, we are told we made no profit We call the executive meeting, but solution is not gotten It is the chairman that dictates He even disgraced one out of the meeting sometimes ago Many people are not satisfied with the progress of the CPH There is no agreement among the board members*

In terms of income generation, the Cooperative Societies started by JAS and Lawanson offered not only a source of income to the CPH sponsors, but also an additional way for individual CBO members to benefit from their association with the CPH by joining a legitimate thrift and savings plan. In the Lawanson Board meeting minutes of 19 July 1997, *"The Chairperson discussed on the CPH cooperative society where 3% will be for the owner of the capital and 5% to the CPH and also the loan by BASICS which gives 15% interest to the CPH As an act of sustainability according to her, all other members agreed on that."*

## **7.2 REACHING OUT TO OTHER AGENCIES**

Although not all community leaders and non-member CBOs are aware of CPH activities, there is evidence from CPH leader interviews that some of them have tried to make contact with other community organizations and resource agencies. Just less than half of the 81 CPH leaders interviewed (47%) said that they had contacted various health agencies such as the LGA PHC Department. Fewer (14%) reported that they or their CPH contacted any development agencies Only 18% had contacted other NGOs, and 21% reported contacting local or state government The comments below give some details of these contacts

*We contacted the Legal Resource and Research Development Centre, Yaba and collaborate with Nigerian Youth AIDS Programme, UNFPA and AIDSCAP (Lawanson).*

*We contacted Surulere LGA for vaccines, Rotary to share information, and the Independent Community Bank concerning handling the CPH money We invited LGA officials for our launching, but they did not turn out because of fuel scarcity.(Lawanson)*

*We linked with the LGA for immunizations to help with the National Immunization Days. We have been in touch with Inner Wheel Club of Surulere and the Nigerian Youth AIDS Programme.(Lawanson)*

*We invited two councilors of Mushin LGA to the last mock parliament. We contacted the Mushin LGA chairman to be our patron. They are showing interest (JAS)*

*We discussed environmental sanitation with the LGA, and they gave us rakes*

*and other equipment. We collected items (leaflets) on family planning from PPFN (JAS)*

*For National Immunization Day we contacted the LGA and they gave us vaccines.(JAS)*

*We have gone and spoken with the chairman of the local government about the activities of the CPH He promised coming down to meet with the Board We went to give lecture in schools last year, and we saw the local education authorities and discussed our activities. We collaborate with Nigerian Youth AIDS Programme and Action Health Inc. We hope to strengthen these relationships.(JAS)*

*We have approached the LGA concerning the women's right as to having good roads in Makoko (Makoko)*

*The LGA gave us vaccines for immunization During environmental sanitation they supply materials and vehicles.(Makoko)*

*We invited the Ojo Local Government to one of our functions, explained our mission, and they even donated some money to us.(Amukoko)*

*We are just at the verge of reaching out to Rotary and Red Cross Society for Family Health gave us some commodities.(Lagos Island)*

*We work with the (LGA) PHC Department to improve immunization We also collaborate with the LGA on environmental issues, and with the Ministry of Health in improving immunization, i.e. they supply us with the vaccines.(Lagos Island)*

Recently (8 October 1997), armed with their government registration, Lawanson CPH took the initiative of contacting and writing to UNICEF, with an introductory letter from BASICS. This ensured that all the CPHs were registered with UNICEF as NGOs and were able to collect ORS packets for an upcoming emergency preparedness programme in response to a cholera outbreak in Lagos. The brief letter from Dr Sowande, Chair of the Lawanson CPH addressed to the Head of the UNICEF Health Section stated -

*We are a new NGO registered with the CAC Abuja after sensitization by Basic Support for Institutionalising Child Survival (BASICS) an implementation partner of USAID.*

*We are six communities in the peri-urban areas of Lagos State - Mushin, Ajegunle, Lagos Island, Amukoko, Makoko and Lawanson We all are partnerships between health facilities and community based organization called Community Partners for Health (CPHs) in a child survival project*

*We would appreciate it if you could supply us with Oral Rehydration Therapy*

*Sachets for our members in cases of cholera attack before it gets bad*

*BASICS is organizing a workshop for all the community based organizations this week on "Being Prepared for Disease Outbreaks" with an emphasis on cholera*

The letter and visits by Dr Sowande resulted not only in the registration of the sic CPHs with UNICEF but also in the supplying of 36,000 ORS sachets to be divided among the health facilities as requested, because as the UNICEF officer noted on the letter, "20 cases with death - Lawanson, Mushin - over the last week "

The table below summarizes the reports by CPH leaders about their external contacts with other agencies This does not necessarily depict the full level of contact, but indicates whether or not a broad spectrum of the leadership of the CPH is aware of and/or has participated in such contacts That being the case, it appears that overall, JAS CPH and Lawanson CPH leaders have had more broadly had contact with a greater variety of external agencies that leaders from other CPHs. It is encouraging to see that the new dyads (in Ajeunle and Lawanson/Ojuegba) have already started to reach out

Reported Links with Other Agencies by CPH Leaders	Community Partners for Health (in %)							
	AJ2	AJE	AMU	JAS	LAI	LAW	MAK	OJU
Health	17	64	50	50	46	27	53	57
Development	33	9	0	14	0	36	7	14
Other NGOs	17	9	17	29	27	27	7	14
Government	17	0	17	36	46	36	7	0
NUMBER of RESPONDENTS	6	11	6	14	11	11	15	7

### 7.3 INTER-CPH CONTACT AND ORGANIZATION

The long term sustainability of the CPH concept may depend in part on how the existing CPHs relate among and support each other. Many training activities have brought the CPHs together, and more recently, they all interacted at the Mock Parliament component of the Democracy and Governance Project. What is important to see is whether there is evidence that the CPHs interact among themselves, and in the longer term how they might formalize such interactions Most CPH leaders (70%) said that they had contacted other CPHs outside of the regular meetings and workshops with BASICS. The comments that follow show why CPHs have taken the initiative to contact and learn from each other where there are perceived areas of expertise

*We have worked together with JAS CPH, given each other advice, and attended*

*each other's meetings We approached the LGA for a truck for refuse disposal and wrote them a letter to let them know that we exist. (Lawanson)*

*We have attended functions of JAS and Ajegunle CPHs (Lawanson)*

*We contacted JAS concerning their credit and loan scheme since they had run it for some time (Lawanson)*

*We wanted to organize a fund raising and contacted them (other CPHs) on how to go about it, and their advice paid off in the end.(JAS)*

*We collaborate with Lawanson CPH because we strongly believe in the benefits of networking One result is a good working relationship (JAS).*

*We contacted other CPHS to learn more on their administrative procedures, and they really open up, and I hope we will surely emulate them. (Ajegunle)*

*We have linked with JAS and Ajegunle CPHs, and it has helped us so much. (Amukoko)*

*I contacted AJCPH and LASCPH to enlighten us more on how to run the CPH They enlightened us, but we have not implemented them (Makoko)*

*I contacted AJCPH and LASCPH to enlighten us more on how to run the CPH They enlightened us, but we have not implemented them (Lagos Island)*

*We visited JAS CPH to see how they organized their secretariat which was used to organize our own (Lagos Island)*

*We visited JAS CPH to see how they organized their secretariat which was used to organize our own. (Lagos Island)*

BASICS staff have called CPHs together since the beginning of the programme to discuss common issues. To date this has happened at the instance of BASICS as an efficient way to pass on information. A meeting on 5th September 1997 addressed the issues of expansion of CPHs and the relationship among CPHs Concerning the former, it was suggested that there was a need for "*a unified application form for the new dyads coming for admission.*" This admission process was thought useful to "*make the new coming dyads to respect the existing ones*" The meeting also noted that, "*expansion is essential fort spreading the benefit to the community*" Monthly meetings among the dyads in a CPH was suggested. Finally the group resolved that, "*There should be another forum for inter-CPH meeting quarterly and inter-state, which is Kano and Lagos, that should be held once a year*" This mechanism provides a basis for organizing a city-wide supportive structure that will be needed to sustain the activities of the existing CPHs and encourage the growth of new CPHs

The growth of new CPHs will be the ultimate test of the context. Will new communities decided to form partnerships even if BASICS is no longer around, or even if

around, not having the priority to expand in the Lagos area? The formation of new dyads in Surulere/Lawanson and Ajegunle are positive developments, but fortunately for these groups (though they might not initially see it that way), they are in the catchment areas of existing/approved CPHs. The real test will come when a group in Shomolu or Agege wants to form. Core activities such as recruiting members, drafting documents, holding planning meetings and electing officers do not have to be expensive. If existing groups who rate such inputs as gifts of furniture and supplies as low can convince newcomers that they can help themselves, then new CPHs might form on their own. The development of a constitution and registration as an NGO with the Federal Government does not require the presence of BASICS, although the guidance of people like the CDPO is essential. If existing CPHs are now reaching to and helping each other, as the evidence suggests, they too might be able to take on facilitative roles in helping new CPHs form.

## 7.4 RECOMMENDATIONS

- 1 Clarify the structure and functioning of dyads within the overall governing process of the CPHs to ensure not only a viable, meaningful and participatory intermediate level structure, but also to guarantee that in the process, individual CBOs and HFs will not feel left out of CPH governance.
- 2 Ensure that all current and new CBO/HF members not only have copies of the MOU but have actually signed it. A system by which new members formally sign the MOU soon after joining needs to be instituted in each CPH.
- 3 An intra-city CPH management or facilitative Board needs to come formally into being within the next few months as this is the main mechanism through which continued CPH activity in Lagos can be ensured and by which the formation of new CPHs can be stimulated. This intra-city Board can also be a "court of last resort" to settle conflicts within individual CPHs.
- 4 Particular attention needs to be paid to Makoko CPH in order to identify active Health Facility partners who can and will handle basic services such as immunization on a regular basis. The need to form strong dyads around these health facilities and the subsequent restructuring of the CPH to encourage wider participation will be necessary to overcome perceptions that the current leadership is authoritarian.
- 5 At this point, the Surulere/Lawanson area and Ajegunle are the farthest along in terms of dyad formation. There is need to ensure that the transition is both amicable and constitutional when it comes time to reformulating the CPH structure and leadership. All parties must be involved in restructuring decisions.
- 6 In the longer term, there is need to experiment with more rapid, focused and cheaper mechanisms for identifying future partner organizations, as it is unlikely that local NGOs would have the time or resources to conduct a full UPSI.
- 7 The upcoming process of elections and potential change of leadership in the CPHs must be monitored and fully documented as an indicator of organizational maturity and sustainability,
8. Proper and timely filing needs to be introduced at the BASICS Lagos office so that all information concerning a particular CPH is kept together in chronological fashion. Effort must be made to obtain promptly and to read through thoroughly the minutes of Board and committee meetings in order to grasp CPH developments and make timely intervention to resolve conflicts and solve problems.

## **8. PRELIMINARY DATA FROM KANO**

Effort was made to collect appropriate data from Kano while the documentation exercise was underway in Lagos. Leadership and member inventory forms were sent to Kano and returned. The self-study management guide was also sent, filled by CPH leaders and returned. Finally, the leadership survey and FGDs were conducted in Kano during the first half of December 1997. That data will be analyzed at a later date. Some preliminary information and impressions were available from BASICS files and from the interview team. These are reported here following a brief description of the city itself.

### **8.1 THE ANCIENT CITY OF KANO**

Kano is truly an indigenous city, unlike the metropolis of Lagos that developed during colonial times. Kano was headquarters of one of the seven Hausa States established between 1000 and 1200 AD. The city itself dates back to the Tenth Century. Being located somewhat in the middle of these seven kingdoms, Kano was a relative safe place to develop into a trading state (Mabogunje, 1976). "Kano became the greatest of all the Hausa cities, and by the sixteenth century this seat of government, trade and Muslim scholarship was among the most important in West Africa," having become a well-ordered market-centre surrounded by "a dense neighbourhood of villages producing textiles as well as food" (Davidson, 1991).

By the Nineteenth Century, Kano was the great manufacturing centre for much of the north of Nigeria, producing especially, textiles and leather, with trade routes extending north to Tripoli, south to Lagos, west to Timbuktu and east to Bornu (Mabogunje, 1968). During that period, the handicraft industries had developed to the extent that Kano was able to supply the whole of the western Sudan from Senegal to Lake Chad (Davidson, 1991).

The original city was encircled by massive mud walls 16 miles in circumference, with several gates (Perkins and Stenbridge, 1966). The resident population was estimated at around 30,000 in the 1820s, but could swell to twice that number during the trading season (Mabogunje, 1976). Estimates during the height of the trading season in 1889 pegged the population between 60,000 and 80,000 (Watts, 1987). The early city was clearly distinguished from the surrounding rural communities because of the clay and mud construction used in houses compared to the use of thatch in villages and hamlets (Mabogunje, 1968). What also made Kano unique from other later colonial urban centres was its status as an emirate in the Sokoto Caliphate, and as such was the centre of "a territory of some 13,000 square miles, supported by three or four million individuals, free and slave, within its boundaries by the last quarter of the nineteenth century" (Hill, 1977 as quoted by Watts, 1987).

Social diversity also distinguished the city from the hinterland. The centre of the ancient city had three main features, the king's palace and related administrative buildings, a central mosque and a central market. Even in the early days, the city was ethnically heterogeneous, with different quarters allocated to the traders from different parts of the Sudan. Even within the Hausa quarters, there was social stratification according to the major occupational groupings or classes. The three central features of palace, mosque and market were repeated within the various quarters (Mabogunje, 1968). Different quarters were

responsible for maintenance of the section of town wall nearest them.

Waje became the residence of new Hausa immigrants, while Sabon Gari ("new town") was where people from southern Nigeria came to live. The groundnut trade, and later cotton, transformed Kano into "a sprawling mercantile city, demographically fuelled by immigrant bureaucrats, clerks and traders from the South who occupied Sabon Gari township outside the old city walls" (Watts, 1987). Through Sabon Gari ran a road to the airport that became the central boulevard of a new business district and industrial estate at Bompai, and in general the new township roads contrasted greatly with their grid-iron structure to those of the old town (Mabogunje, 1976).

Between 1951 and 1965, Kano city grew dramatically, with the old city increasing by 4.8% and Waje by 25%; Sabon Gari reached 40,000 residents by 1965, at least 75% of whom were Igbo (Watts, 1987). Similarly, the number of local industries employing ten or more workers grew from eight to almost 100 (Watts, 1987). Kano's population reached over 380,000 by independence and over half a million in the 1970s (Allen, 1972), with 1980 estimates approaching one million (Watts, 1987). Features of the old city persisted, particularly the "spider web" road network in the old city that spread out from the centre to the city gates. Gardens required to produce food in times of siege are still within the city precincts (Mabogunje, 1976). Growth outside the walls occurred to accommodate migrants attracted to the growing industrial and commercial base of the 1960s, and to some extent focused on the railroad terminus (Mabogunje, 1976). Manufacture in Kano included groundnuts, leather, soap, furniture, tyre retreading, metalware, perfume (Perkins and Stembridge, 1966).

At the time of the Civil War, Igbo traders, who had up to that point been increasingly displacing middle and lower class Hausa traders, fled the city. Their trading niches, particularly in foodstuffs such as rice and *gari* (cassava meal) were filled by Hausa and Yoruba middlemen (Watts, 1987). In subsequent years, Igbo traders did return to the city, and as found through the CPH project, many of them are currently involved in the patent medicine trade.

Kano, being a major commercial centre, was more susceptible to social change than some of the surrounding towns. For example, the 1960s were characterised by various attempts at modern city planning, but these were often met with skepticism, if not forthright opposition by some interest groups. Still, as noted, some ad hoc improvements like the new industrial district and some housing estates resulted. Another social difference observed in Kano was the greater involvement of women in economic activity, such as trade and crafts, than in other parts of northern Nigeria (Allen, 1972).

## 8.2 ORGANIZATIONAL STEPS

A report by the BASICS Country Advisor and the CDPO in March 1997 outlines some of the start-up activities in Kano.

An initial rapid assessment and feasibility trip was made to Kano in the month of November 1996 by BASICS. This was followed by planning and consultation with the Headquarter Office, and other USAID IPs in December 1996. A

consultant was hired in December 1996, in Kano to prepare the ground for BASICS' formal entry into Kano BASICS team (Country Advisor, Community Development Program Officer, Adm Officer) finally entered Kano in January, 1997 to conduct the Urban Private Sector Inventory (UPSI) in three LGAs, and nine highly problematic communities, based on the findings of the rapid assessment trip, and consultation with the Northerners One of BASICS Technical Officers from Arlington, Dr Rose Macauley, joined the exercise along the line The Fora Development Meetings with a few of the selected communities to be used for the formation of partnership, (CPH) and development of rapid sub-project proposal commenced simultaneously as manual analysis of the completed questionnaires were harvested.

### 8.2.1 UPSI

The Urban Private Sector Inventory took place in kano in January-February 1997 The Table below was constructed by BASICS staff to show the number of completed questionnaires obtained by community and type of organization.

LGA	COMMUNITY	TYPE OF ORGANIZATION/ Number of Questionnaires			TOTAL
		HF	CBO	PMV	
NASARAWA	BADAWA	10	14	22	46
	GAMA B	9	9	13	31
	KAWO	11	11	14	36
	TOTAL	30	34	49	113
DALA	YAMOTA	22	3	9	34
	GOBINRAWA	30	17	38	85
	SHIRAWA	9	2	1	12
	TOTAL	61	22	48	131
MUNICIPALITY	YAKASSI	21	5	20	46
	GWALE	7	14	14	35
	SHESHE	16	16	7	39
	MANDAWARI	12	8	20	40
	TOTAL	56	43	61	160
GRAND TOTAL		147	99	158	404

The highlighted communities were eventually chosen for the program Yakasi and Mandawari were grouped as one community

### 8.2.2 Community Fora

Initial community fora were held in early 1996. The first forum in Sheshe/Mandawari community was held on 12 February. The minutes showed evidence of previous community action as well as cultural concerns such as the place of women in public meetings, as seen below -

The venue, a six-class room Community-built Primary School is located within the community with no play ground. The squared building has a space inside that occupied the participants, some of who sat on benches, while others sat on mats. The site was a refuse dumping ground before it was cleared through communal effort, and converted to a multi-purpose three-shift school. The pupils run the morning hour shift (class 1 -3), the Islamic group in the noon, and women Islamic education in the evening

Participants arrived timely, while others trooped in, one after the other, throughout the meeting period. The following categories of participants were present: ward leaders, vigilante' group, a doctor from Mandawari Lafiya Hospital, identified State Security Officers, traditional healers, children, people from other neighborhood communities who had been informed about the meeting somewhere, or elsewhere, outside the target communities. Fantastic !

The female participants were settled in a classroom as they arrived together with Rose, as part of the cultural sensitivity, which the team had been pre-briefed about. From here, they could hear the proceedings, but could not see the visual communication materials.

BASICS staff at the meeting made the following observations about the community

From the way Sheshe Ward Leader interacted with his people showed that he has a good control over them. At a time he stopped the distribution of the "Pathway to Survival" handout to enable people listen carefully. Indeed the group is very cohesive, and this is a positive strength.

From the minutes of the second community fora in Sheshe/Mandawari on 14 February 1996, community problems were prioritized as follows:

- 1) Environmental Sanitation to combat diarrhoea, dysentery, and malaria
- 2) Immunization against measles which is round the corner, chicken pox, meningitis, and poliomyelitis
- 3) Training of TBAs on the prevention of VVF, Tetanus, improved knowledge and skill, and general education
- 4) Control of Diarrhoea using ORT, SSS through health education

The issue of structure of the potential partnerships and dyads was addressed by the BASICS

staff after the concepts “had been interpreted into Hausa language, and a simple diagrammatic partnerships configurations had been prepared on the flip chart, and in small leaflets for take away.” The configurations showed partnership of various combinations of Health Facilities, CBOs, Pharmacies, Chemist Shops, and Patent Medicine Vendors

### 8.2.3 Partnership Formation

Activities in early 1997 included formation of interim leadership committees for the 5 CPH, which were replaced in mid-year by Governing Boards. The formation of interim committees (IC) was a change over the organizational process undertaken in Lagos. An example of this is extracted from the minutes of a meeting in Badawa on 1 July 1997 -

A five-member Interim Committee (IC), including a female, was constituted during the second forum to design, and facilitate the election process taking into consideration the heterogeneous status of the community. This status makes Badawa to be unique out of other selected communities in Kano. The IC designed a model in which certain number of people were to be selected into each post, while an open casting of votes, by hand raising in support of each of these people in a sequential order would be made. The community was said to have opposed this model.

An alternative model was carved out. Posts were said to have been distributed to major CPH groups: CBO, HF, Traditional Healer, Female, Village Head, Patent Medicine Vendors. The purpose of post distribution was to ensure equal representation of all groups, and to maintain ethnic balancing, the IC agreed to the model, thus the following posts were allocated to groups; the following nominations were thus made.

Chairman	-	CBO	Alhaji A Ubale Baron
V Chairman	-	HF:	Dr. G.O Ogbouche
Secretary	-	HF:	Mrs Irene (Non-Hausa)
Asst Secretary	-	CBO	Dan Asabe Baran
Fin Sec/Treasurer	-	PMV:	Mr Michael Amara (Ibo)
P.R.O.	-	Trad. Healer:	Kasimu Audu
Ex-Officio Members	-	Village Head:	Alhaji Tabi Kabiru, and
	-	Opinion Leader:	Alhaji Hassan A. Idris

The chairman’s opening remarks highlighted the following issues

- That the community does not care about whether BASICS will give out money or not.
- Their job is to deliver good management of programs and health services to the community
- Badawa people are noted for helping people, and will continue to do so.

- There is need for the whole community to come together now to solve common problems
- The GB is open to correction, he recognizes the role of women in community development, and the particular roles they had played in immunization
- He is ready to work.

The issue of the CPH Constitution and MOU development was discussed, the need for both, the content, and the process, as well as the brochure, and logo development.

The CPH GB was informed about the need to have a Secretariat. The follow up annual workplan, and SPP development workshop was explained, the requirement for choosing participants, the dates, venue, and time were discussed. The GB was mandated to search for critical information about the community, that will be useful for the SPP.

The introduction of the IC appears to have helped smooth the transition from a collection of interested groups attending the fora to a structured CPH. In Yakası the IC played an important role in developing a roster for permanent governing board members as seen from the meeting minutes of 2 July 1997, below.

IC Chairman, Alhaji Seriki Lawan, was called to handle the election. He introduced members of the IC. Simply, the procedure used allowed nomination of well-thought people into each post, supported by a member, and was voted in, by everybody un-opposed. What surprised me was that, there was no name mentioned for any post that was opposed. It seemed the community must have done their home work thoroughly.

Prior to the formalization of CPOH leadership, Yakası community, under its IC was also able to address the important issue of lack of health facilities, as seen from excerpts of the minutes of the meeting on 2 July 1997.

The community had succeeded in completing the building of the Community Health Centre as promised during the first forum (31/5/97). The building has a consulting room, pharmacy room, waiting room, treatment room, and toilets for male and female. Painting had been completed, electrification had been done. The soak away pit when inspected by the State MOH, needed to meet certain specification, the community is working fast on that. An agreement has been reached between the community and the State MOH to meet the standard requirement for staffing and equipment, both of which are no problems as far as the community is concerned. The Community Health Center is strategically located along a popular motor way at Yakası making it accessible to people. It is located on a piece of land that is spacious enough, and capable of being expanded in the future in all dimensions, upward, or sideways.

At the meeting of 3 July 1997 in Gwale, those present paid the following compliments to

their IC after their new governing board was elected

- “The IC was led by God”
- “The IC really tried its best The IC was nominated to actually elect People cooperated in the process of information gathering about nominees.”
- “Praise to the IC The Governing Board members needs to be as honest ”
- “The group worked very hard during the last environmental sanitation exercise ”

### 8.3 MEMBERSHIP

Between January and July 1997, the UPSI in Kano surveyed 10 communities in Kano Municipality, Nasarawa LGA and Dala LGA. During that survey, 147 Health Facilities (including indigenous healers), 99 CBOs and 158 Patent Medicine Vendors (PMVs) were interviewed

Five communities responded to the program, and thus 5 CPHs were formed in the past year in Kano. Information available from the UPSI indicated that 172 local organizations were qualified for invitation to the 5 CPHs. Of these 116 (67%) actually joined as of September 1997 The five communities with CPHs were Badawa (BAD), Gama B (GAM), Gwale (GWA), Sheshe/Mandawari (SHE) and Yakasi (YAK)

Type of Member	CBO/HF Membership KANO Community Partners for Health					TOTAL
	BAD	GAM	GWA	SHE	YAK	
Indigenous Health Provider	3	8	9	17	23	60 (36%)
Patent Medicine Vendor	16	12	15	1	5	49 (29%)
Religious Society	0	0	1	0	0	1 (1%)
Resident Associations	0	0	4	1	0	5 (3%)
Service Groups	1	1	3	2	0	7 (4%)
Social Clubs	2	4	1	2	1	10 (6%)
Trade Associations	1	0	6	3	0	10 (6%)
Western Health Providers	2	3	1	1	1	8 (5%)
Not Stated	8	4	3	0	2	17 (10%)
<b>TOTAL (9/97)</b>	<b>33</b>	<b>32</b>	<b>43</b>	<b>27</b>	<b>32</b>	<b>167</b>

125

In Kano, BASICS decided to involve patent medicine vendors (PMVs) for two reasons. First, there was a relative scarcity of western facilities in the communities. Secondly, it was felt that there was tighter community control in the more traditional precincts of Kano, so that PMV behavior could be more easily monitored by CPH members. The table below summarizes the various types of members in the new CPHs.

The difference between Kano and Lagos is quite obvious. Both indigenous healers including herbalists, barbers and midwives are the most numerous members. These are followed closely by PMVs. Service groups in Kano communities include vigilante/security groups. Western providers truly are much fewer in Kano communities. Because of the predominance of PMVs, the concept of “triads” was introduced in the north consisting of at least one PMV, one health care provider (either western or indigenous) and one CBO.

The variation among CPHs in number of indigenous healers is partly due to how they were classified on the membership lists. Normally indigenous healers have a solo practice. In some CPHs, they were listed as an association while in others they were listed as individual members.

The interview team observed that the CBOs, “*Generally are not yet well-mobilized, or their level of awareness is low. Some CBOs are one-member organizations. Many (of those representatives interviewed) say they have no CBOs, but are simply members of the CPH. Many CBO leaders do not know the health facility (i.e. hospital) within their CPH. They are more concerned about community social and physical developments.*” In addition, it was seen that the level of poverty was quite high, especially among women, and “*Therefore, expectations for economic benefits (from the program) are quite high.*”

The women’s wings of these CPHs are just getting off the ground. The interview team found that the women’s wing at Gama B has become active, while that of Gwale is still in the formative stages.

## **8.4 LEADERSHIP AND GOVERNANCE**

### **8.4.1 Leadership**

Leadership inventories were obtained from 4 of the Kano CPHs (excluding Gama B). The average Board size in the 4 that reported was 8 members ranging from 7-9. Only 5 (16%) of the 32 Board members were female. Most Board members (22) represented CBOs. The remaining 10 (31%) were divided among western health facilities (4 members), indigenous healers (1) and PMVs (5).

The interview team made some preliminary observations about the CPH leadership. They found, for example, that the chairperson in Badawa did “*fully understand his role and the mission of the CPH and BASICS - to mobilize community resources to develop the community and to solve problems, especially health.*” It was felt that “*Generally (the leaders) expect BASICS to provide everything including such things as water for the community.*”

On the other hand, they found that in Gama B, “*Leadership was more enlightened.*”

*and showed a high level of commitment ” Generally it was found that, “Communication between CPH leaders and CBOs is poor . There is complaint on the part of CPH leaders that BASICS communication is usually impromptu ”*

Finally it was observed that community leaders in general could play both helpful and harmful roles. It was found that in Gama B, community leaders played positive roles in mobilizing people to start the CPH On the other hand, in Gwale, *“Some have engineered rumours that the CPH and BASICS are secret political organizations working for the American Government ”*

#### **8.4.1 Self-Study Guide/Organizational Development**

As seen in the table below, the self-study guide was completed by all Kano CPH Boards in December 1997. This is approximately 7-8 months after formation. The programming element reflects the relatively new status of the CPHs where several, notable Gwale, report that most amming activities have yet to start The total scores of the Kano CPHs are comparable with those of the new dyads that formed within the same period in Lagos

Community Partner for Health	Summary Indicator: Self-Study Guide				
	Structure	Management	Programs	Total Score	Who Responded
Badawa	61	44	26	44	C
Gama B	97	67	74	77	C
Gwale	54	16	36	31	C
Sheshe	59	26	28	35	C
Yakası	72	44	64	56	C
Overall Averages	69	39	46	49	

#### **8.5 PROGRAMMING**

All CPHs have developed their Sub-project proposals as recently as September 1997. Of the 3 SPPs reviewed, all had the same objectives. The following health priorities were reflected in the objectives of these SPPs.

1. By the end of 1998, reduce the number of children under 5 years getting sick from watery diarrhoea in (the community) and/or among organizational members of the CPH, as well as the number dying from dehydration or dysentery despite treatment in a partner health facility
2. By the end of 1998, increase immunization coverage in (the community) and/or among the organizational members of the CPH, and ensure the

availability of effective, quality vaccines to reduce the number of children getting sick or dying from vaccine preventable diseases

3. By the end of 1998, reduce the number of children and pregnant mothers getting sick from malaria in (the community) and/or among organizational members of the CPH, as well as the number dying despite contact with partner health facilities.
4. By the end of 1998, increase the demand for and availability of quality maternal/reproductive health services among CPH members and partner health facilities.
5. By the end of 1998, increase the level of awareness of partner organizations about the epidemiology and control of HIV/AIDS and STDs.
6. By the end of 1998, there will be an increased level of literacy among women of the CPH by 15%.
7. By the end of 1998, the CPH is nearly self-sustaining, requiring less BASICS' support to maintain its improved capacity and services, especially in the area of management, financial capability and revenue generation
8. Strengthen/expand role of family decision making in CPH members and the community it services.

The addition of female literacy is a distinguishing factor between Kano and Lagos. Also the eighth objective has been framed in a culturally more acceptable manner in Kano, instead of the focus on female decision making found in Lagos. Although reproductive health featured in the SPPs, the interview team reported that, "*Any persuasion concerning family planning is generally not welcome.*"

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## APPENDIX: INSTRUMENTATION

- A. LEADERSHIP/MEMBERSHIP INVENTORIES
- B. CPH LEADERSHIP INTERVIEW
- C. CBO/HF LEADERSHIP INTERVIEW
- D. CORE ACTIVITIES RANKING IN CPH DEVELOPMENT
- E. FOCUS GROUP DISCUSSION GUIDE
- F. IN-DEPTH INTERVIEWS OF COMMUNITY LEADERS
- G. SELF-STUDY GUIDE

## A. LEADERSHIP/MEMBERSHIP INVENTORIES

The charts below were sent to each CPH secretariat in early September with requests that they be filled out by CPH leaders and returned to BASICS.

### PART I: ORGANIZATIONAL MEMBERSHIP

Name Of Organization	Type of Organization*	Date Joined CPH
1		
2		
3		
etc.		

\*CBO, HF, PMV, TRAD, etc.

### PART IIa LEADERS WHEN CPH STARTED (1996)

POSITION	NAME	Gender (M/F)	Background C=community H=health worker	Membership (CBO, HF, PMV, TRAD, etc )
Chairperson				
Deputy Chair				
Secretary				
etc.				

### PART IIb: LEADERSHIP SEPTEMBER 1997 (same as above)

### PART III. COMMITTEES (Fill one form for each committee)

NAME OF COMMITTEE: \_\_\_\_\_

Position	Executive Board Member (Y/N)	Name	Gender (M/F)	Background C=community H=health worker	Membership (CBO, HF, PMV, TRAD,)
Chairperson					
Officer					
Member					
etc					

## B. CPH LEADERSHIP INTERVIEW

interview all executive board members and committee heads

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Interviewer: \_\_\_\_\_

### A. BACKGROUND

- 1 CPH Name \_\_\_\_\_
- 2 Respondent's Name \_\_\_\_\_
- 3 Respondent's position in CPH \_\_\_\_\_
- 4 Date when elected to position: \_\_\_\_\_
5. CBO or HF affiliation of respondent:  CBO  Health  
if Health  Facility  PMV  Indigenous  
name of CBO/HF: \_\_\_\_\_
6. age (or year of birth): \_\_\_\_\_
7. gender:  female  male
8. ethnic group  Yoruba  Hausa  Igbo  Other: \_\_\_\_\_
9. educational level  none  primary  secondary  post-secondary
10. occupation: \_\_\_\_\_
11. religion:  Muslim  Christian  Indigenous African  Other: \_\_\_\_\_
12. Is your residence in the same community as the CPH?  yes  no
- 13 Is the location of your work place in the same community as the CPH?  
 yes  no
14. marital status  single  married  separated/divorced  widowed  other: \_\_\_\_\_
15. if married, do your spouse and children live in the same community as the CPH?  
 yes  no ---> if no,  elsewhere in the city  in another town
16. Do any of your other relatives live in the CPH community:  yes  no  
if yes, who (e.g aunt, uncle, brother, sister.. ) \_\_\_\_\_
17. Do you belong to any other CBOs, clubs, societies or voluntary associations:  
 yes  no ---> if yes, please give names: \_\_\_\_\_

**B VIEWS ON CPH AND COMMUNITY**

1. What do you see as the mission or purpose of the CPH? (Tick all mentioned)

- child survival                       reduction in diseases
- community health    women's empowerment
- family health                       clean environment
- others: \_\_\_\_\_

2. Please describe your personal contribution to the CPH in terms of time and resources.

- attend meetings                       office work                       fundraising activities
- donating money                       mobilise community                       share information
- donate labour (e g. during environmental)                       others \_\_\_\_\_

3. What is the benefit or usefulness of the CPH approach to community work (i.e. bringing different CBOs and HFs together)? (Tick all mentioned)

- sharing knowledge                       making health care accessible
- solving problems                       uniting the community
- helping each other                       making health care affordable
- others: \_\_\_\_\_

4. What are the weaknesses/problems with the CPH approach? (Tick all mentioned)

- members have different values/approaches
- different levels of commitment/seriousness
- distrust/fear
- difficult to finance activities
- communication problems
- others: \_\_\_\_\_

5. What has been the two major achievements of your CPH? (Tick first two mentioned)

- clean environment                       increased immunization                       reduced health cost
- youth development                       women's empowerment                       accessible medical care
- cooperation/bring community together                       timely medical care
- coop society                       increased public awareness                       participation/democracy
- others \_\_\_\_\_

Why have those achievements been possible?

What was your personal role in making those achievements possible?

6 What have been the two main difficulties encountered with running your CPH? (Tick first two mentioned)

- lack of finance       lack of commitment       poor communication  
 lack of cooperation       quarrels       lack of understanding/awareness  
 others: \_\_\_\_\_

Why did these problems occur?

What has been your personal role in trying to solve these problems?

7. How have you personally benefitted from the CPH?

- training       reduced health cost       health care available when needed  
 ideas/knowledge       improved health/less disease  
 opportunity to interact/enhanced relationships       coop or loan scheme  
 others: \_\_\_\_\_

8. How has your CBO/HF benefitted from the CPH?

- reduced health care       medical treatment in time       improved health  
 coop society       clean environment       training/skills  
 increased health facility patronage       materials/equipment  
 others: \_\_\_\_\_

9. a. How has your CBO/HF benefitted by your being on the Board of the CPH?

b. Has your CBO faced any problems/difficulties because you are a Board member?

10. Please list the specific training courses you have attended on BASICS' nomination

- financial management       Childhood Diseases       Democracy/Governance  
 sustainability       planning workshop       AIDS/HIV  
 drug revolving scheme       TBA/CHW TOT       immunization/cold chain  
 others \_\_\_\_\_

11 a. How has the writing of a work plan benefitted your CPH?

b. Please list the four priority health problems selected for your CPH's work plan?

- malaria       cough       diarrhoea       HIV/AIDS  
 immunization       environmental sanitation  
 others: \_\_\_\_\_

12 How has the MOU been useful in the running of your CPH?

13 How many dyads/clusters are there in your CPH? \_\_\_\_\_

a If more than one, how has this arrangement been working?

b If only one now, how do you see your CPH functioning with more than one in the future?

14. a. Have you personally tried to recruit new CBOs into this CPH?  yes  no

If yes, did they join?  yes  no

If joined, give names: \_\_\_\_\_

If not joined, why? \_\_\_\_\_

b Have you shared the CPH idea with friends, colleagues and/or other CBOs/HFs outside this community?  yes  no

if yes, who and what was their response?

**C. SELF-CONFIDENCE AND OTHER ATTITUDES**

<i>Self-Efficacy Ratings among CPH Leaders</i>					
<b>as a CPH leader, how confident do you feel to ...</b>	Very confident	somewhat confident	uncertain	barely confident	not at all confident
SE1. resolve conflicts among members					
SE2. go out and get resources, funds and materials for the organization					
SE3 run our programmes smoothly and on schedule					
SE4 negotiate among the different interests of our members to come out with a common programme					

SE5 solve problems that come up with implementing our programmes					
<b>Perceptions of Community Efficacy</b>					
<b>how likely is it that people generally in this community would ...</b>	Very likely	somewhat likely	uncertain	unlikely	very unlikely
CE1 Challenge any children playing in the street instead of going to school?					
CE2. Challenge any child who shows disrespect for an elder					
CE3. try to settle a fight that broke out in front of their house					
CE4. discipline any child who throws refuse in the street					
CE4. Go complain to the LGA is they wanted to close down a local primary school					
<b>Community Interaction and Cohesion</b>					
<b>how likely is it that people generally in this community would ...</b>	Very likely	somewhat likely	uncertain	unlikely	very unlikely
CI1 belong to an association or club inside this community					
CI2. Relate/go talk with their neighbours at least once a week					
CI3. Attend a ceremony organized by their neighbour					
<b>How strongly do you agree or disagree that ...</b>	Strongly agree	agree some	uncertain	disagree some	strongly disagree
CI4. people in this community are willing to help their neighbours					

CI5 This is a community where people know each other well and cooperate					
CI6 people in this community can be trusted					
CI7 people in this community generally do NOT get along with each other					
CI8. people in this community do NOT share the same values and interests					
CI9 people in this community feel free to leave their children with neighbours when they go to market					
<b>CPH Functioning</b>					
<b>How strongly do you agree or disagree that ...</b>	Strongly agree	agree some	uncertain	disagree some	strongly disagree
CP1. Some member groups of this CPH are more important than others					
CP2. Board members are willing to commit their personal time and resources to the success of the CPH					
CP3. New members would NOT be welcome in this CPH					
CP4. All members in this CPH are treated as equals					
CP5. Some members work harder for the success of this CPH than do others					
CP6. This CPH is mature and ready to stand on its own now					
CP7 Most members are NOT satisfied with the progress of this CPH					

<b>Costs and Benefits of Leadership</b>					
<b>How strongly do you agree or disagree that ...</b>	Strongly agree	agree some	uncertain	disagree some	strongly disagree
CB1 Giving time to the CPH usually disturbs the regular jobs and family responsibilities of Board members					
CB2 Board members feel that they have gained a lot by working with the CPH					
CB3. the CPH places too much demand on the time of Board members					
CB4 there is a good working relationship among our board members					
CB5. board members can count on each other for help					
<b>How strongly do you agree or disagree that ...</b>	Strongly agree	agree some	uncertain	disagree some	strongly disagree
CB6 The CPH places too much demand on the money of Board members					
CB7. Most board members are interested only in the prestige and power of their position					
<b>Views on BASICS</b>					
<b>How strongly do you agree or disagree that ...</b>	Strongly agree	agree some	uncertain	disagree some	strongly disagree
BA1 BASICS staff are available whenever we call					
BA2. BASICS makes too many demands and requests of us					
BA3. BASICS lets us make our own decisions					

BA4. BASICS ideas are better suited for Americans than for Nigerians					
BA5 BASICS did everything possible to help us succeed					
BA6 BASICS staff usually dictate what we should do					

**D RELATIONSHIP WITH BASICS AND OTHER ORGANIZATIONS**

1. What do you think is the mission/role of BASICS in Nigeria
  - Child survival  promote community health
  - encourage participation/democracy  improve standard of living of the poor
  - others \_\_\_\_\_
  
2. What specific contributions of BASICS to development of this CPH?
  - training  technical assistance
  - materials/equipment  enhance understanding of health
  - coordination/bring us together
  - others: \_\_\_\_\_
  
3. What were the specific roles of different BASIC staff in CPH development? (Tick only those mentioned and write out specific responses)
  - Uncle Sam \_\_\_\_\_
  - Mrs. Iroko \_\_\_\_\_
  - Dr. Ayodele/CR. \_\_\_\_\_
  - Ms. Ene: \_\_\_\_\_
  - Dr. Williams \_\_\_\_\_
  - Others \_\_\_\_\_

- 4 What are deficiencies in the contribution of BASICS to the development of the CPH?
- implementation of credit scheme
  - not enough funds given
  - more equipment needed (specify \_\_\_\_\_)
  - more training needed (specify \_\_\_\_\_)
  - others \_\_\_\_\_
5. Aside from meetings organized by BASICS, has your CPH on its own made efforts to link with other CPHs?
- yes  no ----> If yes, give reasons and results
6. What linkages have been established with other resource organizations? (Give names, purpose, results)
- other health services (e.g LGA PHC Dept, LUTH, specialists)
  - other development services (educational, social welfare, etc.)
  - other NGOs (like PPFN, Red Cross, etc.)
  - government bodies/administration (e.g LGA, Ministries)

<i>Level of Community Violence</i>					
<b>How often in this community in the past 6 months would you say that ...</b>	Almost weekly	very often	often	rarely	not at all
VI1. a fight occurred where weapons like knives or guns were used					
VI2. an argument occurred where neighbours hit each other					
VI3. a fight occurred between gangs or groups of youth like area boys or cults					
VI4. someone was sexually assaulted or raped					

VI5. a person was robbed on the street					
VI6. a shop was broken into and robbed					
VI7. a house/flat was broken into and robbed					
VI8. Public officials harassed someone and made him pay to stop the harassment					

*Thank you for your time and help.*

*Signature of Respondent* \_\_\_\_\_ *Date.* \_\_\_\_\_ *Time:* \_\_\_\_\_

### C. CBO/HF LEADERSHIP INTERVIEW

interview one CBO/HF leader per organization that met criteria to join

Date \_\_\_\_\_ Time \_\_\_\_\_ Interviewer: \_\_\_\_\_

#### A. BACKGROUND

- 1 CBO/HF NAME \_\_\_\_\_ affiliation:  CBO  HF  PMV
2. Respondent's Name \_\_\_\_\_
- 3 Respondent's position in CBO/HF \_\_\_\_\_
- 4 Date when took up position: \_\_\_\_\_
- 5 age (or year of birth) \_\_\_\_\_
6. gender  female  male
7. ethnic group  Yoruba  Hausa  Igbo  Other: \_\_\_\_\_
- 8 educational level  none  primary  secondary  post-secondary
9. occupation \_\_\_\_\_
10. religion:  Muslim  Christian  Indigenous African  Other: \_\_\_\_\_
- 11 Is your residence in the same community as the CPH?  yes  no
12. Is the location of your work place in the same community as the CPH?  
 yes  no
13. marital status  
 single  married  separated/divorced  widowed  other. \_\_\_\_\_
14. if married, do your spouse and children live in the same community as the CPH?  
 yes  no ---> if no,  elsewhere in the city  in another town
- 15 Do any of your other relatives live in the CPH community:  yes  no  
if yes, who (e.g aunt, uncle, brother, sister. .) \_\_\_\_\_
16. Do you belong to any other CBOs, clubs, societies or voluntary associations:  
 yes  no ---> if yes, please give names: \_\_\_\_\_  
if yes, please give names: \_\_\_\_\_

**B VIEWS ON CPH AND COMMUNITY**

**1. Current Status of CBO/HF in the CPH**

- a. if joined, please give reasons why
  
- b. if never joined, please give reason why.
  
- c. if joined and dropped, please give reasons why.

**2 What do you see as the mission or purpose of the CPH in your area?**

- child survival                       reduction in diseases
- community health                       women's empowerment
- family health                       clean environment
- others \_\_\_\_\_

**3. What is the benefit or usefulness of the CPH approach to community work (i.e. bringing different CBOs and HFs together)? (Tick all mentioned)**

- sharing knowledge                       making health care accessible
- solving problems                       uniting the community
- helping each other                       making health care affordable
- others \_\_\_\_\_

**4. What are the weaknesses/problems with the CPH approach? (Tick all mentioned)**

- members have different values/approaches       distrust/fear
- different levels of commitment/seriousness       difficult to finance activities
- communication problems       others \_\_\_\_\_

**5. What has been the two major achievements of the CPH in your area?**

- clean environment       increased immunization       reduced health cost
- youth development       women's empowerment       accessible medical care
- cooperation/bring community together                       timely medical care
- coop society                       increased public awareness                       participation/democracy
- others \_\_\_\_\_

**6 What have been the two main problems facing the CPH in your area?**

- lack of finance                       lack of commitment                       poor communication
- lack of cooperation       quarrels                       lack of understanding/awareness

others \_\_\_\_\_

*for those whose organizations are members or former members of the CPH continue with question 7. For others, go to Section C*

7. Please describe your CBO/HF's contribution to the CPH in terms of time and resources

8. How has your organization and its members benefitted from the CPH?

- reduced health care     medical treatment in time     improved health  
 coop society     clean environment     training/skills  
 increased health facility patronage     materials/equipment  
 others \_\_\_\_\_

9. a. How often in the past year did you receive communication from the CPH about its activities and programmes?

- often     sometimes     rarely     not at all

b How does this information reach you

- letters/circulars     verbal reports/feedback from Board Members  
 other ways (specify) \_\_\_\_\_

c Please comment on the quality of communication between the CPH and your own CBO/HF

10 a Are you aware of the Memorandum of Understanding?  yes  no  uncertain

b If yes, what is the purpose of the MOU?

c How has the MOU been of benefit to your organization?

11. a. Have you personally tried to recruit new CBOs into this CPH?  yes  no

If yes, did they join?  yes  no

If joined, give names \_\_\_\_\_

If not joined, why? \_\_\_\_\_

b Have you shared the CPH idea with friends, colleagues and/or other CBOs/HFs outside this community?  yes  no

if yes, who and what was their response?

12 Does your CBO/HF have a member on the CPH Governing Board?  yes  no

a If yes, How does this help the position of your CBO?HF in the CPH?

b If no, how does this affect the position of your CBO/HF in the CPH?

**C. ATTITUDES**

<i>Perceptions of Community Efficacy</i>					
<b>how likely is it that people generally in this community would ...</b>	Very likely	somewhat likely	uncertain	unlikely	very unlikely
CE1. Challenge any children playing in the street instead of going to school?					
CE2. Challenge any child who shows disrespect for an elder					
CE3. try to settle a fight that broke out in front of their house					
CE4 discipline any child who throws refuse in the street					
CE4. Go complain to the LGA is they wanted to close down a local primary school					
<i>Community Interaction and Cohesion</i>					
<b>how likely is it that people generally in this community would ...</b>	Very likely	somewhat likely	uncertain	unlikely	very unlikely
CI1. belong to an association or club inside this community					
CI2. Relate/go talk with their neighbours at least once a week					
CI3. Attend a ceremony organized by their neighbour					

<b>How strongly do you agree or disagree that ...</b>	<b>Strongly agree</b>	<b>agree some</b>	<b>uncertain</b>	<b>disagree some</b>	<b>strongly disagree</b>
CI4 people in this community are willing to help their neighbours					
CI5 This is a community where people know each other well and cooperate					
CI6. people in this community can be trusted					
<b>How strongly do you agree or disagree that ...</b>	<b>Strongly agree</b>	<b>agree some</b>	<b>uncertain</b>	<b>disagree some</b>	<b>strongly disagree</b>
CI7. people in this community generally do NOT get along with each other					
CI8 people in this community do NOT share the same values and interests					
CI9. people in this community feel free to leave their children with neighbours when they go to market					
<b>CPH Functioning</b>					
<b>How strongly do you agree or disagree that ...</b>	<b>Strongly agree</b>	<b>agree some</b>	<b>uncertain</b>	<b>disagree some</b>	<b>strongly disagree</b>
CP1. Some member groups of this CPH are more important than others					
CP2. Board members are willing to commit their personal time and resources to the success of the CPH					
CP3. New members would NOT be welcome in this CPH					
CP4. All members in this CPH are treated as equals					
CP5. Some members work harder for the success of this CPH than do others					
CP6. This CPH is mature and ready to stand on its own now					

CP7 Most members are NOT satisfied with the progress of this CPH					
--	--	--	--	--	--

<i>Level of Community Violence</i>					
<b>How often in this community in the past 6 months would you say that ...</b>	Almost weekly	very often	often	rarely	not at all
VI1 a fight occurred where weapons like knives or guns were used					
VI2 an argument occurred where neighbours hit each other					
VI3 a fight occurred between gangs or groups of youth like area boys or cults					
VI4. someone was sexually assaulted or raped					
VI5 a person was robbed on the street					
VI6. a shop was broken into and robbed					
VI7. a house/flat was broken into and robbed					
VI8. Public officials harassed someone and made him pay to stop the harassment					

*Thank you for your time and help*

*Signature of Respondent* \_\_\_\_\_ *Date:* \_\_\_\_\_ *Time:* \_\_\_\_\_

## D. CORE ACTIVITIES RANKING IN CPH DEVELOPMENT

### *PROCESS COMPONENT ASSESSMENT FORM*

- 1 This form is for BASICS Nigeria staff involved in CPH development to rank the various activities, steps and processes involved in establishing and managing Community Partners for Health. Each person involved with CPHs is requested to complete the attached forms independently. Please do not consult others, but give your own honest opinion.
2. This form is for all CPH Chairpersons to rank the various activities, steps and processes involved in establishing and managing Community Partners for Health. Please give your own honest opinion.

The form contains 3 columns. **Column 1** lists activities that have been performed in setting up the CPHs. If you can think of other activities and trainings that are not mentioned, please add them at the end.

**Column 2** is for your honest ranking of the importance of the activity for success and sustainability of a CPH. Think about this in terms of which activities are essential in the future should new CPHs spring up. Also consider the possibility that BASICS will eventually wind up and that communities may not be able to undertake and afford every single activity that has been done under the present programme. Therefore use the following ranking in Column 3.

A(3) = absolutely essential/required for CPH success and sustainability

B (2)= highly recommended

C (1)= complementary to the programme goals, but not essential/required

D (0)= would not recommend for future programmes

Finally, in **column 3**, please justify your ranking. Give reasons for your choice. If you need more space, continue on the back of the page, indicating which item you are addressing.

Thank you for your timely cooperation. We will meet as soon as everyone has completed the forms to discuss the results.

Bill Brieger  
26 September 1997

Activity/Step/Process	Rank	Justification/Comments
UPSI (BASICS Staff only)		
Community Fora		
Work Plan Workshop/SPP		
MOU		
Constitution		
Registration		
Gifts of Furniture		
Provision of Office Supplies		
Provision of Environmental Equipment		
Provision of Cold Chain Equipment		
Gift of Vehicle		
Having Logo, Letterhead and Brochure		
TBA Training		
WEC Formation		
Youth Wing Formation		
Management Training		
D&G Training		
Distribution of Magaphones		
Capacity Building Exercise		
Establishment of Local Secretariat/Documentation		
Micro-Credit Training & Activities		
Cooperative Society Activities		
Subsidized Health Care Scheme		
Technical Training Workshops in ORT, etc		
City-wide CPH Sharing Meetings		
Community Awareness Campaigns		
IEC Material Development		

## E. FOCUS GROUP DISCUSSION GUIDE

### CBO MEMBERS

Introduction of purpose, moderator, recorder and participants

*Greetings we are working with BASICS to help them learn about how the CPH programme has been working in the community We encourage you to discuss freely and share all your opinions and ideas This will help improve the programme Thank you for your cooperation and time*

1 First, please tell us what you know about the Community Partners for Health programme

*Probe* What is the purpose of the CPH?

*Probe* What are some of the activities/programmes undertaken by the CPH in your community?

2 What do people in your CBO think about the programmes of the CPH?

*Probe* How have the programmes been helpful?

*Probe* How has the programme been of value to women?

*Probe* What are some of the needs/problems that the CPH has not been able to address fully so far?

*Probe* Do people have any complaints about the way the CPH has functioned?

3. Please share with us your personal experiences with the CPH?

*Probe:* Have you or your family members personally benefitted from the CPH?

*Probe:* Do you or your family members personally have any complaints with the CPH?

4 The CPH has engaged in many activities in the community as we discussed above, such environmental sanitation, awareness campaigns against some deadly diseases, and the like Please let us know to what extent members of your CBO have actively participated in these activities

*Probe.* What activities were popular with members of your CBO, that is the activities in which they participated fully?

*Probe* What specific contributions (time, funds, labour, etc ) did your CBO members make towards the success of these activities?

*Probe:* Which activities did not interest your CBO members and why?

5. Have you noticed any changes in this community since the CPH got started? If yes, please describe these changes

*Probe:* Did any of these changes have anything to do with health?

*Probe* Did any of these changes have anything to do with the way people relate to each other in the community and the level to which they participate in community activities?

6. There are many CBOs in this community in addition to those who joined this CPH?

a Are you aware of any of these who now want to join the CPH?

Which ones? Why do they want to join?

b Are you aware of any of these who do not want to join the CPH?

Which ones? Why do they not want to join?

7. Please offer your suggestions on

a) what additional work the CPH should undertake,

b) how the running of the CPH could be improved, and

c) what more could your own CBO do to make the CPH stronger?

## F. IN-DEPTH INTERVIEWS OF COMMUNITY LEADERS

*For each of 6 established CPH's*

### Persons to be Interviewed

- LGA Chairman
- Supervisory Councillor for Health
- PHC Department Head
- MCH Services Head, PHC Department
- Baale (or similar person)
- Head of ethnic communities (e.g. Seriki Hausa)
- Iyalode (or other appropriate women's leader)

### A > Background Information

CPH \_\_\_\_\_ Date \_\_\_\_\_  
Name \_\_\_\_\_ Position \_\_\_\_\_  
Gender \_\_\_\_\_ Years in Position \_\_\_\_\_  
Years living in Community \_\_\_\_\_ ("X" if live outside)

### B > Community Needs

- 1 Please tell us what you think are the three most important concerns of people in this community (use name of community).  
\_\_\_\_\_
2. What has been done so far in this community (use name) to address these concerns

#### PROBES:

- a 1. What has been done about environmental sanitation in this community?
  - 2 Who are some of the prominent groups involved in promoting environmental sanitation in this community?
- b. 1. What has been done about childhood immunization in this community?
  - 2 Who are some of the prominent groups involved in promoting childhood immunization in this community?
- c. 1. What has been done about improving the status of women in this community?
  2. Who are some of the prominent groups involved in improving the status of women in this community?
- d 1 What has been done about making health care more affordable and accessible for people in this community?
  - 2 Who are some of the prominent groups involved in making health care more affordable and accessible to people in this community?

- 3 Please tell me what you have heard about the *Community Partners for Health* in this community

*(If the person says he/she has not heard of the CPH, describe it a group made up of local clinics and community based organizations such as trade associations, religious groups and clubs that works toward promoting the health of children and the community. If the person still insists he/she does not know of the CPH, skip to question 4a)*

PROBES

- a What is the purpose of the CPH?
- b. Who is involved in the CPH?  
*(If not mentioned, ask "What local groups are involved?")*
- c. What are the achievements of the CPH in this community?
- d Have there been any problems associated with the CPH in this community?
- 4 How did you come to hear about the CPH in this area?

PROBES

- a. When is the most recent time you had any contact with the CPH?  
. and what was the nature of the contact?
- b. Have any of the CPH leaders visited you?  yes  no  not certain  
If yes, who?  
*(If the person can't recall, mention the name of the CPH Chairperson; if the respondent still does not recall anything about the CPH or and people connected to it, skip to 4f.)*  
  
If yes, why?
- c. Have you attended any CPH functions?  yes  no  not certain  
  
If yes, which ones?  
  
If no, why not?
- d. Have any members of your family participated in or benefitted from the CPH programmes?  yes  no  uncertain  
  
If yes, in what ways?  
  
If no, why not?
- e. Have you yourself contributed or supported in any way to the CPH and its activities?  
 yes  no  not certain  
  
1 If yes, what were your contributions/nature of your support?

2 If no, why not?

f Do you believe in future that you could have any role in contributing to or supporting growth and activities of the CPH in this community?

yes  no  not certain

1 If yes, what might be your contribution/the nature of your support?

2. If no, why not?

## G. SELF-STUDY GUIDE

Please hold a meeting with all governing board members present to discuss the following items about the development of your CPH. Someone should take minutes of the discussion and a second person should mark the form below. Please submit a copy of the completed form and the minutes to BASICS. Be sure to fill in the "Comments" section with specific examples.

### A. ORGANIZATIONAL STRUCTURE

CPH NAME: \_\_\_\_\_

In our CPH we have ...	fully achieved	partially achieved	just started	not yet	COMMENTS
1 a written constitution, bye-laws or charter					
2 a memorandum of understanding among member CBOs/HFs that includes all current members to-date					
3. a clear policy statement that tells our purpose/mission					
4. officers who all have clearly defined titles, responsibilities, and duties					
5. committees that are appropriate for getting our work done					
6 regular board meetings					
7. regular general meetings					
8. Set realistic and achievable goals					
9 Involved all members in programme planning					

<b>In our CPH we have ...</b>	<b>fully achieved</b>	<b>partially achieved</b>	<b>just started</b>	<b>not yet</b>	<b>COMMENTS</b>
10 A reliable system for communicating and sharing information among our members					
11 a concrete way of ensuring that women play a central role in the CPH					
12 A concrete way to ensure that youth play a central role in the CPH					
13. Made necessary or timely changes in leadership as required					

***B. MANAGEMENT AND LOGISTICS***

<b>In our CPH we have ...</b>	<b>fully achieved</b>	<b>partially achieved</b>	<b>just started</b>	<b>not yet</b>	<b>COMMENTS</b>
1. a secretariat					
2. a well kept system of minutes, records and documentation					
3. adequate furniture for our secretariat					
4 Adequate space for meetings (either at secretariat or with CBOs)					
5. minimal essential equipment for our secretariat (bought or loaned)					
6. appropriate volunteer or paid staff to run the secretariat					

<b>In our CPH we have ...</b>	<b>fully achieved</b>	<b>partially achieved</b>	<b>just started</b>	<b>not yet</b>	<b>COMMENTS</b>
7 adequate volunteers any time we run a programme					
8. an organized in-service training programme for our leaders and members					
9 been able to organize successful fundraising					
10. a clearly defined catchment, service or membership area					
11 involved the general community in contributing resources to ensure our long term success					
12 Established links with other organizations, associations and agencies (governmental, non-governmental and voluntary) within and outside the community to help promote our goals					
13 Established standard referral links with other health services as necessary					
14 Established lasting links with various donor agencies					
15 Set up and maintained a bank account					
16 Established an accounting/auditing system with regular reporting to the CPH					
17 Developed an annual budget for overall organizational management					

<b>In our CPH we have ...</b>	<b>fully achieved</b>	<b>partially achieved</b>	<b>just started</b>	<b>not yet</b>	<b>COMMENTS</b>
18 Actual expenditures and income that match in our budget					
19 Set up regular sources on income from dues, membership, etc					
20 Developed other income generation activities for the sustaining the organization					
21 Set up a monitoring system to get feedback about progress toward our goals - e g immunization coverage					
22 Have a plan for expansion of the CBO/HF membership of the CPH					
23 Hve actually recruited new CBO/HF members into the CPH within the past year					

**C. PROGRAMMING**

<b>In our CPH we have ...</b>	<b>fully achieved</b>	<b>partially achieved</b>	<b>just started</b>	<b>not yet</b>	<b>COMMENTS</b>
1. A written overall plan of action that has been revised/updated as needed					
2. A specific plan of activities for the current quarter (3-month period)					
3. A specific budget for each plan of action or activity					
4 Expenditures that match the budget for each programme					

161

<b>In our CPH we have ...</b>	<b>fully achieved</b>	<b>partially achieved</b>	<b>just started</b>	<b>not yet</b>	<b>COMMENTS</b>
5 A system for reviewing progress on plans and activities					
6 Written reports on each specific activity on an annual basis and when the activity was completed					
7 A health education component of each of our major activities and programmes					
8 Developed locally appropriate health educational materials and activities (e.g. posters, drama)					
9. Engaged in advocacy to ensure that local policy makers are aware of the needs of children, youth, women, mothers and poor people					
10 Planned a comprehensive programme of activities that address all aspects of primary health care.					
11 Adequately trained personnel and volunteers to undertake each programme and activity					
12 Established a good working relationship with the local media: TV, radio, newspapers, magazines					
13. Maintained a regular, standard and reliable childhood immunization programme for the community					

*(Please list any additional activities and achievements of the CPH on a separate sheet and attach.)*

# DOCUMENTATION

A	SAMPLE MEMORANDUM OF UNDERSTANDING	D 2
	A.1 MOU Between CBO and HF Partners . . . . .	D 2
	A.2 MOU Between CPH and BASICS . . . . .	D 8
B	SAMPLE CONSTITUTION . . . . .	D 13

LAGOS ISLAND COMMUNITY PARTNERS FOR HEALTH

A  
PARTNERSHIP FOR CHILD  
SURVIVAL

MEMORANDUM OF UNDERSTANDING

(MOU)

ROLAND HOSPITAL AND MATERNITY  
40, JOSEPH STREET,  
LAGOS ISLAND

MAY, 1996

1 THIS MEMORANDUM OF UNDERSTANDING is made this . . . day of . . . . 1996, BETWEEN

1 1 HEALTH FACILITY

ROLAND HOSPITAL & MATERNITY,  
40, JOSEPH ST , LAGOS ISLAND

1 2 COMMUNITY BASED ORGANIZATIONS

HAPPY CLUB  
107, TOKUNBO ST., LAGOS ISLAND

LAGOS ISLAND HAIRDRESSERS'S ASSOC  
15, RICCA ST., LAGOS

UNITED TAILORING ASSOC ,  
26, RICCA ST., LAGOS

MARQUIS CLUB INT.,  
29, RICCA ST., LAGOS

MARKET WOMEN ASSOC  
14, ESUBI ST , LAGOS

2 OBJECTIVES OF PARTNERS SIGNING THIS MOU

- 2.1 By the end of 1998, reduce the number of children under 5 years getting sick from watery diarrhoea in \_\_\_\_\_ (community) and or/ among the organizational members of \_\_\_\_\_ CPH, and the number dying from dehydration or dysentery despite treatment in a partner health facility.
- 2.2 By the end of 1998, reduce the number of children getting sick with cough (ARI) in \_\_\_\_\_ (community) and/or among the organizational members of \_\_\_\_\_ CPH, and the number dying from acute respiratory infections (ARI) despite treatment in a partner health facility
- 2.3 By the end of 1998, reduce the number of children and pregnant mothers getting sick from malaria in \_\_\_\_\_ (community) and/or among the organizational members of \_\_\_\_\_ (CPH), and the number dying despite contact with partner health facility.
- 2 4 By the end of 1998, increase the immunization coverage in \_\_\_\_\_ (community) and/or among the organizational members of \_\_\_\_\_ CPH, and ensure availability of effective, quality vaccines

165

- 2 5 By the end of 1998, increase the demand for and availability of modern child spacing/family planning services among \_\_\_\_\_ CPH organizational members and health facilities
- 2 6 By the end of 1998, increase the level of awareness of partner organization on epidemiology and control of HIV/AIDS and STDs
- 2 7 By the end of 1998, \_\_\_ CPH is functionally self sustaining, no longer requiring BASICS support to maintain its improved capacity and services, especially in the area of management, financial capability and revenue generation capacity.
- 2.8 Strengthen/expand role of female decision making within \_\_\_ CPH and in .. . . . . . community

**3 NOW IT IS HEREBY AGREED AS FOLLOWS**

- 3 1 The partnership/dyad shall be carried under the name and style of \_\_\_ Community Partners for Health ( \_CPH)  
The partnering of the health facility(ies) and the community-based organizations at the community level is what is here, referred to as the **DYAD** which have mutual responsibilities to ensure the sustainability of the organization
- 3 2 The partnership/dyad shall be a non-discriminatory, non-governmental, non-religious, non-political, non-ethnic, organization
- 3.3 The partnership/dyad shall be voluntary, and shall generate self-sustaining income and pecuniary services from each partner, the general public, government agencies, and donor agencies that may be interested in the partners community projects
- 3 4 The Partners for Health Organization shall be managed by a 5 member Management/Trustee Board named after the partnership, and shall consist of the Chairman, Vice Chairman, Secretary, Assistant Secretary, Treasurer/Financial Secretary who should be elected by at least two thirds of the majority members  
The period of service shall be at least one calendar year, and at most two years  
  
The role of the Management/Trustee Board shall be to see to the smooth running of the organization in terms of ensuring regular meetings (at least once in a month), election of officers to posts, planing, implementing, supervising, monitoring, and evaluating program activities, including financial accountability and sustainability of dyad organization.
- 3.5 At least one or two women must be members of the management/trustee board, and one signatory to the bank account

166



## A - HEALTH FACILITY(IES) PARTNER(S)

- 1 Must be ready to serve in the Board of management, or special committees In collaboration with the CBOs, participate in identification of community health problems, annual workplan and current programs planing, implementation, monitoring, and evaluation. Always working towards sustaining the partnership by encouraging regular meetings, communication, participating in fund raising activities and expansion of partnership size
- 2 Ensure prompt attention to cases referred by the CBO partners, providing quality management for fever, diarrhoea and ARI at the health facility and maintaining appropriate referral system to higher institution of care Referred clients should not be denied care even where the bill for service cannot be settled on the spot, in honor of the laid down agreement. (see B2 below) Charges for service to partners should also be very considerate.
- 3 Ensure that potent vaccines are made available at the facility at all times in collaboration with the efforts of the CBO partners. Outreach immunization services should be provided whenever required in the community. Health Facility(ies) should participate in mass immunization Campaigns from time to time
- 4 Participate in all regular continual education (in & out of health facility) as will be dictated by the staff needs. Assist in the training of CBO partners in home case management of diarrhoea, fever, ARI, measles.
- 5 Provide health education and counselling services on all health matters relating to MCH, FP, HIV/AIDS to CBO partners, using appropriate IEC materials
- 6 Keep proper medical, and health records of all MCH, FP, HIV/AIDS activities , and forward such to appropriate health Authorities e.g immunization records, notification of diseases, etc and participate in capacity building exercise for planning

## B COMMUNITY-BASED ORGANIZATION PARTNERS

- 1 Must be ready to serve in the Board of management, or special committees In collaboration with the HFs, participate in the identification of community health problems, annual workplan and current programs planing, implementation, monitoring, and evaluation. Always working towards sustaining the partnership by encouraging regular meetings, communication, participating in fund raising activities and expansion of partnership size
- 2 Ensure that clients are referred to the health facility in good time for quality management. The referral CBO leader/group will be responsible for ensuring that bills of referred clients (who are not able to pay the health facility on the spot) are paid within a maximum of fifteen days

- 3 Should participate in advocacy for the regular supply of potent vaccines in collaboration with the health facility(ies).
- 4 Participate in all training programs (in & out of the CBO places of work) as will be dictated by the CBO needs Trainers will assist in training other CBO members in home case management of diarrhoea, fever, ARI, and measles
- 5 Provide health education on immunization using IEC materials Mobilize and refer clients to health facilities for immunizations. Participate in contact tracing for completion of schedule Organize mass immunization campaign in collaboration with health facility partners
- 6 Keep proper record and participate in capacity building exercise for local monitoring planning and evaluation purposes

.....  
 BASICS-NIGERIA

.....  
 CHAIRMAN BOARD OF TRUSTEE

.....  
 FEMALE MEMBER OF THE TRUSTEE/BOARD

MEMORANDUM OF UNDERSTANDING

(MOU)

BETWEEN

BASICS-NIGERIA

AND

LAGOS ISLAND COMMUNITY PARTNERS FOR HEALTH  
(LICPH)

ROLAND HOSPITAL AND MATERNITY  
40, JOSEPH STREET,  
LAGOS ISLAND

APRIL, 1996

1 THIS MEMORANDUM OF UNDERSTANDING is made this . . . day of . . . . . 1996, BETWEEN

(a) BASIC SUPPORT FOR INSTITUTIONALIZING CHILD SURVIVAL (BASICS) of Victoria Island, Lagos, and

(b) LAGOS ISLAND COMMUNITY PARTNERS FOR HEALTH comprising

1 HEALTH FACILITY

ROLAND HOSPITAL & MATERNITY,  
40, JOSEPH ST , LAGOS ISLAND

2 COMMUNITY BASED ORGANIZATIONS

HAPPY CLUB  
107, TOKUNBO ST., LAGOS ISLAND

LAGOS ISLAND HAIRDRESSERS'S ASSOC.  
15, RICCA ST , LAGOS

UNITED TAILORING ASSOC ,  
26, RICCA ST , LAGOS

MARQUIS CLUB INT.,  
29, RICCA ST., LAGOS

MARKET WOMEN ASSOC  
14, ESUBI ST., LAGOS

2 OBJECTIVES OF PARTNERS SIGNING THIS MOU

2.1 By the end of 1998, reduce the number of children under 5 years getting sick from watery diarrhoea in \_\_\_\_\_ (community) and or/ among the organizational members of \_\_\_\_\_ CPH, and the number dying from dehydration or dysentery despite treatment in a partner health facility

2.2 By the end of 1998, reduce the number of children getting sick with cough (ARI) in \_\_\_\_\_ (community) and/or among the organizational members of \_\_\_\_\_ CPH, and the number dying from acute respiratory infections (ARI) despite treatment in a partner health facility.

2.3 By the end of 1998, reduce the number of children and pregnant mothers getting sick from malaria in \_\_\_\_\_ (community) and/or among the organizational members of \_\_\_\_\_ (CPH), and the number dying despite contact with partner health facility.

171

- 2.4 By the end of 1998, increase the immunization coverage in \_\_\_\_\_ (community) and/or among the organizational members of \_\_\_\_\_ CPH, and ensure availability of effective, quality vaccines
- 2.5 By the end of 1998, increase the demand for and availability of modern child spacing/family planning services among \_\_\_\_\_ CPH organizational members and health facilities
- 2.6 By the end of 1998, increase the level of awareness of partner organization on epidemiology and control of HIV/AIDS and STDs.
- 2.7 By the end of 1998, \_\_\_\_\_ CPH is functionally self sustaining, no longer requiring BASICS support to maintain its improved capacity and services, especially in the area of management, financial capability and revenue generation capacity
- 2.8 Strengthen/expand role of female decision making within \_\_\_\_\_ CPH and in . . . . . community.

**3. ROLES AND RESPONSIBILITIES OF BASICS**

BASICS project is funded by the United States Agency for International Development and is managed by the Partnership for Child Health Care, Inc. BASICS has established an office in Lagos. BASICS project support to \_\_\_\_\_ Community Partners for Health began on \_\_\_\_\_ and will continue through September 30th, 1998

BASICS will also:

- 3.1 Provide the necessary management support as requested in the first year to allow the program take off.
- 3.2 Provide necessary technical infrastructure development planning, monitoring and administrative support for program development, annual workplan, subproject development workshops as outlined in 3-6.

**3.3 Curriculum Development for Integrated Care, Management & Training of Trainers:**

- Preventive/promotive and integrated case management.
- Leadership and female decision making.
- Organizational strengthening
- STD/HIV/AIDS
- FP/Child Spacing

**Training Types**

- TOT (Training of Trainers)
- Organizational (as indicated)

- 3 4 Develop joint core trainers for \_\_\_ Community Partners for Health
- 3.5 Provide the needed IEC materials in the first year of the program expecting the dyad to be self sustaining by the end of the second year of the program.
- 3 6 Ensure (with support) adequate monitoring/evaluation by the partners
- 3 7 Document and disseminate appropriately partner activities
- 3 8 Ensure transfer/maintenance of adequate communication patterns among members and other partner organizations
- 3.9 Collect success stories of the program and submit for publication.
- 3 10 Encourage annual information sharing meeting between \_\_\_ CPH and other community partners for health
- 3 11 Link partners with other agencies that may be interested in promoting the activities of Lagos Island Community Partners for Health
- 3 12 BASICS may directly procure equipment and/or supplies for the \_\_\_ Community Partners for Health to support project activities when BASICS and Partners determine that such equipment is necessary and is within BASICS' budgetary possibilities Any equipment donated to \_\_\_ CPH is to enter into the \_\_\_ CPH inventory and will be maintained by them.

BASICS will not assume responsibility for maintenance of these equipment.

- 3 13 BASICS will also provide seed monies to establish a revolving credit fund for women these funds will be deposited in a separate Bank account to be operated by the \_\_\_ Community Partners for Health.
- 3.14 BASICS's support to the \_\_\_ Community partners for Health may be terminated for any of the following reasons:
  - termination of BASICS contract by USAID.
  - determination by BASICS that termination in whole or in part of this agreement is in the best interest of BASICS.
- 3 15 BASICS project support to the \_\_\_ Community Partners for Health began in September, 1995, and will continue through September 30th, 1998

4 ROLES AND RESPONSIBILITIES OF PARTNERS (HFs and CBOs)

- 4 1 Must be ready to serve in the Board of management, or special committees In collaboration with the CBOs, participate in identification of community health problems, annual workplan and current programs planing, implementation, monitoring, and evaluation Always working towards sustaining the partnership by encouraging regular meetings, communication, participating in fund raising activities and expansion of partnership size
- 4 2 Partners (HFs and CBOs) should ensure that clients are referred to appropriate centers promptly and that quality integrated case management is made available at all times. Both parties must agree on mutually acceptable ways to resolve issues on bills of referred patients
- 4.3 Partners should participate in advocacy for the regular supply of potent vaccines to the health facility(ies) within the Dyad Community.
- 4 4 Participate in all training programs (in and out of the CBO/HF places of work) as will be dictated by the CBO/HF needs Trainers will assist in training other CBO/HF members in integrated case management of diarrhoea, fever, ARI, measles.
- 4.5 \_\_\_ Community Partners for Health is free to copyright any books, publications or any copyrightable materials first developed in the course of or under this agreement, but BASICS reserves on behalf of BASICS and USAID, a royalty free, non-exclusive and irrevocable, the right to produce, publish or otherwise use and to authorize others to use the publications(s)
- 4.6 Provide health education on immunization using IEC materials Mobilize and refer clients to health facilities for immunizations Participate in baby tracking for completion of schedule Organize annual mass immunization campaign to boost coverage among partner organization and the community.
- 4 7 Keep proper records and participate in capacity building exercise for local monitoring, planning and evaluation purposes

.....  
 BASICS -NIGERIA

.....  
 CHAIRMAN BOARD OF TRUSTEE

.....  
 FEMALE MEMBER OF THE TRUSTEE/BOARD

174

# CONSTITUTION

OF

## AMUKOKO COMMUNITY PARTNERS FOR HEALTH

### CONTENTS

#### **PREAMBLE**

1. SUPREMACY OF THE CONSTITUTION
2. AIMS AND OBJECTIVES
3. FINANCE AND MANAGEMENT
4. MEMBERSHIP
5. ADMISSION
6. DUTIES AND RESPONSIBILITIES OF MEMBERS
7. COMPOSITION AND DUTIES OF BOARD OF TRUSTEES
8. REMOVAL OF TRUSTEES
9. CORPORATE SEAL
10. LEGAL ADVISER
11. PROCEDURE FOR ELECTION
12. MISCELLANEOUS

## P R E A M B L E

Having firmly and solemnly resolved that there should be a set of rules and laws guiding the day-to-day running of the AMUKOKO Community Partners for Health on the basis of unity, fair play, justice and equality, we members of AMUKOKO COMMUNITY Partners for Health do hereby make, enact and give ourselves the following constitution

### 1 SUPREMACY OF THE CONSTITUTION

- 1.1 This constitution shall be constitution of Community Partners for Health (hereinafter called “the Association”) situated in AMUKOKO area of Lagos State (hereinafter called “the Community”) and its provisions shall have binding force on all members of the Association
- 1 2 This constitution shall be supreme and if any other rule, directive or bye-law is inconsistent with this constitution, such other rule, directive and/or bye-law shall be null and void to the extent of its inconsistency with this constitution

### 2 AIMS AND OBJECTIVES

- 2.0 The aims and objectives of the Association are:
  - 2.1. To reduce the number of children under the age of five years getting sick from water diarrhoea in the community and/or amongst the various members of the Association
  - 2.2. To reduce the number of people dying from dehydration or desentry despite treatment in members’ health facilities.
  - 2 3 To reduce the number of children getting sick with cough in the community and/or amongst members of the Association and the number dying from Acute Respiratory Infections (ARI) despite treatment in members’ health facilities
  - 2 4 To reduce the number of children and pregnant mothers getting sick from malaria in the community and/or amongst members of the Association and the number dying despite contact with members’ health facilities.
  - 2 5 To increase the immunization coverage in the community and/or amongst members of the Association and ensure the availability of effective quality vaccines.
  - 2 6 To increase the demand for and availability of modern child spacing/family planning services amongst members of the Association
  - 2 7 To increase the level of awareness of members on epidemiology and control of HIV/AIDS and other sexually transmitted diseases (STDs)
  - 2.8. To make the Association functionally self sustaining; or no longer requiring Basic

Support for Institutionalizing child survival (BASICS) and to maintain its improved capacity and services especially in the area of management, financial capability and revenue generation capacity

- 2 9 To strengthen and/or expand role of female decision making amongst female members of the Association in the community

### **3 FINANCE AND MANAGEMENT**

- 3.1. The Association shall keep bank accounts in any bank as may be determined by the Trustees from time to time.
- 3 2 All Association's monies not required for current expenses shall be paid promptly into the Association's Account by the Treasurer and all securities for money shall be promptly deposited within two days into the account of the Association.
- 3 3 All cheques, bills and other negotiable instruments shall be signed by the designated signatories namely Chairman, Treasurer/Financial Secretary and another member of the board of Trustees who MUST be a female (where Chairman and Treasurer/Financial Secretary are not female) In the absence of the Chairman, the Vice Chairman shall be signatory in place of the Chairman
- 3 4 No cheques, bills or other negotiable instruments shall be honoured by the bank unless signed by the aforementioned signatories
- 3 5 The Treasurer/Financial Secretary shall ensure that there are proper books of account showing appropriate accounting procedures of the Association and business transactions which shall be kept and properly posted and all entries made therein of all matters transacted in the name and on behalf of the Association
- 3.6 All records of the Association shall be kept in a place agreed upon by members and shall be made available at all reasonable times for inspection by any of the members and auditors
- 3.7. There shall be a review of Accounts every six (6) months by selected members of the Association
- 3 8. The accounts of the Association shall be audited yearly by an appointed external auditors

### **4 MEMBERSHIP**

- 4 1 Membership of the Association shall be open to all persons and community based organisation (hereinafter called DYAD) which shall have mutual responsibility of ensuring the sustaining income and pecuniary services from each member, the general

public, government agencies and donor agencies that may be interested in the community projects of the Association

## **5 ADMISSION OF MEMBERS**

5 1 Admission procedure for new members shall be as follows.

- (a) A person, community development association or health institution who desires to join the Association shall apply in writing to the Trustees and obtain an application form at a fee to be determined by the Trustee,
- (b) face an interview panel to be constituted by the board of trustees,
- (c) after becoming successful in the interview be given an admission upon payment of non-refundable N500 00 admission fee or any sum that may be fixed from time to time as well as submit his/her profile

## **6 DUTIES AND RESPONSIBILITIES OF MEMBERS**

6 1 Members shall at all times show utmost commitment and responsibilities towards ensuring the fulfilment of the aims and objectives of the Association

6.2 Health Facility members (hereinafter referred to as "HF") shall be ready to serve on the board of Trustees.

6.3. HF members shall in collaboration with the community based association/organisation (CBO) participate in identification of community health problems, annual work plan and current programs planning implementation, monitoring and evaluation.

6 4 HF members shall work towards sustaining the association by encouraging regular attendance of meetings, communication, participation in fund raising activities and expansion of members' size

6.5 HF members shall ensure prompt attention to cases referred by the CBO members and provide quality management of fever, diarrhoea and ARI at members health facilities as well as maintain appropriate referral system to higher institution of care and for the avoidance of doubt referred clients shall not be denied care even where bill for service given cannot be settled on the spot in honour of the understanding that the leader of the referral CBO shall ensure that bills are settled within a maximum period of 15 days.

6 6 HF members shall ensure that potent vaccines are made available at the members' health facility at all times in collaboration with the efforts of the CBO members And outreach immunization services should be provided whenever required in the community while members' health facilities should participate in mass immunization campaigns from time to time.

- 6.7 HF members shall participate in all regular continual education (in and out of health facility and/or CBO) as may be dictated by staff needs and assist in the training of CBO members in home case management of diarrhoea, fever, ARI and measles.
- 6 8 HF members shall provide health education and counselling services on all health matters relating to Maternal and Child Health (MCH), Family Planning (FP), HIV/AIDS to CBO members, using appropriate I E C materials
- 6.9. HF members shall keep proper medical and health records of all MCH, FP, HIV/AIDS activities and forward such to appropriate health authorities and participate in capacity building exercise for planning.
- 6.10 All members shall ensure full compliance with the terms and conditions contained in the memorandum of understanding duly executed between members inter se
- 6 11 Community based organisation (CBO) members shall be willing and ready to serve on the board or special/ad hoc committee and shall in collaboration with the Health Facility members (HFs) participate in the identification of community health problems, annual work plan and current programmes planning, implementation, monitoring and evaluation.
- 6 12 CBO members shall ensure that clients/patients are referred to health facility in good time for quality management and the referral CBO leader/group shall be responsible for ensuring that bills of referred patients who are unable to pay the health facility instantly are paid within a maximum period of fifteen (15) days
- 6.13 CBO members shall in collaboration with Hfs participate in advocacy for regular supply of potent vaccines to the health facilities.
- 6 14. CBO members shall participate in all training programmes as may be dictated by CBO needs especially in training in home case management of diarrhoea, fever, ARI and measles
- 6.15. CBO members shall provide health education on immunization using Information, Education and Communication (IEC) materials; mobilize and refer patients/clients to health facilities for immunization as well as participate in contact tracing for completion of schedule.
- 6.16. CBO members shall in collaboration with HF members organise mass immunization campaign
- 6 17. CBO members shall keep proper record and participate in capacity building exercise for local monitoring, planning and evaluation purposes

## **7 COMPOSITION AND DUTIES OF BOARD OF TRUSTEES**

7 1 There shall be established for the Association a eight (8) member Board of Trustees made up of

- (a) Chairman
- (b) The Vice Chairman
- (c) The Secretary
- (d) The Assistant Secretary
- (e) The Treasurer/Financial Secretary
- (f) Three (3) ex-officio members

7 2 The board of Trustees shall be elected by at least two-third majority of members of the Association.

7 3 Members of board of Trustees shall hold office for two (2) years with liberty to seek re-election. A trustee shall not hold office for more than two terms

7 4 Election into the board shall hold every two (2) years.

7.5. There shall be at least one female member of the board of Trustees who shall also be signatory to the accounts of the Association.

7 6. The board of Trustees shall be responsible for the smooth running of the Association and for the avoidance of doubt all executive functions are hereby vested in the board of Trustees without prejudice to the right of the board of Trustees to delegate any of its functions to committees and other members

7.7. The board of Trustees shall be responsible for planning, implementing, supervising, monitoring and evaluation programme activities of the Association including financial accountability and sustainability of the Association.

7.8. The Chairman shall preside over all meetings of the board and in his/her absence the vice chairman And in the absence of both chairman and vice chairman by any member of the board nominated to preside

7 9 All secretarial/administrative duties are hereby vested in the secretary who will be assisted by the assistant secretary

7 10 The Treasurer/Financial Secretary shall receive all payments and ensure that proper records and books are kept in relation to all financial transactions of the Association

7 11. The board of Trustees shall be the custodian of all properties of whatever form, movable or immovable that may belong to the Association.

7.12 All consultative, advisory, investigative and legislative functions shall be vested in the

board of Trustees

- 7 13. Whenever it shall be necessary to convene the meeting of the board, the secretary shall issue necessary notices duly served on all members of the board

8 **REMOVAL OF TRUSTEES**

8 1 A trustee shall cease to hold office if

- (a) he resigns his office
- (b) he ceases to be a member of the Association
- (c) he is officially declared bankrupt
- (d) he is convicted of criminal offence by court of competent jurisdiction
- (e) he is recommended for removal from office by the board of Trustees or not less than ten members of the Association and the recommendation is supported by simple majority of vote of members present at the meeting of the Association

9 **CORPORATE SEAL**

9.1 The Association shall have a common seal which shall be kept in the custody of the Secretary who shall produce it when required by the board

9 2. The seal of the Association MUST be affixed to all formal and official documents of the Association and lack of it shall render any such document invalid.

10 **LEGAL ADVISER**

10 1. The Association shall have a Legal Adviser who shall from time to time advise the Association on legal issues.

11 1. Three members of board of Trustees of the Association shall be appointed electoral officers for the purpose of supervising election provided that no member seeking re-election shall participate in the supervision of any election.

12 **MISCELLANEOUS**

(a) **Amendments**

- 1. The constitution may be amended upon resolution passed by simple majority of members
- 2. Any memorandum for the amendment of the constitution shall be made in writing and sent to the secretary who shall upon receipt of such memorandum give at least seven (7) days notice to members of the Association.

12 (b) Quorum

- 1 Quorum for the board of Trustees shall be Five Trustees
- 2 Quorum for meetings of the Association shall be simple majority
- 3 For purposes of election a quorum shall not be formed unless at least two-third of members of the Association are in attendance.
- 4 For purposes of amendment of the constitution not less than two-third of all members shall form a quorum.
5. Where the quorum prescribed by this constitution for election cannot be attained and election cannot hold the trustees shall continue in office for not more than three months and shall within the three months arrange for election to appoint new trustees
- 6 Nothing in the preceding sub section shall preclude the Association from extending the period within which election shall take place

DATED THIS .. .. . DAY OF  
... . . . . .1996

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182