

# Community Partners For Health:

*Working Together to Promote Child Survival*



 **BASICS**

## **BASICS**

BASICS is a global child survival support project funded by the Office of Health and Nutrition of the Bureau for Global Programs, Field Support, and Research of the U.S. Agency for International Development (USAID). The agency's Child Survival Division provides technical guidance and assists in strategy development and program implementation in child survival, including interventions aimed at child morbidity and infant and child nutrition.

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### **Abstract**

As the USAID-funded Basic Support for Institutionalizing Child Survival (BASICS) project began to plan a program in urban Nigeria, continuing political upheaval caused the U.S. to press sanctions forbidding work with the Nigerian government. Faced with rapidly declining immunization rates coupled with data indicating the presence of a robust private sector, BASICS designed an Urban Private Sector Inventory (UPSI) tool to identify and assess the private health sector and community-based organizations in urban Lagos, Nigeria. A plan for a private sector partnership approach to improving child health in Lagos began to unfold. This tool provided a detailed mapping and accounting of the private sector in Lagos's sprawling low income neighborhoods. From the UPSI results, community-based organizations and modern private health clinics that met established criteria were brought together to form six community partners for health (CPHs). The CPHs offer an innovative community approach to addressing child health issues using existing community resources and locally-based decisionmaking complemented with outside technical assistance to improve child health. Diverse community groups have successfully partnered with neighboring private health facilities to carry out a wide range of child survival activities that also improve the member's organizational, management, and governance skills.

### **Contributors**

This summary, prepared by Paula Tarnapol Whitacre, is based on the following unpublished reports, available from BASICS: Silimperi, Diana R., Rose M. Jallah Macauley, J. O. Ayodele, and Sam Orisasona. 1998. *Urban Private Health Sector Inventory: A First Step in Mobilizing Private Initiative for Child Survival*; Silimperi, Diana R., Rose M. Jallah Macauley, J. O. Ayodele, Sam Orisasona, and Cecilia Williams. 1998. *Lagos Community Partners for Health: Innovative Private Sector Partnerships Promote Child Survival*; Brieger, William R., and Peter Bolade Ogunlade. 1998. *Documentation Exercise: A Process Evaluation of the Community Partners for Health Program of BASICS, Nigeria*; and Pyle, David F. 1997. *Support of Monitoring and Evaluation Component of BASICS/Nigeria Program*. BASICS staff reviewing this summary included Hezekiah Adesina, Robin Anthony, Carolyn Kruger, Pamela Marsh, Robert Northrup, and Todd Shenk.

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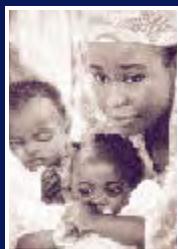


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# Acronyms

<b>BASICS</b>	Basic Support for Institutionalizing Child Survival Project
<b>CPH</b>	Community Partners for Health
<b>CBO</b>	community-based organization
<b>CDC</b>	Centers for Disease Control and Prevention
<b>EPI</b>	Expanded Programme on Immunization
<b>LGA</b>	local government area
<b>MOU</b>	memorandum of understanding
<b>NCCCD</b>	Nigeria Combatting Childhood Communicable Diseases
<b>NGO</b>	nongovernmental organization
<b>NID</b>	national immunization day
<b>ORS</b>	oral rehydration solution
<b>PMV</b>	patent medicine vendor
<b>REACH</b>	Resources for Child Health
<b>TBA</b>	traditional birth attendant
<b>UNICEF</b>	United Nations Children's Fund
<b>UPSI</b>	Urban Private Sector Inventory
<b>USAID</b>	U.S. Agency for International Development

# Introduction

**A** recent trend in international development involves tapping the private sector as a potential partner to assist overburdened and underfunded public sectors to improve critical health and human services. These partnerships are often praised as the way to involve stakeholders and maximize scarce resources to achieve a common development goal. The formation of successful private sector partnerships requires careful selection of partner organizations, clear identification of goals and objectives, and focused technical assistance to assist the partnerships in carrying out their mission. Often, however, despite the best of intentions, partnerships begin on an optimistic note but then flounder. One or more causes—such as a lack of money, initiative, or internal cohesion—stall the effort, and the energy that went into bringing a diverse group of partners together cannot be sustained.

Yet, a partnership model developed in Lagos, Nigeria—one of the most densely populated cities in Africa—holds promise as a way to maintain activity and enthusiasm to benefit, in this case, child health. The Community Partners for Health (CPH) program, designed by the Basic Support for Institutionalizing Child Survival (BASICS) project, bring private health facilities and community-based organizations (CBOs) together in low-income neighborhoods in Lagos. Lagos was selected as the initial site for BASICS' work because of its rapid urban growth and indication of a growing, robust private health sector. Prior to BASICS, the United States Agency of International Development (USAID) had funded an immunization program that included Lagos, but worked with the public sector. For this project, USAID hoped to link the private sector with the community through the CPHs, drawing on the community's capacity to create their own solutions and resources to improve child survival in their neighborhoods.

The project began in 1994 as an urban immunization project tasked with reversing an alarming national trend of decreasing immunization coverage. BASICS was to work with the government, but a ban on U.S. government funding of Nigeria's public sector because of the military's annulment of national elections forced USAID and BASICS to redesign the project. A new, more innovative approach emerged aimed at identifying potential health partners in the private sector in some of Lagos's most underserved communities. Using carefully selected criteria and the shared goal of improved child health, unique partnerships were created between private sector health providers and community-based organizations in six communities.

In Nigeria, the private sector attempted to fill the void created by a decline in public health services. There was an active civil society in which CBOs and other nongovernmental organizations (NGOs) proliferated. The CPH model provides an innovative solution to meeting the needs of the people where public sector services are inadequate and the private sector has the potential to provide a significant level of health services.

While the model requires supervision and targeted technical assistance to provide the partnerships with a solid foundation, the partnerships are responsible for maintaining financial

sustainability and carrying out their chosen health activities. This type of participatory model that focuses on sustainability from the beginning and uses existing, latent community resources has application well beyond Nigeria. The model offers agencies working with urban areas in developing and developed countries a program that not only integrates different groups of people to work for a common cause, but does so by empowering them to identify and prioritize their needs and allowing them to creatively use their community's resources to fulfill those needs.

Although it is too early to evaluate long-term impact, one indication of the model's benefit is the number of people that the CPHs have mobilized to improve maternal and child health. An estimated 250,000 people in Lagos and 640,000 people in Kano have a direct connection with the existing CPHs as members of one of the CBOs or clients of one of the health facilities. Indirect impact via CPH members' contact with extended family and friends is estimated at 1.7 million in Lagos and 4.3 million in Kano. As another indication of success of the CPH model, new groups are requesting to join existing CPHs or form new partnerships, despite the sizable commitment that CPH membership requires.

Over the past five years, BASICS' technical interventions have been built on the premise that an integrated approach to health care—an approach that treats the whole child as opposed to treatment for a single disease—provides children with the best chance of survival from disease. BASICS staff and collaborators have developed research and field activities that look at case management in the home (including caretakers' preventive measures); the interface between the home and outside services (including caretakers recognizing when they should seek outside treatment for a sick child); and case management outside the home (including health facilities' capacity to provide appropriate care).

A conceptual framework entitled the Pathway to Survival (see figure 1), developed by BASICS, USAID, and the U.S. Centers for Disease Control and Prevention (CDC), assists health program planners in the development and monitoring of a more holistic and integrated approach to the management of childhood illness. It acknowledges that most care of childhood illness occurs outside health facilities and that caretaker recognition of illness and provisions of care are critical components. For example, caretakers promote wellness within the home by breastfeeding and by providing adequate nutrition to their children. The community promotes the health of its children by providing adequate water, sanitation, and other services. When a child is ill with a potentially life-threatening disease, a combination of behaviors of the caretaker, such as knowing when to seek outside care, and the quality of service that the practitioners provides, determine whether the child recovers.

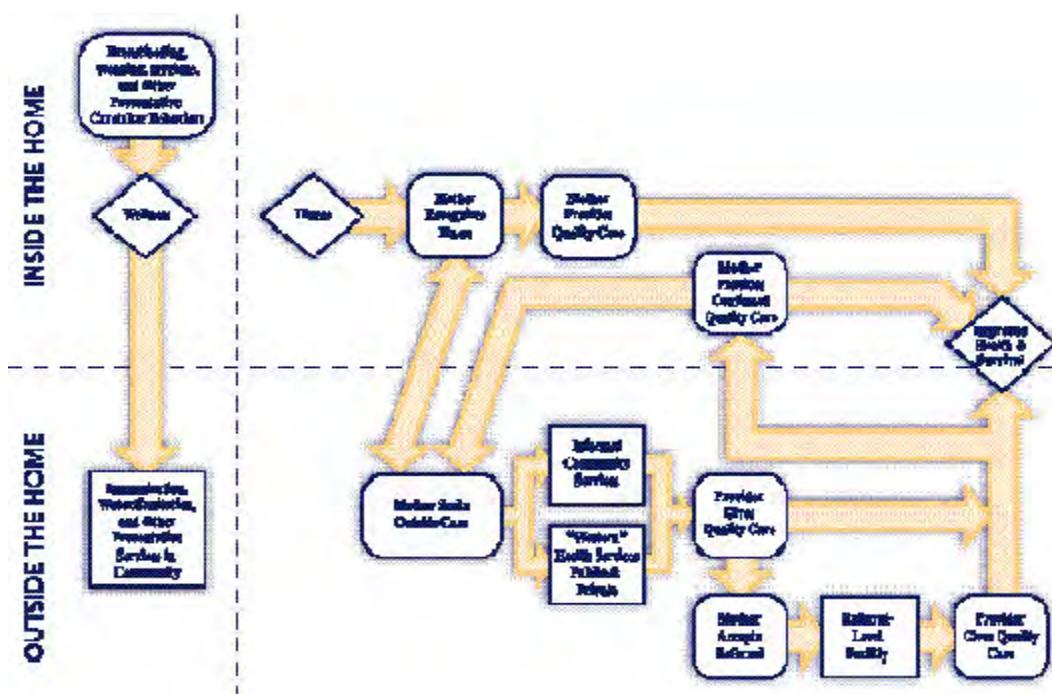
In looking at the Pathway to Survival in the context of the Nigerian CPHs, BASICS found that the CPHs have the potential to affect all of the behaviors and decision points along

the Pathway, resulting in an increase in child survival. As seen in the CPH activities of the past three years, CPHs can strengthen the link between families and the health facilities in their community. CPH outreach programs can teach or reinforce health-improving behaviors within the home. The partnership can also mobilize communities to advocate for improved sanitation and for increased participation in immunization days, as well as to organize the infrastructure to provide affordable quality care at private health facilities. Outside technical assistance from the implementing agency can help teach health workers new skills to be better health providers and improve the health facility's services to the community.

Preliminary indicators show that community mobilization and other CPH efforts are having a positive effect on the number of children receiving immunizations, proper nutrition and breastfeeding, and other care. In a situation like that in Lagos, in which inadequate or nonexistent public health services characterize many communities, it appears that this private-sector focus on the Pathway to Survival will lead, in time, to measurable results.

As the memberships of the CPHs have shifted and expanded in Lagos, and the process has been replicated in northern Nigeria, in Kano, a city with very different demographics and cultural characteristics than Lagos, it has become clear that the initial work from

Figure 1: The Pathway to Survival



Lagos can be adapted to different circumstances with success. In the case of the development of the Kano CPHs, adaptations to the UPSI resulted in reducing the up-front costs of partnership formation from the original model. This report describes how the Community Partners for Health were formed, some of the obstacles they overcame, and factors that should be considered in replicating or adapting the model elsewhere.

First, *Community Partners for Health: Working Together to Promote Child Survival* describes the Urban Private Sector Inventory (UPSI), a methodology developed by BASICS to identify and characterize two main categories of potential private-sector partners: CBOs and private health providers, including both comprehensive care facilities and medicine sellers. Thirteen communities were chosen based on demographic and socioeconomic considerations. They were surveyed to identify the CBOs and private health providers operating within the communities. These organizations were then visited individually to find out how many entities exist, where they operate, and how they provide and fund their services to the community, especially regarding health. The UPSI served the purposes of assessing in a purposive way details regarding the operation and strength of organizations, especially regarding health and providing the basis for choosing entities as partners and issues of success as partners.

Next, the report explains how the six pilot partnerships formed and what they have accomplished. BASICS served as the initial catalyst in facilitating a series of community-wide discussions, suggesting ways to set up the governance structure in each of the six partnerships and conducting workshops so that each partnership could draft a work plan with emphasis on child health issues. BASICS continues to provide technical assistance in implementation and evaluation of the CPHs. The BASICS' approach was clearly a departure from most donor projects—it does not fund the partnerships. From the outset, the CPHs understood and accepted that their existence depended on their own initiative.

Finally, the report provides an analysis of some of the ingredients in the success of the CPHs to date and the next steps for the partnerships in Nigeria. The CPH model has been shown to be an effective way for private-sector partners to collaborate on pressing community health issues to improve the health status of children. Program planners interested in applying the approaches described may contact BASICS to obtain additional documentation that describes the model and implementation process in greater detail.





# 1

## Identifying and Characterizing Potential Partners to Support Child Survival

**U**SAID has supported Nigeria's Expanded Programme on Immunization (EPI) since the 1980s. USAID contributed to Nigeria's accelerated immunization effort by providing technical assistance, equipment, and training through the Nigeria Combatting Childhood Communicable Diseases (NCCCD) Project. BASICS' predecessor project, Resources for Child Health (REACH) began work in Nigeria in mid-1992 with the aim of improving the quality and coverage of urban EPI in metropolitan Lagos. While REACH was able to stimulate interest and activities within the Federal and Lagos State Ministries of Health and 15 local government areas (LGAs) in Lagos, efforts were thwarted by increased civil unrest, prolonged strikes in the city, and the government's diminishing availability of funds for immunization services.

By mid-1994, the manner in which BASICS could work in Nigeria on an immunization program changed. BASICS had continued activities begun by the REACH project until the U.S. government placed a ban on funding Nigeria's public sector because of the Nigerian government's annulment of democratic elections in 1993. The USAID mission in Lagos requested that BASICS design a project to address the rapidly deteriorating immunization rates and health status amongst Nigeria's children, particularly in the urban areas.

A private-sector focus to the program plan resulted, partly in response to the government sanctions. In addition, the population of Lagos was rapidly expanding and an unpublished USAID study in 1995 indicated the public sector could not keep up with the demand for health, sanitation, and other basic services. The study also reported that national rates of immunization coverage and many indicators of child health had declined since the early 1990s. As a result, Lagos' private health sector was providing an increasing percentage of health services. The BASICS/Nigeria program worked with the private sector, helping to identify potential health partners and creating community groups that could mobilize its members to improve child health.

Despite the widespread perception of the dominant role of the private sector, accurate identification of the participants in this sector was problematic. Lagos is one of the poorest and most densely populated in the world, and no directories or comprehensive listings existed to identify these private facilities or assess the services they provided. Thus, BASICS' first challenge was to target a workable number of low-income communities and then systematically gather information on the numbers, types, and characteristics of the health providers and facilities in each of these communities.

In addition to the for-profit providers of medical services and drugs, not-for-profit NGOs were perceived as playing an active role in health education and other preventive activities. It was generally accepted that a large and diverse group of social, religious, youth, professional, and other CBOs proliferated throughout the city. These CBOs could serve as a trusted source of

information on health issues to their members and families, leading to changes in home health behaviors. Given direction and support, they might also serve as a bridge between the community and the health facilities located within it. Yet CBOs, like the private health facilities, were largely unidentified, and their capacity to carry out activities was largely undetermined. Which were the active organizations? Where were they located? Which CBOs had track records of success?

To answer these questions, BASICS designed and implemented the UPSI, a multiple component survey methodology. The UPSI had three short-term objectives:

1. Locate all the private health providers, community-based organizations, and medicine vendors within designated community boundaries.
2. Gather basic information about their operations.
3. Select an initial group of participants by comparing their UPSI responses against a list of criteria that seemed to indicate that they would be successful and motivated members of a private-sector health partnership.

Longer-term use of the findings that make up the UPSI database was also envisioned, including program monitoring and the generation of data for local decisionmaking and capacity building.

In many cities, an assessment of private sector capacity would be time-consuming but fairly straightforward. In Lagos, however, the absence of any comprehensive listing of providers or CBOs, combined with a lack of accurate street maps and a

deteriorating infrastructure, made the task much more difficult. The private health sector encompasses for-profit and non-profit facilities, modern and traditional practitioners, formal clinics and informal providers, and medicine sellers ranging from hospital-based pharmacies to unlicensed street vendors. CBOs include members of the same religion, ethnic group, occupation, age group, or sex, and hundreds exist throughout the city.

## **Identifying and Assessing the Players**

Using data from the Federal Office of Statistics in Lagos, the Nigeria Demographic and Health Survey of 1990, and a 1993 retrospective study of high-risk neighborhoods in Lagos conducted on behalf of BASICS/REACH, five LGAs were selected on the basis of their degree of urbanization, population size, adverse public health risk or health status, and socioeconomic status. Data also indicated immunization rates were dropping in Lagos and that there was a growing private participation in immunization services. Looking to work with the private sector, BASICS began the process of surveying the high-risk communities to ascertain the feasibility of a private sector urban immunization program. Five LGAs were chosen: Ojo, Shmolou, Mushin, Lagos Island, and Lagos Mainland (see figure 2). The criteria were then applied and 13 communities were selected within these LGAs.

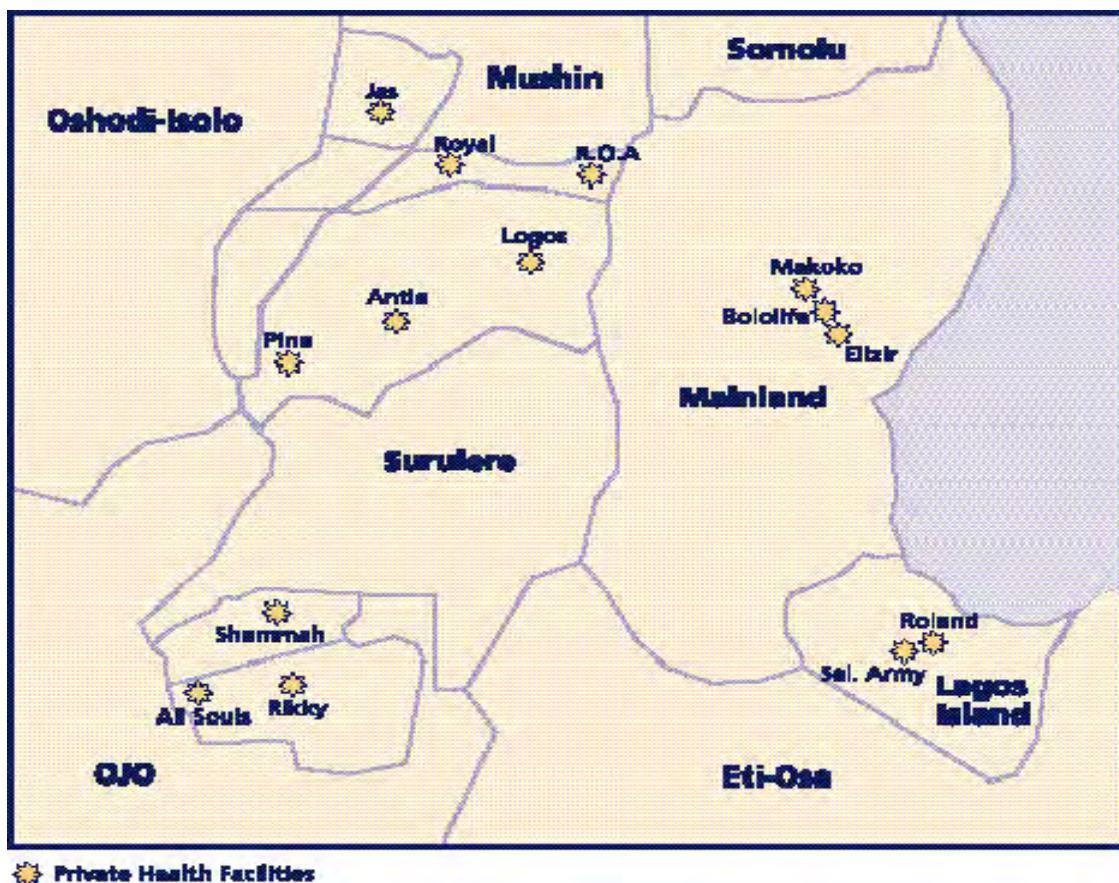
The survey team, consisting of a principal investigator, two field supervisors, and twenty-one interviewers, carried out the inventory in the selected thirteen communities.

They participated in six days of training: two days of initial training on interviewing techniques and data collection, two days of pretesting the questionnaires in the field, and two days of follow-up training once the questionnaires were revised, based on the results of the pretest. The pretest uncovered potential problems with the questionnaires and introduced the interviewers to the on-the-ground realities of conducting the inventory. For example, because the team encountered problems with the length of the questionnaire for the health facilities, a shortened questionnaire was developed, and the interviewers learned how to respond to the time factor, such as scheduling a follow-up session to complete the questionnaire at the respondents' convenience.

The team used three methods to locate the health facilities and CBOs for the inventory:

- ◆ They reviewed registries of providers kept by governmental or professional organizations (although these were rarely available, difficult to obtain, and often incomplete).
- ◆ They conducted interviews with key informants in the community, including health facility workers, community development officers, local ward leaders, traditional and religious leaders, representatives of professional organizations, and health providers.
- ◆ They walked street by street in a designated area to verify street names and community boundaries and to look for signboards and other evidence of

Figure 2: Map of Lagos



operations, in what were termed "rapid street assessments" and "visual surveys."

The rapid street assessment and visual survey methods, although labor intensive, revealed almost two hundred streets not depicted on any Lagos city map and numerous signboards for small clinics, traditional healers, medicine stalls, and other facilities that would otherwise have been missed.

After locating the entities, the survey team then interviewed the leaders of the organizations, administering questionnaires to collect basic information to assess their

potential for impact on improving child health and playing an active role in partnership activities. The interviewers were trained to request an interview with the director or leader of the entity to administer the questionnaire. The questionnaires for the CBOs and medicine sellers each took about 30 minutes to administer; the questionnaire for the health facilities took 60 minutes. Figure 3 shows the UPSI information gathered.

Over a period of eleven days, each interviewer inventoried between three and eight streets a day. Massive traffic jams, the

**Figure 3: UPSI Information Collected from Each Type of Organization**

<i>Type of information requested</i>	<i>CBOs</i>	<i>Health facilities</i>	<i>Pharmacies/ chemist shops &amp; PMVs</i>
<b>Identification</b>	x	x	x
name	x	x	x
address/location	x	x	x
head of organization	x	x	x
<b>General information</b>	x	x	x
years of duration	x	x	x
type of organization	x	x	x
membership	x	x	x
staffing	x	x	x
profit status	x	x	x
general finances	x	x	x
status of registration with the local or national govt.		x	x
<b>Immunization services</b>		x	x
schedules		x	x
vaccine source		x	x
cold chain		x	x
outreach		x	x
EPI		x	x
staff training		x	x
reporting		x	x
fees		x	x
<b>Health program experiences</b>	x		
Services and referrals		x	
Client profiles		x	x
Financial system		x	

accessibility of roads (especially after bad weather), the number of facilities on a street, and other factors affected how many streets an interviewer could cover per day. In total, the team identified 395 CBOs, 330 health facilities, and 414 medicine sellers and they administered the questionnaires to most of them. Although the UPSI was designed to gather general information and did not ask for any subjective judgments or assessments on the part of the interviewers or the respondents, the responses revealed some of the strengths and weaknesses of each organization surveyed.

## Using the Findings

Based on the data from the UPSI, BASICS developed general criteria to select which communities, and which organizations and providers within those communities, might be approached to become members of the partnerships for health. This general information provided a way to make objective what could have become highly personal or controversial selections.

The general information collected from the UPSI contributed to the decisionmaking process to select six target communities from among the 13 inventoried. It included—

- ◆ absolute numbers of CBOs and health facilities per community
- ◆ types of CBOs and health facilities
- ◆ number of CBOs or health facilities with the largest potential impact, based on staff or membership size and current service population/patient load
- ◆ networking potential of the CBOs and health facilities to work with broad groups of community members

The general information, along with data about population size and public health need, was incorporated into a matrix that ranked the 13 communities. The six communities invited to form the first Community Partners for Health were Ajegunle and Amukoko in Ojo LGA, Mushin Proper in Mushin LGA, Alapere in Shomolu LGA, Ward E in Lagos Island LGA, and Makoko LGA (see figure 4). These six communities have a total population of nearly 1 million, approximately 183,000 of who are under age 5. There were 144 health facilities and 241 CBOs identified by the UPSI within these communities. To identify optimal CBO and health facility partners, BASICS developed further criteria to determine the optimal composition of the partnerships (see figures 5 and 6).

## Issues regarding the UPSI

The UPSI was designed as a results-oriented tool to inventory what had been an unknown pool of private-sector organizations. The survey instrument was intended to be easy to administer and tabulate. The interviewers were not trained social science researchers; in fact, BASICS was quite deliberate in hiring people who could develop the skills and, therefore, build local capacity for future survey work. The team worked under extremely tight deadlines and arduous conditions. One of the strengths of the UPSI inventory is that it is a pragmatic and powerful tool designed for use by local organizations and individuals.

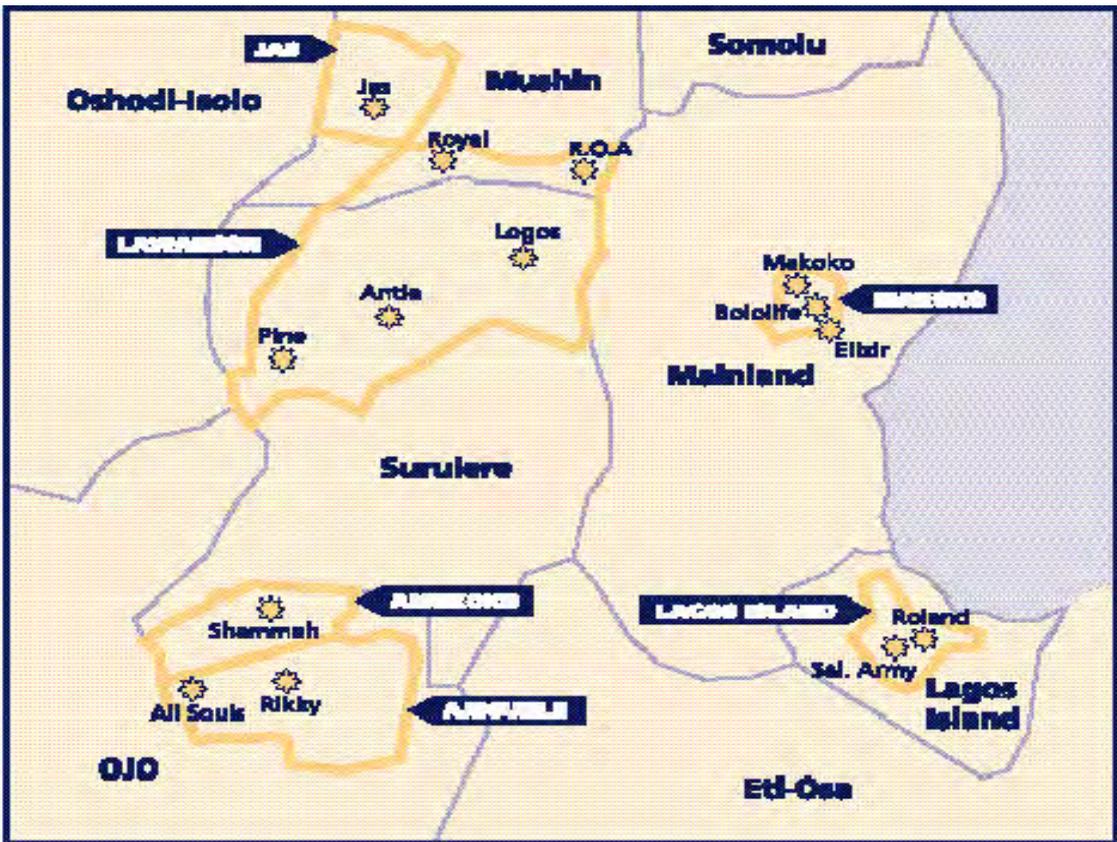
Further experience with the UPSI in Kano, however, as well as considering how the

UPSI might be used elsewhere, suggest that there were weaknesses in the inventory as it was conducted the first time.

Some observations included—

- ◆ Six days devoted to training and pretesting the survey forms were not enough for the team. More time, especially for the pretesting of forms in the field and revising them, would likely yield more reliable results.
- ◆ The UPSI in Lagos had a supervisor-to-interviewer ratio of one to ten. More supervision, particularly of an inexperienced team, would provide greater quality control. For example, in a verification exercise conducted at the end of the inventory, the supervisors discovered that the interviewers probably underestimated the total number of traditional healers.
- ◆ The length of the questionnaire should be as short as possible. The questionnaire that was used with health facilities took one hour to administer. Even with dividing the interview into more than a single visit, it was too long a questionnaire for busy facility directors.
- ◆ Sufficient attention must be paid to the logistics of conducting such an inventory. Transport time, interviewer safety, and

Figure 4: Map of Lagos



processing of data, were issues that were critical to the success of the endeavor.

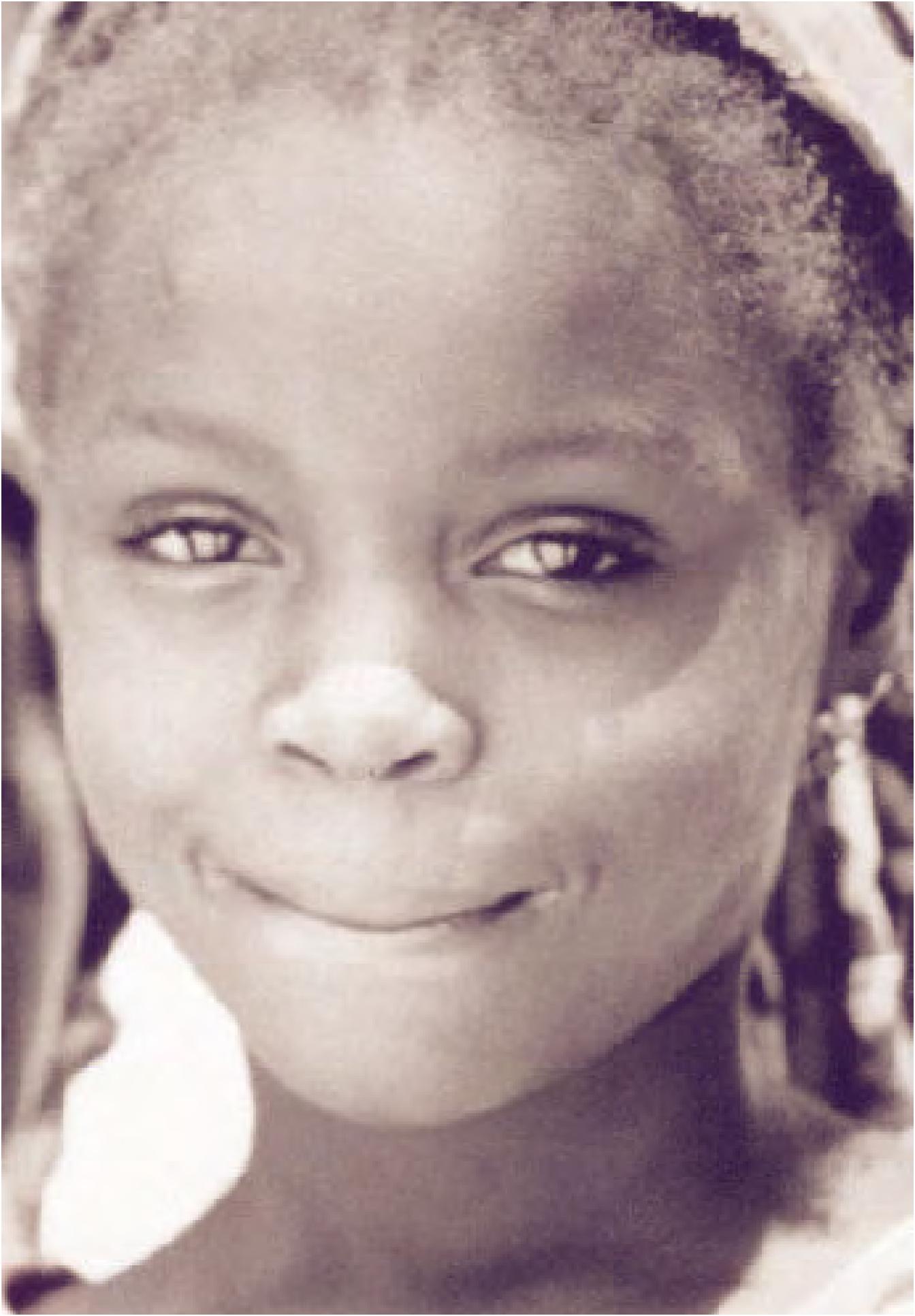
Since the first UPSI was conducted in 1995, inventories have taken place in Kano and in other locations in Lagos. These subsequent UPSIs required less up-front work and supervision by BASICS staff and more work shouldered by local teams. However, with the development of the survey instruments, training process, rapid street assessment and visual survey methods, and other tools, subsequent inventories have taken place with far greater reliance on local capacity. A further enhancement took place when BASICS incorporated core statistical calculations, summary tables, and graphics into an UPSI software program based on EPI Info 6.0.

BASICS/Nigeria focused on Nigeria's private sector. However, the UPSI is a tool that is also appropriate for use by the public sector. In settings where the public sector wants to establish better links with private providers, a private sector inventory can identify gaps in service, select private sector partners for collaborative health programs, and provide information for use in formulating public policies to support private providers.

Certainly other methods exist to identify potential partners. For example, BASICS could have begun the partnership process with prominent or otherwise familiar health facilities and CBOs. Alternately, the team could have publicized the opportunity to see which organizations would respond, conducted key informant interviews to



develop a list of potential partners, or gone to the LGAs to find out who was registered with them. However, it was felt that the more comprehensive UPSI would better serve the project over the long term for several reasons. First, it gave BASICS the data to make informed choices about the composition of the partnerships to help ensure that the partnerships could maintain their momentum to address health issues. Second, by visiting the facilities and organizations, the UPSI became the first step in making the communities aware and enthused about what CPHs could accomplish in improving health. Finally, the UPSI increased local capacity in conducting surveys and in analyzing and using the data collected.



# 2

## Facilitating the Formation of the Community Partners for Health

From the outset, BASICS made clear that it would serve as the initial catalyst for the partnerships, but that the members would determine their own priorities and activities. Furthermore, although the partnerships would benefit from BASICS technical assistance and some material incentives, they learned early on that they would receive very little, if any, donor funding. The strength of the CPH model has been the combination of targeted technical assistance and committed local networks of organizations. On the one hand, it is possible that the CPHs would not have survived or maintained their health focus without an outside facilitator launching the process and contributing technical expertise and perspective at key points. On the other hand, an outside facilitator alone, no matter how knowledgeable about group processes and health strategies, would have failed if he or she had tried control authoritatively the direction of the evolution of the CPHs or to smooth over some of the difficult situations that the CPHs solved on their own.

### Selecting Potential Partners

As noted earlier, the UPSI findings were used to select six target communities from the original thirteen inventoried, with the numbers and potential impact of a community's health facilities and CBOs playing a large role in the selection process. A further set of criteria was used to make an initial determination of whether or not a CBO or health facility within each community was a likely partner (see figures 5 and 6). BASICS staff returned to the health facilities and CBOs that seemed to meet these selection criteria to verify the UPSI findings and to conduct interviews to collect information about the criteria not contained in the UPSI, such as interest and enthusiasm. These visits also served as an opportunity to invite representatives of the CBOs or health facilities to participate in a series of meetings, called Community Partnership Fora. The purpose of these meetings was to bring together members from the health facilities and CBOs to discuss community health problems and explore the feasibility of joining together in a private sector partnership to solve some of these problems.

Over a period of six months in 1995, BASICS held 34 Community Partnership Fora, usually two and sometimes three in each community. Typically, the first such meetings in a community lasted 90 minutes or less and took place in a school, community center, or other public place within the community. The sessions were conducted in Yoruba, Pidgin English, or English, depending on the composition of the group, and gave

#### Figure 5: Selection Criteria for CBO Partners

- ◆ Established or potential for outreach capacity
- ◆ Established or potential ability to participate in EPI promotion services
- ◆ Evidence of effective management systems and administrative infrastructure
- ◆ Minimum membership size of 50
- ◆ Priority membership types: women's, religious, and predominantly female occupational
- ◆ Networking potential
- ◆ Existing or potential linkage with health facilities
- ◆ Nonpolitical
- ◆ Reputation for achievement
- ◆ Interest in and enthusiasm for participating in partnership

**Figure 6: Selection Criteria for Health Facility Partners**

- ◆ Established network or network potential
- ◆ Existing or potential linkage with CBO or other outreach capacity
- ◆ Established or potential ability to provide EPI services
- ◆ Evidence of effective management and administrative infrastructure
- ◆ Evidence of sustainability and resource base
- ◆ Registration with government of Nigeria
- ◆ Established or potential cold chain equipment
- ◆ Minimum of five paid staff (including two professionally trained staff capable of administering immunizations)
- ◆ Interest in and enthusiasm for participating in partnership

participants a general introduction to BASICS, the Pathway to Survival, and the concept of private-sector partnerships for health. While each session was different, common themes emerged: a lack of cooperation between most health care providers; a communication gap between health providers and CBOs; a high degree of superstition in the community surrounding illness and ways to prevent it; and limited vaccine

**Figure 7: Examples of Pilot Partnerships*****Makoko CPH: 13 partners***

- 4 for-profit allopathic health centers
- 4 religious CBOs (2 mosques, 2 churches)
- 2 occupational CBOs (taxi drivers, market women)
- 2 neighborhood CBOs
- 1 social CBO

***Mushin CPH: 10 partners***

- 1 for-profit allopathic health center
- 1 nonprofit church-affiliated health center
- 1 traditional healer practice
- 3 religious CBOs
- 1 private school CBO
- 1 occupational CBO (local affiliate of transit workers union)
- 2 neighborhood CBOs

supply at private health facilities, which might even worsen if public education campaigns increased demand. Many of the participants left these sessions intrigued, and went back to their organizations to gauge interest in moving forward. From their reactions, it seems that very few had ever discussed their community's problems in such an open setting.

The second round of Community Partnership Fora built on the earlier general discussion. BASICS staff presented a model, comprised of at least one health facility and three or more CBOs, and suggested how the health facility, CBOs, and BASICS could cooperate to improve the health of children in the community. By the end of 1995, six partnerships had been tentatively formed, one in each of the six communities. As an early encouraging sign, they continued to meet on their own without waiting for or depending on BASICS to arrange follow-up meetings.

**Organizing Partnership Structure**

The six pilot partnerships included a total of 15 health facilities and 42 CBOs, although the exact memberships have shifted since then (see figure 7). They adopted formal names, usually the community name followed by "Community Partners for Health," and established secretariats to maintain minutes and communications between the partners and to provide logistical assistance. Some partnerships funded a part-time position to staff the secretariat, paid for by member contributions, while others provided in-kind staff support for these functions. Each partnership developed an individual memorandum of understanding (MOU), signed by representatives of the member

organizations, and also signed a MOU with BASICS. In addition to addressing health issues, each MOU defined a strengthened role for women as decisionmakers in the community, through such means as requiring female participation on the partnership governing boards.

A critical issue of each partnership was how to deal with its finances. Reaching consensus within a partnership about such a sensitive issue as money was a clear indication of the partners' commitment to this new venture. In most cases, a bank account was established using the existing account of one of the health facilities. BASICS assisted the partnerships by performing a financial review of the organization responsible for the bank account.

The BASICS team also facilitated a series of meetings with each of the six CPHs to prioritize local health problems, especially those related to child health, in order to develop partnership work plans. For many of the partners, including the health

professionals, such a formal, logical approach to problem identification and priority setting was new. The sessions also assisted the partners in the collection of background materials and information they would need to develop an action plan. Generally, each partnership held two of these meetings to prepare for participation in a BASICS-led Work Plan Development Workshop, at which each partnership began to draft the action plan that would guide its efforts.

At the workshops, the CPH participants worked together on four exercises that led to their draft action plans:

- ◆ Developing and refining partnership objectives
- ◆ Developing activities associated with the objectives
- ◆ Creating work plans (including resource assessment and time frame)
- ◆ Budgeting by objective

The action plans had one overall goal and five core objectives related to child survival

### Figure 8: Examples of Goals and Objectives: Lawanson CPH Work plan

**Goal:** By the end of 1998, reduce maternal and child morbidity and mortality in Lawanson.

**Objectives:**

1. By the end of 1998, reduce the number of children and pregnant mothers getting sick from malaria in Lawanson and/or among the organizational members of the LCPH and the number dying despite contact with partner health facilities.
2. By the end of 1998, reduce the number of children getting sick with cough (incidence of acute respiratory infection) in Lawanson and/or among the organizational members of the LCPH and the number dying despite contact with partner health facilities.
3. By the end of 1998, reduce the number of children under age 5 getting sick from watery diarrhea in Lawanson and/or among the organizational members of the LCPH and the number dying from dehydration or dysentery despite contact with partner health facilities.
4. By the end of 1998, LCPH 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.
5. Strengthen/expand the role of female decisionmaking in LCPH and the community it serves.



and strengthening the role of female decisionmaking (see figure 8). BASICS' major roles with the CPHs involved the following:

- ◆ Facilitating participation amongst the community groups to solve problems
- ◆ Providing the health facilities with technical support for child health interventions
- ◆ Helping communities learn how to mobilize themselves on behalf of child survival
- ◆ Teaching capacity-building exercises to help the CPHs become sustainable

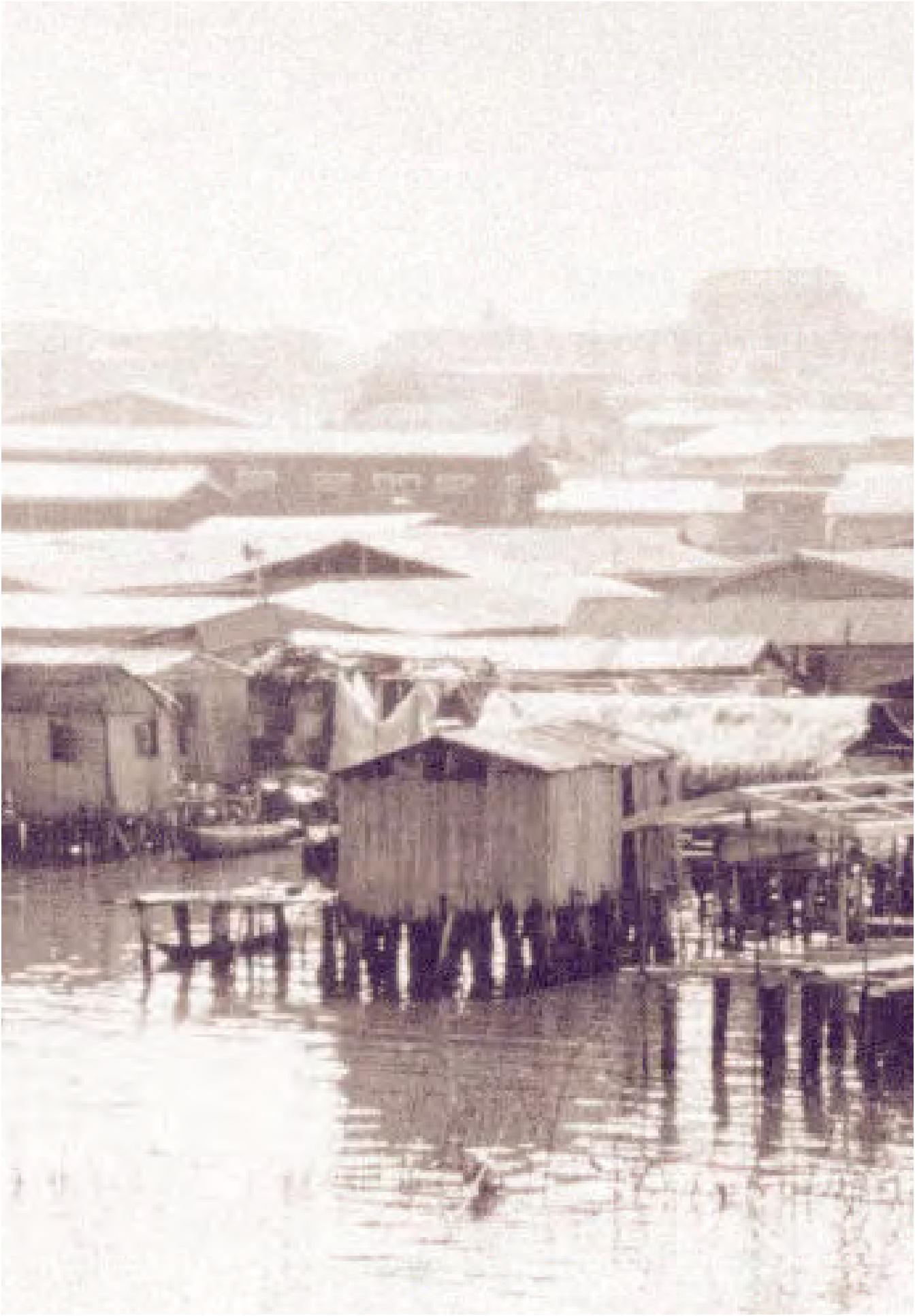
Funding the activities took a lesser role compared to that of supporting the CPHs through facilitation and technical support. USAID's funding was used to support the CPH health objectives, as defined in their action plans, by paying for such specific items as environmental sanitation equipment, generators to stabilize health facilities' source of electricity, fees to establish the partnerships as registered NGOs, and laboratory equipment. USAID did not provide general operational support to the CPHs.

## **New Opportunities**

Participants in the community fora told BASICS that no previous endeavor in Lagos had brought together health providers and

community organizations to jointly examine local capacity to improve child health. No previous endeavor had so clearly validated these communities by believing in their ability to contribute to their own betterment, recognizing their intrinsic resources, and empowering them to take action. The fact that the meetings were held in the communities, at local facilities, with little fanfare or showy incentives convinced the participants that this effort was sincere, with no hidden political agenda. From the first session, the catalytic but transient role of BASICS was emphasized—and the responsibility for action, as well as sustainability, placed firmly with the community partners. The organizations and health facilities were surprisingly accessible to BASICS' initial contacts. They spent hours away from important work and service to attend the fora, suggesting that the assumption was not true that private health providers would not be willing to take time away from their practices because it would result in a loss of revenue.

The considerable time that BASICS spent to identify and contact potential partners paid off in gathering together representatives of groups that had both the capability and motivation to follow through to develop a CPH. Each partner organization was able to contribute to the good of the whole, whether through its existing networks in the community; its resources; or its administrative, health promotion, or other skills. But these contributions alone would not have been sufficient. Each also had the enthusiasm to devote the time needed to tackle the organizational and interpersonal challenges to make the partnerships active in improving maternal, infant, and child health in their communities.







## The CPHs and Child Survival

**D**uring the three years since the initial steps in CPH formation, the CPHs have played a vital role in energizing their members to work together to improve the health of the children of the community. Health facilities have reported increased case loads, resulting in part from greater trust in their services by the community. Youth have worked together through the CPHs to create street theater and peer-to-peer educational presentations to communicate the risks of and provide preventive measures against HIV/AIDS and other targeted youth health problems. Traditional birth attendants have participated in training to promote better hygiene and to recognize when they need to make referrals to modern health facilities. Women have learned techniques to advocate for better health services for themselves and their children.

To reach this point, BASICS has provided assistance in organizational development, technical training, and minimal supplies and equipment to enable the CPHs to achieve their objectives. During the past three years, the partnerships have focused on two main areas of effort, those aimed at their own sustainability and those related to child health. The sustainability efforts have taken most of the time, particularly when the CPHs were new. The BASICS team watched this with some concern because of its desire to make progress in achieving the health objectives of the project, but found that the CPHs that have worked through their organizational issues are now developing the strongest health-related activities. It has become clear that as the partnerships have strengthened their governance, they have strengthened their abilities to empower their members, increase their funding, and expand their health activities.

### **Partnership Management and Structure**

Even with BASICS' initial selection of potential members on the basis of their capabilities and interest, most of the organizations had limited experience with such tasks as organizational management, financial accountability, and record-keeping. Moreover, as happens in many places, the organizations—both CBOs and private facilities—were more oriented toward guarding their interests than toward developing coalitions and working together.

Against this backdrop, the CPHs have achieved the following accomplishments to strengthen their management and structure:

**Group Cohesion:** The partnerships are powerful but fragile alliances. From the first round of the Community Partnership Fora, people articulated apprehension and distrust about working together, and such feelings do not disappear without hard work. Thus, each CPH has spent a considerable amount of time to determine how it would govern itself, publicize its activities, raise funds, deal with groups interested in joining, and implement special projects. Minutes from the partnership meetings indicate that disagreements accompany many of these discussions. Yet, in most cases, the partners have talked through their

differences. When needed, BASICS facilitates groups to formulate a solution for problems, such as how to deal with new members.

**Expanded Networking:** The CPHs have started to reach out to other agencies beyond BASICS to access both resources and technical assistance. They have begun calling on each other for advice in starting new projects and solving problems. The Jas CPH was the first partner group to establish a cooperative and thrift society to promote savings and income generation amongst its members. With the success of their initiative, they offered technical assistance to the other CPHs so that they could launch similar programs in their communities. The youth groups had similar exchanges of information, with officers of one youth group sharing their successful programs with other CPH youth groups. As the groups open up to one another, cross fertilization of ideas takes place and everyone goes back to their community with new ideas (see figure 9).

**Self-Assessment:** BASICS developed an activity to enable the CPHs to monitor progress toward their goals. Called a capacity-building exercise by the project, the CPHs learned to conduct interviews with women of childbearing age in the

vicinity of their partner health facilities regarding their health practices, care-seeking behavior, home management of illness, and their and their children's health status. The interviews are also conducted among women of childbearing age within the membership of the CBOs. In learning the single survey approach, the CPHs learned how to collect, tally, and analyze their findings, and how to use the findings to develop educational messages, plan their activities, and, in cooperation with BASICS, develop monitoring and evaluation plans.

**Financial Sustainability:** The CPHs have developed three main mechanisms to raise money: collection of dues and donations, raffles and other fundraisers, and income-generating projects. All of the CPHs have started cooperative and thrift societies that aid individual members by establishing a savings account, offering small loans to assist in their businesses, and generating a small annual profit targeted for health activities within their CPH.

**Women's Empowerment:** Each CPH took steps to increase women's empowerment so that women could serve as more effective advocates on child survival issues. The partnership structure was set up to

### Figure 9: Why stay committed to the CPH?

Why did individual CPH members continue to devote their time and energy to making the partnerships work? As part of a BASICS documentation exercise, conducted by external evaluators in late 1997, CPH leaders were asked to list the personal benefits they had gained from their involvement.

Top on the list of the 81 leaders questioned was the opportunity to interact with others (60.5 percent), followed by ideas and knowledge gained (53.1 percent).

Other commonly perceived benefits included improved health access and care and training opportunities. Thus, the CPH leaders saw that the benefits to themselves, their organizations, and their community were worth the hard work.

ensure that women had decisionmaking roles in how the CPHs were organized and governed. One-third of the board positions on all of the CPHs are held by women. In addition, each CPH established a women's empowerment committee. The committees made explicit the link between a woman's economic and social power and her children's health. They identified women's scarcity of income and lack of decisionmaking power within the family as reasons why medical care is delayed or not sought for sick women and children. As a result, BASICS assisted the CPHs in establishing microcredit and cooperative programs to directly benefit low-income women and increase their access and utilization of health services. In Kano, adult education classes are available in the CPHs offering women who have never had a formal education the chance to learn to read and write. In turn, by using their literacy skills, these women become stronger and more effective advocates for their children and their community.

**Democracy and Governance:** As with the gender dimension discussed above, it became clear to the CPHs and to BASICS that the strengthening of democracy could have a positive effect on community health (see figure 10). BASICS facilitated work-



shops to enable CPH members to advocate for child survival issues with their local governments. Unprecedented mock parliaments were held in Lagos and Kano to train participants to apply principles of democratic participation, fundamental human rights, and women's empowerment when advocating for child survival issues. The parliaments, which involved 600 women and men in Lagos and 800 in Kano, identified linkages between child survival, and democracy and governance that will guide future activities of the CPHs.

#### Figure 10: A Joint Consultative Forum Formalizes Networking Efforts

In 1998, efforts were launched to formalize their relationship through the formation of a Joint Consultative Forum and a Youth Consultative Forum with a goal to promote, deliver, and institutionalize effective Integrated Child Survival Programs in deprived communities by building a network strategy with governments, NGOs, and interested indigenous and international donors.

The elections put into practice the democracy and governance training the CPH members have received in the past several years. With delegates elected to represent the six CPHs, candidates were nominated, campaign speeches announced, and votes counted. At the end of two days of parliamentary procedures, two boards were elected that represent the six CPHs as a unit.

## Health Activities to Improve Child Survival

Equipping people to advocate and organize for child survival, as described above, is one way the CPHs can contribute to improved health conditions in the participating communities. In addition, the CPHs are providing health education and services that are linked to the priority issues identified in each CPH's action plan (see figures 11 and 12). These efforts have included the following:

**Increased Patient Load:** One of the underlying premises of the project is that, as the community's knowledge and awareness about the importance of child health increases and people have greater confidence in their local health facility, the facility's quality of care will improve, and the utilization of the health facilities will increase. BASICS has provided health worker training to improve the relationships between health workers and patients. Health workers learn to talk to mothers about their children's health and offer encouragement to mothers to practice healthy behaviors. Increased usage is also essential if the partnerships are to be sustained. Both in-patient and outpatient

loads in most partner health facilities have increased since the CPHs began.

**Immunizations:** Most of the participating facilities provided no—or very limited—immunization services before participating in the project. Two years later, most are administering immunizations as part of their routine activities and have increased their involvement in National Immunization Days. The CPHs established Community Immunization Days at many of their health facilities for an intermediary period to increase awareness of the community to the need for timely immunization of their children. All CPH facilities are obtaining their vaccine supply from the local governments instead of from private pharmacies. The benefit is that they do not have to pay for the vaccines from the government and can thus pass the savings on to their clients.

To ensure safe handling and storage of vaccine, health workers in CPH clinics have participated in a series of workshops offered by BASICS, while the CDC provided cold chain equipment for each clinic ready to launch an immunization program. Record keeping has been

### Figure 11: An Established CPH Hospital Expands into High-risk Area

Rikky Hospital, one of the private clinics that comprises the Ajegunle CPH, recently expanded its services into a neighboring community. Responding to the need for maternal and child health services in nearby Amukoko, Rikky Hospital built an annex to accommodate the women and children of the neighborhood.

The expansion was initiated and implemented by Rikky Hospital without help from BASICSC health workers applied skills learned from BASICS technical assistance, such as the UPSI instrument to establish the baseline data in the community. They identified appropriate CBOs to partner with the annex and mobilized the community to participate in the clinic's opening immunization day.

UPSI results established that TBAs deliver the majority of babies in the neighborhood, and in response Rikky annex has partnered with the TBAs and provided training for improved maternal and child health care. Rikky Hospital's initiative offers evidence of the CPHs ability to grow and function independently of BASICS' assistance.

**Figure 12: CPHs Look to Expand**

While one set of capacity-building exercises help the CPHs monitor and evaluate their activities, another exercise teaches members to promote growth by adding additional health facilities (partnered with their own CBOs) to the existing partnership. These new clusters of CBOs working with a health facility are referred to as a dyad. With additional dyads in each CPH, the outreach to mothers and children in the community is increased.

Jas, the only partnership composed of a single dyad, is anxious to recruit new health facilities. Volunteer members conducted interviews with health facility owners in different areas of the community to gauge interest, and they found three health facilities interested in committing to membership. A growing enthusiasm in the CPH model can be seen throughout the communities—some health facilities have been waiting to join, pending CPH agreement on recruitment and application procedures. Members are following up with interested health facilities using the CPH-wide adapted application for membership, memorandum of understanding, and a condensed UPSI instrument.

standardized with monthly reporting formats the health workers know how to use.

**Traditional Birth Attendant Training:**

Traditional birth attendants (TBAs) are often preferred by Nigerian women to deliver their babies, rather than modern health clinics. For many there is a cultural belief that having a baby at home is an indication of a healthy mother and child. While cultural beliefs may take time to change, bringing the TBAs into partnership with the modern facilities in the community offered a way to improve the services the TBAs offer mothers. A series of workshops trained TBAs and traditional healers to learn to recognize danger signs for children and expectant mothers and taught them to refer sick children and mothers immediately to the partnering private health facility. The TBAs and healers are proud of their training certificates and have formed working relationships with neighboring facilities.

**Epidemic Preparedness and Response:**

A 1997 cholera outbreak demonstrated the capacity of the CPH network. BASICS convened a workshop on home-based management of cholera. The Lawsonson CPH contacted UNICEF on behalf of all six CPHs and obtained 36,000 sachets of oral rehydration solution (ORS) for distribution through the CPHs. Although not the only factor, the use of the ORS along with other practices imparted through the workshop accompanied a drop in the number of cholera cases in CPH health facilities and diminution in outbreak in the CPH communities.

**Youth Involvement in Health Education:**

All of the CPHs have an active youth wing. The youth have organized parades, drama presentations, talks at secondary schools, and other programs to deal with such youth health issues as HIV/AIDS, teenage pregnancy, prostitution, and sexually transmitted disease prevention. The youth have been credible and convincing educators with their peers,



as well as motivated networkers and mentors for one another. In addition, they are gaining knowledge and skills that will serve them when they begin to raise their own families.

The youth groups provide the manpower for many community health activities: they are social mobilizers for the community and national immunization days and the physical labor behind the regularly scheduled sanitation days in each community. In late 1998, they will participate with other NGOs in Lagos in formal targeted training for improved mobilization strategies.

**Environmental Sanitation:** Although environmental sanitation was not part of the original set of objectives in the work plans of the CPHs, it has become a program focus. Solid waste and water quality problems are a visible link to such health concerns as malaria and diarrhea, whose reductions are included as CPH objectives. Public awareness and clean-up campaigns take place on a regular basis in all of the communities as the link between health and the environment has been emphasized.

**Breastfeeding:** Women have learned the health reasons behind exclusive breastfeeding for infants for their first six months of life, as well as techniques to approach the community in changing old behaviors. Many of the CPHs' women's empowerment committees have launched support groups for mothers as a way to promote breastfeeding.

## Evaluating CPH Activities

Both observers of and participants in the Community Partners for Health have been interested in evaluating the impact of the partnerships on child health. Moreover, because health status is entwined with other aspects of development, such as those related to democracy and governance, women's empowerment, and economic growth, many people have wondered how the CPH model can contribute to progress towards these other development indicators.

Several mechanisms were integrated into the project design from the outset so that both external evaluators and CPH members can address these questions. For example, the UPSI supplied important baseline data for each health facility and CBO entering a partnership. In 1995, USAID coordinated an Integrated Baseline Health Survey with all of the implementing partners working in Nigeria. This survey established a baseline against which changes in fertility, family planning, and health and morbidity indices can be measured at a later date.

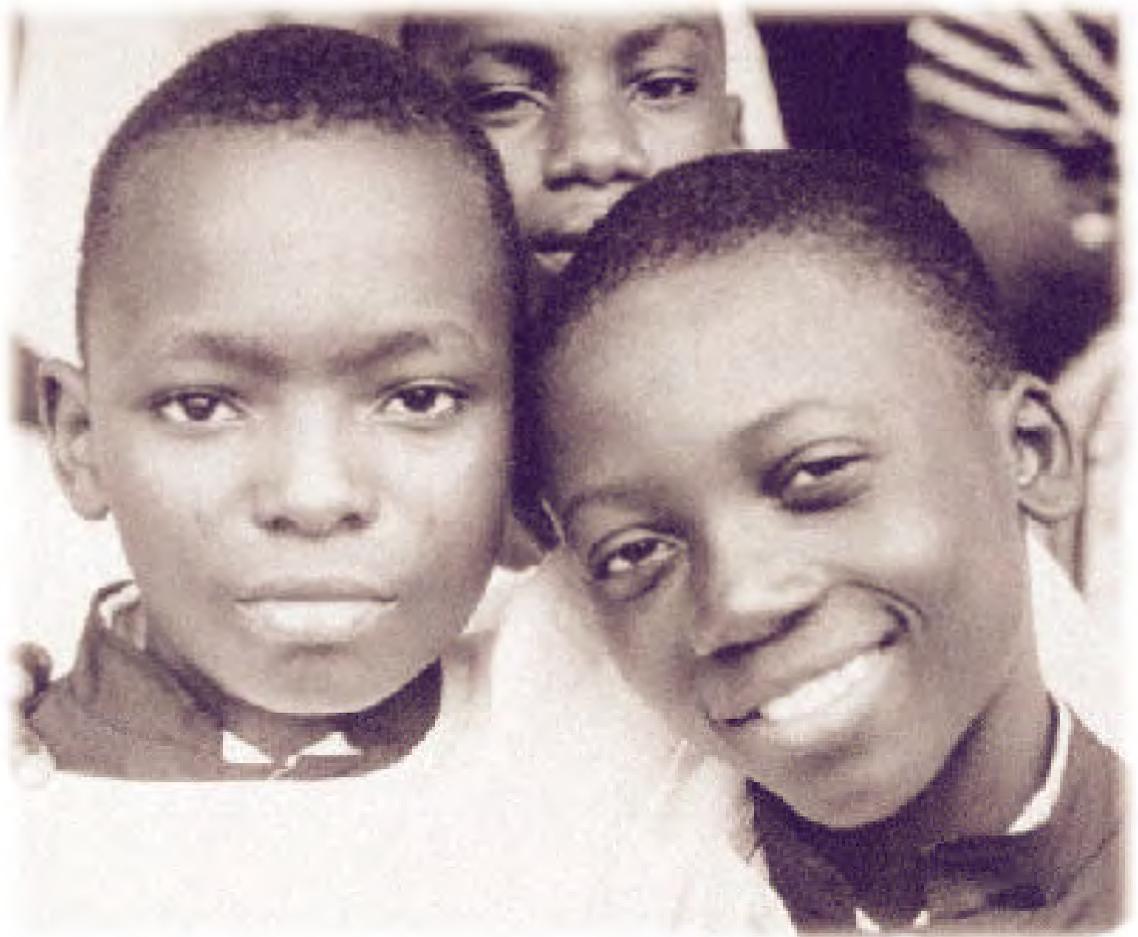
CPH members evaluate their progress through the use of surveys that BASICS introduced to the partnerships as a capacity building exercise and local monitoring tool. Two surveys are carried out: one is health facility–

based and the other targets CBO members. The surveys focus on health practices, care-seeking behavior, home management of illness, and health status of women of childbearing age and their children under age 5 that are either members of a CBO or living near a participating private health facility. The first round was completed in April 1998 and the results provided the CPHs with information to improve their health interventions. The capacity-building exercises will be administered every six months to allow close monitoring of the CPH programs.

In addition, to serve as a control BASICS has collected baseline data using the UPSI

from four new health facilities who have not yet participated in CPH activities, but are about to join. As these surveys are repeated at regular intervals, they can help ascertain what the CPHs have accomplished and what must still be done.

Another means to gauge CPH effectiveness, as seen by the members themselves, is through a self-assessment tool first used in late 1997. The CPHs rated themselves on progress related to their organizational structure, management and logistics, and programming on a scale of 0 ("not yet") to 4 ("fully achieved"). The tool can be useful for monitoring and evaluation, as well as a way to plan future activities.





# 4

## Reflecting On and Adapting the CPH Model

**T**he partnerships have overcome both internal and external challenges, and undoubtedly, more lie ahead. However, the CPHs have been able to work through the inevitable conflicts and other pitfalls that affect any organizational effort. Despite abysmal social and economic indicators, these high-risk communities have mobilized with a sustained collective energy. People are banding together across the boundaries of religion, ethnicity, language, education, gender, and age to participate in organized, directed activities to improve the health of their children. The partnerships have fueled feelings of empowerment in their membership and have developed the tools and skills they need to make a difference on their own.

### Implementing the Model in Kano

After the CPHs in Lagos had been active for two years, USAID and BASICS were interested to test the model to see if the ingredients could be modified to establish CPHs more quickly, but in an equally productive manner in a different urban environment. Kano, a predominately Muslim and indigenous city in northern Nigeria, offered many cultural differences from Lagos, but also suffered from many of the same challenges as Lagos, such as rapid urban growth resulting in a large, underserved population.

Kano is divided into two sections by an ancient wall: within the city live the indigent Hausa population and outside immigrants continue to move into ever-expanding communities. Unfortunately, poverty, low education levels, and poor health conditions for mothers and children exist throughout the city. BASICS conducted a rapid assessment and nine highly problematic communities were identified. An urban private sector inventory (UPSI) followed soon after, where a simplified version of the Lagos UPSI was used. Three hundred twenty-four pharmacies and patent medicine vendors (PMVs), 279 health providers, and 359 CBOs participated in the inventory, which revealed some interesting deviations from the results of the Lagos UPSI.

More than half of the health providers interviewed were traditional healers or traditional birth attendants, whereas in Lagos only ten percent identified themselves as such. In some communities, it was difficult to find a modern health facility that could serve as a potential partner with the traditional providers. PMVs were an important group of health providers that needed to be addressed in Kano, whereas in Lagos they were not part of the community partnerships.

The profile of the Kano CBOs showed further variations from the groups in Lagos. Nearly seventy percent of the CBOs surveyed in Kano were non-profit, compared to only three percent of Lagos CBOs identifying themselves as such. Far more CBOs in Kano were experienced in social mobilization and community activities to promote immunization than their Lagos counterparts. Youth groups and men's groups were the predominant types of



CBOs in Kano (nearly double the amount in Lagos), while there were very few identifying themselves as religious groups surveyed in Kano (9%) compared to Lagos (65%). There were slightly more groups identifying themselves as women's groups in Lagos (35%) than in Kano (27%), which was expected, as women in Kano were less likely to be out in public and involved in activities outside the home.

The original selection criteria (page 9-10) used to consider potential CBO and health facility partners were developed in the context of the Lagos communities in which BASICS worked. These criteria were reconsidered when choosing potential partners in Kano. Some are applicable over many settings, but appropriate criteria should be tailored for use in each specific area. For example, unlike in Lagos, PMVs were considered an integral part of the formation of the CPHs in Kano.

The inclusion of PMVs called for an adaptation to the CPH structure used in Lagos. The UPSI revealed three important private sector groups that would be a part of the partnerships. In Lagos, there are two main groups: health facilities are partnered with five or more CBOs in groups called dyads. Each CPH is made up of one or more dyads. In Kano, triads became necessary to partner the patent medicine trades with a modern health facility and a group of community-based organizations.

A total of five CPHs, three within the ancient walled city and two outside the wall, began the process of identifying priority child health interventions and related activities. Using lessons learned from the Lagos experience, the start-up period in Kano proceeded quickly into work plan activities. The communities identified their key problems, many of which were similar for the Lagos CPHs. Work plan activities were developed for addressing diarrhea, immunization coverage, reproductive health, and environmental problems, including malaria. In recognition of the Kano cultural context, BASICS worked with women to establish literacy programs for them, using child health messages as the content. Kano has one of the lowest literacy rates in Nigeria, making education programs a necessity to provide basic literacy skills for community members. These classes have been so well received that the men have requested to attend as well.

Training and workshops used in Lagos, were adapted to the cultural environment in Kano which is greatly influenced by the Moslem traditions. A BASICS satellite

office staffed with program officers in community development and child survival provide local technical support to the communities. They work directly with the CPH members to assist them with the technical assistance they need to carry out child survival activities. The Kano CPHs have been able to apply lessons learned from the Lagos CPH's experiences, resulting in some streamlined processes and a quicker start-up period. Workshops and training used in Lagos that are also applicable to Kano have been adapted to the context of the Kano environment and implemented with success.

In Kano, training in improved traditional birth attendant practices, oral rehydration therapy training for patent medicine vendors, and support of local and national immunization days in private health facilities are the initial integrated child survival activities. Sanitation clean-up days, now regularly conducted in all the communities; democracy and governance training exercises that culminated in an overflow of attendees at a mock congress; and the family economy advancement program that provides a member-owned savings and loan program for CPH members all help establish a stable, healthier community by which continued child survival activities may be supported.

### **Ingredients for Success**

Appropriate technical assistance, experienced consultants, innovative methodology, and useful tools on the BASICS side and inspired leadership, high morale, enthusiasm, and energy on the community side are important ingredients for success. The

following ingredients contribute to the long-term success of the CPH model:

- ◆ Use of the UPSI instrument to determine which organizations had the potential to be members of the partnerships.
- ◆ The CPH development process, including the community fora and the community workplan development activities that resulted in targeted activities custom fit to the needs of the community.
- ◆ Legal status of each CPH as an independent NGO, thus able to obtain assistance from the government and other organizations and agencies.
- ◆ Technical assistance, rather than transfer of money, on the part of the donor organization.
- ◆ A few limited but visible incentives, such as sanitation tools for neighborhood clean-ups, cold chain equipment for health clinics, and computers for CPHs with established secretariats.
- ◆ Capacity-building training in such key areas as management, finance, monitoring and evaluation, and child survival strategies.
- ◆ Income-generating activities and cooperative savings and loan programs that respond to the needs of the poorest in the community, usually women.
- ◆ Women's empowerment activities that encourage female decisionmaking and advocacy for improved child health.
- ◆ Emphasis on participatory methods of group goal-setting and problem-solving.
- ◆ Leadership and governing of organizations based on principles of democracy.
- ◆ Mobilization of women's group and peer youth counseling groups in support of positive maternal and child health behaviors and prevention of HIV/AIDS.

It has also become evident that democracy and governance approaches have a key role to play in a child survival project in urban communities like Kano and Lagos. At the CPH level, for example, the participatory models first used in the Community Partnership Fora have made their way into board meetings and the consultative forum, which helped overcome the dissension that characterized some meetings and, at times, threatened to derail the process. Members of the CPH boards have applied these approaches to their organizations and facilities. Women's empowerment and other measures taken to bolster the position of women within their family and community structures have helped women better advocate for their children's survival—with the men in the family, with health care providers, and with local authorities.

**Ongoing Role of BASIC and Next Steps**  
Once a partnership has begun operations, what has been the role of BASICS? More broadly, what should be the role of the external agency, which was instrumental in setting up the partnerships, in working toward their continued success? Throughout the project, BASICS prepared the CPHs for its eventual departure. The BASICS technical staff in Lagos and Kano, backed by technical and administrative support at BASICS headquarters, has focused its technical assistance to improve local capacity to resolve conflict, develop and disseminate educational materials, conduct training, manage child health activities, and design and implement meaningful monitoring and evaluation measurements.

Over the long term, USAID, BASICS, the CPHs, and other interested observers will

want to know more about how the partnerships can benefit child survival, including the cost-effectiveness of this process.

While BASICS does not give direct financial support to the CPHs, the cost of providing technical assistance and ongoing support is significant. In Lagos, after two and-half years of technical support to the six CPHs, BASICS technical assistance and training programs became less frequent and, yet, the citywide network of CPHs continued to grow and support themselves. The BASICS team is reviewing the extent to which the active involvement of itself or another external technical assistance group is necessary to guide the project and how to develop this capacity for facilitation in other organizations.

A process evaluation completed in the Kano and Lagos CPHs was only one step in the review of lessons learned by the CPHs and BASICS, thus far. The value and necessity of the steps of BASICS' CPH development process were ranked by BASICS staff and CPH leaders and members. The top five CPH components included the UPSI, community fora, registration as an NGO, provision of cold chain equipment, and the constitution. These five core components provided the foundation for the CPHs to operate and carry out child survival activities. BASICS streamlined and standardized these processes after their pilot use in Lagos and implemented the modified versions in Kano with success. A third CPH program is underway in the southeast region of Nigeria in Abia State. The city of Aba has a different cultural context than Kano or Lagos, but similar high-risk health factors in the community.

A further test will be the adaptation of the model in a rural setting, which is planned for later in the project.

Experience shows that what took two to three years to achieve in Lagos was replicated in Kano in one to two years, and BASICS program managers are confident that the new CPHs in Aba will be established in less time by taking advantage of the lessons learned in the previous models. Evaluations of these two subsequent efforts, in addition to continued evaluation of the models in Lagos and Kano, will strengthen the model and its applicability for use in other locations in the developing world.

Monitoring and evaluation plans to track child survival indicators were established at the beginning of the partnerships as part of the workplans. While fine-tuning the data collection process has continued over the life of the CPHs, baseline and follow-up sets of data have been routinely collected in Lagos and Kano. As mentioned earlier, preliminary results from the monitoring and evaluation reports point to a rising trend in immunization coverage and the use of sugar salt solution and ORS for managing diarrheal diseases. Results from the most recent NIDs show that the CPHs in Lagos and Kano immunized 250,000 children under age 5 against polio. Only a few years ago the same private clinics did not participate in NIDs. Another sign is that despite the significant amount of time and the small financial commitment that each partner must make to the program and the lack of any direct payment, additional groups (both health facilities and CBOs) are requesting to become involved.

The CPHs reinforce many of the behaviors along the Pathway to Survival framework (see figure 1 on page v). For example, one key point along the Pathway is a child's caretaker recognizing when the child needs outside treatment. Qualitative research shows that community use of health facilities has increased in direct relation to the improved interaction between health workers and patients that the CPHs have helped foster. The impact on population is significant: It is estimated that the 11 CPHs have direct contact with over 877,000 people in Lagos and Kano, and an estimated sphere of influence of more than 6 million people overall. As the CPHs mature and continue to improve their monitoring efforts, it is clear the improvement in child health will become more evident.





# References

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