

Lagos Community Partners for Health:

Innovative Private Sector Partnerships Promote Child Survival

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Abstract

This report describes the formation of partnerships between private-sector health facilities and community-based organization in six lower-income communities in Lagos, Nigeria. The Community Partners for Health serve as models for involving local institutions in identifying the issues that most affect child health in their communities and in developing solutions that address these issues. The Basic Support for Institutionalizing Child Survival Project of the U.S. Agency for International Development played an essential but limited role in facilitating the formation of the partnerships and in developing action plans, memoranda of understanding, and budgets.

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Acronyms

ARI	acute respiratory infection
BASICS	Basic Support for Institutionalizing Child Survival
CBO	community-based organization
CPH	Community Partners for Health
EPI	Expanded Program on Immunization
HF	health facility
IEC	information, education, and communication
LGA	Local Government Authority
MOU	memorandum of understanding
PMV	patent medicine vendor
UPSI	Urban Private Sector Inventory
USAID	U S Agency for International Development

Executive Summary

The Urban Private Sector Integrated Health Project of the Basic Support for Institutionalizing Child Survival (BASICS) Project facilitated the development of partnerships within the private health sector in the predominantly urban state of Lagos, Nigeria. Rapid urban growth, an expansion of private health services, and the U S Government sanction against direct agreements with any branch of the Government of Nigeria prompted the U S Agency for International Development to concentrate BASICS' work in this sector from mid-1994 through 1998.

The model that BASICS developed to fulfill this mandate is the Lagos Community Partners for Health (CPH). CPHs, which are partnerships between community-based organizations and health facilities, now operate in six low-income communities. After forming, the partnerships identified the priority issues that affect child health in their communities and are now designing and implementing action plans that address those priorities.

Identification of the Private Health Sector

The first challenge in the creation of the Community Partners for Health was to identify viable private-sector partners. No database or other listing existed of the community-based organizations (CBOs) or of the entities that composed the "private health sector", in fact, no map even accurately showed where all were located. To identify these organizations and institutions and collect information from them, BASICS developed the Urban Private Sector Inventory (UPSI). A team of 21 interviewers, 2 field supervisors, and 1 principal consultant inventoried 13 target communities, chosen on the basis of their population size, degree of urbanization, poor public health status, and low socioeconomic status.

To locate community-based organizations, health facilities (HF), and pharmacies/chemist shops and patent medicine vendors (PMVs) to interview, the team began with existing maps, which they augmented with interviews with community leaders and other informants and with a rapid street assessment and visual survey in the field. Ultimately, they interviewed 358 CBOs, 279 HFs, and 324 pharmacies/chemist shops and PMVs. They requested information from CBOs about their membership, governing structures, and current activities. From the health facilities and pharmaceutical sellers, they sought information about catchment population, staffing, and services, particularly in regard to provision of immunizations. It was understood that more in-depth information would be sought as needed over the course of the project.

Selection of Target Communities

The UPSI findings helped quantify the absolute numbers and types of CBOs and health facilities per community, as well as target CBOs and HFs with the largest potential impact and networking capability. This information was used to select 6 target communities from the original 13. CBO and HF representatives in these communities received a hand-delivered invitation to participate in community fora, or meetings that BASICS convened to explore the formation of CBO-HF partnerships for health. At least two and in a few cases three, sessions were held in each community.

The first session typically included an introduction to the BASICS Urban Integrated Private Health Project, discussion of common community health problems, presentation of the concept of private partnerships for health, exploration of the feasibility of the concept in their community, examination of

potential partners, and identification of next steps for BASICS, HFs, and CBOs. The BASICS Pathway to Survival, depicted in both English and Yoruba, was used as a way to illustrate the role that the home, the community, and the health care system play in providing effective health care for children. To carry out this work, BASICS proposed prototype dyads, used here to describe partnerships between one or more health facilities and three or more community-based organizations. At the meetings, participants discussed and modified the membership of the dyads. A number of factors, including previous collaborations, played a role in the final composition of the partnerships.

Some of the concerns raised by meeting participants that might impede the success of the partnerships included the limited vaccine supply at private health facilities, the ability of health facilities to handle the needs of clients mobilized by CBOs, and the communication gap between health facilities and CBOs. Despite these concerns, most participants strongly supported the development of Community Partnerships for Health in their communities. By the conclusion of the second session of these meetings, dyads had formed in each of the six communities. These six pilot partnerships have an initial outreach of approximately 250,000 people based on organizational membership and/or current patient load. Their potential sphere of influence is estimated to be several million.

After the meetings, each partnership set up its governing and management structures, which included a secretariat and governing board. They drafted memoranda of understanding among the partners and between each partnership and BASICS. Each partnership also established a bank account.

The BASICS team facilitated individual meetings with each partnership as a prelude to Workplan Development Workshops, in which the partnerships designed their action plans. For many of the partners, including the health professionals, such a formal, logical approach to problem identification and priority setting was a new approach.

A series of three workshops took place, each lasting one-and-a-half days, with two partnerships participating per workshop. Through the workshops, the partnerships were able to develop and refine partnership objectives, develop activities associated with their objectives, create workplans, and draw up budgets. Generally speaking, each workplan consisted of three core objectives directed toward improving child health through prevention and treatment of diarrhea, malaria, acute respiratory infection, or measles. Two additional core objectives aimed at strengthening institutional capacity through such means as sustainability of services and development of women's decision-making capabilities.

The workplans formed the basis for subproject proposals, which were submitted to USAID for approval and funding. The proposals, which have a three-year time horizon, establish a list of outcomes that the partnerships hope to accomplish through improved communication, training, increased supply of vaccines, and other means. Baseline data on health in the communities before the BASICS intervention will be used by BASICS and the partnerships themselves to monitor results.

Value of the Partnership Model

The process used in forming the CPHs serves as a model to initiate private sector involvement in public health. It lays out a practical method to link facility-based services with community outreach and promotion. The partnerships also engender a sense of community responsibility for health and overall empowerment by finding feasible solutions to local problems using local resources. Inherent to the partnerships are principles of representation and equity. Even in the first year of the partnerships, the

contributing partners and their constituencies are spontaneously adopting more representative modes of decision making. In addition, increased responsibility for local health concerns forms a natural bridge to other local governance issues. The partners themselves recognize that their newly discovered strengths can be used to address other community concerns, such as the environment, crime, and infrastructure.

In summary, the three critical characteristics of the partnership model are the following: the initial catalytic function of an external agency in an essential, but limited, facilitation role; early presentation of the concept to the community to examine its feasibility and shape; and the gradual evolution of the partnerships' governance structures and responsibilities as self-determined by their members. Although BASICS provided initial impetus to partnership development by introducing the concept, the partners then made all key decisions.

Urban Private Sector Integrated Health Project

Introduction

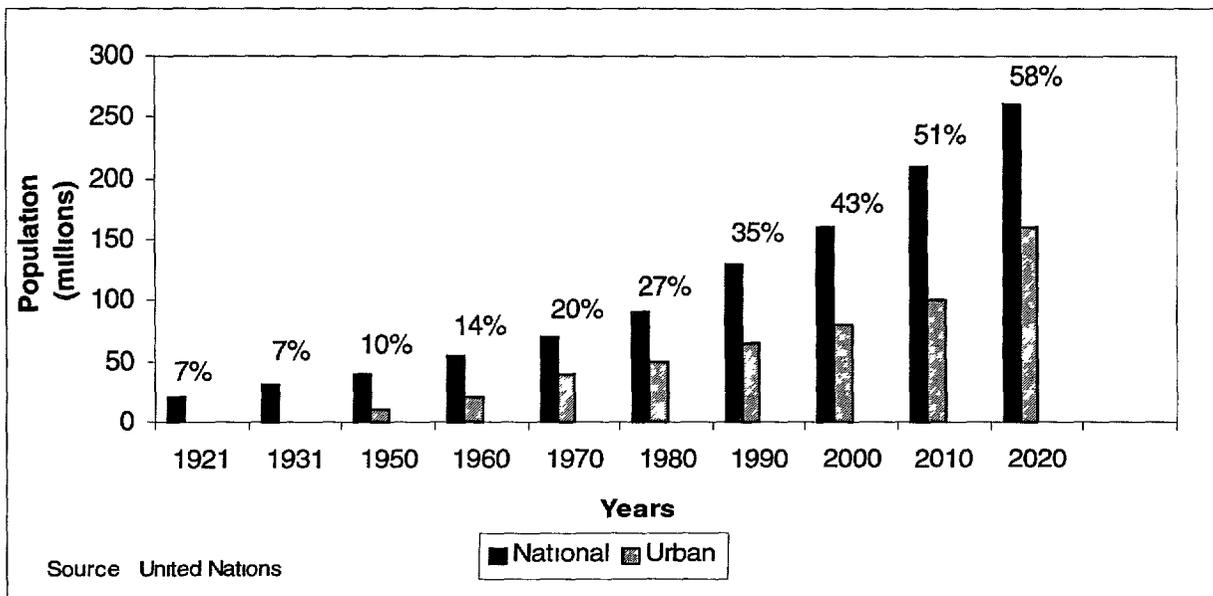
The Urban Private Sector Integrated Health Project of the Basic Support for Institutionalizing Child Survival (BASICS) Project facilitated the development of partnerships within the private health sector in the predominantly urban state of Lagos, Nigeria. Rapid urban growth, an expansion of private health services, and the U.S. government sanction against direct agreements with any branch of the Government of Nigeria prompted the U.S. Agency for International Development (USAID) to concentrate BASICS' work in the private sector from mid-1994 through 1998.

The model that BASICS developed to fulfill this mandate is the Lagos Community Partners for Health (CPH). CPHs, which are partnerships between community-based organizations and for-profit and non-profit health facilities, have formed in six low-income urban communities. They have begun to develop and implement action plans to improve the health of children living within these communities.

Exhibit 1 BASICS' Mandate

Improve child health services and home health practices in underserved, high-risk urban communities by developing a model that strengthens the quality, outreach, and management of private nongovernmental health services, promotes community responsibility and involvement in health, and fosters increased community demand for quality services.

Exhibit 2 Rapid Urban Growth Rates Challenge Public Sector Capacity for Health Services



Identification of the Private Health Sector

The first step in the creation of Community Partners for Health was to identify viable partners in the private health sector. However, identification of the private health sector in Lagos was not simple. The term “private health sector” encompasses many entities: for-profit and nonprofit facilities, allopathic (modern) and traditional providers, and even pharmacies and patent medicine vendors (PMVs). When BASICS began work in Nigeria in 1994, no directories or databases of these diverse private providers existed. Furthermore, because of its goal to improve health-related behaviors in the home, BASICS sought to work with community-based organizations (CBOs) as potential partners to mobilize and educate community members about health promotion and home care. Again, no CBO directory or database existed.

In order to define the composition, size, and service capacity of the Lagos urban private health sector, BASICS designed an Urban Private Sector Inventory (UPSI). The inventory collected information about three broad groups in 13 communities: (1) community-based organizations (not only health, but also social, religious, and occupational organizations), (2) health facilities (nonprofit and for-profit, allopathic and traditional), and (3) pharmacies/chemist shops and patent medicine vendors.

BASICS chose the communities on the basis of their population size, degree of urbanization, poor public health status, and lower socioeconomic status. They were located in five local government areas (LGAs) in Lagos, with a total estimated population of 1.7 million. Three methods helped us identify CBOs, health facilities, and pharmacies/chemist shops and patent medicine vendors from which to collect information: (1) review of existing registries and records, (2) interviews with local key informants, and (3) a rapid street assessment and visual survey. The rapid street assessment and visual survey consisted of literally walking the length and breadth of each street in the 13 communities, recording the changes in street configurations and names that deviated from a baseline map, and identifying the types, names, and locations of health facilities and organizations by spotting their signboards and street advertisements. Although time-consuming, the visual survey was the most productive method for detecting allopathic and traditional health facilities and pharmacies/chemist shops and patent medicine vendors that did not show up in the existing records. On the other hand, key informants were particularly useful in identifying additional CBOs.

Exhibit 3 UPSI Purpose

Define the composition, size, and service capacity of the urban private health sector in Lagos

Exhibit 4 Three Types of UPSI Instruments

- Community-based organizations
 - Health facilities
 - Pharmacies/chemist shops and patent medicine vendors
-

Exhibit 5
Colorful Signboards for Traditional Healers Augmented the Visual Survey



The UPSI was used to perform a census that attempted to collect information about every private health facility and CBO in the 13 communities. Exhibit 6 summarizes the totals identified and successfully interviewed in each respondent category, as well as refusal rates. The relatively high refusal rate among the pharmacies/chemist shops and patent medicine vendors can be explained by a concomitant Government of Nigeria drive to enforce official registration (and was not surprising in light of pretest findings, which had indicated that their response rate was likely to be adversely influenced by this action). A validation study revealed that the UPSI underidentified traditional healers, believed to be the result of interviewer bias.

The data were analyzed at three levels: aggregate, local government areas, and community-specific. The findings helped BASICS develop realistic criteria for target communities within which to work, then helped in the identification of potential private-sector partners and design of strategic project interventions. The findings will also be used to monitor changes in private-sector health capacity.

**Exhibit 6
UPSI Interviews by Type**

Instrument	No Identified	No Interviewed	Refusal Rate (%)
CBOs	395	358	9
Health facilities	330	279	15
Pharmacies/chemist shops and patent medicine vendors	414	324	22
Total	1,139	961	

Although originally designed for use in Lagos, the UPSI can be adapted for use in urban communities elsewhere. The UPSI has a companion computer software package based on EPI Info (public domain software), complete with codebook and instruction guide for data entry. A detailed account of the methodology and findings is reported by Silimperi et al (1998).

Selection of Target Communities

We used the following information from the UPSI to select 6 target communities from among the 13 inventoried:

- Absolute numbers and types of CBOs and health facilities per community
- Number of CBOs and health facilities with the largest potential impact, based on their staff or membership size or current service population/patient load
- Networking potential, based on range and type of potential private sector partners

This information, along with data about population size and public health need, was incorporated into a matrix to rank each of the inventoried communities. Ultimately, we selected six communities with a total population of nearly 1 million within which to work initially. Within these six communities, the UPSI identified 144 health facilities and 241 CBOs. Aggregate as well as community-specific datasets were developed.

**Exhibit 7
Selection of Six Target Communities**

- * Nearly 1 million population
 - * 144 health facilities
 - * 241 community-based organizations
-

Identification of Potential Private Sector Partners

The aggregate findings from the target communities were used to establish realistic selection criteria for the identification of optimal private-sector partners from among the total number identified. Because BASICS focuses on community and household-level behavioral changes to improve health and strengthen local decision-making capacity, the selection of potential health facility and CBO partnerships

was our priority. The UPSI data on pharmacies/chemist shops and patent medicine vendors will be useful at a later date during the development of partnership interventions.

Exhibit 8 delineates the major criteria for CBO and health facility partners. These criteria were based on information from the UPSI, except for the criteria relating to interest and enthusiasm, reputation of achievement, and nonpolitical philosophy. Additional on-site field interviews supplemented the criteria relating to networking and linkage. Minor criteria were also developed. We then created selection matrices using these criteria and the associated UPSI data to rapidly identify a list of potential partners. Schematic mapping of these potential partners was performed using the map identification codes developed in the UPSI. The codes, based on commonly available Lagos street maps, allowed us to rapidly find the general location of a health facility or CBO so that nearby entities might form one partnership. The Inventory was thus a powerful tool, essential for the ultimate selection of private partners within the target communities.

Development of Prototype Partnership Structure

The schematic mapping of potential partners revealed groupings of geographically proximal CBOs and health facilities that might function as “clusters” within each community. Initially two clusters were identified for each target community. Exhibit 9 depicts a diagram of a sample cluster developed from the UPSI database. Within each cluster, potential dyads (cooperative partnerships between at least one health facility and three or more neighboring CBOs) were also defined, initially based largely on geographic proximity or common characteristics, such as religious CBOs.

The UPSI findings helped classify CBOs according to their membership criteria: religious, educational, occupational, gender, or social. Health facilities were classified as traditional medicine clinics or as allopathic polyclinics or small hospitals, primary health care clinics, maternity homes, or private voluntary organizations or community-based organization clinics. The findings helped define four initial prototype cluster types: (1) allopathic for-profit health facility and CBOs, (2) allopathic nonprofit health facility and CBOs, (3) for-profit allopathic health facility, traditional healer, and CBOs, and (4) a group of collaborating health facilities each associated with a different CBO.

Exhibit 8 Criteria for Partner Selection

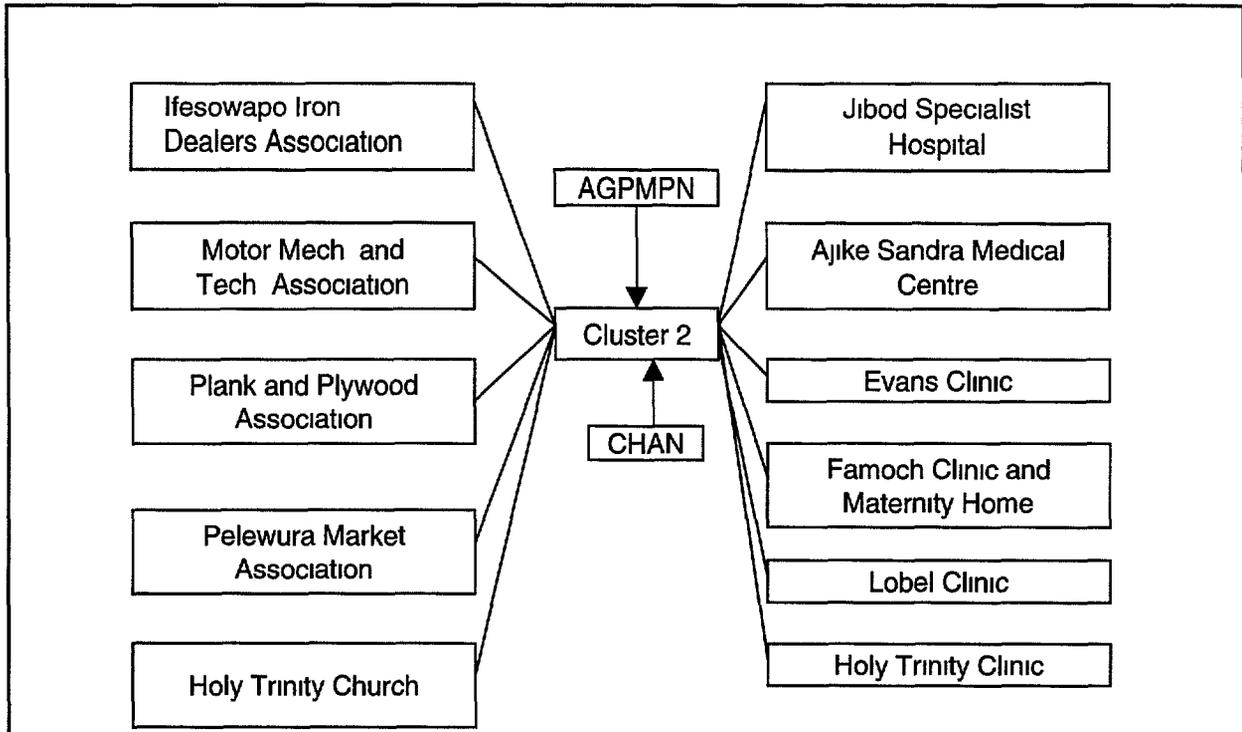
Community-Based Organizations

- History or potential ability to participate in Expanded Program on Immunization (EPI) promotion services
- Evidence of effective management
- Membership size of 50 or more
- In existence five years or longer
- Membership fees that provide financial support to organization
- Existing or potential linkage with health facility
- Organizational type, with women's groups given preference
- Nonpolitical
- Reputation of achievement
- Interest and enthusiasm

Health Facility

- History or potential ability to provide EPI services
- Evidence of effective management
- Minimum of five paid staff
- In existence five years or longer
- Evidence of financial sustainability and resource base
- Existing or potential linkage with CBO or other outreach capacity
- Established or potential cold chain equipment
- Registered with at least one Government of Nigeria authority
- Facility type, with polyclinic/hospital preferred
- Interest and enthusiasm

Exhibit 9
Prototype Partnership Cluster Based on UPSI Findings



A BASICS team member then visited the organizations and facilities in each target cluster to ensure overall consistency with the reported data in the inventory and to conduct interviews to collect information about the remaining selection criteria not contained in the UPSI, such as interest and enthusiasm. The interviews also served as an opportunity for the Project to offer a personal invitation to the CBO or health facility to participate in a series of meetings, or fora, called the Community Partnership Fora, to explore the concept and feasibility of private-sector partnerships for health.

The development and field implementation of the UPSI took about six weeks, with an additional three to four weeks needed to analyze the data and use the findings to select target communities, identify potential partners, and delineate clusters and dyads. The UPSI therefore provided critical information for the design of private sector partnerships and greatly augmented initial project planning.

Exhibit 10
Examples of Partnership Types

- Allopathic for-profit health facility and CBOs
- Allopathic nonprofit health facility and CBOs
- Allopathic for-profit health facility, traditional healer practice, and CBOs
- Group of collaborating health facilities, each associated with a different CBO

Facilitation of Community Fora

Over a period of six months, BASICS held 34 community partnership fora throughout the target communities. Within the 12 prototype clusters (two clusters per target community, each containing 10 to 20 partner organizations), we invited representatives from 74 health facilities and 90 CBOs to participate. As facility and organizational addresses were clarified, we reduced the number of clusters by combining several with more proximate members. Representatives from each target community could participate in at least two fora. During the course of the fora, additional organizations were identified as viable partners that would build on existing collaborations already established by the original set of participating organizations.

A community forum typically took place in local buildings such as private schools, religious institutions, or meeting rooms of the invited organizations. Commonly, health facilities provided the venue for the meetings, making special arrangements for patient coverage so that participants could be virtually undisturbed.

The week before each forum, BASICS staff hand-delivered invitations and discussed the purpose of the forum with invited participants. Such personal outreach may have contributed to high attendance—an

Exhibit 11
Potential Participants for Community Fora
Identified by the UPSI

- 90 community-based organizations
 - 74 health facilities
-

Exhibit 12
Schools and Other Local Venues Were Used for Community Partnership Fora



average of ten people per session, not including BASICS staff. The recent UPSI also increased interest and participation, since everyone invited had participated in the inventory and, hence, had some recent exposure to BASICS.

Session 1

The first round of forum sessions was used to introduce BASICS and present the concept of HF-CBO partnerships for health. The feasibility of such partnerships was examined, as well as the willingness of the attendees to participate. Diagrams of the four prototype partnerships developed from the UPSI were also shared with the groups to graphically illustrate the partnership concept and stimulate further discussion. The participants made recommendations about possible dyads comprised of the groups invited to the fora, as well as of other organizations or facilities with potential—especially those with which they already had collaborations. During these first sessions, some of the groups progressed to discussion of specific roles for health facilities and CBOs in such partnerships.

The typical agenda of Session 1 included the following discussion points:

- Introduction to BASICS Urban Integrated Private Health Project facilitators, Project mission, goal, 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

Generally, BASICS facilitated two or three fora each week. Each session required two facilitators to assist with registration and logistics and to facilitate discussion. We developed special flip charts, fliers, and other health-related materials to reinforce key points. The sessions also modeled good meeting and community organization techniques—for example, sending out agendas in advance, starting on time, following an outlined agenda with scheduled times for each topic, and presenting clear objectives.

Exhibit 13 **Accessible Community Sites Used for Fora**

- Private nursery and primary schools
 - Meeting rooms in religious institutions
 - Community centers
 - Meeting room of one of the proposed partner organizations (second session only)
-

Exhibit 14 **Operational Definition of a Dyad**

Partnership between a health facility (one or more) and neighboring community-based organizations (three or more) to improve maternal and child health in their community.

Exhibit 15
Community Fora Stimulated Lively Discussions

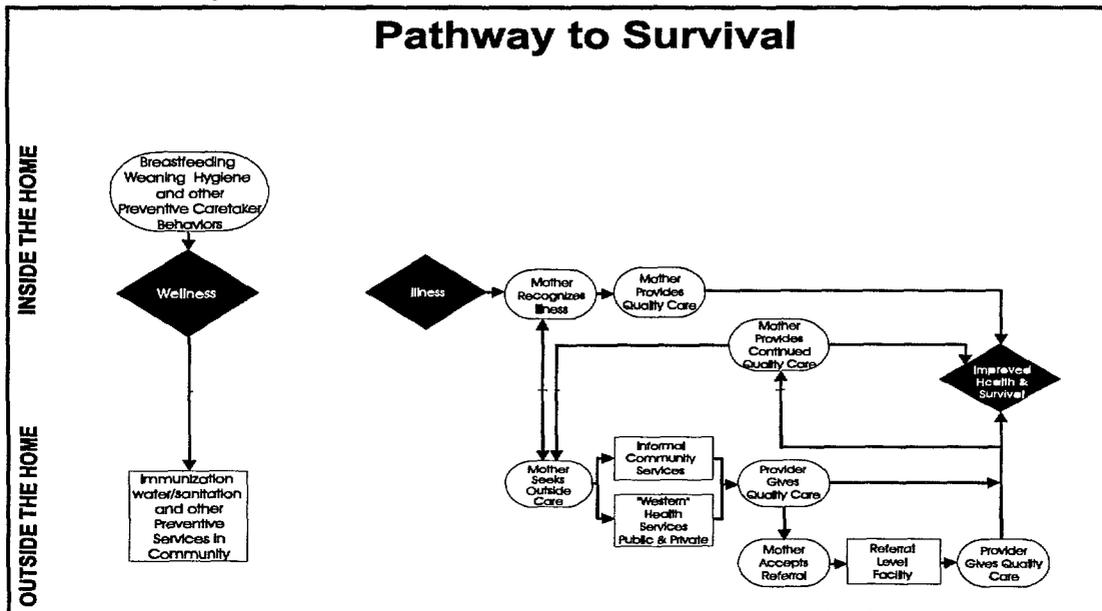


We used participatory methods and conducted the sessions in the local language of the group, which was usually Yoruba, Pidgin, or English. In cases when participants came from diverse ethnic backgrounds and did not know English, the material was presented in English and immediately translated to other languages as needed.

The BASICS Pathway to Survival, as shown in Exhibit 16, was translated into Yoruba and depicted on a large wall poster. The poster proved most valuable in communicating the importance of improving the knowledge of parents and caretakers so they can provide effective home-based care for children. The critical

interface between home/community and health facilities was also clearly depicted, as well as the need to include both private and public providers in considerations of the available local delivery system. The Pathway poster not only explained BASICS' program to the community participants but also provided a framework for discussion about roles, responsibilities, and potential interventions of health facilities and community organizations.

Exhibit 16
BASICS Pathway to Survival



Lagos Community Partners for Health

Each forum session lasted 90 minutes or less. A total of 187 people participated in Session 1 meetings across the 12 clusters, including representatives of allopathic and traditional health facilities, all types of CBOs, and local affiliates of network or umbrella organizations such as the Nigerian Red Cross. By the end of the first series of meetings, the initial set of participating organizations and facilities had been confirmed, with their core identifying information from the UPSI validated. The prototype partnership schematics and partner lists were refined using the actual organizations and facilities participating in the fora. Partner profiles were developed for each, again building on the UPSI, and consolidated in a directory. Annex A presents a sample profile.

Common concerns expressed during the initial sessions that would influence the development of the partnerships included the following:

- Lack of knowledge among parents in the community about effective home-health practices and the importance of preventive actions such as immunizations
- Limited vaccine supply at private health facilities
- Ability of health facilities to handle the needs of clients mobilized by the CBOs
- Potential conflict of interest between for-profit health facilities and CBOs who might refer needy patients to them
- Lack of cooperation between health facility providers, both traditional and allopathic, due to the tendency to protect their own client pools
- Rising level of poverty necessitating special provisions for the poor to receive services
- Communication gap between health providers and community-based organizations
- High degree of superstition in the community surrounding illness and its prevention

The participants also discussed solutions to these health problems and to the challenges that the partnerships would face. Most groups mentioned three solutions: (1) community education about preventive health, home care, and sources of quality care outside of the home, (2) community education to overcome fear and distrust of private health providers and to counter commonly held superstitions and related practices, and (3) improvement of the capacity and capability of local health providers, including assurance of a sufficient vaccine supply. Despite the concerns they discussed, the groups overwhelmingly supported the partnership concept and its feasibility. However, they cautioned that continued dialogue between providers and community representatives and between public and private-sector providers, as well as increasing community awareness of the partnership concept, was vital to the success of the proposed partnerships. Even at this early stage, some participants spoke of the potential for such partnerships to address other community problems such as poor environmental conditions and the lack of safety.

Exhibit 17
Community Members Recognized That Rising Level of Poverty Necessitates Special Provisions for the Poor



Session 2

In the second round of forum sessions, participants delineated partner roles and responsibilities, discussed operational guidelines, and initiated the development of partner action plans by defining current community health problems. The generic agenda for this session included the following discussion points

- 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)

Exhibit 18
Comments of Community Participants

- There is a need to change the orientation of people from "prevention is better than cure" to "prevention is cheaper than cure".
 - We need to train community-based organizations on how to inform, educate, and communicate child health messages to the people.
 - Parents have a critical responsibility in child health programs, but many cannot fully assume such responsibility due to their lack of knowledge or education, time, and maintaining practices and beliefs which should long have been forgotten.
 - Education is needed to combat deep-seated ignorance.
-

- 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

A flip chart, as shown in Exhibit 19, was developed that illustrated specific partner roles in addressing diarrhea, one of the most commonly noted health problems. This simple example of potential contributions by each type of partnership member (health facility, CBO, and BASICS) clarified the abstract concept of community partnerships. In addition, the facilitators used several schematic diagrams showing diverse partnership types to explain the variety of partnerships that might evolve depending upon the community served.

More people in a community usually attended the second session than the first, with 15 as the average number of participants, not including BASICS' facilitators, more than 20 people attended several of the meetings. Not all groups from Session 1 attended the second session, conversely, some new

Exhibit 19
Diarrhea Example Potential Contributions, by Partner Type

Health Facility & Community-Based Providers	Community-Based Organizations
<ul style="list-style-type: none">- Accept cases of diarrhea- Treat cases of diarrhea referred by CBO- Provide education on diarrhea in clinic/community- Set up an ORS corner- Communicate with CBOs on health problems- Plan preventive and promotive education programs with CBOs- Refer difficult cases- Follow up difficult cases- Document cases	<ul style="list-style-type: none">- Prevent cases of diarrhea- Manage cases of diarrhea at home- Refer/report cases of diarrhea- Assist serious cases of diarrhea to reach health facility- Organize community awareness campaign on diarrhea- Encourage breastfeeding- Encourage the use of boiled water- Encourage provision of clean neighborhood water supply- Maintain provision of clean water supply
BASICS	
<ul style="list-style-type: none">- Provides necessary training to both HF and CBOs- Provides posters for education- Encourages two way communication between partners (HF, CBOs) and BASICS- Provides technical support on documentation, monitoring and evaluation, and expansion of the CPH (no monetary transfer)	

organizations which had not participated previously, attended Session 2. Thus, at the close of all the second sessions, we revised the partners list and dyad schemata. Over the full forum series, a total of 306 people from CBOs and health facilities participated.

By the conclusion of the second session, participants had defined and activated six dyads (including one cluster composed of four dyads functioning as a unit), one in each of the six target communities. They had agreed upon initial operating guidelines and governing structures. Several communities held third sessions to focus on or to continue the discussion around preliminary identification of key local health problems. Holding a third session also gave the participants time to return to their organizations and facilities to gather more information from their constituencies.

In addition to increased attendance in Session 2, evidence of interest and willingness to support the concept of local responsibility for health through community partnerships was obvious in the feedback regarding interim activities or "assignments" from Session 1. Most of the partners had initiated some organizational activity either to identify other local partners or to examine health problems in their communities. Exhibit 20 describes several examples of the self-directed actions undertaken by the new partners.

During all the forum sessions, participants asked questions about the concept and feasibility of private sector partnerships for health. Realistic responsibilities for each partner type were examined in depth. Some of the most common questions regarding BASICS' role and responsibility in the partnerships follow:

- Will BASICS employ staff for a partnership that has insufficient staff to carry out the activities it designs?
- Is BASICS going to help the health facility partners become government-recognized immunization centers?
- Is BASICS a Christian organization?
- Will BASICS assist in payment for patients who cannot afford to pay when they go to a partner health facility?
- Since BASICS is not giving money to the private clinics, what will they gain from this effort?

Exhibit 20
Actions Taken by Partners Following
Session 1 of the Community Fora

- One imam went to ten mosques and three churches in his neighborhood to explain the concept of Partners for Health, and they all promised to cooperate.
 - The doctor in a participating health facility disseminated information about the partnerships to 15 branch churches, working through a coordinating pastor.
 - One CBO partner contacted people at least one kilometer from his organization in all four directions to explain the concept and get their feedback.
 - A partner Chief advised her local constituency to come together and support the partnership to find solutions to their health problems as a way to improve the economy of the area.
 - One of the partnerships acted as a working secretariat.
-

One common discussion throughout most of the second session revolved around warning signs for which the evolving partners should “watch out” to avoid failure. These signs included breakdown in communications between partner groups, poor leadership, and loss of contact through infrequent follow-up with people in the community.

The fora were incredibly dynamic scenarios that attracted a diverse set of people—representatives from occupations such as hairdressers, market women, landlords, and taxi drivers, representatives from churches and mosques, and members of a range of social clubs. These individuals were sitting together, many for the first time in their lives, with doctors, nursing matrons, traditional healers, and other members of private health facilities. Given the range of educational backgrounds, ages, religious and ethnic groups, occupations, and socioeconomic levels at each session, it was truly a feat to conduct meaningful, much less productive meetings. Furthermore, the sessions introduced new methods, styles, and concepts in ways that were culturally appropriate and not intimidating.

The process encouraged and stimulated BASICS’ facilitators and the community partners. Perhaps it was particularly meaningful because of the dire circumstances of the involved communities and the survival challenge each partner faced in a time of poverty, crime, unemployment, and political uncertainty. One of the target communities was known locally as “the jungle city” because of its densely packed, violence-

Exhibit 21 Factors Partners Should Consider to Avoid Failure

- Breakdown in communications between partner groups
 - Poor leadership
 - Loss of contact through infrequent follow up with community members
-

Exhibit 22

Partners for Health Represent a Diverse Cross Section of the Community



filled neighborhoods. No previous endeavor had brought together health providers and community organizations in Lagos 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 (Exhibit 23)—and the responsibility for action, as well as sustainability, placed firmly with the community partners. They heard no promise of major capital investment, but instead received a pledge to receive assistance in the development of their own management capabilities to better generate revenue through quality services and efficient management.

The high motivation and interest level among the practitioners was refreshing. Although some of this reaction was undoubtedly related to their rapid recognition that the partnership model might be financially lucrative, they showed a genuine spirit of altruism and commitment to improving their communities. Some of this commitment may stem from the fact that many of the practitioners live in the communities they served.

In summary, by the end of the community fora, six dyads had been formed, the roles and responsibilities of the health facility partners, CBO partners, BASICS, and the overall partnership agreed upon, BASICS' inputs clarified, partnership operational guidelines outlined, community health problems discussed, and a process for development of action plans established. The dyads continued to meet on their own and did not wait or depend upon BASICS to arrange forthcoming meetings. Three of the dyads had agreed upon formal partnership names and were aggressively moving ahead to develop operating guidelines, establish secretariats, and examine the implications that their participation in the partnership might have on their individual organizations or existing affiliations. BASICS continued to assist the partners in the development of their action plans and the consolidation of the partnerships' organizational structures and operating frameworks.

Exhibit 23
BASICS' Role

From the first session, the catalytic but transient role of BASICS was emphasized and the responsibility for action, as well as sustainability, placed firmly in the lap of the community partners.

Exhibit 24
Accomplishments of Community Fora

- Obtained commitment to form Community Partners for Health (CPHs) in six target communities
 - Determined composition and structure of six pilot CPHs
 - Agreed upon roles, responsibilities, and inputs of each type of partner organization
 - Developed initial operational guidelines
 - Identified individual community health problems
 - Approved process for development of CPH action plans
-

The fora also provided many lessons for future work with the urban private health sector and increased our understanding about how best to mobilize inner-city communities known for their alienation and survival-line existence (Exhibit 25). This experience disproved many commonly held assumptions about the private health sector and urban poor communities. For example, the organizations and health facilities were surprisingly accessible to our initial contacts. Staff spent hours away from important work and service to attend the fora, invalidating the assumption that private health providers would be less willing to take time away from their practices because it would result in a loss of revenue.

Exhibit 25 Lessons Learned from the Community Fora

- Notify invited organizations or facilities about a week in advance of an intended meeting so that patient schedules or workloads can be reorganized. More advance notice is not useful.
- Hand-deliver written invitations to the person in charge to clarify the purpose of the meeting and answer questions. A personal invitation also initiates the relationship in a more personal manner and begins to build a foundation of trust and transparency, critical in urban environments rife with corruption.
- Encourage participation of the person with decision-making authority for the organization or health facility, so that institutional support is ensured. Later, he or she may delegate participation to an appropriate colleague.
- Make sure that the venue is approved by the highest authority responsible for the site to avoid embarrassing conflicts the day of the meeting.
- Hold the meeting at a commonly known site, easily accessible by foot or local transport. (BASICS did not provide transport or reimburse transport for participants.) Visit the site in advance to set up and prepare for the session, bring all supplies along.
- Remain apolitical, avoid venues associated with political parties.
- Schedule meetings for convenient times identified by the potential partners themselves. In Lagos, most found mid-day meetings optimal (between 11:00 a.m. and 1:00 p.m.).
- Start on time even if attendance is minimal at first, and keep to the schedule. Promptness and efficient use of time signals recognition that the individuals are busy, productive people whose time is valuable.
- Conduct meetings in the local language of the majority of the participants and translate when necessary for subpopulations who may not speak the majority language.
- Explain clearly the goals and purpose of the catalyzing agency (BASICS), and stress its temporary role.
- Encourage self-determination and sufficiency from the start; avoid unrealistic expectations of long-term external donor funding.
- Focus on the partnership concept to minimize hopes for major infrastructural improvements or inputs outside the Project's health mandate.

Exhibit 26

Community Fora Took Place in Communities Facing Poverty and Declining Services



Establishment of Community Partners for Health

The six partnerships that exhibited the most potential, as evidenced by their initiative to plan and begin activities on their own, became the models for others. They will serve as catalytic agents and technical advisors for other partnerships in the future. Most impressive is the fact that the other dyads not selected for initial BASICS' facilitation continue to express their interest in developing partnerships, and, hence, a "waiting list" has been started for future technical assistance.

The six pilot partnerships have a total initial outreach of approximately 250,000 people based on organizational membership and/or current patient load. However, their potential sphere of influence is estimated to be several million. Each of the partnerships includes one to four health facilities and two to ten CBOs.

Governance and Structure of Partnerships

The six pilot partnerships include a total of 15 health facilities and 42 CBOs, but each partnership is composed of diverse membership configurations, as illustrated in Exhibit 27. Hence, each partnership needed to reach a consensus about its governance and fiscal responsibility. The partnerships were not legal entities, at least initially, so the status of the member organizations did not change. However, they established governing boards to implement and monitor health activities that would be agreed upon in their CPH action plans. In

general, each participating partner organization contributed one member to the board, with the selection process and criteria determined by each partner. The board members then chose a chair and a vice-chair to make executive decisions and to assume financial responsibility for the partnership.

The partnerships adopted formal names, usually the specific community name followed by "Community Partners for Health"—for example, the Ajegunle Community Partners for Health. They 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, and others provided in-kind staff support for these functions. The partners provided meeting space and equipment, often rotating among the members, but in some cases sponsored by a "leading" partner, commonly the health facility. The CPHs used existing organizational resources and structures, instead of investing in new purchases.

The 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

Exhibit 27 Example of Selected Pilot Partnerships

Makoko CPH, 13 partners

- 4 for-profit allopathic health centers/hospitals
- 4 religious CBOs (2 mosques, 2 churches)
- 2 occupational CBOs (taxi drivers association, market women's association)
- 2 neighborhood CBOs (2 landlord/tenants associations)
- 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 (National Union of Road Transport Workers [NURTW]-local affiliate)
- 2 neighborhood CBOs (residents association, welfare association)

Lawanson CPH, 14 partners

- 4 for-profit allopathic health centers/hospitals
 - 5 occupational CBOs (carpentry association, NURTW local affiliate, market association, tailoring association, photographers association)
 - 5 neighborhood CBOs (residents associations)
-

Lagos Community Partners for Health

MOU was developed between each partnership and BASICS. The core components of an MOU are outlined in Exhibit 28, a full text is located in Annex B.

In addition to addressing health issues, each MOU established a strengthened role for women in the community as an objective. This objective is addressed through such means as requiring female participation on the partnership governing boards.

A critical issue for each partnership was the development of a joint structure for processing financial transactions, while simultaneously ensuring fiscal responsibility. The first step was the establishment of a bank account in the name of each respective partnership, in most cases using the existing account of one of the health facilities or another member. Joint signatories were then established including the organizational representative sponsoring the account and the chairperson of the governing structure and, in some cases, a representative of another member organization. Reaching

consensus about such a sensitive issue was a clear indication of the partners' commitment to this new venture. BASICS assisted the partners by performing a financial review of the organization responsible for the bank account to identify financial system areas that could benefit from strengthening.

All of the health facility partners are registered with some level of government. The majority of the CBOs are government-registered, although some, particularly those affiliated with religious institutions, function through umbrella organizations. The new partnerships discussed the utility of registering the partnerships themselves as nonprofit entities, but they decided to wait until they had a proven track record of actions and fund-raising.

Each partnership adopted its own written operating guidelines, which concisely delineated the roles and responsibilities of HF partners, CBO partners, and BASICS. These guidelines included the following:

- Definition of terms
- Partnership purpose
- Structure
- Communication
- Roles and responsibilities of each type of partner organization
- Potential inputs and resource contributions of each type of partner organization

Exhibit 28 Core Contents of Ajegunle CPH Memorandum of Understanding

- Names and addresses of partners
 - Objectives of partnership
 - Governance of partnership
 - Roles and responsibilities of HF partners
 - Roles and responsibilities CBO partners
 - Signatures of representatives of partner organizations
-

Exhibit 29 Evolution of Partnership Governing and Management Structure

- Determination of partnership names
 - Development of governing structure board with representation of each partner organization
 - Establishment of secretariat with partnership support
 - Drafting and signing of MOU
 - Determination of financial agent for partnership (establishment of CPH bank account)
 - Creation of partnership operating guidelines
 - Consideration of partnership registration
-

The partnerships developed their own logos and brochures with BASICS' printing assistance. A sample of a partnership informational brochure is reprinted in Annex C.

Application of UPSI Findings in Partnership Planning

Information from the UPSI was also extremely useful in developing preliminary strategic interventions during and after the workshops. For example, findings on the types and numbers of potential partners in a target community influenced strategic options. Communities with large numbers of CBOs but few health facilities might capitalize on building CBO outreach capacity, focusing on interventions to strengthen prevention and to recognize health danger signs and symptoms needing referral. The health facilities in such a community might focus efforts on developing mobile teams and outreach sites linked with CBO promoters, the CBOs might also support transport services for emergency referrals to the health facility. Conversely, in a community with large numbers of health facilities, the partner health facilities might focus efforts on improving their quality of care and networking to ensure effective continuity of care and referrals between facilities.

The UPSI also elucidated topics that would benefit from more in-depth examination, such as facility catchment populations and patient profiles, use of local data (and community epidemiology) for tailoring services to client needs, vaccine supply and cold chain capacity for immunizations, facility billing and management of services, patient record-keeping and files, and quality and continuity of care (Exhibit 30). UPSI findings were thus used to stimulate discussions regarding interventions that each partner could perform—including new skill and capacity building—to improve maternal and child health in its community.

Workplan Development: Agenda for Action

The BASICS team facilitated a series of individual meetings with each of the six pilot partnerships to prioritize local health problems, especially those relating to child health, in order to develop partnership workplans. For many of the partners, including the health professionals, such a formal logical approach to problem identification and priority setting was a new approach. The sessions also assisted the partners in the collection of background material and information useful for their planning. Generally each partnership needed two such sessions to prepare for participation in Workplan Development Workshops, where the partnerships prepared the action plans that would guide their efforts.

A series of three workshops took place, each lasting one-and-a-half days, with two partnerships participating in each workshop. Exhibit 31 summarizes total participants for the three workshops. Every partner organization selected representatives (two from each partner HF and three from each CBO) to

Exhibit 30 Longer-Term Use of UPSI Findings

- Strategic planning for partner interventions
 - Identification of specific areas requiring more in-depth examination or skills/capacity development among partners
 - Definition of client/patient profiles
 - Determination of service population size/catchment
 - Vaccine supply and cold chain
 - Patient referral and follow-up
 - Billing and financial management
-

Lagos Community Partners for Health

attend the workshops, which were held in a well-known professional organization's community meeting room. Participants arranged their own transportation. Criteria for selection of the representatives included participation in at least one of the community forum sessions and strong knowledge about the organizations they represented. Eighty-nine people representing 13 health facilities and 37 CBOs took part.

BASICS developed a workbook for the workshops that included four exercises:

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

Exhibit 31
Overall Participation in Workplan
Development Workshops

- 13 health facilities
 - 37 community-based organizations
 - 89 individual participants
-

The workbooks also addressed budget planning, financial accountability, monitoring workplans through the use of indicators, and memorandum of understanding development, although these topics required field follow-up. BASICS' team members facilitated the sessions, which were conducted in Yoruba or English, with simultaneous translation as needed for other local languages. (Copies of the workbook are available through BASICS.)

The enthusiasm level again was very high. Participants received no per diem or incentives other than a mid-day meal during the full-day session. Attendance was maintained on the second day of each workshop, with no dropout. Participants arrived on time, remained actively engaged throughout the day, and often stayed after the end of the workshops for additional discussion. The diversity of individuals, as illustrated in Exhibit 32, contributed to the sense of energy and enthusiasm that infused each workshop. Although all partners had participated in previous meetings, their comments revealed that none had previously undertaken such an intensive, collaborative exercise.

By the conclusion of the workshops, each partnership had identified the top two or three child health problems that they felt were feasible to address within currently available resources. The four most common health problems addressed in the action workplans were—

- Diarrheal disease
- Malaria
- Acute respiratory infections (ARI)
- Measles and other vaccine-preventable diseases

Exhibit 32
Diverse Partners Developed Workplans Together



The draft action plans each had one overall goal and five core objectives (Exhibit 33). Three core objectives were directed toward improving child health through prevention and treatment of diarrhea, malaria, ARI, or measles. Two core objectives were aimed at strengthening institutional capacity through such means as sustainability of services and organizations and development of women's skill-building and decision-making capabilities.

Each partnership developed activities with a proposed implementation plan that included preliminary estimates of human resources, equipment or supplies, and time frame. Activities were discussed in terms of each partner organization's contribution. Every partner did not have to contribute to each objective or activity; rather, partners participated according to their strengths, mandates, and capacities. Draft budgets and the development of preliminary program monitoring indicators were also initiated.

Exhibit 33
Examples of Objectives Lawanson CPH
Workplan

- 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 ARI) 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 decision making in LCPH and the community it serves

During each workshop, participants completed written exercises in their own workbooks. Each partnership also chose a scribe who maintained an institutional workbook. Thus, at the conclusion of the workshop, each partnership had its own functional record of the partnership action plan. As a result of the workshops, the partnerships had completed draft workplans, preliminary budgets, and memoranda of understanding.

Subproject Proposals

The Partners for Health workplans formed the basis for subproject proposals, which BASICS submitted to USAID for approval and funding.

The Jas CPH, for example, developed a proposal that focused on prevention and treatment of diarrhea and prevention of malaria. Projected outcomes included an improved referral system between partner facilities and treatment centers, an increased supply of potable water, and relevant training-of-trainers. To achieve increased immunization coverage rates, the proposal set as outcomes improved cold chain maintenance, increased vaccine supply from the government, and improved health-facility reporting of immunizations and cases.

To reduce the numbers of children and pregnant mothers getting sick from malaria, the proposal developed by the Lawanson CPH set 12 outcomes, including improved knowledge and practices by community members about mosquito nets and other prevention techniques. In addition, it proposed improvement in fund-raising, advocacy, and public relations skills, among other objectives, to increase the sustainability of the partnership itself. And to strengthen and expand the role of female decision making in the partnership and the community it serves, the Lawanson CPH proposed to develop women's knowledge of their legal rights, increase access to credit by CPH partner organizations with large female memberships, and develop and expand leadership skills of women in CPH organizations and on the governing board.

Both partnerships stated in their proposals that they will implement activities to increase the use of voluntary family planning services in the second phase of their activities. Although the community fora and proposals focused on child health, the proposals, being longer term in scope, incorporated additional topics into their objectives, particularly female/reproductive health and STD/AIDS prevention. In this way, the proposals contained integrated objectives for improving health in the communities served by the private-sector partnerships.

Prior to submission of the proposals, BASICS and the Mission used a three-step process to examine the financial accountability of each partner organization with fiscal responsibility for a partnership. The financial and management information provided on the UPSI served as the first level of assessment. Next, the Integrated Health Baseline Survey-NGO Management Assessment provided more in-depth information about each institution. Finally, an independent accountant performed an on-site review using an adaptation of Pathfinder's financial assessment instrument. Thus, only organizations deemed to possess a reasonable measure of financial accountability were included in the final submission of proposals. After approval and a minimal, although crucial, amount of funding from USAID, the partnerships are now implementing their proposals.

Monitoring through Use of Local Data

The status of health in the communities before the BASICS intervention was obtained as part of an integrated health baseline survey sponsored by USAID. The sampling frame in Lagos for this survey was drawn from the catchment populations of the partner organizations. The Lagos results from the survey were disaggregated per partnership. BASICS created graphics depicting the key findings to share with the partners. Capacity-building exercises helped them 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.

Review of the Partnership Model

Summary of the Process

In summary, the selection of private sector partners and formation of the Lagos Community Partners for Health included the following components

- Use of UPSI data to identify the private health sector, target communities, and potential private health sector partners
- Interviews and site visits with potential partners
- Development of prototype partnership structures
- Community Partnership Fora to develop operational frameworks and confirm partners
- Selection of six pilot partnerships
- Evolution of governance and structure of partnerships
- Action plan development to delineate specific partnership activities and interventions
- Submission of subproject proposals to USAID for approval and funding
- 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

Value of the Model

The private partnership model has proven false the assumption held by some people in the public health sector that for-profit health providers cannot be motivated to serve less privileged members of society. It has highlighted the deep humanitarian motivations that cut across ethnic groups, educational levels, religions, gender, and socioeconomic classes. Communities known more for their deprivation and public health risks have emerged as models of nonpartisan cooperation for the welfare of their children. Individuals participating in the partnerships have shown dedication, energy, and talent. Finally, the partnerships have empowered the partners and strengthened their recognition of an inherent capacity to find solutions and alter wrongful conditions in their communities.

**Exhibit 34
Communities Known for Their Deprivation and Public Health Risks Have
Emergred as Examples of Nonpartisan Cooperation for the Welfare
of Their Children**



The process used in forming the CPHs also illustrates one way to initiate private sector involvement in public health. It lays out a practical method to link facility-based services with community outreach and health promotion, which has utility in both the public and private sectors. The partnerships build on a synergy between facility-based and community-based health promotion, as well as augment facility-based care with appropriate community-based prevention and home care. By involving a variety of community organizations, the outreach potential of the partnerships is impressive, overlap in community recipients

has served to reinforce the messages and services provided. Hence, the partnerships become living examples of behavior change via practice, as evidenced by CBO members whose own behaviors have modified as they teach and help others. The interface between home-care and facility interventions by health practitioners is strengthened, breaking the arbitrary division between the community and the health-care delivery system.

As Exhibit 35 summarizes, the value of the partnership model is that it can address a range of issues. For example, communication and understanding between allopathic and traditional medicine practitioners are improved through joint participation in solving common health problems. Members are exposed to alternative perspectives in a nonthreatening, supportive environment. The partnership model particularly focuses on capacity building with women's groups and community women, starting with family and self-health but moving beyond to other areas of decision making and skill building.

Exhibit 35
Value of the Partnership Model

- Links facility-based services with community outreach and health promotion
 - Reinforces health messages by involving overlap of community recipients
 - Changes behavior as partnerships become living examples through their own practices
 - Increases communication between allopathic and traditional health facilities
 - Builds capacity, especially among community women
 - Provides solutions using existing local resources and abilities
 - Forms bridge to other local governance issues
-

Implications for Local Governance

The partnerships engender a sense of community responsibility for health and overall empowerment by finding feasible solutions to local problems that use existing local resources and abilities, rather than depend on external financial, political, or technical inputs. The mutual respect and recognition that characterize successful partnerships encourage trust and understanding between quite disparate groups and individuals who are often separated by ethnic, professional, educational, or religious divides.

Inherent to the partnerships are principles of representation and equity. Some of these principles are formally introduced through the governance system, others are incorporated as part of the design process or during implementation. Even in the first year of the partnerships, the contributing partners and their constituencies are spontaneously adopting more representative modes of decision making. They are expressing confidence in their own abilities to solve problems, rather than looking to the government or outsiders.

Increased responsibility for local health concerns forms a natural bridge to other local governance issues. The partners themselves recognize that their newly discovered strengths can be used to address other community concerns, such as the environment, crime, and infrastructure.

Conclusion

Through the Lagos Community Partners for Health, partnerships between community-based organizations and health facilities show that private initiative can be mobilized to promote child survival in urban communities. The cooperation and dedication, in-kind resources, and local abilities that the partners have contributed to the development of the partnerships, as well as their early implementation of action plans to improve child health, have validated the public contribution that the private health sector can make. That these partnerships have developed in some of the least advantaged communities in a city known throughout the world for its violence and poverty only emphasizes the strength and credibility of this approach. If the partnership concept is workable in hard core, urban communities such as those in Lagos, it has the potential to succeed with other isolated and needy urban populations.

Although the partnerships are new and their sustainability is not yet ensured, they nonetheless are a breakthrough in working with the urban private health sector and provide a method worth examining in other urban contexts. In an era of decentralization, the partnerships bring responsibility for health back to the community, which becomes the first step in accepting more responsibility for other areas of local governance.

The partnership concept inherently supports an integrated approach to health. It emphasizes the importance of parental actions in prevention, home care, and interface with the formal health-delivery system. The partnering of CBOs and health providers breaks down the barriers of clinic walls and extends the responsibility and capability for ensuring healthy children into each and every home.

Critical characteristics of the partnership model include the initial catalytic function of the external agency (in this case, BASICS) in an essential, but limited facilitation role, early presentation of the concept to the community to examine its feasibility and shape, and the gradual evolution of the partnerships' governance structures and responsibilities as self-determined by their members. Although BASICS provided initial impetus to the partnership development by introducing the concept, the partners then made all the key decisions. They determined the CPH structure, guidelines, functions, and pragmatic workplans.

The partnerships form a vehicle to reach many communities and individual families for health promotion, prevention, and treatment. Thus, they form an infrastructure that can be used to mobilize participation for other causes worthy of community effort.

Perhaps the most important contribution of the partnership is the restoration of hope and belief in the participants' own ability to make a difference, which are lost commodities in many urban communities. The words of one partner say it best: the partnership "brings a light of hope" to the community.

Exhibit 36
Critical Characteristics of the
Partnership Model

- Initial catalytic function of external agency
 - Early presentation of partnership concept to community to examine its feasibility and shape
 - Evolution of partnerships' governance structures and responsibilities
 - Key decisions made by CPHs
-

References

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* Report prepared for the U S Agency for International Development by the Basic Support for Institutionalizing Child Survival (BASICS) Project Arlington, Va

Annex A. Sample Health Provider Partner Profile

Health Providers and Facilities

General Identification

- 1 Name of Facility All Souls Clinic
- 2 Address Ojo Road, Ajengunle
- 3 Name of Proprietor Mrs Sado
- 4 Community Ajengunle
- 5 LGA Ojo
- 6 Contact Person Mrs Sado Tel No _____
- 7 Classification Medical/Health Practice - Group based in clinic
- 8 Ownership Partnership of providers
- 9 Facility/Type of Practice Polyclinic with specialty services
- 10 Type of organization (P/NP) Profit

Sustainability Factors

- 11 Period of Active Operation in the Community >5 years
- 12 Effective Management Structure Supported Without organigram

Staffing

- 13 Full-time Doctors 6 Part-time Doctors 4 Specialist Doctors 0
- 14 Registered with Federal government
- 15 Affiliated with Luth, Igbobi

Outreaches

- 16 No of Children <5 yr Attended to per Day 15
- 17 No of Families/Households Attended to per Week 0
- No Attended to Within 5 minutes walk (long distance)
- No Attended to Within 1 minute walk (short distance)
- 18 Main Source of Financial Support Fee for services

Annex B. Ajegunle Community Partners for Health

Memorandum of Understanding, May 1996

I THIS MEMORANDUM OF UNDERSTANDING (MOU) is made this day
of 1996 BETWEEN

HEALTH FACILITY

RIKKY HOSPITAL

197, Ojo Road,
Ajegunle

COMMUNITY-BASED ORGANIZATIONS

ASSEMBLIES OF GOD CHURCH (BRANCH)

58, Cardoso St ,
Ajegunle

CHRIST APOSTOLIC CHURCH

50/52, Ligali Rd ,
Ojo Rd , Ajegunle

THE CHURCH MIRACLE CHAPEL

16A, Cardoso Lane,
Ajegunle

CHRIST REDEMPTION CHURCH

16, Charles Avenue,
Ajegunle

HOLY FOUNTAIN CHURCH OF CHRIST

1, Ibitoye St ,
Ojo Rd , Ajegunle

ETERNAL SACRED ORDER OF CHERUBIM & SERAPHIM CHURCH

New Jerusalem,
Behind Otto Warf

OPELOYERU MOSQUE

47 Adekeye St ,
Ojo Rd
Ajegunle

EJIRO YOUTH ASSOC

7 Mokoya,
Olodi-Apapa

EKUWGBE YOUTH ASSOCIATION

105, Idewu St ,
Olodi Apapa,
Lagos

ASSEMBLIES OF GOD CHURCH

23, Itire Rd ,
Ajegunle

ASSEMBLIES OF GOD CHURCH

Amukoko

ASSEMBLIES OF GOD CHURCH

Alaba

MARKET WOMEN ASSOCIATION

Block 139,
Alaba-Suru,
Ajegunle

OLUWA NI SOLA MOSQUE

30, Ibitoye St ,
Ajegunle

FOLORUNSO MOSQUE

79, Oyedeji St ,
Ajegunle

OLAYENI CENTRAL MOSQUE

206, Ojo Rd ,
Ajegunle

ASSEMBLIES OF GOD CHURCH

7, Akibu Street,
Kirikiri

ASSEMBLIES OF GOD CHURCH

46, Omololu St ,
Amukoko

ST EBENEZER CHURCH

174, Ojo Rd ,
Ajegunle

OYEDEJI COMMUNITY

2, Oyedeji St ,
Off Ojo Rd ,
Ajegunle

TRADITIONAL MEDICAL ASSOCIATION

43, Mosafejo St ,
Amukoko

GOD'S CARE NURSERY & PRIMARY SCHOOL

23, Itire Rd ,
Ajegunle, Apapa

WORLD WIDE MIRACLE MINISTRIES

5, Akinsipe St ,
Amukoko

II OBJECTIVES OF PARTNERS SIGNING THIS MOU

- 1 By the end of 1998, reduce the number of children under 5 years getting sick from watery diarrhea in Ajegunle and/or among the organizational members of **Ajegunle Community Partners for Health (AJCPH)**, and the number dying from dehydration or dysentery despite treatment in a partner health facility
- 2 By the end of 1998, reduce the number of children getting sick with cough in Ajegunle and/or among the organizational members of **AJCPH**, and the number dying from acute respiratory infections (ARI) despite treatment in a partner health facility
- 3 By the end of 1998, reduce the number of children and pregnant mothers getting sick from malaria in Ajegunle and/or among the organizational members of **AJCPH**, and the number dying despite contact with partner health facility
- 4 By the end of 1998, increase the immunization coverage in Ajegunle and/or among the organizational members of **AJCPH** and ensure availability of effective, quality vaccines
- 5 By the end of 1998, increase the demand for and availability of modern child spacing/family planning services among **AJCPH** organizational members
- 6 By the end of 1998, increase the level of awareness of partner organization on epidemiology and control of HIV/AIDS and STDs

Lagos Community Partners for Health

- 7 By the end of 1998, **AJCPH** 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 role of female decision making among female members of **AJCPH** and in Ajegunle community

III NOW IT IS HEREBY AGREED AS FOLLOWS

- 1 The partnership/dyad shall be carried under the name and style of **AJEGUNLE COMMUNITY PARTNERS FOR HEALTH (AJCPH)** The partnering of the health facilities and the community-based organizations at the community level is what is here referred to as the **DYAD** and which have mutual responsibilities to ensure the sustainability of the organization
- 2 The partnership/dyad shall be a nondiscriminatory, nongovernmental, nonpolitical organization
- 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
- 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, planning, implementing, supervising, monitoring, and evaluating program activities, including financial accountability and sustainability of dyad organization

- 5 At least one or two women must be members of the management/trustee board, and one signatory to the bank account
- 6 There shall be establishment of special committees as the need may arise, and each should have at least one female representative The committees shall be accountable to the Management/Trustee Board
- 7 The bankers of the partnership/dyad shall be _____ (Name/Address) or as maybe agreed from time to time
- 8 All partnership/dyad monies not required for current expenses and all checks shall be paid promptly into the partnership/dyad bank account and all securities for money shall be promptly (within 48 hours at most) deposited in the bank in the name of **Ajegunle Community Partners for Health**

9 All checks, bills, and other negotiable instruments shall be signed by the signatories, namely, Chairman, Treasurer/Financial Secretary, and a designated member of the Trustees, who must be a female. In the absence of the Chairman, the Vice Chairman, Treasurer/Financial Secretary, and a female trustee, member shall be signatories. No such checks, bills, or other negotiable instruments shall be honored by the bank unless signed by the above-named signatories.

10 There shall be proper books of account showing appropriate accounting procedures of the partnership/dyad business transactions, which shall be kept and properly posted and all entries made therein of all matters transacted by person(s) engaged/designated to carry out the business (e.g., the Treasurer/Financial Secretary) on behalf of the partnership/dyad.

These shall be kept in a place agreed upon by the partners and shall be made available at all times for inspection by any of the partners and auditors. The review of account must be done every six months by selected members of the organization. The auditing of account must be done yearly by the appointed external auditor.

11 Admission of new members criteria/modules

- a Application letter/Application form
- b Interview
- c Admission fee of N500.00 (nonrefundable)
- d Assessment of new members or partners outfit, i.e., profile

IV ROLES AND RESPONSIBILITIES OF PARTNERS

Each partner shall at all times show the utmost demonstration of role and responsibilities, and these shall include the following:

A HEALTH FACILITIES PARTNER(S)

- 1 Must be ready to serve on the Board of management or on special committees. In collaboration with the CBOs, participate in identification of community health problems, annual workplan and current programs planning, implementation, monitoring, and evaluation. Always work toward sustaining the partnership by encouraging regular meetings and communication, participating in fund raising activities, and expanding partnership size.
- 2 Ensure prompt attention to cases referred by the CBO partners, providing quality management for fever, diarrhea, and ARI at the health facility and maintaining an appropriate referral system to a 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 B.2 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.

Lagos Community Partners for Health

in the community Health facilities should participate in mass immunization campaigns from time to time

- 4 Participate in all regular continuing education (in and out of health facility) as will be dictated by the staff needs Assist in the training of CBO partners in home case management of diarrhea, fever, ARI, and measles
- 5 Provide health education and counseling services on all health matters relating to maternal and child health (MCH), family planning (FP), and HIV/AIDS to CBO partners, using appropriate information, education, and communication materials (IEC)
- 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 on the Board of management or on special committees In collaboration with the HFs, participate in the identification of community health problems, annual workplan and current programs planning, implementation, monitoring, and evaluation Always work toward sustaining the partnership by encouraging regular meetings and communication, participating in fund raising activities, and expanding 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 15 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 and 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 diarrhea, 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 tracking 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

**FEMALE MEMBER OF THE
TRUSTEES/BOARD**

**CHAIRMAN BOARD OF TRUSTEES
BASICS-NIGERIA**

**Memorandum of Understanding Between BASICS–Nigeria and
Ajegunle Community Partners for Health (AJCPH), May 1996**

I THIS MEMORANDUM OF UNDERSTANDING (MOU) is made this day
of 1996 BETWEEN

- (a) **Basic Support for Institutionalizing Child Survival (BASICS)**
and
- (b) **Ajegunle Community Partners for Health** comprising

1 **HEALTH FACILITY**

RIKKY HOSPITAL

197, Ojo Road,
Ajegunle

2 **COMMUNITY-BASED ORGANIZATIONS**

ASSEMBLIES OF GOD CHURCH (BRANCH)

58, Cardoso St ,
Ajegunle

CHRIST APOSTOLIC CHURCH

50/52, Ligali Rd ,
Ojo Rd , Ajegunle

THE CHURCH MIRACLE CHAPEL

16A, Cardoso Lane,
Ajegunle

CHRIST REDEMPTION CHURCH

16, Charles Avenue,
Ajegunle

HOLY FOUNTAIN CHURCH OF CHRIST

1, Ibitoye St ,
Ojo Rd , Ajegunle

ETERNAL SACRED ORDER OF CHERUBIM & SERAPHIM CHURCH

New Jerusalem,
Behind Otto Warf

OPELOYERU MOSQUE

47, Adekeye St
Ojo Rd ,
Ajegunle

EJIRO YOUTH ASSOC

7, Mokoya,
Olodi-Apapa

EKUWGBE YOUTH ASSOCIATION

105, Idewu St ,
Olodi Apapa,
Lagos

ASSEMBLIES OF GOD CHURCH

23, Itire Rd ,
Ajegunle

ASSEMBLIES OF GOD CHURCH

Amukoko

ASSEMBLIES OF GOD CHURCH

Alaba

MARKET WOMEN ASSOCIATION

Block 139,
Alaba-Suru,
Ajegunle

OLUWA NI SOLA MOSQUE

30, Ibitoye St ,
Ajegunle

FOLORUNSO MOSQUE

79, Oyedeji St ,
Ajegunle

OLAYENI CENTRAL MOSQUE

206, Ojo Rd ,
Ajegunle

ASSEMBLIES OF GOD CHURCH

7, Akibu Street,
Kirikiri

ASSEMBLIES OF GOD CHURCH

46, Omololu St ,
Amukoko

ST EBENEZER CHURCH

174, Ojo Rd ,
Ajegunle

OYEDEJI COMMUNITY

2, Oyedeji St ,
Off Ojo Rd ,
Ajegunle

TRADITIONAL MEDICAL ASSOCIATION

43, Mosafejo St ,
Amukoko

GOD'S CARE NURSERY & PRIMARY SCHOOL

23, Itire Rd ,
Ajegunle, Apapa

WORLD WIDE MIRACLE MINISTRIES

5, Akinsipe St ,
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- 4 By the end of 1998, increase the immunization coverage in Ajegunle and/or among the organizational members of **AJCPH** and ensure availability of effective, quality vaccines

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- 5 By the end of 1998 increase the demand for and availability of modern child spacing/family planning services among **AJCPH**, organizational members, and health facilities
- 6 By the end of 1998, increase the level of awareness of partner organization on epidemiology and control of HIV/AIDS and STDs
- 7 By the end of 1998, **AJCPH** 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
- 8 Strengthen/expand role of female decision making among **AJCPH** and in Lawanson community

III ROLES AND RESPONSIBILITIES OF BASICS

The BASICS project is funded by the United States Agency for International Development (USAID) and is managed by the Partnership for Child Health Care, Inc. BASICS has established an office in Lagos at Plot 248, Muri-Okunola St, Victoria Island. BASICS' project support to the Ajegunle Community Partners for Health began in January 1996 and will continue through September 30, 1998.

BASICS will also

- 1 Provide the necessary management support as requested in the first year to enable the program to take off
 - 2 Provide necessary technical support for program development, planning, and monitoring, annual workplan, and development workshops as outlined in III-6
 - 3 Provide curriculum development for integrated care, management, and training of trainers
 - Preventive/promotive and integrated case management
 - Leadership and female decision making
 - Organizational strengthening
 - STD/HIV/AIDS
 - Family planning/child spacing
- Provide training types
- TOT (Training of Trainers)
 - Organizational (as indicated)
- 4 Develop joint core trainers for **AJCPH**
 - 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
 - 6 Ensure (with support) adequate monitoring/evaluation by the partners

- 7 Document and disseminate appropriately the partner activities
- 8 Ensure transfer/maintenance of adequate communication patterns among members and other partner organizations
- 9 Collect success stories of the program and submit for publication
- 10 Encourage annual information sharing meeting between **AJCPH** and other community partners for health
- 11 Link partners with other agencies that may be interested in promoting the activities of **AJCPH**
- 12 **BASICS** may directly procure equipment and /or supplies for **AJCPH** to support project activities when **BASICS** and Partners determine that such equipment is necessary and is within **BASICS'** budgetary possibilities Any equipment donated to **AJCPH** is to enter into the **AJCPH's** inventory and will be maintained by them

BASICS will not assume responsibility for maintenance of this equipment

- 13 **BASICS** will also provide seed monies to establish a revolving credit fund for women This fund will be deposited in a separate bank account to be operated by the **AJCPH**
- 14 **BASICS'** support to the **AJCPH** 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**
- 15 **BASICS'** project support to the **AJCPH** began in September 1995 and will continue through September 30, 1998

IV ROLES AND RESPONSIBILITIES OF PARTNERS (HFs and CBOs)

- 1 Must be ready to serve on the Board of management or on special committees In collaboration, Partners should participate in the identification of community health problems, annual workplan and current program planning, implementation, monitoring, and evaluation Always work toward sustaining the partnership by encouraging regular meetings and communication, participating in fund raising activities and expanding partnership size
- 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

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Lagos Community Partners for Health

- 3 Partners should participate in advocacy for the regular supply of potent vaccines to the health facility(ies) within the dyad community
- 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 and home case management of diarrhea fever ARI, and measles
- 5 **AJCPH** 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, nonexclusive, and irrevocable right to produce, publish, or otherwise use and to authorize others to use the publication(s)
- 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
- 7 Keep proper records and participate in capacity building exercise for local monitoring, planning, and evaluation purposes

**FEMALE MEMBER OF THE
TRUSTEES/BOARD**

**CHAIRMAN BOARD OF TRUSTEES
BASICS-NIGERIA**

**PRIVATE SECTOR
INTEGRATED HEALTH
PROJECT**

WHAT IS LICPH ALL ABOUT *

Lagos Island Community Partners for Health (LICPH) informally known as the "Lagos Island Dyad" came into existence in 1995 as a result of sensitization from an International Organization called BASICS. BASICS "Basic Support for Institutionalizing Child Survival" funded by USAID is concerned with reducing infant and child illnesses and deaths in high risk communities worldwide. In Nigeria it is urban focused.

CONCERN OF LICPH

LICPH is a non-discriminatory, non-religious, non-political, non-ethnic and non-governmental organization. It is a reflection of private sector efforts of concerned citizens/groups to compliment the efforts of the government in reducing infant and child deaths and improving the quality of lives of children in the community.

OBJECTIVES FOR LICPH

By the end of the year 1998

- 1 To reduce the number of children under 5 years and pregnant mothers falling ill and dying from malaria
- 2 To reduce considerably the number of children under 5 years having diarrhoea and dysentery

and dying from dehydration

- 3 To reduce the number of children falling sick with cough and dying from Acute Respiratory Infections in Lagos Island
- 4 To increase the immunization coverage of children ages 0 - 2 years and ensure availability of effective quality vaccines in Lagos Island.
- 5 To increase the demand for and the availability of modern child spacing / family planning services in Lagos Island.
- 6 To increase the level of awareness of partner organizations and the community on the incidence and control of HIV / AIDS and sexually transmitted diseases in Lagos Island.
- 7 To ensure that LICPH is self-sustaining to maintain its improved capacity and services
- 8 To strengthen and expand the role of female decision making among members of LICPH and the community

COMPOSITION OF LICPH

LICPH presently involves the partnering of concerned Private Health Facilities (for profit & non-profit) and Community Based Organizations with the major goal of achieving improved child health in Lagos Island.

RESOURCES OF LICPH

LICPH initiative is new and unique because it is the first of its kind in this community and is determined

to succeed using existing community resources to solve child survival problems. It is funded by membership dues, donations from governmental and Non-governmental Agencies/Organizations and support from members of community.

CONTRIBUTION OF LICPH

Members otherwise called partners are contributing immensely their ideas, time, space and materials for organizational activities according to the objectives set out during the initial planning workshop.

REQUIRED SUPPORT FOR LICPH

LICPH requires to a large extent, a non-distabilizing community support as efforts are geared to improve the local capacity of the organization in community development activities.

Such support could be in the form of voluntary donations during fund raising activities, community mobilization for child survival programs, space donation for community outreach activities such as immunization and logistic support e.g. provision of vehicles. Also provision of IEC (Information Education and Communication) materials e.g. posters, handbills and stickers on health issues as well as promotion & advertisement of child survival programs etc.

INSTITUTIONAL/FINANCIAL MANAGEMENT OF LICPH

LICPH is managed by a governing board through a framework of operation guided by Memorandum of Understanding (MOU) among the partners. It is cur



rently deriving knowledge and skill building in technical areas institutional management financial accountability and sustainability through training workshops with assistance from BASICS - Nigeria and other collaborating Agencies The project also affixes at strengthening & expanding the role of female decision making among members of LICPH and the community it serves

CHALLENGE AHEAD

LICPH is aware of the challenge ahead without BASICS and therefore has been tailored as an independent NGO striving to achieve its objectives without continuous financial support from BASICS

Our goal is the survival of the children in Lagos Island

— ○ —
**LONG LIVE
OUR CHILDREN IN
LAGOS ISLAND**

— ○ —

SECRETARIAT

**LAGOS ISLAND COMMUNITY
PARTNERS FOR HEALTH**

Roland Hospital & Maternity
40 Joseph Street
Lagos Island Nigeria

Contact

Dr O Aworo

tel 2635863



LICPH

Lagos Island Community Partners
for Health

**A
PARTNERSHIP
FOR CHILD
SURVIVAL**

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