

World Vision Relief and Development, Inc

**WVRD/Nigeria**  
Final Evaluation  
**Ogbomoso South**  
**Child Survival Project**  
December 31, 1996

Grant # FAO-0500-A-2042-00

Beginning Date: October 1, 1992  
Ending Date: September 30, 1995

Submitted to:

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# **Final Evaluation of the Ogbomoso South Child Survival Project**

**September 11-20, 1996**

**Orire and Ogo Oluwa LGAs, Oyo State Nigeria  
World Vision Relief and Development  
Baptist Medical Center, Ogbomoso**

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This Final Evaluation Report is in compliance with **USAID** requirements as outlined in Cooperative Agreement #2049 for Grant No.: FAO-0500-A-00-2042-0  
October 1, 1992-September 30, 1996

## **Acknowledgment**

The evaluation team extends its sincere thanks to the Ogbomoso project **staff**, the implementing partners, the community development committees and especially to the community health workers whose devotion and hard work are providing quality child survival services to a needy and deserving population in spite of a difficult socio-economic climate prevailing in Nigeria.

The project has aptly demonstrated its ability, under the able leadership of Dr. **OmoOlorun Olupona** to “connect the nine dots“ in the provision of community-based health services. It is our sincere hope that this devotion and persistence will sustain these services and contribute to the promotion of “Health for All” Nigerians.

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## Executive Summary

World Vision's Ogbomoso South Child Survival Project began in 1988 with a USAID PVO Child Survival Grant. The project is located in Ogo Oluwa Local Government Area in Oyo State. Phase 2 (1992-1995) expanded the project to the adjacent LGA of Orire. A one year no-cost extension continued through September 1996. The project goal is to reduce infant and child morbidity and mortality by strengthening the community and local Ministry of Health system and capability to provide child survival interventions -- immunizations, control of diarrheal diseases, growth monitoring, nutrition promotion, child spacing, and control of malaria -- for a population of approximately 88,400.

This final evaluation measured the attainment of project objectives; examined project expenditures; identified lessons learned; and assessed sustainability efforts. The evaluation was a participatory process which included all the implementing partners. The team conducted interviews, group discussions, field visits, and reviewed project documents. Two other assessment activities were completed prior to the evaluation -- 1) a final Knowledge, Practice and Coverage survey, and 2) a sustainability assessment of project management and income generation activities.

According to USAID, "Nigeria's health sector is bankrupt and for all practical purposes, Government has ceased to provide essential services." National EPI coverage has dropped from 80% in 1990 to around 25%. USAID's humanitarian assistance is now channeled primarily through PVOs and the private sector. This project is an excellent example of the potential for working through PVOs to encourage community, local NGO and local government collaboration.

Activity	End of Project Targets	1992	1996
<b>Immunization</b>	80% Coverage DPT3	49%	90%
	80% Coverage Measles	44%	91%
	80% Fully Immunized Children	42%	83%
<b>Control of Diarrheal Diseases</b>	70% of mothers increase breast-feeding during diarrheal episodes	17%	73%
	60% of infants/children treated with SSS or ORS for diarrhea	44%	80%
<b>Nutrition &amp; Growth Monitoring</b>	60% mothers breast-feed within 1 hour of delivery	16%	60%
	70% of children 0-23 months are weighed monthly	15%	80%
<b>Maternal Health</b>	40% of couples with children <2 yrs. use modern contraception	13%	48%
	90% births attended by a trained person	63%	76%
<b>Malaria</b>	90% of children with malaria (fever) are treated with anti-malarials	77%	82%
	90% of mothers know at least two methods of preventing malaria	9%	69%

Local communities demonstrated a remarkable capacity and willingness to work with the project. Community Development Committees described dramatic reductions in morbidity and mortality for fever, convulsions, diarrhea, measles and bleeding at birth. The evaluators found that almost all of the interventions can be sustained by the communities with a minimum of supervision and in-service training from a local NGO (the Baptist Medical Center) and the local government. However, the immunization program, which the community considers the most important intervention, requires technical resources and support not available at the community level. Meetings with the implementing partners during the final evaluation demonstrated that the elements and commitment for sustaining the program are available, but have yet to be fully implemented. The next year of activity will determine if a three way collaboration and co-management of health services between communities, local government and local NGOs can be firmly established and sustained. The results of this effort could establish an important model of collaboration for other areas of Nigeria.

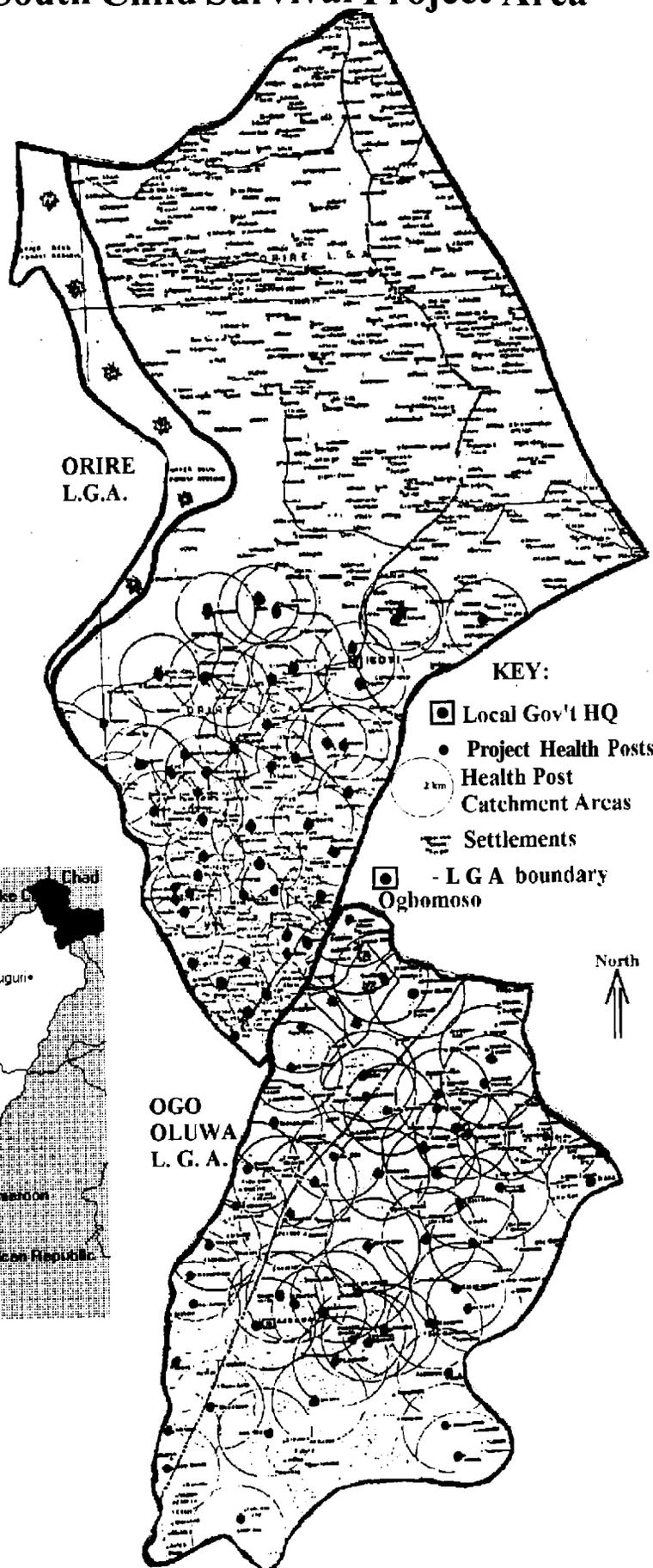
## Acronyms

BCG	Bacille Calmette-Guerin vaccine
BMC	Baptist Medical Center, Ogbomoso
CDC	Community Development Committee
CDD	Control of Diarrheal Diseases
DIP	Detailed Implementation Plan for Child Survival Grant
DPT	Diphtheria, Pertussis, Tetanus Vaccine
EPI	Expanded Program on Immunization
GM	Growth Monitoring
HIS	Health Information Systems
IGA	Income Generating Activity
KPC	Knowledge, Practice and Coverage survey
LGA	Local Government Area
MOH	Ministry of Health
w	Naira (unit of local currency)
NGO	Non-Governmental Organization (National)
NANGO	Nigerian Association of Non-Governmental Organizations on Health
<b>NPS</b>	Nutrition Promoters
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy for Treatment of Diarrhea
PHC	Primary Health Care'
PVO	Private Voluntary Organization (International)
SD	Standard Deviation
s s s	Sugar-Salt Solution
TA	Technical Assistance
TMs	Traditional Mid-Wives
TT	Tetanus Toxoid
USD	U. S. dollar
USAID	United States Agency for International Development
CDC	Community Development Committee
WHO	World Health Organization
WVRD	World Vision Relief and Development (U.S. headquarters)
VHWs	Village Health Workers

# Maps of the Ogbomoso South Child Survival Project Area

These maps shows the project area location within Nigeria (map below)

and the distribution of project-assisted health posts within the Local Governments of Orire and Ogo Oluwa (map at right)



## **I. INTRODUCTION**

### **A. Final Evaluation Purpose**

In compliance with USAID requirements as outlined in Cooperative Agreement #2049, a final evaluation has been conducted of WVRD's Nigeria Child Survival Project. This evaluation was conducted in accordance with USAID Final Evaluation Guidelines. The purpose of this Final Evaluation was to:

- determine project accomplishments of the goals and objectives stated in the Detailed Implementation Plan (DIP) and identify unintended positive and negative effects of project activities;
- assess project expenditures in terms of projected spending and actual spending;
- identify lessons which have been learned during the project implementation which are applicable to other PVO Child Survival projects or other relevant USAID supported projects; and
- assess project sustainability plans, steps taken to date toward sustainability, and projected or actual outcomes of sustainability activities.

### **B. Evaluation Methodology**

The evaluation strategy which corresponded to the USAID Child Survival Final Evaluation Guidelines assessed project accomplishments, expenditures, lessons learned and sustainability plans. The evaluation was as a participatory process which included a seven member team of representatives from the implementing partners. The team collected information through interviews, group discussions, field visits, and review of project documents. Group discussions were held with the project staff, with two Village Health Workers (VHWs) and executive committees. Field visits to four health posts included interviews with VHWs, Traditional Midwives (TMs), Community Development Committees (CDCs), inspection of health posts and local government health facilities, and observation of the project mobile teams in action.

Two additional assessment activities were completed by the project prior to the evaluation:

- 1) The final Knowledge, Practice and Coverage (KPC) survey was carried out in August 1996, and provided information to determine the degree of achievement of project objectives.
- 2) A sustainability assessment was completed to evaluate the level of sustainability of the project and to assess the potential for income generation from a variety of health and non-health activities. The preliminary results of this assessment were made available to the evaluation team,

The final evaluation report was compiled by the evaluation team members under the general guidance of the team leader. Debriefings and discussions regarding the major findings and conclusions of the final evaluation were held with the project staff, the Baptist Medical Center, the Local Governments of Orire and Ogo Oluwa, and USAID/Lagos.

### C. Project Background and History

World Vision's Ogbomoso South Child Survival Project began in October 1988 with funding from a United States Agency for International Development (USAID) PVO Child Survival Grant to World Vision Relief and Development (WVRD). The project was located in Ogo Oluwa Local Government Area (LGA), in Oyo State, southwestern Nigeria. Phase 2 of the project (1992-1995) added three health districts of the adjacent Orire LGA. The project is now in its eighth and final year, after having received a one-year no-cost extension until September 30, 1996. In addition to monthly and quarterly reports throughout this period, documentation concerning the project includes the following:

5/89	Ogbomoso South Baseline Survey - Phase 1
7/89	Detailed Implementation Plan - Phase 1
1 0f89	First Annual Report - Phase 1
11/90	Mid-Term Evaluation - Phase 1
11/91	Third Annual Report - Phase 1
12/91	Extension/Expansion Proposal - Phase 2
12/92	Sustainability Assessment Final Evaluation - Phase 1
12192	Knowledge and Practice Survey Final Evaluation - Phase 1
4193	Knowledge, Practice and Coverage Baseline Survey - Phase 2
4/93	Detailed Implementation Plan - Phase 2
1 0/93	First Annual Report - Phase 2
12/94	Mid-Term Evaluation - Phase 2
10/95	Third Annual Report - Phase 2
8196	Knowledge, Practice and Coverage Survey Final Evaluation - Phase 2
9/96	Sustainability Assessment

### D. Political and Economic Environment in Nigeria

Following independence in 1960 and a few years of relative peacefulness, Nigeria experienced a turbulent history of alternating civilian and military governments, coups, and a three-year civil war which claimed hundreds of thousands of lives. The current socio-political situation under an increasingly authoritarian military regime is very unstable.

Nigeria has experienced a steady economic and production decline over the past decade. The average gross national product per capita dropped 2.3 percent per year between 1980 and 1991, Inflation averaged 21% between 1980 and 1993, but by 1994 exceeded 400%. The economy is dominated by the petroleum industry (over 90% of the government's revenues), but this has been largely at the expense of the development of other sectors. Government expenditures on social services have declined in real terms since the mid- 1980s. The national population was estimated at 88.5 million in 1991.

Today, the Nigerian government allocates only one percent of its budget to health. According to a recent USAID Nigeria Strategy Update, "Nigeria's health sector is bankrupt and for all practical purposes, Government has ceased to provide essential services." National EPI coverage, for example, dropped from a peak of about 80 percent in 1990 to under 10 percent by 1994. Moreover, according to USAID, "There is no longer the expectation that resources put into the public system will be used for the public good." USAID's humanitarian assistance, like that of other bilateral and multilateral donors, has decreased significantly and is limited primarily to PVOs and the private sector.

## **E. Project Goal, Objectives, and Strategies**

The goal of the project has been to *reduce infant and child morbidity and mortality due to diarrheal diseases, vaccine preventable diseases, frequent child bearing, malnutrition and malaria by supporting and strengthening the community and local Ministry of Health (MOH) system capability*

The main interventions of the project include immunization, control of diarrheal diseases (CDD), growth monitoring, nutrition promotion, child spacing, and control of malaria. Additional activities have included distribution of Vitamin A and Ivermectin, deworming, promotion of local production of soybeans, sanitation education, and support of community efforts to provide potable water. The population (mostly subsistence farmers) within the project area is estimated at 88,400 people,

Due to the absence of a strong MOH presence, the project has emphasized community participation in project activities. Eighty-nine Community Development Committees (CDCs) have been formed, and three categories of community-based, volunteer workers have been trained: Village Health Workers (VHWs), Traditional Midwives (TMs), and Nutrition Promoters (NPs). The CDC members are nominated and elected by the villagers and, in turn, nominate candidates to be VHWs, TMs, and NPs. VHWs (who number 204) are multi-purpose workers responsible for the mobilization of communities, health education, growth monitoring, distribution of family planning supplies, case management of malnutrition, malaria, diarrhea, and other minor ailments, and management of the village health posts. The 69 TMs and over 500 NPs support the maternal care activities and conduct food demonstrations, respectively. All community health workers are responsible to the CDC.

Each village or cluster of villages in the project area is visited on a monthly basis by one of four project mobile teams to: 1) support village-based activities, 2) monitor and supervise the volunteer workers, 3) provide health education, and 4) administer immunizations.

## **H. PROJECT ACCOMPLISHMENTS**

### **A. Comparison of Project Accomplishments with DIP Objectives**

The Detailed Implementation Plan (DIP) lists a large number of objectives relating to knowledge, practices, and coverage relating to the five principal areas of child survival intervention. It is noteworthy that in a country where most health services have stopped due to the political and economic crisis, the Ogbomosho South Child Survival project has effectively implemented its child survival program and achieved and exceeded most of its objectives. Table 1 compares the 1992 baseline measurement of these objectives with the results of the August 1996 KPC study.

Local communities assisted by this project have demonstrated a remarkable capacity and eagerness to improve their health status. Community Development Committees described dramatic reductions in childhood and maternal morbidity and mortality for fever, convulsions, diarrhea, measles and bleeding at birth. However, to sustain these achievements, particularly immunizations which they consider the most important, requires technical and material resources which are not generally available at the community level. Improved community, LGA, NGO and project collaboration and support are urgently needed to secure and maintain the cold chain, to coordinate logistics and to provide vaccinators.

**Table 1: Comparison of Project Accomplishments with DIP Objectives (1992, 1996)**

Activity	End of Project Targets	1992	1996
<b>Immuni- zation</b>	80% Coverage BCG	57%	98%
	80% Coverage DPT1	57%	97%
	80% Coverage DPT3	49%	90%
	80% Coverage OPV3	49%	89%
	80% Coverage Measles	44%	91%
	80% Fully Immunized Children	42%	83%
	80% TT Coverage of Women with children < 2 years of age	32%	68%
	90 VHWs and 100 TMs trained in immunization	--	214
	36 project and LGA staff trained in immunization	--	44
	90% of mothers know the correct age to give measles vaccine	28%	55%
	90% of mothers know that a pregnant woman needs at least two doses of TT to protect her newborn against tetanus	71%	93%
	90% of mothers know that TT protects both mother and newborn	36%	44%
<b>Control of Diarrheal Diseases</b>	70% of mothers stated the correct formula for SSS, in SSS/ORT Usage	26%	68%
	60% of infants/children treated with SSS/ORT for diarrhea	44%	80%
	70% of mothers increase breastfeeding during diarrheal episodes	17%	73%
	70% of mothers know the signs and symptoms for seeking advice (vomiting, fever, signs of dehydration, prolonged diarrhea, weakness or tiredness)	43%	93%
	70% of mothers know it's important to give small, more frequent feedings during diarrheal episodes	5%	16%
	70% of mothers know it's important to give extra fluids during diarrhea	55%	86%
<b>Nutrition and Growth Monitoring</b>	60% mothers breastfeed within 1 hour of delivery.	16%	60%
	60% mothers exclusively breastfeed for 4 mos, i.e., 0-3 mos.	22%	62%
	90% mothers introduce supplementary foods between 4 & 6 months	57%	75%
	70% of children 0-23 months are weighed monthly (this or last mo.)	15%	80%
	85% of children 0-23 mos. attaining appropriate weight-for-age ( $\leq 2SD$ )	77%	79%
	80% of mothers know a child's first foods should contain extra protein	64%	89%
	70% of mothers know 2 or more actions to help her continue breastfeeding	1%	11%
	40 Village Health Posts in the new LGA are supplied with weighing scales	--	44
	1,600 farmers supplied with soybean seeds for planting	--	1975
	500 mothers trained as nutrition promoters	--	416
	100 Village Health Workers (VHWs) trained in nutrition	--	132
	90 VHWs and trained in Growth Monitoring	--	132
100 Traditional Midwives (TMs) trained in Growth Monitoring	--	92	
<b>Maternal Health</b>	60% of women know at least two methods of contraception	33%	80%
	40% of couples with children <2 yrs. use modern contraception.	13%	48%
	90% births will be attended by a trained person.	63%	76%
<b>Malaria</b>	90% of pregnant mothers (3rd trimester) receive malaria prophylaxis	76%	89%
	90% of children with malaria (fever) are treated with anti-malarials.	77%	82%
	90% of mothers know at least two methods of preventing malaria	9%	69%

## **B. Circumstances Which Aided or Hindered Meeting Project Objectives.**

The project encountered numerous circumstances which positively and negatively affected its outcomes. The project has effectively demonstrated that with some creativity, and considerable persistence, many obstacles can be overcome.

### **1. Circumstances which Aided Meeting Project Objectives**

- Much of the success of this project can be attributed to the keen interest and strong support that the project has created at the community level.
- Good stewardship of funds (and inflation) permitted a 12 month no-cost extension.
- A high commitment of the project staff to work with very needy communities and to go the extra mile succeeded where other projects might have failed.
- The transparent honesty and consistency of responses as to what the project could or could not do to assist communities established a positive working relationship.
- Reliable and prompt support from World Vision (WV)/Ghana, WV/West Africa Regional office and WVRD ensured a continual flow of resources to keep the project on schedule.
- The auditing of health post accounts at least once a year or whenever a problem is suspected kept the communities “on their toes.”

### **2. Circumstances which Hindered Meeting Project Objectives**

- Decertification of Nigeria by the U.S. Government restricted the use of USAID funds.
- A 500% hike in transport costs decreased VHW attendance at monthly in-service training.
- A strike by banks prevented access to project funds and slowed certain activities.
- Periodic scarcity of fuel sometimes left VHWs and mothers stranded in town and resulted in them missing their monthly health clinic.
- Civil disorder sometimes hindered the work of the mobile teams.
- Frequent changes in LGA leadership and poorly functioning government health facilities were detrimental to the sustainability of the project.
- Severe vaccine shortages since August 1995 will probably reduce EPI coverage next year.
- Land disputes, political differences and chieftaincy conflicts occasionally prevented some segments of a community from participating in project activities.
- During harvest and planting, some mothers don't participate in health care activities,

**C. Unintended Positive and Negative Effects of Project Activities.**

- + The project distributed soybeans with the objective of increasing supplemental protein for feeding children. The community reported that the cultivation of the soy also improved the fertility of the soil, which produced an extremely good crop of cassava the following year.
- + The objective and activities to empower communities for health activities has also expanded into other areas. The community is no longer simply a passive recipient of services from the government, but has started to demand additional services, They are no longer satisfied with simply accepting what is provided by the government.
- + Most of the communities assisted by the project have opened bank accounts. These will be useful in other areas of development
- + Nutrition promoters who are responsible for training mothers have expanded their activities into the production and sale of soya products as income generating activities.
- + It was intended that communities would establish health posts by borrowing or renting a room in an existing structure. Some communities are now taking the initiative to build their own health posts.
- + One village health worker was motivated sufficiently by his work to pursue training as a Community Health Extension Worker.
- + The health system established by the communities has also been used for the provision of Ivermectin and. vitamin A.
- + The assistance provided by the project for lining wells was intended primarily as a CDD activity, but has also reduced the incidence of guinea worm.
- I The official name of the project, the Ogbomoso South Child Survival Project, created an unintended negative effect because the population of the LGA of Orire traditionally does not want to be associated with anything that has to do with Ogbomoso.
- I The intended incentive system of the IGA's in a few instances provided opportunities for fraudulent practices.
- Three Community Health Workers who were trained to provide voluntary service to their community, abandoned this service and became unsupervised drug peddlers.

#### **D. Results of the Final Knowledge Practice and Coverage (KPC) Survey**

A KPC survey is a key component of the final evaluation and also provides information for future project planning and monitoring. The survey objectives were 1) to formulate or improve strategies to address deficiencies in knowledge and practice; 2) to train implementing partners in the methodology for a cluster sample survey; and especially 3) to provide quantitative information on the progress toward reaching the stated objectives. The questionnaire was designed to provide information on appropriate target groups for health education; access to immunization and growth monitoring services; coverage rates for BCG, DPT, polio, measles and fully immunized children; ORT and contraceptive use rates; and knowledge and practices of mothers of children under two with respect to the health interventions promoted by the project.

Questionnaires were directed at mothers of children under two years of age. While certain project interventions target a broader group, all interventions include under-twos as the primary target. Restricting the sample to these mothers also allows the survey to measure the extent to which the project has been able to reach those children born during the life of the project.

Preparation for the survey, training, household interviews, data analysis, report writing, and feedback were conducted from August 19 - September 20, 1996. The survey followed the WHO/EPI 30 cluster methodology, but used a larger than normal sample size of 240 (30 clusters of 8) because of the multiple interventions which were provided in addition to immunizations. A comparison of the results of the final KPC survey and the 1992 baseline survey are shown in Table 1. Selected findings are summarized below. The complete KPC report is attached as Annex F.

- **Tetanus Toxoid Vaccination of Women:** The KPC survey found from vaccination cards that 63% of women with children under two years of age had received at least two doses of TT. Since project staff knew that some women had lost their cards and restarted vaccinations at “zero,” they cross-checked with project registers and found a number of mothers who had already received been vaccinated. This increased vaccination coverage to 68%.
- **Breastfeeding within one hour:** The attitude that breastfeeding within one hour after delivery is not realistic was disproved by the KPC finding that 60% of mothers are breastfeeding within one hour. This demonstrates that with proper education from community-based health workers mothers appear to be willing to change and adopt a practice that they perceive as beneficial.
- **Actions which promote breastfeeding:** Only a few mothers were able to cite any of the expected responses to the question, “What can a mother do during to keep on breastfeeding?” 88% of mothers indicated that they should simply maintain a proper nutrition, No mother mentioned the importance of avoiding bottle feeding. These results may reflect improper understanding of the question or that many of these practices, e.g., frequent sucking, and avoiding bottle feeding, are almost universally practiced and are therefore taken for granted.
- **Use of Modern Contraception:** The contraceptive use rate among not-pregnant mothers who did not want another child in the next two years was 48% (I 3% at baseline). This does not include those who abstain from sexual relationships because they are breastfeeding. If this is included, as many as 58% of couples practice contraception. Knowledge of contraceptives improved, with only 9% of unable to name one method of contraception ( 40% baseline).

## **E. Actions Taken on Mid-Term Evaluation Recommendations**

The mid-term evaluation (Dec. 1994) made one major commendation and nineteen recommendations. A project staff retreat, held in January 1995, examined and accepted all but two recommendations. Those not accepted had recommended that central monitoring of nutritional and immunization data at the community level be limited to quarterly reviews rather than monthly examination of growth charts by the mobile teams. While the project team saw the relevance of the recommendations, they felt that it was necessary to continue monthly monitoring in order to meet donor reporting requirements. However, distribution of monthly computer printouts to the VHWs was stopped.

The final evaluation team reviewed the actions which had been taken to implement each of the recommendations. A summary of actions taken in response to the mid-term evaluation is included as Annex B. The evaluation team was generally satisfied with the efforts and progress which had been made to implement the mid-term recommendations. However, two recommendations essential to the sustainability of the project were only partially implemented.

***Recommendation 16: The project should experiment with alternative outreach strategies such as splitting teams to visit two villages at a time, visiting on alternative months, or biannual campaigns in remote rural areas to identify ways to maintain benefit at lower cost.***

While the project did reduce the number of vaccination points by clustering health posts for immunization, the program is still dependent on a mobile team approach. Options, such as establishing or reinforcing fixed vaccination sites through community initiatives are only now being explored.

***Recommendation 18: Project convene a task force of project staff, Baptist Medical Center, LGA, and CDC representatives to explore options to ensure long term sustainability of benefits for the target population.***

The project did create a task force to look at sustaining the Income Generating Activities (IGAs), since they were seen as a key factor in sustaining the work of VHWs. While the task force did achieve some improvement of the IGAs, the project did not build on this initiative and expand their mandate into the area of immunizations. However, given the frequent change of leadership and internal crises which were affecting both the BMC and LGA during this period of time, it is understandable why the project was not able to proceed further with this recommendation.

## **III. PROJECT EXPENDITURES**

### **A. Pipeline Analysis of Project Expenditures**

The management of the project's budget appears to have been conducted in a responsible and competent manner. The project's monthly reporting to WVRD headquarters has been both timely and accurate. An audit in July 1994 confirmed that the project's accounts were well-kept in accordance with WV and USAID accounting procedures. Another audit was being conducted during the period of the final evaluation. See Annex C for the 1996 pipeline analysis.

The project staff noted that financial guidelines for phase II provided considerably more flexibility in the budget management than did phase I. During phase II, the project could move budget allocations between line items within a major cost element. The current system is considered a marked improvement and greatly appreciated by the project staff.

## B. Comparison of the DIP Budget with Actual Expenditures

The pipeline analysis of field expenditures was examined (see Annex C). The report format was slightly different from the one included with the final evaluation guidelines, but provided the same information. The report included one line item which estimated headquarters expenses. The pipeline analysis was reviewed and discussed with the project manager, the project financial officer and the health information coordinator. They explained why some line items were higher or lower than planned. The evaluation team found these explanations (see Table 2) to be satisfactory.

**Table 2: High and Low Project Expenditures**

<b>Line Item</b>	<b>Why expenditures were much higher or lower than planned</b>
<b>Supplies 160%</b>	<p>During phase II, the exchange rate increased from W 19/USD to W 82/USD, but prices of local supplies, especially in 1993-4, increased more rapidly than the exchange rates.</p> <p>The project purchased meningitis vaccine and contraceptives (condoms and vaginal tablets) which were not originally budgeted. The project also had to replace syringes and needles with relatively expensive , but locally available, disposable products</p> <p>The no-cost project extension affected all budget areas except evaluation.</p>
<b>Equipment 107%</b>	The purchase of a replacement computer and typewriter were not originally budgeted.
<b>Services/ Consultants 30%</b>	<p>Technical assistance from World Vision/West Africa Regional Office decreased the need for external consultants.</p> <p>As part of the WV/Ghana office, the project was able to share their computer software, training and installation resources. This saved several thousands of dollars.</p>
<b>Evaluation 39%</b>	<p>Since the baseline survey for Phase two occurred just after the Final baseline of phase I, the project did not have to train new interviewers. Also TA for the survey from Tom Ventingila was covered by WVRD.</p> <p>A mid-term evaluation survey was budgeted, but was deemed unnecessary. Expenses for the team leader for the mid-term evaluation were paid from another source.</p>
<b>Travel/ Per Diem in-country 61%</b>	<p>The project saved money by switching from “actual expense” reimbursement system to a “daily rate” per diem system where receipts for lodging and food were not required.</p> <p>Increases for per diem rates, authorized from WV/Ghana, did not keep pace with the increases by other PVOs. Also, while per diems were budgeted in payment for full days, they were paid in partial days which usually decreased the amount paid.</p>
<b>Travel/Per Diem (Int'l) 131%</b>	Two trips in 1996 were not originally budgeted -- a trip to the WVRD West Africa Regional team meeting and participation in a Quality Assurance course at Johns Hopkins School of Hygiene and Public Health, Baltimore.
<b>Other Direct costs 123%</b>	The costs of public utilities (water, electricity, telephone), courier services, and fuel increased faster than the exchange rate. For example, during Phase 2, the cost of fuel increased by 1600% while the official exchange rate increased 400%.

#### **IV. LESSONS LEARNED**

Over an eight year period, the project has amassed many lessons learned. While many lessons are “cross-cutting,” for the purposes of this report they have been put into one of three groups: Child Survival Interventions, Community Participation, and Project Management and Sustainability Efforts

##### **A. Lessons Learned from Child Survival Interventions**

- The key to sustaining a child survival program is **often** linked to one intervention such as the immunization program. The **VHWs** of this project stated, “When immunizations go, everything else goes.” Project management should identify the key intervention early in the project and concentrate on creating the support system to sustain that intervention.
- The health of children is so intertwined with their nutritional status that efforts to impact malnutrition in the community must necessarily be linked with the agricultural sector and other community activities aimed at improving the diet.
- Penalties are sometimes necessary for people to become sensitive and responsible. When the project began charging for replacing maternal health cards, the incidence of missing cards reduced drastically.
- On-the-job training of mothers for selected technical skills is a good way to provide backup for **VHWs**, e.g., trained mothers can weigh the children when the **VHW** is unavailable.
- Absence of patient referral feedback from higher levels of health care may demotivate the first-line health care providers, and limit their ability to monitor disease trends in their catchment areas.
- Not all mothers whose children are doing well like attention to be drawn to them. One mother stopped attending the growth monitoring clinic because she feared that “malevolent spirits” might target her healthy child for harm. Project staff must be sensitive to those who hold such thoughts.
- Health workers must always be flexible to accommodate changes in roles and responsibilities of **VHWs**. One woman who was originally trained as a **TM** found there was no demand for her services. With project encouragement, she learned to prepare meals from soybeans and switched roles to become a successful nutrition promoter.
- Total population project coverage ensures equity in health and widens the revenue base needed for project sustainability.

##### **B. Lessons Learned from Community Participation**

- Community mobilization should emphasize ownership and self-reliance from the outset of the project through specific activities such as creating bank accounts, managing a revolving drug fund, and contributing financially through fees for service.
- The most interest shown and the hardest work often comes from communities which are farthest away from the community health post. Creating healthy competition between communities is a positive factor.

- Communities, even relatively poor ones, are willing to pay for health services, provided they perceive these services to be of high quality. To encourage communities to place a value on services, user fees should be initiated as early as possible.
- The collection and use of data at the community level is a key to promoting community “ownership” of project activities and results and thus to promoting sustainability.
- In community development work, patience and persistence pay off. Initially, some communities will be reluctant or indifferent to participating in project activities; it takes time and effort before they begin to see results and the potential impact of the project.
- Fostering true community participation requires a willingness to allow communities to make their own decisions (based on guidelines) and to learn from their mistakes.
- Project staff must recognize and respect influential powers in the community. When a non-performing VHW was relieved of her duties there was a drastic decrease in clinic attendance because the influential community member who had originally nominated the VHW felt humiliated.
- Communities should consider both the advantages and disadvantages of having mixed gender VHW teams. While a mixed team allows for broader interaction with the community, it may also permit male VHWs to culturally dominate the female VHW.
- Differences of religious faith between a community and project staff should not deter the staff from giving up on meeting community health needs, Experience has shown, that such obstacles can be overcome and that the community will eventually fully embrace and actively support child survival activities.
- VHWs, TMs and NPs are willing to take on additional responsibilities; this should be explored as a means of generating more funds for project sustainability.

**C. Lessons Learned from Project Management and Sustainability Efforts**

- The mobile team approach (whereby the project staff takes on much of the responsibility for service delivery) can result in high levels of achievement during the life of the project, but can also limit prospects for sustainability.
- Quarterly review of project by all participating partners is essential to determine progress, identify strengths and weaknesses in project strategies. This may elicit increased commitment from failing partners.
- Project partners must strive to work together as a team, even when there are personal disagreements, so as not to render project goals and objectives unachievable.
- Technical assistance is vital to improving project quality when the right consultant is chosen. If the goals of technical assistance are vague, then the best results will not be obtained from consultants hired by the project.
- Working as a team, e.g., regular meetings and regular training to correct errors, improves the effectiveness of the activities.

- A well managed information system is a key activity to monitor project activities,
- Since VHWs volunteer to improve the health of their communities, some incentives must be considered so they can continue their efforts over time. Income-Generating Activities (IGAs) that provide some income can also help to sustain project activities, since VHWs will continue to work if they are rewarded.
- The project must take responsibility for raising the status of volunteer health workers if their work is to be effective and sustainable. Means of achieving this can include: 1) conducting formal awards ceremonies upon “graduation” from initial training and providing means of identification (e.g., T-shirt and identification card); 2) regularly upgrading technical skills and equipping the workers appropriately; and 3) directing communities to the health workers rather than project staff as the initial point of contact.
- In the absence of consistent government or other institutional assistance, giving responsibility for the sustainability of project benefits to communities is possible, but it requires many years and much support.
- Protocol agreements with collaborating partners such as local government should be discussed and signed as early as possible. However, in addition to securing such commitments from top levels of government, mobilizing the involvement of junior and mid-level staff must be equally emphasized, and specific, written plans for coordination in training, supervision, and service delivery are essential.
- Protocol agreements between all collaborating parties should be discussed and signed as early in project life as possible, in order to avoid confusion and misunderstandings. Such agreements should have specific quantifiable and measurable obligations to be undertaken by each partner and mutually agreed sanctions against failure to perform.

## **V. PROJECT SUSTAINABILITY**

### **A. Community Participation**

Community participation is at the heart of this project through the hard work of the CDCs, VHWs, TMs and NPs. The evaluation team met with the executive committee of Village Health Workers (VHWs) from each local government to discuss the future of the project. This group stated that project interventions have drastically reduced deaths among children and pregnant women. In their view, immunization is the most important intervention and is the one mothers like most.

In view of the tremendous benefits offered by the project, the executive committee has held consultations in various communities and resolved to assume even more responsibility for the project (see Annex D). When World Vision leaves, the committee said the communities would not like to be handed over to the local government authorities because of their lack of confidence in them. Rather they would prefer to continue running the project on their own. However, the communities would welcome meaningful collaboration with the LGA authorities in the running of the project. The executive committee said the communities are prepared to sustain the child survival project by:

- hiring their own staff to perform special tasks such as immunization which they cannot handle, citing the examples of appointment of teachers by parents teacher association to meet shortage of teachers in schools as their justification;

- 0 increasing user charges and income generating activities;
- 0 introducing new services such as adult weighing and blood pressure monitoring for which clients will pay;
- 0 encouraging **cost** sharing by raising levies on a monthly basis from the health posts in order to meet the expenditure on staff hiring; and
- 0 increasing organized fund-raising activities.

## **B. Non-Governmental Organizations**

The project received a request for assistance from Oyo Catholic Diocese for Rural Health Services for logistic and material support in Ogo Oluwa LGA to take over the vaccination program in some of the communities where the project is currently working. The project plans to discuss this option, and the provision of logistical support to the Diocese, with the LGA authorities,

The project is also an active member of the Nigerian Association of Non-Governmental Organizations on Health (NANGO), to which a variety of other PVOs working in child survival belong, and chairs NANGO's Committee on Food and Nutrition.

## **C. Counterpart Institutions**

The principal counterparts in the project are the BMC, the State Ministry of Health and the LGA authorities, Memoranda of Agreement between the project and these counterparts were signed during the project's Phase 1 implementation and detailed the roles and responsibilities of each of the project's partners. The agreements with BMC and the LGA of Ogo Oluwa carried over into Phase 2. An additional memorandum of agreement was added for Phase 2 activities in the LGA of Orire.

The project was designed to transfer responsibilities for activities to the LGA. However, government participation has not reached expected levels. Two of the Public Health Nurses were seconded by the Oyo State MOH and the MOH provides the vaccines (but not the ORS or family planning supplies).used by the project. Training sessions were organized by the project for LGA staff and made use of government resource persons. Occasionally, government staff did accompany the project outreach team, but this participation was minimal. In fact, in Ogo Oluwa LGA, where the project had initially left immunization services entirely in the hands of the government, all immunization stopped. After it was recognized that the LGA was not ready to take over, the project reinstated services. In Orire, an understaffed motivated core is providing minimal services. Unless there is a major change in the level of government services, benefits will not be maintained by LGAs.

The BMC provides a wide range of inpatient, outpatient and community health services by a well trained and dedicated **staff**. Decreases in external funding have forced the hospital to finance its services through patient fees, While committed morally and professionally to community medicine, BMC does not have the resources needed to take over the project at its current level of activities. It does, however, have the vision and commitment, provided resources can be identified. Areas of support from BMC could include the provision of in-service training for VHWS, field supervision of CDCs and VHWS, the use of BMC premises and **offices**, and the use of BMC as a referral center.

Meetings with each of the implementing partners during the final evaluation demonstrated that the elements and commitment for sustaining the program are available, but have yet to be fully implemented. A second meeting of all implementing partners, including community representatives, was held the week after the final evaluation. This meeting resulted in a very positive renewed effort to sustain project activities by improving collaboration among the implementing partners (see Annex D). The next year of activity will determine if a three way collaboration and co-management of health services between communities, local government and local NGOs can be firmly established and sustained. The results of this effort could establish an important model of collaboration which could be replicated, and supported by USAID, in other areas of Nigeria.

## **D. Sustainability Plan**

### **1. Steps taken to promote sustainability of child survival activities**

The evaluation team reviewed the sustainability plan which had been prepared as part of the DIP. For each sustainability goal the team discussed the end of project objectives, the steps taken to date, and the outcomes. The results of this analysis have been summarized in Table 3.

### **2. Sustainability Assessment Report**

The project requested technical assistance to evaluate the level of sustainability of the project and to assess the potential for income generation from a variety of health and non-health activities. The preliminary results of this assessment were made available to the evaluation team and are included as Annex E. Major findings from this assessment were that:

- 0 the costs of providing services were 2.03 US\$ per vaccination dose given; 0.96 US\$ per training contact on CDD; 1.15 US\$ per family planning contact; and 3.7 1 US\$ per contact for control of malaria;
- 0 the level of community participation in project activities is beyond dependency and moving towards self-reliance;
- 0 the project scored 63% (30 out of 48) on a Sustainability Readiness Index indicating that the project is ready to undertake sustainability initiatives but lacks practical skills in many aspects such as cost-recovery, revenue strategy, management and operations. High scores were obtained in technical standards of program service and readiness to apply business principles.

Recommendations from the sustainability assessment were that the project should:

1. Create a mission statement for commitment to quality service and financial sustainability.
2. Shift the project organizational and management paradigm from a grant/project mentality to a “business-like”, self-sustainable mind set; from beneficiaries to clients; and from guardian participant CDCs to co-owners and co-managers of services.
3. Exert more efforts to address financial sustainability issues such as cost management, revenue-generation, efficient procedures and productivity measures.

4. Proceed with the streamlined management strategy with the reduced number of staff and reduced cost of travel and per diem.
5. Redesign the project service package to delegate non-EPI services to VHWs, TMs and NPs; add new services which are revenue-generating.
6. Change the pattern of staff workload to maximize productivity in such a way that the new service package can be effectively delivered and paid for by the community.
7. Consider relocating or deploying staff to strategic locations in the community.
8. Give high priority to raise revenues locally through new or expanded activities. (A list of 13 suggested activities estimated a potential annual revenue of US\$43,580 .)
9. Improve on current cost reduction measures by using driver/mechanics as logisticians for revenue-generating activities, e.g., film-showing and photocopying.
10. Apply social marketing concepts and tools to promote existing and new services.
11. Execute more rigorously the planning, organizing and monitoring activities
12. Implement task-specific, skill and performance-based training for each cadre of workers.
13. Obtain technical assistance in organizational productivity, business principles for generalist organizations, planning and performance monitoring, management accounting; information system, and social marketing.

The final evaluation team reviewed each recommendation with the project manager and health information officer. They agreed with the recommendations, and indicated that many are, in fact, already being implemented. However, given the uncertainty of future funding, and the proposed reduction of the project staff from 30 to 10 (including the probable loss of the top four technical people), they are not optimistic about sustaining the project solely from income generating activities.

The evaluation team agrees with this assessment and concluded that the project should not count on an initial revenue of \$10,000-15,000 per year. This means that the project will need to come up with other sources of **funding** and support. Two sources have been tentatively identified - World Vision Taiwan has pledged \$50,000 for one year of operation, and the Chairman of the LGA of Orire has publicly stated that he will ensure Orire provides the W 200,000 which it promised in its Memorandum of Accord with the project.

**Table 3: Steps Taken to Promote Sustainability of Child Survival Activities**

Goal	End of Project Objectives	Steps Taken to date	Outcomes
<b>Strengthening of Health Infrastructure</b>	3 maternity centers upgraded by the LGA to provide full PHC activities	The project stated that they would stop EPI programs in communities where an LGA-managed facility should be providing those services.	One maternity in Ogo Oluwa was upgraded to PHC center  Two PHC centers were opened in Orire
	Two secondary health facilities to be provided one in each LGA	Given the lack of success in upgrading maternity centers, there was little action possible at the secondary health care facility level.	None
	Transfer skills and knowledge of the community-level delivery system to LGA health staff who will monitor the activities of VHWs and provide advice	Letters to the LGA inviting them to request training assistance received minimal response.  In communities with an LGA health facility vaccinations are held in or nearby the LGA facility (rather than at the health post) LGA personnel are invited to participate in the clinic activities.  There were numerous training opportunities that the LGA did not take advantage of.	The project trained LGA staff in the area of child survival interventions.  This has been partially successful. While the project may hold EPI in an LGA facility, the level of LGA personnel is not adequate to provide vaccinations even when they have immunization equipment.
<b>Community Ownership, Utilization and support</b>	90 CDCs functional (continuous community mobilization)	The project keeps track of what CDCs do.  CDCs have been encouraged to open bank accounts.	Most CDCs meet regularly and are operating satisfactorily. Almost all CDCs have opened their own bank account.
	90 VHWs, 100 TMs and 500 nutrition promoters trained	Surprise visits to communities are arranged to see if VHWs, TMs, and NPs are performing as planned.  Annual awards are given based on criteria of performance (60%), attendance (20%) and reports (20%)	This has created a healthy competition between health workers. When women dominated the top awards in 1995, men were “encouraged to improve their performance  80% of community health workers qualified for 1996 incentive awards. The average award was W 228.
	build confidence in mothers and community members to rely on VHWs/TMs	The project transferred the responsibility for weighing of children entirely to the VHWs	The result seems to have been positive.

Goal	End of Project Objectives	Steps Taken to date	Outcomes
<b>community Ownership, Utilization and support</b>	Continuous exchange of ideas and info about the performance of each community's health delivery system through quarterly meetings of the CDC representatives	These meetings have taken place on a regular basis with the executive committee of VHWS.	This has been an excellent mechanism for open communication with the community. It has also been effective way to mobilize communities.
<b>Participating Institutions</b>	The State EPI/CDD store shall supply all the required vaccines and ORS sachets as required	<p>The project helped the State to install a backup generator for their cold chain. The project has also provided fuel and transportation on numerous occasions for the collection of vaccines at the zonal state store..</p> <p>The project plans to move from 4 to 2 mobile teams; reduce the number of outreach sites; and increase the clusters of villages for EPI.</p> <p>There is a tentative agreement with the Oyo Catholic Diocese to take over vaccination activities in some communities of Ogo Oluwa LGA.</p>	The supply of immunizations and ORS was good until August 1995. The poorly functioning LGA supply and delivery system means that the current levels of vaccination coverage will probably not be sustained after the end of project.
<b>Income-Generating Activities/Cost Recovery Activities</b>	5 IGAs shall be established for VHWS/TMs	5 IGA mills and one IGA store were established.	The productivity of this type of IGA intervention has not been as good as expected.
	VHWS/TMs shall be able to provide essential drugs on demand at 90 village health posts	A resupply system has been established with a local private pharmacy at wholesale prices to CDCs for some purchases. CDCs are free to resupply wherever they wish.	The resupply system, often the weak link in project sustainability, has been secured through private sector collaboration.
	Charge competitive prices on health supply and services	CDCs resell drugs with a very small markup, e.g., 5% in order to remain competitive with private practitioners.	The sale of drugs and their resupply is sustainable. The community wants to expand this activity. This would be a good area for continued operations research.

## **Annex A: Evaluation Team Members**

**Franklin Baer (team leader)** - International Public Health Consultant, Baertracks

**Idris O. Adigun**, Director Primary Health Care/Disease Control, Oyo State

**Sanyaolu Olusegun Aduloju**, Health Information Coordinator, WV Project

**Daniel Gbadero** - Pediatrician, Baptist Medical Center

**OmoOlorun Olupona** - Project Manager, Ogbomosho WV Project

**Bayo Parakoyi**, Independent Health Consultant to USAID

**Tom Ventimiglia** - WVRD/West Africa International Programs Officer

## **Annex B: Actions Taken in Response to Mid-Term Recommendations**

***Commendation 1: The Evaluation Team unanimously commends all involved in the Child Survival Project (mothers; VHWs, TBAs, NPs and CDCs; and the project staff) for their excellent work in bringing Primary Health Care to a needy population of 68,000. Special commendation is given to the dedication, commitment, technical expertise, and leadership of the Project Manager, Dr. OmoOlorun Olupona***

***Recommendation 2: World Vision project staff hold a one day retreat to find ways to alter village operations to focus on increasing the visibility, importance, quality, and prestige of the village based workers.***

The recommendations were presented to the project staff before the Christmas break (1994). The one-day retreat was held in January 1995 at the University guest house. Actions which were taken to respond to this recommendation were that :

- 1) VHWs now do the weighing instead of the mobile team;
- 2) Rather than waiting for the mobile team to begin weighing, VHWs now begin the clinic themselves with the weighing and cooking exercise. The health education session led by the VHW begins with the arrival of the mobile team and usually includes the use of posters songs, demonstrations, and plays.
- 3) Any mother who tries to bypass the VHW is referred back to the VHW for treatment and/or referral. The VHW has and uses referral slips.
- 4) Graduation and Award ceremonies are organized to recognize the work of the VHWs

The final evaluation team learned that some communities have independently organized end-of-the-year parties to show appreciation to the VHWs and TMWs. The team also noted evidence of respect between community members to their VHWs and TMWs. CDC representatives stated that the work provided by the VHWs is vastly superior to those of the quacks. The quality of the medicines is not only better, but the VHW also provides appropriate health'education.

***Recommendation 3: VHWs' nutrition responsibilities be simplified to weighing, recording the weight on the child's chart, and giving immediate feedback to mothers. Village monitoring be limited to the number of children weighed, the number gaining weight, and the number not gaining weight.***

The project has tried to implement this. VHW responsibility has been simplified. However, immediate feedback from the VHW to the mother is not always given. The project has not yet found a mechanism to ensure that this always occurs. The final evaluation team suggested that perhaps mothers should be taught to always ask after each weighing, "How is my child doing?"

Part two of the above recommendation (village monitoring) has been implemented as road-to-health charts are sorted into two stacks -- "proper weight" and "decreasing weight" so that mothers can see the physical proportion of one pile versus another.

***Recommendation 4: Field teams be provided training in supportavision @referable to***

*supervision) to ensure as a first priority VHW quality weighing, recording the weight on the child's card, and counseling the mother on appropriate feeding practices. In this training, priority needs to be given to strategies to empower village based staff. It is also recommended that mechanisms be explored to provide visible (picture sign board) community feedback on the community status on nutrition, immunization, and drug expenses.*

The project has trained staff in a "Beyond the Clinic Walls" strategy of case studies as homework assignments. The project has also used "Frontline Leadership Training" approaches. Picture sign boards were tried, but testing was not successful. Feedback was principally observed for the drug system at an individual level.

***Recommendation 5: Central monitoring of nutritional data be limited to quarterly reviews of growth charts in the field with the VHWs, TBAs, and NPs; the discussion of these findings with those involved; and the collection of data for central project monitoring. Distribution of computer printouts to the field should be discontinued***

This recommendation was **not** accepted, because monthly monitoring was deemed necessary in order to meet donor reporting requirements. The project currently allows the community to do its own thing. Distribution of printouts to the VHWs has been stopped, however, the team still uses them for data collection to update the records of the children.

***Recommendation 6. All those involved in immunization at the community and project be commended for their excellent performance. Central monitoring of immunization should be limited to quarterly reviews of immunization with village based staff with recording of essential information for project monitoring.***

Part two of this recommendation was not accepted for the same reason as given for Recommendation 5.

***Recommendation 7: Consideration be given to the development of strategy to monitor immunization at the village level.***

Monitoring of who needs to be immunized each month has been transferred to the community. Project has let the VHWs keep track, but with discontinued use of the register which had too much information, this has not been realized. Steps which have been taken have not adequately resolved this problem. A simplified register is needed. The project has not satisfactorily resolved this problem.

***Recommendation 8: Project obtain the services of a consultant to carry out a two week in-vivo test of chloroquine sensitivity in parasitemic pre-school children.***

The project met with Prof. Walker in January 1995 to develop the protocol and to obtain authorization for the study. The lack of a microscope locally to confirm the positive malarial smears and the travel of Walker postponed the work for sometime. Eventually, Dr. Ngadole took responsibility for the study, but problems with finding sufficient candidates who have not already been "contaminated" with chloroquine and poor response for follow-up visits resulted in the study not being completed.

***Recommendation 9: Project solicit the assistance of the Nigerian Malaria Society in reviewing its current strategy for malaria prophylaxis in pregnancy.***

The project identified a contact within the Nigerian Malaria Society, but was unable to proceed further because of internal conflicts within the society.

***Recommendation 10: The project through continuing education of village based and project staff increase priority being given to diarrhea prevention.***

This has been done during the monthly refresher courses as more emphasis was placed on CDD. The result has reportedly been positive.

***Recommendation 11: Project continue to support community efforts to improve the availability of safe water. The project is encouraged to seek additional funding from village leaders and external agencies.***

The project has continued this activity within their constraints. The process is dependent on community action to dig the wells. CDC usually hires someone from outside the community to actually dig the well for an estimated cost of ₦3,000. Additional funding, however, has not yet been identified or secured.

***Recommendation 12: Project institute on a trial base the addition of pneumonia treatment to a selected group of VHWs to determine their ability to detect and treat pneumonia and to judiciously use cotrimoxazole.***

The project did a training for VHWs on ARI management, diagnosis and treatment. It was found, however, that most VHWs could not satisfactorily count respirations using a watch. Project has inquired about obtaining ARI counters, but “time” has run out.

***Recommendation 13: Project seek the assistance of the MotherCare Project to assess opportunities for improved maternal care with available resources.***

The MotherCare project closed their activities last year, as part USAID’s move from 13 to 5 Implementing partners. MotherCare was not able to make new commitments for 1995.

***Recommendation 14: Project develop with LGAs written plan for coordination in training, supervision, and service delivery. Monthly reports of this activity be provided to the LGA Chairmen.***

The project tried on several occasions to change supervision schedules to accommodate LGA schedules. The result has never been satisfactory.

The project found that its immunization reports which were sent to the LGA were being passed on to the State as LGA-provided vaccinations to cover up their lack of activity. To avoid being a partner to this “cover-up” the project stopped sending reports to the LGA.

A representative from the LGA of Orire meets with the VHWs during the in-service training. It is hoped that someone from the LGA will take charge of continuing this activity or perhaps BMC. The BMC outreach program which does monthly in service training would be a logical coordinator for this activity if participants could accept to come to Ogbomoso for the training sessions.

***Recommendation 15: Project obtain the services of a consultant (NCCCCD) to identify information***

*needs, to simplify procedures for data entry and analysis, and to provide training to appropriate personnel.*

This was done. The team was quite very satisfied with the results, and wishes the consultant could return to see how much they have improved. The project now uses many more of the features of EPI Info and in a more efficient manner, e.g., combining communities into one data file for growth monitoring and EPI rather than having separate files for each community.

***Recommendation 16: Project experiment with alternative outreach strategies such as splitting teams to visit two villages at a time, visiting on alternative months, or biannual campaigns in remote rural areas to identify ways to maintain benefits at lower cost.***

The team has tried this along with the idea of clustering health posts for immunization. With Polio Plus the project participated in a mass immunization campaign. ***NOTE: The Project will quantify the reduction in the number of immunization posts.***

***Recommendation 17: Project request a one year no cost extension of the current project to September 30, 1996.***

This recommendation was gladly accepted and implemented.

***Recommendation 18: Project convene a task force of project staff; Baptist Medical Center, LGA, and CDC representatives to explore options to ensure long term sustainability of benefits for the target population.***

The project made an effort to create a task force to look at the aspect of IGA sustainability. The project felt that this would be a key factor to keeping the VHWs involved. The committee did not meet as often as was expected, but the committee did make some visits and produced some improvement of the IGAs. However, the working relationships and internal crises of the implementing partners (BMC and LGA) resulted in a lack of interest in continuing the task force.

***Recommendation 19: Consideration be given to a 2-3 day visit by a member of the project staff to each project village to get to know the village and its workers, to understand the constraints facing the workers, to assess by house to house survey coverage of the population, and to develop strategies to elevate the status of village-based workers and the CDC. All project staff including office staff and drivers should be a part of the village visits,***

Some the project staff spent five days with selected communities. The feedback from this learning experience was very positive.

***Recommendation 20: The project convene a retreat in early February 1995 to review the above recommendations and identify those appropriate for adoption. That adoption be accompanied by the assignment of responsibility, the identification of a time frame, and the establishment of a mechanism for monitoring their implementation.***

This was done during the January 1995 retreat.

FIELD

1996 COUNTRY PROJECT PIPELINE ANALYSIS  
 PVO/COUNTRY PROJECT: W.V.R.D / NIGERIA OGBOMOSO SOUTH CHILD SURVIVAL PROJECT  
 # FAO-0500-A-00-2042-00

Actual Expenditure to Date (10 / 01 / 92 to 09 / 30 / 96)      Projected Expenditure Against Remaining Obligated Funds ( / / to / / )      Total Agreement Budget (Columns 1 & 2) (10 / 01 / 92 to 09 / 30 / 96)

COST ELEMENTS	A.I.D	PVO	TOTAL	A.I.D	PVO	TOTAL	A.I.D	PVO	TOTAL
<b>I. PROCUREMENT</b>									
A. Supplies	31407	17768	49175	-18104	-1371	-19475	13303	16397	29700
B. Equipment	4760	50169	54929	0	-3519	-3519	4760	46650	51410
C. Services/Consultants	0	0	0	0	0	0			
1. Local	3422	459	3881	5970	1199	7169	9392	1658	11050
2. Expatriate	842	0	842	3408	750	4158	4250	750	5000
SUB-TOTAL I	40431	68396	108827	-8726	-2941	-11667	31705	65455	97160
<b>II. EVALUATION</b>	5759	216	5975	18740	4107	22847	24499	4323	28822
SUB-TOTAL II	5759	216	5975	18740	4107	22847	24499	4323	28822
<b>III. INDIRECT COSTS</b>									
HQ/HO Overhead_20_(%)	74206	16880	91086	1	1143	1144	74207	18023	92230
SUB-TOTAL III	74206	16880	91086	1	1143	1144	74207	18023	92230
<b>IV. OTHER PROGRAM COSTS</b>									
A. Personnel(list each position & total person months seperately)	254625	33563	288188	-11848	8870	-2978	242777	42433	285210
1. Technical		0		0	0	0			
2. Administrative									
3. Support									
B. Travel/Per Diem	0	0	0	0	0	0			
1. In Country	12159	5446	17605	11791	-1220	10571	23950	4226	28176
2. International	2454	14759	17213	6046	-8759	-2713	8500	6000	14500
C. Other Direct Costs (Utilities, Printing, Rent maintenance, etc)	0	0	0	0	0	0			
SUB-TOTAL IV	60366	12189	72555	-16004	2143	-13861	44362	14332	58694
	<b>329604</b>	<b>65957</b>	<b>395561</b>	<b>-10015</b>	<b>1034</b>	<b>-8981</b>	<b>319589</b>	<b>66991</b>	<b>386580</b>
<b>TOTAL FIELD</b>	<b>450000</b>	<b>151449</b>	<b>601449</b>	<b>0</b>	<b>3343</b>	<b>3343</b>	<b>450000</b>	<b>154792</b>	<b>604792</b>

• Excludes Evaluation Costs

Annex C: 1996 Pipeline Analysis

## Annex D

MINUTES OF THE MEETING OF THE COMMITTEE SET UP TO LOOK INTO SUSTAINING THE GAINS OF OGBOMOSO CSP HELD AT THE CONFERENCE ROOM, SCHOOL OF NURSING, BMC ON WEDNESDAY, 25 SEPTEMBER. 1996 AT 11.30 AM

### Membership:

- |  |          |
|--|----------|
| 1. Dr I O Adigun, Director, PHC/DC, Oyo State                      | Chairman |
| 2. Mr C Uzoamaka, Baptist Medical Centre, Ogbomoso                 | Member   |
| 3. Mr A N Obansola, "  | "        |
| 4. S I Akanbi, Ogo Oluwa VHW/TM Cooperative Society Chairman       | "        |
| 5. Ezekiel Ojoawo, Orire VHW/TM                                    | "        |
| 6. Chief (Mrs) M B Ajoni, Catholic Diocese R H P Oyo               | "        |
| 7. Mr A K Mofolasere, Ogo Oluwa LGA, Supervisor for Health         | "        |
| 8. Elder MA Ogunniran Ogo Oluwa LGA, PHC Coordinator               | "        |
| 9. Mrs F A Akindiya, Ogo Oluwa LGA, Traditional Midwife            | "        |
| 10. Rev Sr M Elizabeth Akinlotan, Catholic Diocese RHP, Oyo        | "        |
| 11. Dr (Mrs) O A Abosede, Child Association of Nigeria, Lagos      | "        |
| 12. Mrs Deborah Obalakin, Orire LGA, Traditional Midwife           | "        |
| 13. Saka F Aremu, Supervisor for Health, Orire LGA                 | "        |
| 14. K A Olaniyan, PHC Coordinator, Orire LGA                       | "        |
| 15. G A Salami, EPI/CDD Manager, Orire Local Govt.                 | "        |
| 16. Dr OmoOlorun Olupona, World Vision CSP Manager                 | "        |
| 17. Rev Sanyaolu Aduloju, World Vision Health Info. Coordinator    | "        |
| 18. Rev Debo Adeyemo, Chairman, Committee on IGA/WV Admin. Officer | "        |

### Opening:

The meeting was declared open with prayers from Rev S O Aduloju. Dr Olupona said that the business for the day would be conducted in two languages i.e. Yoruba and English because The VHWS/TMs are not comfortable with English while Mr Uzoamaka does not speak Yoruba.

### Reason for the meeting:

Dr Olupona gave reasons why we were gathered. He gave an overview of how the project started and traced the history to date. The reason for calling the meeting was to discuss the sustainability of the gains of the project as funding would cease in five days time from the date of this meeting. The rationale for the composition of the committee was given as follows: the primary partner is the Baptist Medical Centre (BMC), the Local Governments have the responsibility for PHC and health generally. The VHWS/TMs have been invited to represent the various communities. Mrs Ajoni, Oyo Catholic Diocese Rural Health Project (RHP) has been providing some immunization and other health care in some communities in Ogo Oluwa. Dr (Mrs) O A Abosede was until recently the resident advisor for Wellstart International in Nigeria. Wellstart closed its office in June and Dr Abosede and the Child Association of Nigeria are trying to sustain previous activities. Advantage of her presence in Ogbomoso for a training programme was taken so that she could share experiences with the committee and explore possibility of collaboration.

### Discussion:

The Chairman thanked members present. He said that he has deep interest in multi-sectoral and inter-sectoral collaborations. This meeting was called in order to address how the gains could be sustained since funding has ended.

The following were inputs into sustainability issue on CSP:

**Ogo Oluwa LG:**

1. Committed to fulfil earlier promises to sustain the project. To this end and to address perennial staff shortages, the government is embarking on recruitment of nurses and midwives on GL 6 with the hope that their employment would be regularized with time by the appropriate body. In addition, eight students are currently undergoing training as Community Health Extension Workers, Environmental Officer and Medical Record Officer.
2. Committed to buying bicycles to enhance VHWS mobility.
3. The monthly VHW/TMS meetings would be supported with the provision of refreshments for the volunteers. Incentives would also be given to voluntary health workers.
4. Cold store has been resuscitated to maintain cold chain system to guarantee the supply of vaccines for immunization.

**Orire LG**

1. Provision of ₦200,000.00 to sustain the program.
2. Training and re-training of voluntary health workers would continue.
3. Monthly transport cost and meals for VHWS/TMS.
4. Hiring of CHEWs, Medical Record Officer, Environmental Health Officers before the end of October, 1996.
5. Provision of drugs, including haematinics, to the VHWS.
6. The issue of bicycles for the VHWS will be discussed with the Chairman.
7. The LG would provide reliable cold-chain system to supply vaccines.

**The Communities:**

1. Strong commitment to the success of the gains of the project.
2. Willingness to continue to pay fees for service.
3. Financial support by the communities.
4. Active and functional Community Development Committees to be in place.
5. Patronage of the IGAs - the mills and the VHPs.
6. Continue to support by donating land and other things for development purposes.
7. Incentives for the VHWS/TMS.
8. Communal labour to continue.

**Baptist Medical Centre (BMC):**

1. The memorandum of agreement among the four partners (WV, BMC, Ogo Oluwa, Oyo State MOH) would continue to be honoured.
2. Supervision.
3. Training and re-training.
4. Technical support.
5. Interaction with VHWS/TMS is needed (BMC's CHCP and VHWS/TMS to interact).
6. Cannot make any commitment on funding.
7. Continues to serve as a referral centre.

**Oyo Catholic Diocese Rural Health Programme:**

1. Additional staff hired to join Chief (Mrs.) Ajoni.
2. Waiting for more communities to be handed over to them.

3. Will like to obtain vaccines and EPI equipment from Ogo Oluwa LGA.
4. Can provide training for VHW/TMs.
5. Would seek for external funding to broaden the scope of the work.
6. Catholic Church will continue to pay its staff salaries and maintain its vehicle.
7. Token fee for service will continue to be charged.

**Child Association of Nigeria (CAON):**

1. Trained Master Trainers and State Trainers.
2. Produced IEC materials and training modules.
3. Radio programme, health educational film already in place.
4. Fund raising within and outside Nigeria.
5. Will support training efforts in Oyo State, especially in LGAs where there are State trainers in place.
6. Monitoring and Evaluation.
7. Will enhance IEC efforts to entire project area where WV worked.

**World Vision International:**

1. May continue to serve for another one year with reduced staff.
2. Will fulfil her own part of the agreement, except where the agreement has been abrogated with Ogo Oluwa LGA. However, if Ogo Oluwa shows seriousness, WV is open to re-negotiation.
3. Would share assets as signed in the agreement with due consideration of No.1 above. However, if funding is available for another year, the sharing of certain items will have to wait.

**Oyo State (Ministry of Health):**

In line with the National Policy on Primary Health Care it will continue to:

1. Muster advocacy for health programme at the LG level.
2. Provide technical assistance in the form of training and re-training.
3. Provision of equipment and logistic support when this is possible.
4. Will embark on supervision, monitoring and evaluation of all project activities in these two Local Governments.
5. The State will liaise and collaborate meaningfully and effectively with other stake holders in ensuring sustainability of CSP and other health related issues in the two LGAs.

Major activities to sustain gains of child survival project to the communities by the stake holders as agreed upon are **as** follows:

**Technical Issues**

1. Supervision of VHWS/TMs/NPs.
2. Continuous education of the VHWS/TMs/NPs through their monthly meetings.
3. **Immunization - key to the sustenance** of this project.
4. Supervision of IGAs and VHPs accounts.
5. Drug restocking.
6. Health Information System.
7. Evaluation.

The following were **political issues** identified and agreed upon:

1. Strong commitment on the part of policy makers.
2. Funds.
3. Personnel recruitment - adequate and appropriate
4. Training and re-training of staff.
5. Equipment.
6. Logistic support.

**Closing:** It was resolved that each representative should go home and discuss with the appropriate quarters points agreed upon in today's meeting. (Please see next page for assigned roles). The house agreed to have a standing committee. It also resolved that BMC should become the rallying point for the sustenance of the gains, akin to WV's present role. It (BMC) should convene the next meeting, which was tentatively fixed for 16 October, 1996 at 11.00 a.m., with logistic support provided by **W**. All of the participants today should be encouraged to be present. During the next meeting the degree of participation in the assigned areas will be discussed. It was hoped that at least one representative of **W** should be at the meeting. Dr Olupona said he would endeavour to be present. The membership of the steering committee should be reduced to a more manageable size. The custody of resources could be left with BMC but resources for each LGA should be spent for that particular LGA. Mrs Ajoni said the closing prayer at 3.55 p.m.

Assignment of Activities to Stake Holders

Activities	ngo luwa	Orire	BMC	Community	Catholic	WV	OYS	CAON
Supervision	+	+	+	+	+	+	+	+
Funding	+++	+++	(+)	+	?+	?+	(+)	?+
Advocacy	+	+	+	+	+	+	+	+
Continuous Education	+	+	++	+	+	+	+	+
Immunization	++	++	+		+	+		
Drug Restocking		+		+				
Information System	+	+	+	+	+	+	+	+
Technical Support			++		+	+	+	+
Referral Centre			++					
Patronage of VHP & IGA				++				
Auditing of A/C			+					
Logistic & Equipment	++	++		+		++		+
Personnel	++	++	+	++	+	+		
Former WV staff employment	+	+						
IEC Materials							++	++

Key:

- + Indirect provision, e.g. cost of providing service.
- ?+ Possible, but no commitment yet.
- +

**SUSTAINABILITY ASSESSMENT  
OGBOMOSHO SOUTH  
CHILD SURVIVAL PROJECT  
OYO STATE, NIGERIA**



World Vision Relief & Development, Inc.

*Prepared by  
Jay Banjade, Lassen Associates  
Fe D Garcia, WVRD USA  
S ti Aduloju WVT Nigeria  
September, 1996*

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### Key to abbreviation

- I. Introduction
- II Objectives of the Assessment
- III. Methodology
- IV Analysis and Findings
  - A. Market Assessment: What the clientele say about the services?
  - B. Service Package: What is to be sustained?
  - C Cost Analysis: Cost of sustaining proposed services
  - D Revenue Analysis: Potentials for revenue generation
  - E. Managing the Transition
- v Recommendations

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- 1. Scope of work
- 2. List of people interviewed
- 3. Sustainability Readiness Index
- 4. Cost-Consciousness Opinion Survey Questionnaire
- 5. Community Participation Survey Questionnaire
- 6. Schedule of activities
- 7. Activity Plan
- 8. Statement of Revenue and Expenses
- 9. Focus Group Questions

## KEY TO ABBREVIATIONS

CDD	Control of Diarrhoeal Diseases
CSP	Child Survival Project
EPI	Expanded Program for Immunization
GM/N	Growth Monitoring/Nutrition
MC	Maternal Care
NM	Nutrition Monitor
OSCSP	Ogbomosho South Child Survival Project
SRI	Sustainability Readiness Index
TM	Traditional Midwives
USAID	United States Agency for International Development
WVRD	World Vision Relief & Development

## I. INTRODUCTION

In 1989, World Vision Relief & Development (WVRD) started the Ogbomosho-South Child Survival Project (OSCSP) in the Oyo state of Nigeria with financial assistance from USAID. It began as a three year project, was extended for another three years in 1992, and a one-year no-fund extension in 1994. During the seven years of project life the OSCSP spent a total of US\$1, 129,583 of which \$786,181 was funded by USAID and (US\$343,402) from World Vision United States. The project carried out its child survival activities initially in Ogo Oluwa Local Government Area (LGA) and expanded in Orire LGA in 1992 covering a target population of 68,000 with 32,000 women and children as direct beneficiaries. The project is managed by a crew of 30 personnel (18 technical and 12 administrative & support staff) directly hired by the project and 641 community volunteers (187 village health workers, 78 traditional midwives, 376 nutrition promotionists) and 64 community development committees. The Baptist Medical Center in Ogbomosho and the Ministry of Health in Nigeria have also provided some assistance to the project. Several evaluations conducted during the life of the project indicate that the project has performed very well technically.

As the donor funding to the project is going to end on 30th September, 1996, project staff and communities are greatly concerned about how to sustain the benefits of this technically sound project. In the past, some sustainability initiatives such as mobilization of communities and setting up income-generating activities were initiated by the project, but these would not be enough to sustain the project once donor funds cease. This assessment was proposed to explore the possibility of sustaining some or all of the services of the project through a variety of revenue and cost saving mechanisms.

## II OBJECTIVES

In order to explore and develop the possibility of sustaining the project benefits, this assessment was undertaken to:

- a. Assess the perception of the target beneficiaries about the services offered by the project, their choices, desirability, and ability to pay for the services
- b. Determine the new service package based on the market assessment and suggest what existing services should be continued or cut back and what new services should be introduced
- c. Analyze the existing cost structure and explore the possibilities of cutting costs and improving productivity and performance of staff
- d. Analyze existing revenues, explore new sources of revenue, and estimate potential revenue amounts from these sources

- e. Suggest managerial improvements for efficient and cost-effective operations.

### III. METHODOLOGY

The assessment used a mix of methodologies: Interviews with key informants such as community members, health workers, project staff, and the target population; review of project documents; analysis of project records; and field trips and observation by the assessment team. Focus group interviews (11) were conducted to find out how target beneficiaries assess the services, what services they value the most, what new services would they demand, and how much would they be prepared to pay. Mill operators (3 out of 5) were interviewed to assess the performance of the mills-income-generating activities of the project (see annex 2 for the list of people interviewed).

Three assessment tools were used to gather information on cost consciousness among project staff, sustainability readiness of the project and level of community participation in project activities (see annexes 3, 4, and 5 for the tools). Analysis of records dealt mainly with costs, revenues, staff efficiency, and cost effectiveness. Key project staff were fully involved in these analyses. Staff also participated in brainstorming sessions used to develop sustainability strategies such as what new services to start and charge fees, what alternative revenue sources to develop, what measures to use to cut costs, and how to improve staff efficiency and cost effectiveness. These sessions were utilized to orient and train key staff on issues that are important for sustainability

The core assessment team included the following individuals:

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Key findings and recommendations were shared with the project staff, WVI Nigeria, and USAID local mission in Lagos

#### IV. ANALYSIS AND FINDINGS

##### A. The Market

At the outset, the assessment looked at the size of market for child survival and related services in the current project area. The market, as defined here, is examined in terms of the size of clientele groups, types of services they would buy, their purchasing power, and other agencies or individuals providing similar services in the area.

The total population of the current project area is about 68,000 with 32,000 women and children who are the direct beneficiaries. There is an untapped market of 36,000 men who are the potential buyers of services such as curative treatments, immunization against yellow fever, etc. The project also has the possibility of selling services to generate revenue in the adjacent villages provided such sales result into revenues higher than the incremental costs.

The project area is mainly inhabited by poor people who work primarily in subsistence farming, petty trade, and craft making. However, the rich soil, proximity to markets, and availability of transport have a positive impact in people's income and cash flow in the area. They may not afford expensive services, but they can pay for basic medical care. The local community categorically expressed the view that they would pay 20 to 30 Naira (US\$0.23 to 0.35) per contact for services like Extended Program on Immunization (EPI) and treatment of common ailments including malaria and maternal care, in order to continue these services after the closure of the project in September 1996. Besides, local residents spend a larger part of their medical expenses on drug peddlers and quack doctors, as the latter sell expired medicines cheaply and give injections and antibiotics-services not allowed and provided by the health workers of the project. A proper promotional strategy aimed at exposing the dangers of dealing with drug peddlers and quacks will gain a market for project services. There are no other competitors in the area. Villagers patronizing the services of Village Health Workers (VHWs) say that they prefer VHWs because they not only treat them and their children but also provide health education.

##### B. Service Package

The existing service package delivered by the project includes the following

- a Expanded Program on Immunization (EPI)
- b Control of Diarrhoeal Diseases (CDD)
- c Nutrition and Growth Monitoring (N/GM)
- d Control of Malaria (CM)
- e Maternal Care (MC)
- f Family Planning (FP)

The community members and targeted mothers would like all of these services continued. They, however, consider EPI as the most important service followed by (not necessarily in the order of importance) nutrition/growth monitoring, control of malaria, and family planning. Other than control of diarrhoeal diseases, which is mainly an educational intervention, all other services can be sold for a reasonable fee. The clients are willing to pay between 10 to 20 Naira per contact for these services.

Services not provided by the project that villagers would like delivered and would pay for include treatment of adult ailments, blood pressure monitoring, and adult weighing. The key project **staff** believe that services other than above can also be delivered for a fee. These include adult immunization against yellow fever and meningitis, circumcision, ear piercing, maternal delivery, and curative services. To take advantage of these potential services, the project should consider redesigning its service package to include the following:

- a. Expanded Program on Immunization (EPI)
- b. Control of Diarrhoeal Diseases (CDD)
- c. Nutrition and Growth Monitoring (N/GM)
- d. Control of Malaria (CM)
- e. Maternal Care (MC)
- f. Family Planning (FP)
- g. Treatment of adult ailments, blood pressure monitoring, and adult weighing
  - a. Immunization against yellow fever and meningitis
  - b. Circumcision
  - c. Ear piercing
  - d. Maternal delivery, and
  - e. Other curative services

The program can cover a substantial amount of its costs by providing these services for fees because they can be delivered without incurring additional labor and overhead costs

### **C. Cost Analysis**

Like most other child survival projects, the OSCSP focused its attention on achieving excellence in the technical aspects of the service and did not give much attention on recovering its costs. This was reflected on the cost/revenue consciousness opinion survey which showed different understanding of cost items by the staff and a wide range of cost estimates to deliver a unit of service to a beneficiary. The staff considered travel to cost significantly higher compared to other costs such as personnel, communication, supplies, etc. Travel cost was also considered the most difficult item to predict when budgeting. The analysis of actual costs, however, shows that travel is the second most expensive cost item, and the discrepancy between actual and budgeted travel cost is about 23 percent. The travel cost is certainly the most difficult cost to control. Staff consider EPI as the most expensive service, but the cost analysis suggests otherwise (see table - 2 below)

The OSCSP's actual core operating cost for nine months (Oct 1, 1995 to June 30, 1996) is \$110,244. With an estimated 4th quarter expenditure of \$36,745, the total estimated FY96 expenditure amounts to \$146,989. The itemized classification of these costs is as follows,

*Table-1*  
*Project Expenses by Cost items*

<b>Cost Items</b>	<b>9 Months Actual</b>	<b>4th Quarter Estimates</b>	<b>Total FY96</b>	<b>Percentage</b>
<b>Salaries And Benefits</b>	58,807	19,602	78,409	53.5
<b>Training</b>	3,743	1,254	5,017	3.4
<b>Travel/per diem</b>	22,959	7,653	30,612	20.8
<b>Supplies</b>	11,389	3,796	15,185	10.3
<b>Rent Utilities</b>	2,212	737	2,949	2.0
<b>Communication</b>	3,089	1,030	4,119	2.8
<b>Professional Services/TA</b>	139	2,273	2,412	1.6
<b>Capital Equipment</b>	6,501	0	6,501	4.4
<b>Maintenance</b>	1,113	400	1,513	1.0
<b>Income Generating Activities</b>	272		272	0.2
<b>Total</b>	110,244	36,745	146,989	100.0

As the table above shows, salary and benefits alone consume more than half of the total project revenues. Travel and per diem are the other most expensive cost items which amount to 20 percent of the total costs. Training and supplies cost only about 15 percent and other overhead costs are about 10 percent of the total project costs. If cost-saving measures are to be put in place, salaries and travel must be targeted first. The project management has similarly identified these measures and has taken initial steps to address them.

An analysis of FY96 cost structure for nine months by project services shows the following.

Table-2  
Unit Costs of Providing Services

Services	Allocated Total Cost	\$ Services (Total items or contacts)	Cost Per Unit S
<b>EPI</b>	44,037	2 1,694 doses	2.03
<b>Control of Diarrhoeal Diseases</b>	15,859	16,554 tr. contacts	0.96
<b>Nutrition/Growth Monitoring</b>	24,624	13,258 contacts	1.86
<b>Maternal Care</b>	6,344	2,73 5 contacts	2.23
<b>Family Planning</b>	12,788	11,096 contacts	1 15
<b>Control of Malaria</b>	6,583	1,773 contacts	3.71
<b>Other activities</b>	10,893		
<b>Total</b>	110,244		

To determine the unit costs of providing services, the total project costs were allocated to different services based on direct supplies used by each service, time spent by staff to deliver the services and logistics involved in them. The ratio of cost allocation determined, based on these criteria, was 45 : 5.10: 10: 5.10: 15 for EPI, CDD N/GM, MC, FP, CM, and other activities respectively. The above table shows that Control of Malaria is the most expensive service (\$3.71 per contact) offered by the project. It includes distribution of drugs, advice, and education on how to protect against malaria-bearing mosquitoes. Maternal Care, which involves prenatal care of pregnant mothers, costs \$2.32 per contact. EPI, which is the most liked service by the clients, costs \$2.03 per injection, less than what project staff initially thought.

To control cost, the OSCSP has been applying the following measures:

- a. Service delivery to clustered/adjacent villages from a central location instead of village-to-village delivery.
- b. Introduction of local per diem rates to reduce hotel bills and cost of living
- c. Overseas procurement at concessional rates, e.g , meningitis vaccines were purchased at \$0 20 per dose instead of \$2 00 per dose
- d. Communities required to shoulder part of travel cost of VHWs during training
- e. Direct procurement of materials from vendors instead of going through contractors and middlemen
- f. Hiring of drivers-cum-mechanics to save the cost of maintenance

For the FY97 and beyond, the project aims to drastically reduce costs by taking further measures such as reducing the number of salaried staff from 30 to 13 and controlling travel and training expenses (see Annex 8 for details of the minimum costs to sustain project benefits). These reductions, in the wake of increased services and income-generating activities, mean that the staff will have to be two to three times more efficient, which should be possible with appropriate management improvements.

#### **D. Revenues Analysis**

Local revenue-generating measures started by the project include a fee for some selected services, drug sales, and rental of five cassava mills and three market stalls. As of August 1996, the total revenue generated from fees and drug sales amounted to \$1,343 (Naira 15,900 for fee and 91,564 for drug sales). The five cassava mills and three market stalls are rented for a total monthly rent of \$96 (Naira 7,500 + 1 SO)

These revenues are below 2 percent of operating costs of the project and are used to replenish drug supply in health centers and reward volunteers (village health workers, traditional birth attendants, and nutrition promotionists) and, in some cases, to pay for volunteers' travel costs during training. The fees are not yet standardized (range between Naira 10 to 15 for EPI and 0 to 5 for growth monitoring) and are collected by VHWs and managed by CDCs. The mills are operating at a very low capacity (25 to 50 percent) because of seasonality of produce, depressed economy, and farmers' preference to bring their produce to the city for instant cash. Even at this low capacity, mills are making a small profit. In view of the cost of capital, repair, and depreciation costs, the rent charged by the project is too low. Market stalls are rented for \$0.75 (Naira 60) per month and do not have any prospects to raise rent in the near future.

However, good potential exists to raise revenue by charging fees in all the existing services. Introducing new services for a fee, strengthening existing IGAs, and implementing other income-generating activities are other possibilities to raise revenue.

The key project staff believe that the following fee structure can be introduced in the existing services.

*Table-3  
Revenue Potentials From Existing Services*

Services	Fee Per Unit of Service In Naira	Total Units of Service	Total Fee	Naira Total in US Dollars
EPI	20	21,694	433,980	5,425
CDD				0
N/GM	10	2,735	54,700	684
MC	I 20	2,735	54,700	684
FP	10	11,096	110,960	1,387
CM	20	1,773	35,460	443
<b>Total</b>				<b>9,594</b>

The total fee that can be collected from existing services amounts to USD \$9,594 per year. According to the key project staff, an additional fee amounting to US\$14,511 can be collected from providing new services which are demanded by the communities.

*Table-4  
Revenue Potentials from New Services*

Services	Estimated Net Revenues US \$
Circumcision	1,320
Immunization (yellow fever & meningitis)	10,000
Ear piercing	225
Specialty medical camps	450
Maternal delivery	675
Other curative services	1,841
<b>Total</b>	<b>14,511</b>

Other sources to generate income, as identified by the key staff and the evaluators, include monetization of gifts in kind (USD 15,000) use of existing facilities to sell photocopying and typing services (USD 969), film showing (USD, community health membership fee (USD 1,250) interest on privatization of underutilized mills (USD 195) and use of extra vehicles for ambulance service. From these sources about \$19,414 can be generated.

Thus, the total revenue that can be generated from fees as well as other sources amounts to \$43,519 (see Annex 8 for details). However, these figures should not be taken at their face value because they are entirely based on the opinion of staff and community members and are not yet market tested. In addition, they are based on the assumption that the reduced number of staff (13 persons) can deliver all these services and can manage other income-generating activities. To achieve these results, the program should use social-marketing tools to promote the services, adopt more efficient organizational and managerial practices (to the extent that staff productivity increases two

to three fold), successfully compete with drug peddlers and quack doctors, and use management accounting tools to monitor and plan financial performance.

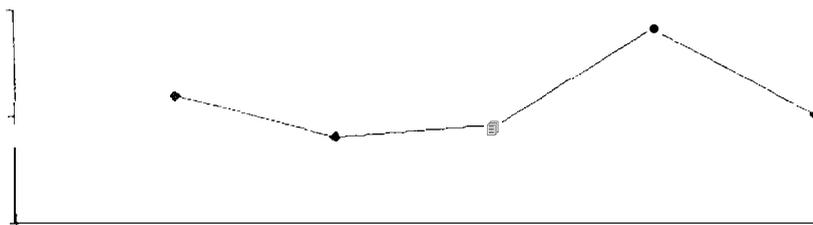
### **E. Managing the Transition**

Currently the project activities are carried out by a crew of 18 technicians (one doctor, nurses, and auxiliary health workers), 12 administrative staff, 187 village health workers, 78 traditional midwives, and 376 nutrition promotionists. Services are delivered through several health posts which are supervised by 64 community development committees. One health post serves between 2 to 5 villages and each village has an average of 20 households.

Since the donor funds are going to diminish substantially by September 1996, the project managers are devising ways to sustain the project benefits. In addition to developing sources of local revenue, a massive cost reduction is planned, specially in salaries and benefits, travel, and training. This means that the reduced number of staff (5 technicians, 4 admin, and 4 support staff) will have to carry out the increased workload. How can this be done? Are staff ready for this? Are operational tools needed to triple staff productivity in place? These remain as the management challenges faced by the project.

The Sustainability Readiness Index (SRI) test conducted at the beginning of this assessment shows that the OSCSP is ready to undertake major sustainability initiative but lacks practical skills in several aspects such as revenue strategy, cost recovery, management, and operations. The overall score is above 60 percent with highest score (90 percent) in organizational culture supporting sustainability values and readiness to apply business principles. High scores were also obtained in technical standards of program services which, however, need to be repackaged with costs, demand, and revenues in mind. The SRI result is depicted in the following graph.

**Sustainability Readiness Index**



*The evaluators' observation, interviews, and analysis of project records support these SRI findings.*

The level of community interest, participation, and ownership in the project activities is another essential element to make the program self-sustainable. A test administered to this end indicates that the level of community participation in project activities is past dependency and is moving towards self-reliance, as seen in the diagram below.



In addition to training and delegating to the volunteers, the management and technicians must find ways to minimize travel and preparation so that more time is available for actual delivery of services. Involving the eight administrative and support staff in preparation work, posting technical teams nearer to the communities in strategic locations, and adapting efficient managerial and operating procedures are extremely important. Every one involved in the project must accept a paradigm change from a donor-added project to a self-supporting service enterprise and should be prepared to work harder and smarter.

In order to execute the increased level of efforts by a reduced work force, training will be required for project staff, volunteers, and members of the Community Development Committees. Particular improvements will be necessary in organizational productivity, application of business principles, planning and performance monitoring, managerial use of accounting information, and application of social-marketing concepts. The OSCSP should seek outside technical assistance in these areas

## V RECOMMENDATIONS

- A Based on the findings presented above, the following recommendations are made:
- 1 Shift the project organizational and management paradigm from
    - a a grant/project mentality to a “businesslike,” self-sustainable mindset
    - b beneficiaries to client
    - c guardian participant CDCs to co-owners and comanagers of program services, and
    - d staff assistant VHWS, TMs, and NPs to coproviders of community-based services.
- B Create a OSCSP mission statement that reflects commitment to quality service and financial sustainability. Use the mission statement to motivate staff, mobilize/empower communities, and to improve the quality of decisions to attain sustainability of project benefits.
- C Continue to maintain the technical soundness of the program while exerting more efforts to address financial sustainability issues such as cost management, revenue-generation, efficient procedures, and productivity measures
- D Proceed with the streamlined management strategy with the reduced number of staff and reduced cost of travel and per diem

- E. Redesign the project service package through the following.
  1. continue existing services such as EPI, GM/N, CDD, MC, and FP, with EPI as the only service to be provided by the technical staff
  2. delegate non-EPI services to VHWs, TMs, and NPs
  3. add new services which are revenue-generating such as yellow fever and meningitis vaccination, treatment of adult ailments, blood pressure monitoring, ear piercing, circumcision, emergency ambulance services, and maternal deliveries.
- F. Change the pattern of **staff workload** to maximize their productivity in such a way that the new service package could be effectively delivered and paid for by the community.
- G. In order to improve staff efficiency, scale up coverage, and maintain the quality of services:
  1. Consider relocating or deploying staff to strategic locations in the community. If this is not feasible for various reasons, encourage staff to stay overnight in the communities to maximize the delivery of services and minimize the cost.
  2. Clearly define changed/expanded roles and responsibilities for each of the staff
- H. Give high priority to raise revenues locally by charging fees in existing services, introducing new services for fee, and implementing new IGAs Pilot-test and refine ideas to build a reliable long-term revenue mechanism
- I. Continue cost-reduction measures currently being carried out; improve on these measures such as maximizing the availability of the driver/mechanics on-site by using them as logisticians, activity-organizers during the implementation of new revenue-generating activities such film-showing and photocopying services.
- J. Apply social-marketing concepts and tools to promote existing as well as new services. Ongoing promotional activities should be targeted based on service and client segmentation
- K. Execute more rigorously the planning, organizing, and monitoring activities to ensure that the increased activity and changed workload is accomplished by the decreased workforce. This will require better management information system, procedures, and control measures.
- L. Implement task-specific skill and performance-based training to the following cadre of workers
  - 1 CDCs core community-based health care management including the use of information for decision making, advocacy, networking, and resourcing

2. VHWs: non-EPI activities including the use of prescription notes for specific consultation, communication, counseling, recording, and reporting
  3. TMs: maternal care monitoring using maternal cards.
  4. NPs growth-monitoring and promotion, counseling, and if feasible running a nutrition education/promotion center for preschoolers.
  5. Technical staff project efficiency and use of productivity tools, planning and monitoring, application of business principles for cost-effectiveness, use of quality assurance tools and techniques, social-marketing tools and techniques.
  6. Finance and administration staff: use of business principles and techniques and management accounting
- M Obtain technical assistance in the following areas organizational productivity, business principles for generalist organizations, planning and performance monitoring, management accounting and information system, and social marketing

#### **POST-EVALUATION ACTIVITIES**

An activity plan for FY97 and an estimation of FY97 revenues and expenses was conducted with key project staff. The results are found in Annexes 7 and 8.

SCOPE OF WORK  
**Sustainability Consultancy, Jay Banjade**  
**Nigeria August 30-September 30, 1996**

**I. PURPOSE**

World Vision Relief & Development (WVRD) Nigeria Ogbomosho Child Survival Project in Oyo State, Nigeria will be ending on September 30, 1996. The Nigeria Child Survival Project (CSP) has received funding from USAID/BHR/PVC/CS for two phases. Phase I of the project was implemented from October 1988 until September 1992 within Ogbomosho South (now the Ogo Uluwa Local Government Area). During Phase II, the project expanded to include the Orire Local Government Area (LGA) from October 1992 until September 1995. During 1996, the project received a one-year no-cost extension to complete project objectives and work towards sustainability.

Efforts to achieve sustainability have been mixed because of the difficult political and social climate of Nigeria in the past two years. Consequently, the project is looking for mechanisms to continue the highly effective services in an austere environment where public services are virtually nonexistent. World Vision has committed to supporting this project at a reduced budget for the next year in order to continue the health benefits for this population while working towards greater sustainability.

This sustainability consultancy is planned to help project staff develop a plan to achieve sustainable services and coverage. Jay Banjade's expertise in business, microenterprise, cost-recovery, and sustainability will be well used during this consultancy. The level of effort required to complete this consultancy, including preparation and follow-up work, is 14 days. Consultant deliverables are due by September 30, 1996. The final evaluation of the project will be carried out from September 2, to 13, and their data collection and findings should provide other useful information.

**II. SPECIFIC ACTIVITIES**

Jay Banjade will work with CSP staff to obtain the quantitative and qualitative information needed to address the following areas and answer the following questions.

- **Cost of Continued Services:** What are the core operating costs of the child survival program after the USAID grant ends? What are the continuing revenue sources and what amount of new revenue is needed? What cost-cutting measures, if any, could be put in place to reduce general operating costs?
- **Cost Recovery:** What services are currently or can become based on local-user fees? What is the willingness and ability of local users to pay? What measures have been

tried in the past? Given both supportive factors and obstacles to cost-recovery, what should be tried in this contract?

- **Other Local Revenue Generation:** What local measures have already been tried? What appears to be successful? What new ideas for local earning could be tried? How is WVRD organized to make program earnings? What kinds of investment and/or other changes would increase program earnings? What can be started without much cost?
- **Organizational and Local Values for Sustainability:** Is cost-recovery and/or earning to sustain the program acceptable to the local management, World Vision, staff, local authorities, clientele of the program? If yes, what models appear most appropriate? If not, what alternatives exist?
- **Strategy for Increasing Project Sustainability:** Given the existing program services and benefits, what should be sustained? What are the options and best possibilities for making these services and benefits sustainable? What are the specific steps required to implement the best options? What are the best options and priorities for cost-management? What additional training, resources, or assistance is needed to implement this strategy? What are the immediate next steps needed within the next few months<sup>3</sup>

### III. DELIVERABLES

- Written report of methods, findings, and recommendations The report should include a detailed strategy for increasing project sustainability as well *as* a detailed list of next steps needed to implement this strategy. Annexes should include any additional data collected and data sources, as well as a list of contacts.
- A draft report should be discussed with field staff and left with the project manager
- The final report is due by September 30 in hard copy and Word Perfect diskette (6 0) unless an extension is granted to incorporate information from the final project evaluation

LIST OF INTERVIEWEES

*OSCSP Staff*

J O. Olowosusi  
Finance/Adm. Manager

CM. Adebambo  
Public Health Nurse

O A Babafunso  
Public Health Nurse/Nutritionist

O Oloyede  
Nutritionist

C O Ajala  
Accountant

S O Aduloju  
Assistant Project Manager

Dr Omo Olorun Olupona  
Project Manager

Dr Joe Riverson  
WVI Nigeria  
Program Director

*Mill Operntors*

Lagbedu site.  
Ahoru Dada site  
Otamokun site.

Olugbode Adedokun  
Paul Adejane Adepoju  
Samuel Adebayo

## SUSTAINABILITY READINESS INDEX

*Score 1 for Yes and 0 for No or Not Applicable. Most answers can be taken from preassessmen forms.*

### Program

- |                 |  |       |
|-----------------|--|-------|
| 1.              | Program services are of a quality that users will pay for.   | _____ |
| 2               | Most country programs/affiliates are focused on 1-2 services.  | _____ |
| 3               | In a representative country program, services can be delivered efficiently to thousands.   | _____ |
| 4               | The program approach does not transfer material goods or cash directly to beneficiaries, either on a household or community level. | _____ |
| 5               | Most participants make contributions (fees, labor, in-kind materials, voluntary services) to receive benefits                      | _____ |
| 6               | User groups admminister services and play, a major role in reducing costs  | _____ |
| 7.              | To access new and technical types of services, your organization partners with others.   | _____ |
| 8               | There is a high degree of standardrization among services provided to individual clients or groups.                                | _____ |
| 9               | Models, methods. and complementary systems are replicated among country programs   | _____ |
| 10.             | Cost-per-benefit comparisons have been made between your program(s) and other similar ones   | _____ |
| <b>Subtotal</b> |  | _____ |

### Cost-Recovery

- |                 |  |       |
|-----------------|--|-------|
| 1               | Fees are charged to cover some or all of the main service costs.           | _____ |
| 2               | The country program does not pay participants to attend training or events | _____ |
| 3               | The country. program recovers a significant part (more than 10%) of costs  | _____ |
| 3               | The country program calculates what percentage of local cost it recovers   | _____ |
| 5               | The country program downsizes or eliminates unfunded services.             | _____ |
| <b>Subtotal</b> |  | _____ |

### Revenue Mechanism for Local Earning

- |   |   |       |
|---|---|-------|
| 1 | At a count? program level.ideasexist about product(s) or service(s) that can charge fees to recover costs   | _____ |
| 2 | Country program staff have set a target for local eamrnngs and are aware of the price to be charged and the volume of sales necessary. to achieve this target | _____ |
| 3 | Country program staff have methods to make users aw are of the price. qualities. and way to access their goods or services                                    | _____ |
| 4 | Country program staff hav e recruited and educated a <i>clientele</i> population (as opposed to a "beneficiary" population)willing to pay fees.               | _____ |
| 5 | Country program staff are organized to deliver and collect efficiently for a good or service  | _____ |

\_\_\_\_\_

**Subtotal** \_\_\_\_\_

**Financing Strategy**

1. Grant funding constitutes 50 percent or less of cash funding of most country programs affiliated with your **PVO**. \_\_\_\_\_
2. Country programs are able to earn 20+ percent of costs locally. \_\_\_\_\_
3. Local monetary contributions cover a significant part (20 percent+) of country program costs. \_\_\_\_\_
4. Governing structures (boards) of country programs are active to raise funds. \_\_\_\_\_
5. Country program management and technical staff are skilled at earning or raising funds locally. \_\_\_\_\_

**Subtotal** \_\_\_\_\_

**Management Systems**

- I. Country program accounting systems can segregate the costs of delivering each principal product/service. \_\_\_\_\_
2. Unit cost per benefit/beneficiary can be calculated for each main service \_\_\_\_\_
3. Models to break-even financially by earning local revenues exist for at least one country program \_\_\_\_\_
4. Country programs have financial information system to track actual versus projected revenues, expenses and cash flow. \_\_\_\_\_
5. At least one country program has a business plan with financial targets for local earnings \_\_\_\_\_

**Subtotal** \_\_\_\_\_

**Values**

1. It is permissible for programs to charge user fees. \_\_\_\_\_
2. Most staff believe low-income users can afford to pay something for services. \_\_\_\_\_
3. Most staff believe too many handouts hinder rather than help development \_\_\_\_\_
4. It is permissible, even preferable, for country programs to earn locally \_\_\_\_\_
5. One can be nonprofit and still think and behave in a businesslike way. \_\_\_\_\_
6. It is acceptable to acquire and make assets perform financially \_\_\_\_\_
7. It is acceptable to eliminate unfunded cost centers. \_\_\_\_\_
8. Country program governance structures are supportive of increased earnings. \_\_\_\_\_
9. Country managers value programs on a scale that can reach many thousands and support efforts to specialize \_\_\_\_\_
10. Good program impact and scale are highly valued and rewarded. \_\_\_\_\_

**Subtotal** \_\_\_\_\_

**Management**

- 1 Program supervisors have financial information which allows them to understand how results are related to expenses. \_\_\_\_\_
  - 2 Country managers receive financial information on impact, expenses, and income, and use it to make program decisions. \_\_\_\_\_
  - 3. Country management has a written strategy for sustainability. \_\_\_\_\_
  - 4 HQ management has a written sustainability strategy for managing and providing assistance to the portfolio of country programs. \_\_\_\_\_
  - 5. Management personnel with business experience are recruited in the organization. \_\_\_\_\_
  - 6. Productivity indicators exist and are used to evaluate performance for field staff and supervisors. \_\_\_\_\_
  - 7. At HQ level, criteria exist and are used to graduate programs from support. \_\_\_\_\_
  - 8 Community members are involved in determining the kind of services to be charged for, the price, and improvements to service delivery. \_\_\_\_\_
- Subtotal** \_\_\_\_\_

## SUSTAINABILITY READINESS INDEX SCORE

*(Count "yes" marks only.)*

Criteria	Score
Program( 10)	
Cost-Recovery (5)	
Revenue Mechanism( 5)	
Financing Strategy(S)	
Values{ 10)	
Management(S)	

Total(48)

1. What are two or three implications for a desired future state for your organization?

**COST/ REVENUE ANALYSIS OPINION SURVEY**

*(This questionnaire is intended to be completed by all key staff associated with the concerned program.)*

In this survey, we are most interested in receiving your OPINION rather than accurate figures. So, please do not spend your time calculating or looking for figures; just answer based on your best judgments.

1. What do you think is the cost of providing a unit of your services to a beneficiary?

Services	costs
a. _____	_____
a _____	_____
a _____	_____

2. What do you think is the major source of income of your program? \_\_\_\_\_

\_\_\_\_\_

Is it growing or decreasing in recent years? \_\_\_\_\_

3. Which service/location represents the best work of your organization? \_\_\_\_\_

\_\_\_\_\_

What percent of total revenue of the PVO is spent in this location or service?

\_\_\_\_\_

4. What are the major cost items? Please list them in order of their volume

- a \_\_\_\_\_  
b \_\_\_\_\_  
c \_\_\_\_\_

5. Which of the following cost categories are increasing or decreasing in the recent past?

<i>costs</i>	<i>Increasing</i>	<i>Decreasing</i>
Personnel		
Transportation		
Supplies		
Overheads		
Others		

6. Which (one to three) are the most expensive services/ products you are providing? Please state below and rank.

a. \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_

7. Which field program, location, and service spend the highest yearly budget'?

Field Program \_\_\_\_\_ Location \_\_\_\_\_ Service \_\_\_\_\_

8. Which services are expanding over the recent years?

a. \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_

9. Which locations are expanding/contracting over the recent years?

Expanding

Contracting

_____	_____
_____	_____
_____	_____

10. Which services are producing the largest revenue? Please state below and rank.

a. \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_

11. Which services are producing the least revenue? Please state below and rank

a. \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_

12. Which costs, do you think, are the most difficult to predict while preparing a yearly budget? (*Discrepancy between actual and budgeted is highest.*)

a. \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_

13. Which are the most reliable and predictable sources of revenue?  
(*Discrepancy between actual and budgeted is lowest.*)

a \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_

14. Which revenue sources have the best potential for growth?

a \_\_\_\_\_ b. \_\_\_\_\_ c \_\_\_\_\_

15. Do you think yearly revenues meet yearly expenses? Y/N \_\_\_\_\_

Is there a positive or a negative surplus? \_\_\_\_\_

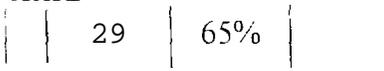
What is the trend? (past, present, future) \_\_\_\_\_

COMMUNITY PARTICIPATION PROCESS MONITORING SYSTEM

110

FACTOR	RATING (0 TO 5)
8 NEEDS ASSESSMENT: CAPACITY TO DIAGNOSE DEV NEEDS 9 (0-NONE; 1-SLIGHT; 2-SOME; 3-MODERATE; 4-CONSIDERABLE; 5-FULLY ABLE)	5
10.	
11 CONSCIOUSNESS: ORIENTATION, UNDERSTANDING AND COMPREHENSION OF ROLES AND RESPONSIBILITIES (0-COMPL. UNAWARE; 1-SLIGHT; 2-SOME; 3-MOD; 4-CONSIDERABLE; 5-FULL)	4
12	
13 PROGRAMMATIC INVOLVEMENT; PROGRAMMING CAPACITY FROM PLANNING TO IMPLEMENTATION (0-COMPL. DEVOID; 1-SLIGHT, 2-SOME; 3-MOD; 4-CONSIDERABLE; 5-FULL)	5
14	
15	
16 ORGANIZATION: CAPACITY TO ESTABLISH STRONG COMMUNITY LEADERSHIP AND VIABLE SUPPORT SYSTEM (0-NONE; 1-MINIMAL, 2-SOME; 3-MODERATE; 4-CONSIDERABLE; 5-FULL.)	5
17	
18 COMPREHENSIVENESS: BREADTH OF PARTICIPATION AND EQUITY IN DISTRIBUTION OF PROGRAM BENEFITS (0-EXCLUSIVELY ELITE MHL: DOMINATED, 1-MIN. EQUITY IN DISTRIBUTION/PARTICIPATION; 2-SOME EQUITY, 3-MODERATE; 4-CONSIDERABLE, 5-FULL.)	5
19	
20	
21 FINANCES (SELF-HELP), INCLUDE COST-RECOVERY AND COMMUNITY-BASED IGA (0-NO FINANCING CAPACITY; 1-MINIMAL, 2-SOME; 3-MODERATE; 4-CONSIDERABLE; 5-FULLY SELF-SUPPORTING)	4
22	
23	
24	
25 LINKAGES: IDENTIFICATION AND UTILIZATION OF EXISTING OUTSIDE RESOURCES AND CAPABILITY OF COMMUNITY TO MAKE DEMANDS FOR THESE SERVICES (0-NO LINKAGES ESTABLISHED; 1-MINIMAL, 2-SOME; 3-MOD, 4-CONSIDERABLE, 5-FULL.)	5
26.	

STATE



0 25 50 75 100

DEPENDENCY

SELF-RELIANCE

COMPOSITE INDEX

29

## SCHEDULE OF ACTIVITIES

September 1 Sunday	Depart from U.S
September 2 Monday	Lagos
September 3 Tuesday	Meeting with senior staff (briefing/orient) Finalize schedule/instruments methodology Selection of comm for focus group/mills for interview
September 4 Wednesday	Site visit-focus group interviews Profitability assessment of Cassava Mills Evaluation of health posts
September 5 Thursday	Review mgt/financial records Conduct key informant interviews
September 6 Friday	Continue dot. review/analysis Draft of key findings and recs
September 7 Saturday	Presentation of preliminary findings Suggestionsirecomm Transition planning and training
September 8 Sunday	Draft report Leave for Lagos Share findings with tech prog eval ream
September 9 Monday	Depart for USA Debriefing w/AID



**OCBOMOSHO SOUTH CHILD SURVIVAL PROJECT**  
**ESTIMATED EXPENSES AND REVENUE**

Expenses and Revenue Sources	F FY 1997	9 9 8	Remarks
<b>Expenses:</b>			
Salaries and Benefits	42,164	44,272	The revenues were estimated by the key project staff Evaluators feel that they are a little too optimistic, particularly for FY 1997. However, even if the project is able to raise local revenue only two thirds of the current estimates (i.e., less 9,900) the project will be raising revenue about 33% of its costs and deficiency for FY 1997 will be about 20,000 dollars
Training	2, so7	1,706	
Travel/Per diem	19,600	20,986	
Supplies	21,676	15,706	
Rent/utilities	3,480	3,857	
Communication	4,000	4,000	
Professional services/TA	5,000	1,900	
Capital Equipment	5,000	-----	
Volunteer (VHW/TMW) incentives	1,500	1,600	
<b>TOTAL</b>	104,927	<b>94,027</b>	
<b>Revenues:</b>			
Fee from existing services	8,155	9,500	
Fee from new services	14,511	15,000	
Income from other IGAs	3,764	4,125	
Local contributions/Membership fees	1,250	1,250	
Local Govt contributions/Supplies	2,000	2,000	
Other income/monitizing Gift-in-Kind	15,000	15,000	
<b>Subtotal</b>	44,680	46,875	
<b>Percent of expenses</b>	43%	50%	
<b>Grant from WV Taiwan</b>	<b>50,000</b>		
<b>TOTAL</b>	94,680	46,875	
<b>Deficiency</b>	10,247	47,152	

**Focus GROUP QUESTIONS**  
*September 4, 1996*

1. What are the health services delivered by the project now?
2. Of these services, which is the most important? Second most important? Third most important?
3. Apart from OCSP, are there other people/groups/organizations providing these important services?
4. Probe: (if answer quack doctors) 6 Why do people go to quacks for health services?
5. If the OCSP is to reduce or limit the number of services provided, which of these services should continue?"
6. For example, for vaccination to continue, how much are you willing to pay (per vaccination) (contract)?
7. Are there services not provided by the project that you would like to have, and would be willing to pay for?"