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World Vision Relief & Development Inc.

**SUSTAINABILITY ASSESSMENT
FINAL EVALUATION
Ogbomoso South Child Survival Project
Oyo State, Nigeria**

**Beginning Date: October 1, 1988
Ending Date: September 30, 1992**

Submitted to:

**PVO Child Survival Grants Program
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ABBREVIATIONS

BMC	Baptist Medical Centre
CCCD	Control of Communicable Childhood Diseases
CDD	Control of Diarrheal Diseases
CHCP	Community Health Care Program
CS	Child Survival
DIP	Detailed Implementation Plan
EPI	Expanded Program on Immunization
FP	Family Planning
FY	Fiscal Year
IGA	Income-Generating Activity
LGA	Local Government Area
MOH	Ministry of Health
MTE	Midterm Evaluation
NGO	Nongovernmental Organization
ORT/ORS	Oral Rehydration Therapy/Oral Rehydration Solution
OSCSP	Ogbomoso South Child Survival Project
PHC	Primary Health Care
PHN	Public Health Nurse
PVO	Private Voluntary Organization
SSS	Sugar/Salt Solution
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
VHC	Village Health Committee
VHP	Village Health Post
VHW	Village Health Worker
WV/WVI	World Vision/World Vision International
WVRD	World Vision Relief & Development

A. SUSTAINABILITY STATUS

- A1. USAID funding for the activities of the Ogbomoso South Child Survival Project (OSCSP) was initially scheduled to end on September 30, 1992. However, an extension and expansion of the project for a period of three years has been granted. This second phase of USAID funding will end on September 30, 1995.**
- A2. Direct service delivery by project staff ceased in some areas at the end of September, 1992. However, Child Survival (CS) activities, including the provision of direct services and support of the Ministry of Health (MOH), will continue in both the original and the expansion areas until September 30, 1995.**
- A3. A gradual handing over of all CS activities to Local Government PHC staff and to the community has begun and will be completed by June 30, 1995. Major project responsibilities and control have already begun to be phased over through the formation of community-based health committees, the training and appointment of Village Health Workers (VHWs) and the establishment of Village Health Posts (VHPs).**

To date 61 Village Health Committees (VHCs) have been formed and more than half of them are functioning at a satisfactory level. Responsibilities of the VHCs include:

- a. Management of the project at the community level on a day-to-day basis.**
- b. Supervision and motivation of VHWs and Traditional Birth Attendants (TBAs).**
- c. Mobilization of community members for project and other health activities.**
- d. Setting prices for essential drugs at the VHPs and managing the Drug Revolving Fund at these posts.**

A Village Health Council has been formed comprising the chairmen and secretaries of the various VHCs. This Council meets quarterly as a forum for discussions regarding technical problems or difficulties arising between the VHCs, VHWs, TBAs, or communities. During FY93, an evaluation of VHC performance will be conducted.

The VHWs are responsible for community education on health practices and behaviors, growth monitoring, treatment of malaria fever and minor ailments, and referral of major problems to the appropriate health facilities. In addition, they distribute non-prescription family planning (FP) commodities and treat children with diarrhea with oral rehydration solution (ORS) when mothers of such children fail to treat or prevent diarrhea dehydration at home.

Effective October 1, 1992, all communities within 5 kilometers of a static immunization center manned by the Ogo Oluwa Local Government PHC staff

will attend these centers rather than those operated by WV for their immunizations. As the capabilities of these workers increase, more communities will be handed over to them.

The purchase and distribution of drugs to the VHPs was initially handled by the project, but this activity has been handed over to a local pharmacist. This pharmacist visits one of the villages which is accessible, makes visits to central locations twice a month, and makes direct sales of essential drugs to the VHWs.

In order to ensure continuity and quality of services during this phase-over, project staff will continue to provide supervision and assistance to local MOH and other health staff as needed. Project staff will continue to meet as well with the VHWs and TBAs during their monthly meetings. Supervisory visits will be paid to the VHWs and TBAs at their posts according to need, but at least once per quarter.

B. ESTIMATED RECURRENT COSTS AND PROJECTED REVENUES

B1. The following CS activities are perceived by project management as being most effective and among those that they would most like to see sustained:

a. Treatment of malaria fever by the VHWs at the VHPs.

The increased access of community members to prompt treatment at VHPs has greatly reduced the complication of febrile convulsion which claimed the lives of many children in the past. Previously, children with such complications were treated with local concoctions that were ineffective or dangerous, and mortality was high.

b. Immunization against the Expanded Program on Immunization (EPI) target diseases

This intervention has been very successful as these diseases have become almost nonexistent. Measles, for example, had reached epidemic proportions in the past but has been reduced tremendously since the onset of the project.

c. Growth Monitoring and Nutrition

Although malnutrition of varying degrees is still prevalent among children in the project area, efforts of the OSCSP during its lifetime, including growth monitoring, practical food demonstrations, and the promotion of soy beans for consumption, have resulted in a dramatic reduction in the level of malnutrition. There has been a marked decline in the number of children from the project area who require treatment at Kersey Children's Home, a nutrition rehabilitation center run by the Baptist Medical Centre (BMC).

d. Control of Diarrheal Diseases

Several communities have been assisted in obtaining potable water through hand-dug and cement ring-lined wells. Through teaching and practical demonstrations, mothers have learned to prepare sugar-salt-solution (SSS) for oral rehydration therapy (ORT), improved practices regarding appropriate feeding during and after diarrhea episodes, and increased knowledge about the interrelationships between diarrhea and the "four Fs"—fingers, flies, feces, food—and water.

e. Training and Supervision of VHWs and TBAs.

The VHWs and TBAs are responsible for the implementation of most project interventions at the community level. Continuous training and supervision are necessary to ensure that standards of performance are maintained and problems which arise are solved satisfactorily. The sustainability of project activities depends a great deal on these voluntary workers.

f. Monitoring of Income-Generating Activities (IGAs)

Two formalized IGAs have been established with funds donated by the US Ambassador to Nigeria and contributions from the VHWs and TBAs. Many more are expected to be established during the period of extension/expansion. Money realized from these IGAs will be used in part to compensate the VHWs and TBAs for their time and efforts in implementing CS activities. Proper monitoring of these IGAs must continue to ensure that they are meeting the needs for which they were established.

- B2.** Expenditures that will be needed if key CS activities are to continue for at least three years after funding ceases include those related to maintenance, supplies, training, travels, and stipends for VHWs.
- B3.** The estimated cost of sustaining project benefits after CS funding ends is US\$55,815 per annum. This includes \$32,105 as stipends for VHWs, TBAs, and Health Supervisors, \$8,550 for training and travel, \$6,560 for supplies, and \$8,600 for the maintenance of vehicles and equipment.
- B4.** The estimate above is reasonable given the environment in which the project operates.
- B5.** The project has received funding from USAID in the amount of \$500,000, which is matched by \$153,193 from WV. In addition, a proposal to use \$65,680 of unspent funds from the first phase of project funding to support an IGA component in the extension/expansion phase has been submitted to USAID. Finally, the projected revenue to be generated by the community each year is \$4,954, including \$650 from IGAs, \$515 from drug sales, and \$2,789 from community contributions.

- B6. None of these costs are not sustainable given the recent commitment of the local government and the renewed commitment of members of the VHCs to ensure that the gains of the project are sustained.
- B7. IGAs should form an integral part of project activities from its inception. Early establishment will ensure that such IGAs have become fully operational by the time funding ceases. Revenues from the IGAs can then be used to fund some of the project activities.

C. SUSTAINABILITY PLAN

- C1. Twenty-eight of the current project staff were interviewed. This number included twenty-three who have been working in the project between one and three-and-a-half years. They included the Project Manager, the Public Health Nurses, the Nutritionist, and the Community Health Supervisors and Assistants. Others are the support staff. At the time of the initial project proposal none of the current project staff had been hired, but the Project Manager who was then employed by the Baptist Medical Centre, the project's primary partner, gave some input. However, full implementation of activities was carried out by the above staff with backstopping from the national office of World Vision (WV) in Ghana (since there was no other presence of WV in Nigeria) as well as World Vision Relief & Development (WVRD) headquarters in Monrovia. There is a health information unit manned by two persons responsible for project monitoring. Evaluation has always involved the staff in varying degrees, and data collection has always been carried out by members of the project community who are supervised by officials of the Oyo State MOH for objectivity. Results of evaluations are discussed with all project staff.
- C2. The following were the plans for sustainability as laid out in the Detailed Implementation Plan (DIP) and other relevant A.I.D. reports.
- a. A community-owned and controlled health system was to be developed and supervised by VHCs and manned by VHWs. The latter were to be selected by the VHCs and trained by the project staff.
 - b. Representatives from participating VHCs were to constitute a Village Health Council which would meet quarterly. Such meetings provided a forum for the exchange of ideas and problems and solutions proffered.
 - c. Constant sharing of information about accomplishments with the community members during monthly meetings with the mothers and VHC members.
 - d. Establishment of Income-Generating Activities (IGAs) which would include raising of funds through levy, establishment of community health posts to be run by the VHWs using basic essential drugs to treat minor ailments, sale of child health cards for a token fee to the community, and farms.

- e. Signing of a collaborative agreement by WV, BMC, Ogo Oluwa Local Government Area (LGA) and Oyo State MOH. The agreement would spell out the roles and responsibilities of each participating partner, especially after cessation of funding.
 - f. All project staff would be nationals.
- C3. The following sustainability promoting activities were carried out by the project staff over the lifetime of the project.
- a. Sixty-one VHCs were established. A good percentage of these are functioning satisfactorily. The VHCs each supervise one village health post, which is manned by trained VHWs.
 - b. One hundred-twenty VHWs have been trained. Over 100 have remained active and are serving their various communities.
 - c. The project supplied essential drugs free of charge to the 61 VHPs. These drugs were sold to community members when they reported sick at the VHPs. The proceeds from the drug sales were kept by the treasurer who is a member of the VHC. Some communities have opened bank accounts into which money from drugs sales is deposited. The money is withdrawn to restock drug supplies or support other child survival activities. The Pharmacist who has been supplying drugs to the project visits one of the VHPs, which is accessible to all the VHWs, at a mutually agreed upon time. The VHWs now make a direct purchase of essential drugs from him. This arrangement ensures that after funding ceases, the VHWs can continue to have access to genuine drugs to replenish their stocks.
 - d. The project staffers meet with the VHWs and TBAs every month for refresher courses. During this period a particular health topic is reviewed, and problems that may be facing the VHWs/TBAs, either technical or administrative, are tackled. Such meetings provide training opportunities which equip these voluntary workers to become more self-reliant in program management.
 - e. During the past year, over 1,400 farmers were supplied with soy bean seeds for planting. This is in addition to 88 farmers, as well as two secondary and two primary schools that were similarly supplied with soy bean seeds during FY91. This step is to ensure that the beans will be available for mothers to enrich the family diet and also for practical food demonstrations during the monthly growth monitoring sessions.
 - f. During FY92, a community recognition/award ceremony was carried out. The communities that performed very well in one aspect or another were duly recognized and given a gift. This award stimulated a healthy rivalry among the various communities.

- g. Two representatives from each VHC formed a larger advisory body called the Village Health Council. The project facilitated the formation of this body and has been supporting the quarterly meetings.
 - h. Project staffers participated actively during workshops organized for the LGA health and other relevant personnel. The LGA health personnel have been participating in the monthly refresher courses for the VHWs. In recent months, they have assumed leadership roles while the project staffers have given the necessary support.
 - i. The project renovated and extended an old building on the premises of the BMC, the primary partner. This is being used currently as the project office. At the end of funding, the BMC will take over the office and the office equipment. Assets, such as service tools, spare parts for vehicles, motorcycles, and computers, would be shared among the collaborating partners to enhance their ability to sustain project activities.
- C4. The project was able to implement satisfactorily plans a through c under C2 above. Village Health Posts were also established as planned. The level of income generated in some of the posts was lower than anticipated because of stiff competition by quacks, refusal of some community members to buy the drugs as prescribed and mismanagement of drug funds by a few people. Fund raising by levy was only successful at the initial stage. It was not expected to be a recurrent event. Community farms were not established because the community members identified several obstacles such as lack of land and provision of labor, obstacles which were not easy to overcome. The child health cards were never sold. Shortly before the commencement of interventions, UNICEF printed millions of such cards for distribution. The government ordered that the cards should be issued free of charge; therefore, no charge was made for the cards.

The following activities were not planned but formed an important aspect of sustainability efforts:

- a. Constitution of VHWs/TBAs into a co-operative association. The association can raise funds and establish IGAs which can provide incentives for their members and, consequently, keep them at their posts.
- b. Establishment of IGAs for the VHWs/TBAs with funds provided by the US Ambassador to Nigeria under the Self Help Project Scheme.
- c. The community recognition/award ceremony was not planned initially. However, when this activity was implemented, it proved to be an effective tool for stimulating healthy rivalry among the various communities. The Chairman of Ogo Oluwa LGA has promised to give special awards to the cleanest communities during the national monthly environmental sanitation exercise.

- C5. The MOH and the BMC did not make any financial commitment. However, the commitments made by these bodies as outlined in the memorandum of agreement have been kept up to date. The Ogo Oluwa LGA continued to give financial support to project activities through its personnel. Recently, the local government made a donation of 500 US dollars to the association of VHWs/TBAs in support of IGAs embarked upon by these volunteers. At the time of preparing this report, the LGA had released funds for immunization campaigns.
- C6. Apart from financial support from the Ogo Oluwa LGA, counterpart institutions did not make any direct financial commitments to project expenditure.

D. MONITORING AND EVALUATION OF SUSTAINABILITY

D1. Indicators for tracking achievements in sustainability.

The following indicators were used.

- a. Number of active VHCs
- b. Number of active VHWs
- c. Monthly quantities of vaccines and ORS sachets supplied by the EPI/CDD store.
- d. Monthly quantities of FP commodities supplied by SMOH, Ibadan.
- e. Number of supervisory visits made by the WV supervisor, or number of times the VHWs were visited by the supervisor in the month.
- f. Cost of drugs purchased by the VHWs on a monthly basis.
- g. Number of facilities upgraded and completed in the year.
- h. Number of communities that start IGAs in the year or month.
- i. Number of workshops on "lessons learned" in Child Survival shared by other NGOs in the year.
- j. Amount realized in "fee-for-service" on a monthly basis.

D2. These indicators have shown some accomplishments, especially those indicators that have to do with the community. The EPI/CDD store has been able to supply the required vaccines except for yellow fever vaccine. There have been shortfalls in the supply of contraceptive commodities and ORS sachets. The local government has not been able to achieve most of its program to achieve sustainability. Two IGAs have been established with funds provided by the US Ambassador and contributions by the VHWs. Many of the VHCs have established proper curative service for a fee despite the competition from quacks.

D3. Positive changes in the sustainability potential of the project are:

- a. A large turnout of VHC members at meetings.
- b. VHCs' willingness to contribute both time and money to support the project.
- c. VHWs' sacrifice of time to do their health jobs.
- d. The high level of operation of the VHC co-operative system.
- e. The objective criticisms made about the project and the level of solutions proffered by community members.

D4. The Oyo State MOH worked on the design, implementation and analysis of the midterm evaluation (MTE). Indeed, the supervisors for the interviewers were senior MOH staff members. The State's Primary Health Care (PHC) Director, Dr Babatunde Adeyefa, trained the supervisors and interviewers and also participated in the analysis and writing of the MTE. For the final evaluation, the supervisors for the interviewers also came from the MOH. Dr. Hezekiah O. Adesina, a consultant to CCCD, served as the team leader for the final evaluation. He was nominated by the local USAID Mission at the request of the project.

D5. The project received feedback regarding sustainability made by the technical reviewers. In fact, the Project Manager met with Dr. Louis Fazen III during a USAID-sponsored workshop in Nigeria and discussed the feedback with him. The strategies for sustainability which were not clearly identified in the DIP were discussed. These strategies have been incorporated in the course of project implementations.

D6. The following recommendations made by the mid-term evaluation team were carried out:

A formal agreement involving the Oyo State MOH, Ogo Oluwa LGA, Baptist Medical Centre and WV was signed.

VHC members and community leaders were continuously trained and motivated to carry on CS activities. Inasmuch as the project wanted to decrease its direct service delivery involvement, the inability of local government health personnel to cope due to shortage of staff, fund constraints and other logistic problems forced the project to continue service delivery in some of the areas. To do otherwise would have meant unnecessary suffering by the children and women the project seeks to serve.

The project could not relinquish areas within a radius of five kilometers to the static centers manned by the local government health staff because the latter often lack logistic support to carry out immunization on a regular basis.

E. COMMUNITY PARTICIPATION

E1. Three categories of community leaders representing various groups were interviewed:

- a. Five members of the Village Health Councils, representing VHCs.
- b. Two women leaders, representing community women.
- c. Eleven VHWs/TBAs, representing VHWs and TBAs.

► The VHC members interviewed were the vice chairman of Iroo Village Health Committee, the organizing secretary of Oluquasi Agbede VHC, the secretary of Oniyeye VHC, the Chairman of Ayetoro Okeawo VHC; and the Secretary of Igbo Ile Oje VHC.

- ▶ The women leaders were Morenike Adewole of Ajaawa and Ruth Akanji of Ayegun Oke Village.
 - ▶ The VHWs/TBAs were the VHWs from Olorunda, Odofo, Ayegun Yemetu, Iroo, Pontela-Olode, and Elegu-Owodo villages; and the TBAs from Iroo, Alawusa Oloye, Tapa, Owolake, and Osupa villages.
- E2.** The CS activities which the community leaders perceived as being effective at meeting current health needs are:
- ▶ Curative services for children.
 - ▶ Nutrition education for women, especially as it relates to use of soya beans.
 - ▶ Provision of rings for wells dug by the communities.
 - ▶ Family planning and child spacing education.
 - ▶ Immunization of children and mothers.
 - ▶ Referral of severe cases to the Baptist Hospital at Ogbomosho.
- E3.** The following activities were carried out by WV to enable the communities to better meet their basic needs and increase their ability to sustain effective CS activities:
- ▶ The communities were facilitated to form VHCs, the members of which were trained.
 - ▶ Members of the communities who were nominated by the VHC members were trained to carry out CS activities.
 - ▶ Free, essential drugs were given to the VHPs. The proceeds from these drugs are being used to meet some financial needs of the project at the community level.
 - ▶ The VHWs and TBAs have been formed into a co-operative association. This body is managing IGAs to support CS activities and their communities. This association can wield a lot of influence, which could have a positive impact on the health of the community.
 - ▶ The chairmen and secretaries of the various VHCs have also formed a council of advisors to the various VHCs.
 - ▶ Several farmers were supplied with soy beans for planting. This ensures a cheap source of protein and vegetable oil for consumption at the household level. Excess grains can be sold to raise the economic status of the family.
- E4.** Based on the findings of the baseline survey, the needs of the communities were incorporated in the DIP. The community members actively participated in the implementation of the CS activities. Members of the communities serve as VHC members, VHWs or TBAs as appropriate. They made cash donations

which they managed themselves to support CS activities. Decisions were made by the VHC members and VHWs/TBAs on behalf of the communities as to the direction in which the activity at that level would go. Project staff offered advice and technical expertise as the need arose.

During evaluations, indigenes of the project area served as interviewers and guides. When the analysis was completed, the results were discussed with the members of the communities.

Also, community leaders, e.g., members of the VHC, women leaders, and the members of the village health services, i.e., the VHWs/TBAs, were interviewed to enable them to express their opinions and impressions of the project.

E5. There are 61 functioning health committees in the project area. During the past six months (April—September, 1992) about 86 per cent of these committees met four or more times during the period under review. Committee members are representative of their communities. For cultural reasons, women members are in the minority. The project staff are constantly encouraging the inclusion of more women in the committees.

E6. The most significant issues currently being addressed by these health committees are how project activities, especially immunization which cannot be handled by the VHWs because of its technical nature, can be sustained when project funding eventually ceases. The issues of VHWs' compensation, technical supervision of their work, and involvement of some women and other members of the community in CS activities are also being addressed.

In many of the communities the following issues are also being addressed:

- ▶ Building of health posts, instead of renting.
- ▶ Provision of transport and food allowances to the VHWs/TBAs when they travel to meetings.
- ▶ Dissemination of major decisions of the VHCs to the community at large.

E7. The following resources have been contributed by the communities that will encourage the continuation of project activities:

- ▶ Rooms or buildings used as Village Health Posts (VHPs).
- ▶ Pieces of furniture in the VHPs.
- ▶ Personnel who serve as VHWs, TBAs and VHC members.
- ▶ Funds to establish IGAs.
- ▶ Provision of potable water through hand-dug wells.
- ▶ Regular monetary contribution by VHC members during meetings.

E8. The success of the committee's contribution of resources for continuation of effective project activities is due to the perceived positive impact the project has made on the health of the community, especially the children and women.

F. ABILITY AND WILLINGNESS OF COUNTERPART INSTITUTIONS TO SUSTAIN ACTIVITIES

F1. The following persons from the Baptist Medical Centre and the LGA were interviewed regarding their relationship to the project:

Dr. P. O. Elemile, Medical Superintendent, (BMC). He is administrative and technical advisor to the project.

Mr. Joseph B. Edowhorhu—Maintenance Engineer, BMC. He is technical advisor to the project on maintenance of vehicles and equipment and purchase of technical equipment.

Dr. Emmanuel Afolabi Amao, Director of General Practice Training and Community Health Care Program (CHCP), BMC. He collaborates with the project in health activities in the communities. CHCP staff is also seconded to the project.

Mr. Adekunle Onile, chairman, Ogo Oluwa LGA. He is the officer who will plan logistics and support for take-over of the project when WV withdraws.

Mr. S. O. Adeyemo, Ogo Oluwa LGA PHC Coordinator. He is the accounting officer for PHC activities in the local government area.

F2. The MOH and the LGA are linked with CSP activities in the following ways:

The Public Health Nurses (PHNs) and Nutritionists are on secondment from the Oyo State MOH. In the past, the State's former Director of PHC had been involved in the training of trainers workshop and the two previous evaluations of the project. Supervisors for interviewers were also drawn from the State MOH. Vaccines, ORS sachets and family planning commodities were obtained free from the State's Store. There is no financial exchange between the State and the project. The PHNs and the Nutritionists are being remunerated by the project.

LGA involvement in CSP activities includes:

- ▶ Supervision and training of VHWs/TBAs.
- ▶ The setting up of the LGA's drug revolving fund.
- ▶ Overhauling of the health facilities so that the VHWs/TBAs will have supervision bases.
- ▶ Provision of means of transportation for the delivery of vaccines at the immunization sites.
- ▶ Making the LGA PHC management committee function so that the project can be properly adopted.

It should be noted that these linkages are currently not very strong, but the chairman of the LGA has promised to renew efforts at strengthening them.

These linkages do not involve any financial exchange.

F3. World Vision expects the following key local institutions to take part in sustaining project activities:

- a. Baptist Medical Centre, Ogbomoso—by giving technical assistance and a base for project staff. The Centre would also serve as the highest referral center for the project.
- b. Oyo State Ministry of Health—would provide vaccines and supervision for the project.
- c. Ogo Oluwa Local Government—would establish all the necessary infrastructure for the takeover of the project by 1995.

F4. The key staff of the BMC perceive the following activities as being effective:

- ▶ Immunization
- ▶ Control of diarrheal diseases
- ▶ Growth monitoring
- ▶ Training and utilization of VHWs and TBAs
- ▶ Family planning promotion
- ▶ Digging and lining of wells for potable water

F5. The project has always involved the staff of the BMC and local governments in the project area in all workshops organized by the project. It has also provided persons who served as resource persons for workshops organized by the local governments. Also, by working side by side with the local government staff during the VHW/TBA training, skills have been transferred to these personnel. The PHNs and Nutritionists are on secondment from the State's MOH. By working on the project they have acquired additional experience which will prove useful in sustainability when funding ceases, since these workers are both nationals and public officials.

F6. The State MOH has demonstrated its ability to allow its PHNs to participate in the training of health workers. Its monitoring team has also paid some visits to the project area to check on the activities of the local government health personnel.

It has, however, not provided one secondary health care facility which will serve as a referral center for the VHWs in the project area. Work has started on this facility.

There is doubt as to the ability of the local government to sustain CS activities at their present level. The government is faced with a dearth of health personnel since most of those who are employed often refuse to take up

appointments because of poor facilities and infrastructure. One of the constraints facing health personnel is transport. Though the project intends to give three vehicles out of its present fleet to the local government, this has to wait until the end of the funding. The chairman of the local government area, Mr. Adekunle Onile, in an interview with two of the members of the evaluation team, said that efforts to address these problems were at an advanced stage. The project will closely monitor these efforts during the period of extension.

The sustainability of the project when CS funding ends rests squarely on the LGA administration. Currently, the LGA has enough financial resources if the willingness to absorb the program is present. Apart from the ability to generate funds through taxes, rates, levies, and sales of landed properties, the LGA had received the Federal subvention meant to be spent on such programs as Child Survival. The chairman, during our interview with him, promised to pump some funds into health which would augment the CS funding. In addition, material resources were also promised by the Chairman. Currently, human resources are inadequate, but, through sponsored training, the LGA believes that the staff capabilities would be strengthened.

The BMC, unfortunately, is unable to provide any financial resources to help sustain project activities once CS funding ceases. It has very limited material resources, but it can provide community health personnel to carry on with interventions in the communities. At present the Community Health Care Program of the BMC works in 13 villages in the project area with a total of five health staff of various categories in addition to the Director of the Program. The BMC might be able to absorb some of the project staff, but it would need financial support to maintain them. Assistance could be sought from the Nigeria Baptist Convention. The staff of the CHCP could help train and give refresher courses to VHWs and TBAs.

F7. There is no other PVO operating in the project area.

G. PROJECT EXPENDITURE

G1. A pipeline analysis of project expenditures is attached.

G2. There were some categories of expenditure which were much lower than originally planned. These were salaries, professional services and travels. On the other hand, budget for supplies and capital expenditure was overspent.

G3. Project finances were handled in a competent manner. The finance unit was headed by a professionally qualified accountant with experience in hospital accounting and auditing.

G4. The following lessons are relevant for efficient project expenditures:

- a. The project hired drivers with certificates in mechanic craft. This has saved a lot of money on preventive maintenance of the vehicles since these driver/mechanics provided such services.
- b. With the deregulation of the foreign exchange market in the country, the project exchanged its funds at the autonomous market, thereby earning more local currency to finance its activities.
- c. Employees who needed to stay overnight were advised to check hotel rates of the venues of assignments at other nearby towns and choose to lodge where the rates were most reasonable. For instance, it cost about US\$150/day to lodge in a hotel in the Federal Capital territory, whereas the cost in a town not too distant cost only \$10 per day.
- d. Project staff chose to go through the rigors of obtaining exemption from import duty instead of spending about US\$23,000 for import duties on imported vehicles and other technical equipment.
- e. Direct purchases of office equipment and supplies were made by project staff instead of contracting them out.
- f. Most of the training of staff on the use of computers was done in the office using a local trainer and project facilities instead of sending the staff to distant places. Costs of travel, hotel lodging and, invariably, a higher training fee, were thereby considerably reduced.

H. ATTEMPTS TO INCREASE EFFICIENCY

- H1. Strategies to reduce costs have been enumerated under G4 above. In addition, proper planning ensured that resources were not wasted. For example, when travel plans were made, several activities were combined, thereby reducing cost/unit of activity. In addition, the project staff undertook various training programs which have increased the productivity and efficiency of the staff.
- H2. The reasons for the success of these strategies are:
 - a. There is an effective network of internal checks.
 - b. Staff were employed on merit and with recommendations of previous employer/college president as to the perceived behavior of the candidate(s) involved.
 - c. Dedication of staffers and their transparent honesty.
 - d. High level of educational qualification and field experience.
 - e. The project is a member of the Nigerian Association of Non-Governmental Organization on Health where we shared information and experience about rural communities and health.

- H3. In-service training programs which increase the efficiency and productivity of staff must be given a priority. Once the staff have been made to feel that they are accepted on the project and are given opportunity to make contributions, the fear of losing such staff after training will not be relevant.

Hiring driver/mechanics instead of only drivers and equipping them will ensure good returns on the investments. Whereas the compensation for drivers/mechanics are slightly higher than for drivers, the extra pay yields greater dividends. For instance, it cost the project about 6 per cent of what a garage charged to fix one of the truck's air conditioners when it became faulty.

The application for exemption from import duty should be made months before the goods are shipped. This ensures that all necessary bureaucratic hurdles are cleared before the goods arrive.

I. COST-RECOVERY ATTEMPT

- I1. Specific cost-recovery activities implemented by the project include:

- a. Putting the project copier into a quasi-commercial use.
- b. Setting up income-generating activities—stores and mills—for the voluntary village health workers.
- c. Establishing community clinics with basic drugs to generate income for each community.

The use of the copier for limited commercial use was managed by the project's accountant. The executive committee of the VHWs Cooperative Association managed the IGA set up for them. The various VHCs managed the community clinics. However, the project's accountant audited the books for the VHWs and the VHCs.

- I2. During the project's life, cost-recovery activities brought in \$2,960, representing about 0.6% of total project cost. These cost-recovery mechanisms have brought in commensurate returns compared with the amount of investment and the location of the rural communities, which are far removed from basic infrastructures and public utilities.

Cost recovery activities have a salutary effect on WV's reputation. This is more so as the management of such a mechanism was in the hands of the community members. WV served as facilitators of this process. No one was denied service on the grounds of inability to pay for service. The project did not charge fees for any of its services to the community.

- I3. The gains from the mechanism resulted in all members of the communities being equally served healthwise and appreciated by the communities concerned.

- I4. The reasons for the success of such programs are:

- a. The communities are consulted, bringing in their inputs before the establishment of the mechanism.
 - b. These activities are managed by the communities themselves except for the copier run in the office by project staff.
 - c. Each community made a cash contribution to the investment in the program.
 - d. Periodic auditings are made to each community to ensure proper management.
15. It is important that VHWs are taught how to keep simple and accurate records of drug sales. Periodic auditing of such records with reconciliation with bank accounts or cash on hand will ensure that funds belonging to the entire community are not mismanaged. Appropriate sanctions should be taken against anyone who is found wanting.

IGAs should be made to function in such a way that the well-being of the person(s) responsible for them depends on the survival of the IGAs. Adequate supervision and checks and balances must be an integral part of the design of the IGA. The design of the IGAs, at the onset, must ensure a reasonably adequate and rapid return for the investments; otherwise, enthusiasm and participation of the community members may be dampened.

J. HOUSEHOLD INCOME-GENERATION

- J1. Household income-generating activities supported include:
- a. Distribution of soy seed and training supports for the cultivation of the crop.
 - b. Training of nutrition aides. Some of the aides later on commercialized their services by providing nutritious diets at affordable prices to the communities.
- J2. An average of \$25 was realized on soya cultivation last year per household of participants in this activity. Some of the committed nutrition aides realized about \$5 per month on the average.
- J3. Some of the income realized from such activities aided the individuals to contribute to the community levy for supporting health activities, which accounted for 0.2% of project costs.
- J4. It is known that poor health is a direct result of poverty and ignorance. Any program that improves the financial capability of the communities will equally improve their health. The present household income-generating activities are, therefore, steps in the right direction. However, to achieve a desirable result, the level ought to go beyond its present level.

K. SUMMARY

K1. The final evaluation team for World Vision's Nigeria Ogbomoso South Child Survival Project (OSCSP) implemented in Ogo Oluwa and part of Orira LGAs of Oyo State addressed the project's needs and promoted sustainability of CS activities. The team found that there were remarkable results in meeting the objectives of the project. The four-year project which ought to have started in October 1988 had a delayed start-up by a few months. The project sought to reduce infant and child morbidity and mortality due to diarrheal diseases, malnutrition, and malaria by supporting and strengthening community and local MOH health systems' capability.

The project organized the communities into 61 VHCs, and two representatives from each of these VHCs formed a larger body known as the Village Health Council which advises the various VHCs. Over 100 community members have been trained as volunteer VHWs/TBAs and have remained active in CS activities in their various communities. Sixty-one village health posts were established which serve as centers for the treatment of malaria fever, training of mothers in ORT, growth monitoring, and nutrition of infants and children and other CS activities. The members of the communities have been highly mobilized and sensitized to assume greater responsibilities for their health. They, as individuals and/or groups, have taken steps which have made positive impacts on their health. The project also helped to establish IGAs for the various communities and the VHWs/TBAs who have been constituted into a co-operative association.

At the local government level, the project also supported the training of personnel charged with the responsibility of health care delivery to the community members. All of these activities have promoted the sustainability of effective child survival activities.

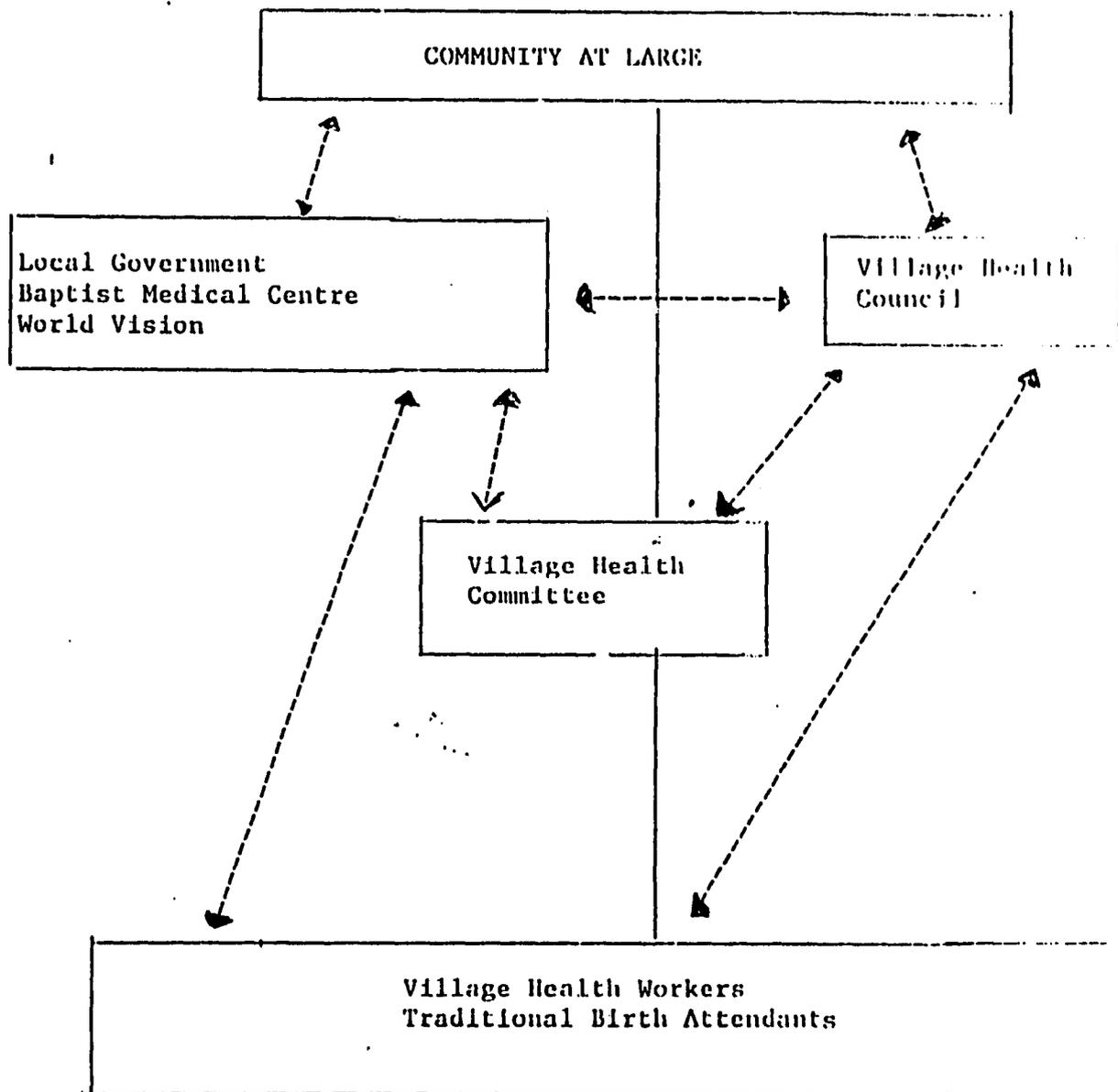
The project's competence in carrying out its sustainability-promoting activities is attested to by the observable results of its activities in the project area. The period of extension that has been granted will enable the project to further consolidate its achievements.

The following lessons were learned with regard to the sustainability of Child Survival Projects: (1) Training the VHWs/TBAs to keep simple and accurate records will ensure that funds belonging to the community which are meant for CS activities are not mismanaged; (2) IGAs' proper management should be linked with the well being of person(s) responsible for them; (3) any program which improves the financial capability of communities will equally improve their health, and positive results of new healthy practices are bound to be absorbed and sustained by the community members.

K2. Members of the Final Evaluation Team:

<u>Team Members</u>	<u>Organizational Affiliation</u>
Dr. Hezekiah O. Adesina (Team Leader)	Consultant, USAID/CCCD Project
Dr. Joe Riverson	National Director, WV Ghana
Tom Ventimiglia	WVRD/Monrovia, California
Dr. OmoOlorun Olupona	Project Manager, WV Nigeria
Joseph Olowosusi	Finance/Admin. Manager, WV Nigeria

APPENDIX I



—— Line of Authority and accountability
----- Advisory role

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1992 ANNUAL REPORT FORM A: COUNTRY PROJECT PIPELINE ANALYSIS
W.V.R.D./NIGERIA OGBOMOSO SOUTH CHILD SURVIVAL PROJECT
#PDC-0505-A-00-5065-00

FIELD	Actual Expenditures To Date (10/01/88 to 9/30/92)			Projected Expenditures Against Remaining Obligated Funds			Total Agreement Budget (Columns 1 & 2) (10/01/88 to 9/30/92)		
	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL
COST ELEMENTS									
I. PROCUREMENT									
A. Supplies	33,338	2,285	35,623	(18,338)	5,165	(13,173)	15,000	7,450	22,450
B. Equipment	0	132,351	132,351	0	(6,351)	(6,351)	0	126,000	126,000
C. Services/Consultants	15,624	8,025	23,649	26,021	6,975	32,996	41,645	15,000	56,645
SUB-TOTAL I	48,962	142,661	191,623	7,683	5,789	13,472	56,645	148,450	205,095
II. EVALUATION/SUB-TOTAL II*	0	0	0	0	0	0			0
III. INDIRECT COSTS									
Overhead on Field (X) 9	27,392	3,081	30,473	0	(1,189)	(1,189)	27,392	1,892	29,284
SUB-TOTAL III	27,392	3,081	30,473	0	(1,189)	(1,189)	27,392	1,892	29,284
IV. OTHER PROGRAM COSTS									
A. Personnel	143,350	30,032	173,382	74,655	(23,006)	51,649	218,005	7,026	225,031
B. Travel/Per diem	23,237	570	23,807	1,642	7,430	9,072	24,879	8,000	32,879
C. Other Direct Costs	34,796	5,312	40,108	(25,536)	18,212	(7,324)	9,260	23,524	32,784
SUB-TOTAL IV	201,383	35,914	237,297	50,761	2,636	53,397	252,144	38,550	290,694
TOTAL FIELD	277,737	181,656	459,393	58,444	7,236	65,680	336,181	188,892	525,073

* Included under "Services/Consultants".

Note: An extension was requested to spend the remaining funds of this grant.

APPENDIX II
PIPELINE ANALYSIS

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1992 ANNUAL REPORT FORM A: COUNTRY PROJECT PIPELINE ANALYSIS
W.V.R.D./NIGERIA OGBOMOSO SOUTH CHILD SURVIVAL PROJECT
#PDC-0505-A-00-5065-00

FIELD	Actual Expenditures To Date (10/01/88 to 9/30/92)			Projected Expenditures Against Remaining Obligated Funds			Total Agreement Budget (Columns 1 & 2) (10/01/88 to 9/30/92)		
	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL	A.I.D.	W.V.R.D.	TOTAL
COST ELEMENTS									
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A. Supplies	33,338	2,285	35,623	(18,338)	5,165	(13,173)	15,000	7,450	22,450
B. Equipment	0	132,351	132,351	0	(6,351)	(6,351)	0	126,000	126,000
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SUB-TOTAL I	48,962	142,661	191,623	7,683	5,789	13,472	56,645	148,450	205,095
II. EVALUATION/SUB-TOTAL II*	0	0	0	0	0	0			0
III. INDIRECT COSTS									
Overhead on Field (%) 9	27,392	3,081	30,473	0	(1,189)	(1,189)	27,392	1,892	29,284
SUB-TOTAL III	27,392	3,081	30,473	0	(1,189)	(1,189)	27,392	1,892	29,284
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