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A Plan
For The Establishment
Of A Nigerian
National Institute Of Family Health



Institute Of Child Health
Lagos

A PLAN FOR THE ESTABLISHMENT OF

A NIGERIAN NATIONAL INSTITUTE OF FAMILY HEALTH

by

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July 11, 1975

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FORWARD

The plan for the establishment of a Nigerian National Institute for Family Health has been developed in support of the Federal Military Government's policy on basic services within the Third Development Plan. The establishment of the National Institute of Family Health is crucial to the quick and smooth formulation and implementation of a plan for basic health services serving Nigerian families in rural and urban areas.

Nigeria is a country that is taking its place among the leaders of the world. We are blessed with many resources, and our future as a nation is bright. Yet, the lives of our children and mothers are threatened by the spectre of disease and malnutrition. As many as 50% of our young have been estimated to die before reaching the age of 6 years. As many as 20/1000 mothers are estimated to die during each pregnancy, delivery and early post-natal period. This means that a woman with 5 pregnancies has an estimated 100/1000 or 1/10 chances to die because of hazards of reproduction. Many more mothers suffer anaemia and exhaustion due to improper child spacing.

In the past, many dedicated nurses, doctors, and other health personnel have tried, to the very best of their ability, to rid our

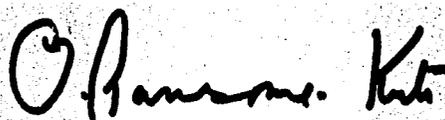
children and mothers of disease and death, but they have not been rewarded with the success they deserve. It is therefore imperative that a new approach to our health problems must be forged if our nation is to reach its fullest potential.

This plan describes a way of attacking the health problems of our families. This comprehensive approach that is consistent with the policies of our government and our leading health specialists. It is our sincere hope that this paper will be the first step to the implementation of a National Family Health Programme for the improvement of the quality of life of all Nigerians.

This plan developed out of the Lagos University Institute of Child Health/Family Health Training Project which has the full support of the Federal Military Government and is financed by the Federal Military Government and the United States Agency for International Aid. The project aimed at developing a training course for health personnel - particularly nurses and other paramedical staff - for the delivery of Family Health Services, and also at establishing a Model Family Health Training Clinic in eight State capitals of Nigeria. So far, Training Family Health Units have been established in Somolu (Lagos State), Calabar, Sokoto; work has already started in Katsina.

This plan could not have evolved without the dedication of members of the Institute of Child Health University of Lagos, who have worked on the Family Health Project from its inception in 1967.

A few of these are Sister Tinubu, Dr. Kolawole, Sister Ojo, Ann Bamisaiye, Robert Morgan and Nicholas Cunningham. I also wish to acknowledge the important contribution of Johns Hopkins University in developing the Training Programme, and George Contis of the Medical Service Consultant, INC in preparing this brochure.



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A PLAN FOR THE ESTABLISHMENT OF

A NIGERIAN NATIONAL INSTITUTE OF FAMILY HEALTH

I. STATUS OF FAMILY HEALTH CARE IN NIGERIA TODAY

A. Introduction

The Federal Military Government's Third National Development Plan accurately describes the major problem areas in Nigeria's health care system. These are:

- Shortage of Health Manpower
- Inadequate Distribution of Health Facilities and Institutions in the Country
- Inadequate Preventive Health Services, and
- Poor Management and Utilization of Health Institutions

To deal with these problems during the next National Development Plan period, the Federal Government has formulated specific health policies and objectives. These are aimed at:

- Health Manpower Development and Deployment
- Development and Expansion of Hospital Services
- Comprehensive Health Coverage of the Nation
- Disease Control
- Efficient Management and Utilization of Health Institutions
- Medical Research
- Health Planning

In the frame of the national health planning effort for the third development plan, the Federal Military Government has formulated a plan to provide basic health service for 40% of the population within 5 years (1975-80).

The implementation of these policies and objectives will require the involvement of every aspect of the health care system. This paper will describe the response of the Institute of Child Health, Lagos to this challenge. It will outline a program for addressing the health care needs of Nigeria's most important resource - its children, its mothers and its fathers.

In this chapter of the plan, the status of family health problems and programs will be reviewed briefly. The basic issues related to improving health care will be identified. In Chapter II a Family Health Care Program will be described for addressing these issues, and solving these problems. Chapter III will outline the management and organizational structure required for implementing the proposed program. The final chapter will discuss the resource requirements for implementing the proposed plan.

B. Family Health Care Needs in Nigeria

No population based statistics on family health needs for the whole of Nigeria are available. But it has been estimated that over 50% of our children die before the age of six years. The death rate for our women between the ages of 15 and 49 is high - about 1.5 to 2 times that of men of the same age. This is probably because of factors related to unsupervised pregnancy, unsafe childbirth, and too short spacing of children.

In early childhood the interaction of malnutrition and infection accounts for over 70% of deaths. Early neonatal deaths in Nigeria are largely due to trauma and infections during or immediately after the delivery. The high mortality for women between 15-49 years of age is mainly determined by the hazards of reproduction. Too many Nigerian women have to deliver in unhygienic conditions without skilled help, and too many have no knowledge about proper child spacing and adequate nutrition during pregnancy and lactation.

The staggering and cruel high child and maternal mortality has touched the life of every Nigerian. It is for this reason that we believe that improved family health should be among our country's top developmental priorities.

The best statistics available are hospital based. They reflect an unknown bias as many illnesses and deaths take place without any hospital contact. These hospital statistics by and large support the above estimates. The infectious morbidity alone, or in combination with malnutrition, accounted for more than

70% of all illnesses. The 1970 statistics show that the leading causes of infectious morbidity for all age groups are: malaria, dysentery, gonorrhoea, pneumonia, measles and tuberculosis.

Although children and mothers are the highest risk groups, it is clear from the above statistics that fathers will be exposed to some of the communicable disease danger and should be protected. The high morbidity can be largely prevented through nutrition programs, appropriate immunization, proper childspacing, basic personal and environmental hygiene and early detection and treatment of disease. Essential complements to these health services are the food distribution system, safe water supply, and sewage system. Thus, while this proposal concentrates on the health service needs, it fully recognizes the high value to health of overall national development.

Fulfilling the family health needs of Nigerian families is not an impossible task. Our country already has experience in this area through the program which virtually eradicated smallpox over a five year period.

Both the nutrition and communicable disease problem can be solved by methods and resources that our country possesses or can easily obtain. These include programs of nutritional education in agriculture, hygiene and diet. It may be appropriate to stress again the often forgotten crucial role of nutrition. Death is a not infrequent fearful complication of malnutrition. But most importantly, malnutrition severely affects many lives of adults and children. Its manifestations include physical and mental retardation, apathy, low resistance to infections, and significantly reduced economic productivity.

C. Components of a Health Care System

WHO has defined basic services as the minimum of health services that should be organized for maximum coverage of the population. In the fifth report of the WHO Expert Committee of MCH (1969), it is suggested that the following activities could and should be provided to all rural and urban communities and are therefore crucial parts of the basic services:

- (1) The recognition and primary management of certain of the most common diseases and problems in the area.

- (2) Elementary health education, with special emphasis on nutrition, hygiene, childbearing, child rearing, and fertility problems. Such education can accompany all other activities.
- (3) The screening of expectant mothers and children, identification of high risks and abnormalities, and referral to more qualified personnel.
- (4) Assistance during delivery and the puerperium, ensuring maximum safety and cleanliness. Care should be taken to avoid undue interference and harmful practices.
- (5) Simple record-keeping.
- (6) The distribution of simple medicines, food supplements, and whenever in accordance with policy, some types of contraceptives.
- (7) The provision of information on community health problems. The peripheral unit or worker should serve as a point of contact and arrange attendance for itinerant services and mass campaigns.

It is recognized that the activities listed will be effective only if the following conditions are fulfilled:

- (1) The responsibilities of the health workers must be clearly defined and controlled, and the geographical area in which they are to work must be specified.
- (2) Whenever applicable, personnel should work as a team.
- (3) There should be a system of referral to the next higher health unit.
- (4) The next higher health unit must exercise supervision and give constant in-service training, guidance, and encouragement.
- (5) Facilities, supplies, and equipment must be available to enable workers to perform these activities.
- (6) The community must participate in the services.

Such basic health services for the family are still inadequate in most Nigerian urban areas and almost non-existent in the rural areas.

Also the health manpower at all levels is in short supply and health care facilities are maldistributed and not really equipped to serve the health needs of families. Given these problems and the Federal Military Government's policy to develop such basic services within the next five years for at least 40% of the families, what route can this development take?

D. Curative Medicine, Preventive Medicine and Combined Approaches

In recent years there has been a great deal of controversy over which medical approach is most appropriate for countries with health care problems similar to ours. Curative medicine has its advocates in the traditional school. The basis of our own health care system is in the hospital services and other clinic facilities throughout the country. The advocates of preventive medicine, on the other hand, offer convincing evidence about the efficiency and maximum utilization of resources that preventive measures promote.

Curative medicine occupies an important part of health care in Nigeria. At present, about 60% of the Federal Military Government's health budget is allocated

to curative services. For children and mothers, these services are essential for the treatment of illnesses. Of children brought to the Lagos University Teaching Hospital, 5% die before they can be admitted to the wards. We cannot ignore the plight of these children.

At the Institute of Child Health, we believe that preventive and curative services must be integrated if we are to make an impact on our people. Both approaches must be improved and expanded through careful planning and implementation. We believe that it would be a mistake to emphasize one type of service at the expense of the other.

Furthermore, we believe that integrated curative and preventive services should be closely related to health manpower development and medical research. These four factors are all part of a comprehensive health care system, and we must begin to think of them as indispensable elements in the total health structure.

This, then, is the foundation of our approach to meeting the family health care needs of the Nigerian people. Our plan is based upon a reasonable balance of four elements:

- Curative services
- Preventive services
- Manpower Training and development
- Medical research

In the next chapter, we will describe our proposed plan for improving the health care of Nigerian families.

This plan has been developed with two purposes in mind. The first and foremost has been the health and well-being of our people, and the strengthening of our nation. The second aim is related to our role as an emerging world power. Today, all Africa is looking to Nigeria for leadership. We have a responsibility to the developing nations of Africa who are less fortunate and less well endowed than Nigeria. Just as we are providing leadership to African nations in social, cultural and economic matters, we must be in a position to give direction in health. Therefore, it is important for Nigeria to strive to improve its health care system for its own people, and for the future of Africa. We believe that this proposed plan can assist our government and Nigeria's existing health care providers to accomplish these aims.

II. PROPOSED FAMILY HEALTH CARE PROGRAM

A. Basic Policies and Principles

In the preceding section, we indicated that the proposed Family Health Care Program will contain four elements:

- Curative services
- Preventive services
- Manpower training and development
- Medical research

In a later section of this chapter, each of these key components will be described in more detail.

Our plan is also based upon several specific principles. These will be discussed briefly here, and in more detail in subsequent sections. The principles underlying our plan are:

Building on Existing Strengths

While it has many shortcomings, our health care system possesses many strengths also. Wherever

possible, the proposed Family Health Program will be structured so that it may become incorporated into existing plans, facilities, services and organizational structures. We are not proposing that a separate, independent and altogether new program be created.

Sensitivity to Federal-State Government Relationships

Our plan seeks to address a national health problem -- the improvement of family health care. The two most important groups that must be active participants in this program are federal and state governments. This proposed program is mindful of the needs, priorities, prerogatives and existing programs at the federal and state level. There are clearly defined, yet flexible roles, for both federal and state governments in this plan.

Importance of Close Working Relationships with Federal and State Ministries of Health

The proposed program can be carried out only with the cooperation and involvement of the Ministries of Health. This plan does not call for the establishment of a

program outside the jurisdiction of existing governmental agencies that are charged with the responsibility for Nigeria's health care system. The State Institutes of Family Health and the National Institute of Family Health would be available to the government and the respective ministries for consultation on family health delivery. Therefore, it will be imperative that the Federal Ministry of Health and State Ministries of Health be involved in the development of operational plans for the institutes and that close cooperation be maintained in the implementation stage.

Involvement of Academic Institutions

Nigeria's academic institutions are one of the great strengths of our country. Our medical schools already conduct advanced medical research and training, as well as provide guidance in the development and expansion of health care services. They should be actively involved in the detailed planning and implementation of this proposed plan, particularly in the training of health manpower, in service delivery and in medical research.

Community Orientation

Each locality in Nigeria has different health needs. This is because our country covers a large geographic area with many different ecologies, and our people have different backgrounds, customs and traditions. As a result, the health care needs of each area will differ. If our nation is to control the major causes of morbidity and mortality, it must accommodate the specific health requirements of each area. This means that our health programs must seek out, and be receptive to, the needs of each community. The delivery of services and training must conform with the requirements of the people that it wishes to serve. For this reason, our proposed plan is structured so that there can be community input into the planning and implementation of services. Without this, the support and cooperation of the Nigerian people will not be gained and the health plan will not succeed.

Comprehensive Services

Our proposed plan emphasizes the importance of a comprehensive approach to dealing with family health

problems. In our plan, there is an appropriate balance between curative services, preventive services, manpower training, and research. This is based on our belief that every effort must be made to provide health care to our people in an equitable manner. We recognize that urban/rural differences make this goal a difficult one. In spite of this, we feel that our program should seek to extend modern medical care to every Nigerian citizen. Our proposed plan is structured so that health care personnel and facilities will be deployed and utilized in such a way so that comprehensive services will be accessible to all persons despite urban/rural, transportation, communications, and other differences.

Main Thrust Will Be Child and Maternal Health

The most pressing health needs of our country are in the areas of child (under six) and maternal health. Therefore, the main emphasis in our proposed program will be on maternal and child health services. This is because fathers are not at such great risks for disease as are their children and wives. Nevertheless, the involvement and care of fathers will not be downplayed in this proposed program.

Program Flexibility

As noted before, the proposed program must accommodate various health needs at the federal, state and local community level. Furthermore, it must seek to address the requirements of a broad age spectrum from infancy through the reproductive years. As a result, the proposed program must be flexible. The services which it must provide should not be rigidly prescribed by persons who are out of touch with the different needs of various areas. The specific structure for delivering services in each locality must be flexible to permit accommodation of local priorities and needs.

Program Dynamic Change

Our country is undergoing enormous changes in every aspect of its social and economic life. These changes will eventually reach practically every area of Nigeria, no matter how rural or isolated it may be now. For some parts of the country, particularly the urban areas, the proposed health care program must be so structured so as to be able to accommodate

rapid changes in health care needs. In this way, the program will be able to keep pace with shifting patterns of disease, and not be bound down to a stereotyped system that is unresponsive to the health problems of the people.

B. Components of the Proposed Family Health Program

In this section, a brief overall description will be given of the proposed Family Health Program. Details about the component parts, their structure and functions follow in succeeding sections of this chapter.

On the 15th of March, 1975, the Federal Commissioner of Health, Brigadier E.O. Abisoye announced that the FMG is committed to the establishment of Institutes of Child Health in every state of the Federation. At the opening of the seminar on Family Health on the 2nd July, 1975, the Federal Commissioner of Health, Brigadier E.O. Abisoye stated that the FMG is eager to see Family Health implemented within the framework of the Third Development Plan and its proposed basic health services. The intent of this action will be

to create the necessary momentum for further development and expansion of maternal and child health programs throughout the country as desired by the FMG.

At present, four Family Health Training Units have been created by the Institute of Child Health. They are located at:

Sokoto, North Western State

Somolu, Lagos State

Calabar, South Eastern State

Kaduna, North Central State (in an advanced
stage of planning)

A fifth Unit is scheduled to begin operations in December, 1975 at Ife. During the next eighteen months, the remaining seven state Family Health Training Units will be established. We have worked out a tentative plan for the development of family health which we would only like to formulate more definitely after extensive negotiations and discussions with the Federal Ministry of Health and SMOH's.

Our plan proposes that the Institute of Child Health in Lagos be expanded to serve as the National Institute of Family Health. In this capacity, the Institute would:

- Work closely with the FMG Ministry of Health in policy development, planning, implementation, evaluation, training and research for the national Family Health Program.
- Serve as a liaison between the State Institutes of Family Health, and the FMG Ministry of Health.
- Provide technical consultants to the State Institutes of Family Health, or any other governmental or private health agency.
- Render curative and preventive health services to some segment of the population living in the Lagos area.
- Develop and conduct manpower training and research programs, for local as well as national needs.

We further proposed that the State Institutes of Family Health become operational as quickly as possible. They would be responsible for assisting their State Ministries of Health in planning, guiding, implementing and evaluating family health programs within the State. The individual State Institutes would:

- Provide curative and preventive family health services for some portion of the state population (usually these persons living nearest the Institute).
- Organize and conduct manpower development programs for health personnel in state programs.
- Provide leadership for the extension of Family Health Services throughout the state, both rural and urban.
- Design and implement research programs geared to health problems of the particular state.

The programs and responsibilities of each State Institute would be tailored to the particular requirements of the State. They would be developed in conjunction with the State Ministry of Health, and would serve as the focal point for policy, planning, implementation, evaluation, and training in family health for that state.

We further propose that the National and State Institutes of Family Health should be established as autonomous non-governmental agencies to function under the supervision of the Federal and State Ministries of Health respectively. They should be chartered as independent corporations or foundations subject to all the laws and regulations governing such non-profit organizations in Nigeria. Their Boards of Directors would be appointed by the Supreme Council of the FMG in the case of the NIFH, and by the State government in the case of the SIFHs. Funding would be from the FMG and the State governments on the basis of budgets submitted by the Directors of the NIFH and SIFH, and approved by the Federal or State Ministries of Health.

There are several reasons for establishing the NIFH and the SIFHs as autonomous organizations. These include:

- Continuation of the precedent already established by the FMG in creating the Institutes of Child Health and Family Health Clinics.

- Recognition of the Family Health Program as a national health priority and special emphasis program.

- The need to permit the Program to continue and expand its academic ties and projects.

- Relieving the Ministry of Health, already overburdened with massive responsibilities, from the task of planning and implementing a new national health effort.

The proposed Family Health Program would, however, interface with existing health care programs at many levels, and the functions of the Institutes would compliment other ongoing health activities. For example, the National Institute of Family Health (NIFH) would act as the chief advisor and consultant agency to the FMC Ministry of Health. It would relate, in an advisory and consulting capacity, to the State Institutes of Family Health. In addition, the NIFH would serve as the training site for higher level personnel who would ultimately work at the national and state level. It would provide curative and

preventive health services to families living near the Institute, and would conduct clinical and operations research on health problems of national concern.

The State Institutes of Family Health would conduct similar services at the state level. They would augment state health delivery services in the State Institute's immediate area, and would provide leadership in extending services to the rural areas. They would develop and conduct manpower training programs that would be responsive to state needs. In addition, they would carry out research aimed at solving state health problems.

The primary intent of this proposal is to generate discussion between all concerned parties on the roles a NIFH and SIFHs could play in developing a national family health service in fulfillment of the mandate contained in the Third Development Plan. We suggest that it would be most fruitful to consider family health within the context of basic health services. It would work with, and complement, the existing health

delivery system. Where possible, the health program of the Federal and State governments and the Institutes of Health would be closely linked. This would be done through improved program planning, but also through joint training, research and health delivery systems.

This section has briefly described the overall proposed program. The following section will give more detail on the roles and functions of the National Institute of Family Health and the State Institutes of Family Health.

C. Organization and Structure of the National Institute of Family Health

In organizing the National Institute of Family Health, it is proposed to make use of the extensive experience and expertise with family health available in the Institute of Child Health. This plan was developed out of the Lagos University Institute of Child Health/Family Health Training Project which has the full support of the Federal Military Government and is financed by the FMG and the USAID. The purpose of

the project was to develop a training course for health personnel - particularly nurses and other paramedical staff - for the delivery of Family Health Services, and to establish a Model Family Health Training Clinic in eight State capitals of Nigeria. So far, Training Family Health Units have been established in Shomolu (Lagos State), Calabar, Sokoto, and work has already started in Katsina.

1. Functions of the NIFH:

The National Institute of Family Health (NIFH) would perform the following functions:

- Chief advisory body to the FMG's Ministry of Health, on all matters relating to Family Health. The NIFH would assist the MOH in policy and program planning, implementation, evaluation, and financial planning for the Family Health Program. In addition, the NIFH would act in an advisory capacity to the MOH regarding the Family Health activities at the state level.

- Principal advisory and consultant organization to the State Institutes of Family Health (SIFH). In this capacity, the NIFH would assist the SIFHs in planning, implementing, evaluating and budgeting their programs at the state level. The NIFH would be the primary liaison channel between the SIFHs and the Federal MOH. The NIFH would also provide technical assistance in the form of expert consultants to the SIFHs and the State MOH to assist these organizations in dealing with problem areas.

- Delivery of curative health care services to families living in the immediate vicinity of the Institute. It is anticipated that approximately 50,000 fathers, mothers and children would receive their acute care in this way. The Institute of Child Health currently conducts such a clinic for mothers and children. It has therefore been demonstrated that a curative-preventive service delivery unit can be made an integral part of the Institute.

- Delivery of preventive health care. These services would be integrated with the curative services delivered through one and the same clinic. The purpose would be to provide comprehensive medical services to the whole family at the same location.

- Training and education activities. The Institute of Child Health in Lagos has considerable experience in the training of health professionals at the physician, nurse, and field health worker levels. This training would be expanded to encompass trainers of all types of health workers involved in the proposed Family Health Program. The training of trainers would be carried out at the request of the federal government or state governments in Nigeria, of other countries in Africa or regional agencies such as WHO. Similarly certificate courses would be organized in planning and management of Family Health. Until all health training institutes and colleges are providing adequate courses in Family Health, there may also be a need to organize courses upgrading the knowledge and skills of different types of health workers in Family Health.

Training materials, curricula and audio-visual aids would be prepared for modification and use by the State Institutes for Family Health and other health training institutes and colleges in Nigeria or Africa. There may even be considerable scope to develop training materials of world-wide value.

The National Institute of Family Health would develop and conduct training programs leading to certification for physicians and top level health administrators. Persons who had successfully completed the required study would be candidates for executive positions in the National and State programs. In this way, the Family Health Program would deal directly with the critical problem of skilled manpower shortages through the creation of a cadre of professionals specifically trained for the program.

- Research. The Institute of Child Health is currently engaged in a broad range of research activities. These would be expanded and would deal with all aspects of Family Health problems. The types of research would include:

- Basic research in such areas as the epidemiology of diseases, statistical analysis of disease trends, and attitudinal studies on illness, health and family planning.

- Operations research about management and administrative aspects of the Program, including cost-benefit analyses, efficiency studies and performance measurements.

- Evaluation research regarding the impact of the Program on morbidity and mortality, changes in health habits and outcome analyses.

- Laboratory research into such areas as the development of a genetic map of the nation that would assist in the identification and treatment of families at high risk for hemoglobinopathies and enzymatic defects.

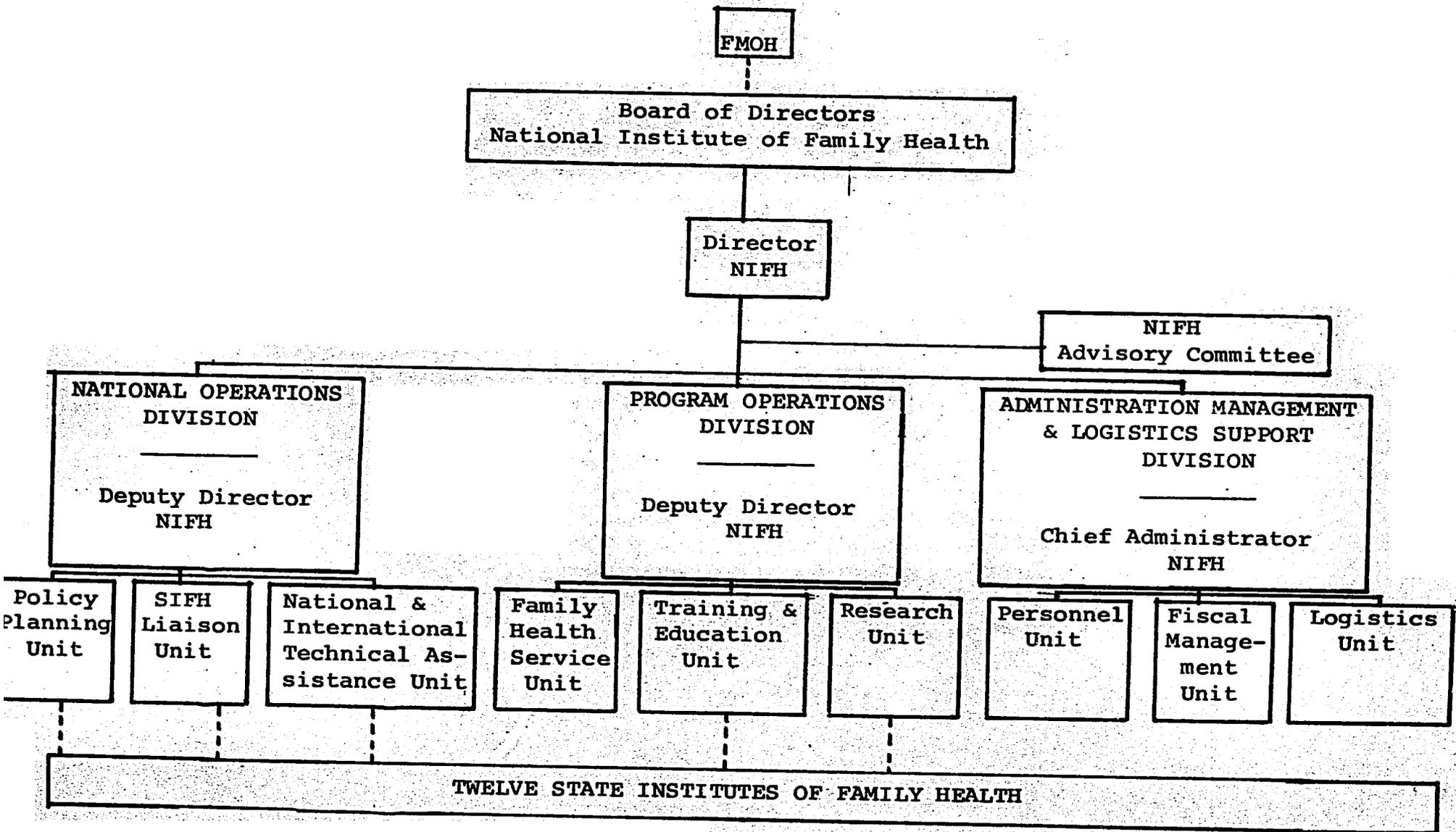
- Consultant Assistance. The NIFH would solicit the help of national and international consultants to assist in any aspect of its work.

2. Organizational Structure of the NIFH:

The suggested overall organizational structure of the proposed NIFH is shown in EXHIBIT I. Briefly the functions of the various policy boards and major executive staff of the Institute would be as follows:

- Board of Directors - The Board of Directors would act as the overall supervising body responsible for the policies, programs and actions of the NIFH. Its members would be appointed by the Supreme Council of the FMG, and they would be responsible to it. The members would be selected from among Nigeria's most respected leaders in the public and private sectors. Membership would not be limited to health professionals alone. Rather, the members would represent a board spectrum of distinguished citizens whose dedication to the ideals of our country and its people was well recognized.

SUGGESTED ORGANIZATIONAL STRUCTURE OF
THE NATIONAL INSTITUTE OF FAMILY HEALTH



The members of the Board of Directors would serve without pay. Their term of office would be at least 3 years, subject to renewal by the Supreme Council.

Advisory Committee - This Committee would serve in an advisory capacity to the Director on all policy, program and financial matters. The Advisory Committee would have between eleven to fifteen members representing a broad base of health care professionals and other respected leaders. These persons should include:

- Federal Commissioner of Health
- State Commissioners of Health - (at least three members)
- Member of the Armed Forces
- Member from the Federal Ministry of Finance and the Ministry of Economic Planning (Federal)
- Member from the Ministry of Social Welfare
- Representatives from the Nigerian Pediatric, Obstetrical-Gynecological, and Community Medicine Societies (at least three members)

- Professors of Pediatrics, Obstetrics-Gynecology and/or Community Medicine from at least two universities (at least two members)
- Director of one State Institute of Family Health
- The Chief Nursing Officer, Federal Ministry of Health
- Representatives of the Nigerian Public Health Association, Nursing Council of Nigeria, and other health care organizations (at least two members)
- Representatives of the Nigerian Bar Association, Certified Public Accountant's Association, Teachers' Association and other professional, non-health organizations (at least two members).

The members of the Advisory Committee would be appointed by the Supreme Council from recommendations forwarded to it by the Federal Commissioner of Health and the Director of the NIFH. Their appointments would be staggered to ensure continuity. The term of office would be two years, except in the case of the Federal Commissioner of Health who would be a permanent member of the Advisory Committee.

- Technical Experts or Expert Committees - The Director would have the authority to constitute ad hoc technical expert committees. These would serve as ad hoc consultants to NIFH or one of its division. Similarly, the Director could contract with individual consultants to advise NIFH, or act on its behalf, as advisor to government or health agencies.

- The Director - The Director would be the chief executive officer of the Institute. He would be responsible to the Board of Directors for the management and administration of the Institute, the development of its policies, and the implementation of its programs.

The Director shall be of the status of a Professor of Pediatrics, Community Health or Obstetrics/Gynecology, who shall be appointed either by secondment or by direct appointment through the action of the Board of Directors. He shall hold permanent or contract appointment at his choice. He shall be remunerated in accordance with the provisions in the instrument of his appointment. If the Director shall retain his chair in the University, he shall be

entitled to only an honorarium from the Institute. Such honorarium shall not exceed one-third of the salary attached to the post, but the Director shall be entitled to all other perquisites. The retirement age for a permanent appointment shall be 60.

- The Deputy Directors - The Deputy Directors would be directly responsible to the Director. Their responsibilities would be delegated by the Director as needs arise but would include the supervision and planning of the day to day functions of the Divisions of Program Operations and National Operations respectively. They would assist the Director in coordinating the activities of the Institute. The Director would designate one of the Deputy Directors as Acting Director whenever he had to absent himself for more than 24 hours.

Deputy Directors shall be Associate Professors or professionals of the equivalent level. They shall hold office on a permanent or a contract basis at their choice. Their remuneration shall be provided in the instrument of their appointment. They shall be full-time executives of the Institute.

- Chief Administration for Administration, Management and Logistics. The Chief of the Administration, Management and Logistics Division will coordinate supportive and logistic functions necessary to smoothly carry out the mission of the Institute and of its two main divisions: Program Operations and National Operations. The specific functions to be assigned to his division will be determined over time by the Director in consultation with the Deputy Directors. The Chief of the Administration, Management and Logistics Division shall be a university graduate with an honors degree or equivalent professional level. He will report to the Director.

We will now briefly outline the tasks and structure of each of the major divisions of the proposed NIFH. The outline should be taken only as a suggestion entirely subject to discussion. There may even be a need to emphasise flexibility during the actual development, as experience may teach better alternative arrangements.

- Program Operations Division - This Division would implement the various operational programs of the NIFH in health care services delivery, training and research. As the NIFH expands, each of the above functions could be given unit level status within the Program Operations Division.

ICH in its present Lagos based operations has developed the nucleus for such activities. Their continuation and expansion is essential to programmatic developments in the NIFH.

- National Operations Division - This Division would have the crucial task of distilling the experience in program operations and applying them in liaison activities with the SIFHs in national policy and program planning, and in consultations with State MOHs if requested. The Division would provide technical assistance to SIFHs at their request in areas of policy, programming, management or specific technical issues.

The national policy and program planning function would gather all information available to basic services health delivery and develop suggestions for policies.

Administration, Management and Logistics Division - This Division would deal with the general supportive services and administrative aspects of the Institute. At this time, it would seem useful to include the following functions under this Division: fiscal management, personnel management, general administration, logistics (travel, transport, supplies), publications and teaching materials (editing, arts production, distribution, etc.), information service (library, article retrieval, distribution, recent literature on family health etc.). As mentioned before, this list of functions would be subject to review.

3. Relationships of the NIFH to Other Organizations.

The Advisory Committee would provide the NIFH with the main channel for outside input into the policies and programs of the Institute. In

addition, however, liaison would be established with other agencies and organizations. Foremost among these, of course, would be the Federal Ministry of Health. As noted previously, the ties to the Federal MOH would be strong, even though the NIFH would be an autonomous organization. The NIFH would look to the Federal MOH for guidance and financial support. In turn, the Federal MOH would turn to NIFH for recommendations concerning the development and implementation of efforts aimed at strengthening Family Health activities. Neither group would have final decision-making responsibility over the other, but both would have a clear mandate to cooperate fully in the implementation of the National Family Health Program.

The NIFH would also work closely with universities. This relationship would undoubtedly be mutually beneficial in the areas of research and training. It is envisioned that facilities, manpower, and equipment would readily be shared by both groups, in the interest of conserving space, resources and minimizing duplication of effort.

Other organizations with which the NIFH would relate would be the teaching hospitals and medical schools. The Lagos Teaching Hospital would act as a support service to the NIFH Family Health Clinic, particularly for the care of patients with complicated illnesses. In turn, the NIFH would provide the Lagos Teaching Hospital and Medical School with an excellent out-patient teaching situation for its students and house officers.

NIFH would also make use of the planning and research capabilities in the other faculties of Lagos University and in the Nigerian universities in general. NIFH would actively seek collaboration with all universities and would, in selected cases, issue contracts for the development of specific teaching material or research.

4. Staff of the NIFH

In addition to the major executive staff we have mentioned before, we list here the division staff required for the NIFH:

- Office of the Director

- Director
- Executive Officer
- Administrative Assistant
- 2 Secretarial/Clerical Support Personnel

- Administration, Management and Logistics Division

- Chief of Division

a) Accounts Department

1 HEO Accounts

1 EO Accounts

1 AEO Accounts

b) General Administration

1 EO Administration

1 AEO Administration

c) Personnel Management

HEO Personnel

d) Passage, Transport, and Guesthouse

1 Driver I

2 Driver II

2 Driver III

2 Messengers

- 1 Asst. Domestic Warden/House Keeper
- 1 Cook/Stewart
- 1 Porter/Attendant
- 1 Cleaner/Gardener
- 1 Night Watchman
- 1 Equipment & Maintenance

e) Supplies

- 1 HEO Logistics
- 1 Storekeeper
- 1 Store Attendant

f) Information Service

- 1 HEO Librarian
- 1 AEO Library Assistant (information
retrieval and
distribution)

g) Publications and Teaching Materials

- 1 Language editor
- 1 Artist (drawing, photography, outlay)
- 1 EO publications and teaching material

h) Clerical Assistance to the Division and
typing pool

- 1 Personal Secretary II/I
- 1 Asst. Pers. Sec.
- 2 Clerk Typist.
- 1 Clerk III

- Program Operations Division

- Deputy Director

a) Family Health Service

- 1 Senior research fellow (physician)
- 3 Research fellow I
- 3 Research fellow II
- 1 Senior Health Sister
- 3 Health Sisters
- 2 Senior Nursing Sister
- 10 Nursing Sisters
- 1 Staff nurse
- 4 Senior Community Sisters
- 8 Community Nurses
- 2 Senior Clinic Assistants
- 1 Senior Technologist
- 1 Lab Assistant
- 1 Lab Attendant

4 Clinic Assistants II
4 Clinic Assistants III
4 Dispensary Assistants
4 Cleaners
3 Messengers
1 Senior Night Watchman
6 Watchmen
1 Driver III
1 EO Administration
2 Typists
1 Field health worker supervisor
(interviewer supervisor)
2 Grade I Field Health Workers
(interviewers)
7 Grade II Field Health Workers
(interviewers)
3 Grade III Field Health Workers
(interviewers)
1 Physiotherapist
1 Senior E.E.G. Technician
1 Laboratory Attendant
1 Senior Nutritionist
1 Nutritionist
1 Higher Nutrition Officer
2 Nutrition Officers
1 Assistant Nutrition Officer
1 Senior Nutrition Assistant
1 Nutrition Assistant

b) Training and Education

- 1 Senior Research Fellow (physician)
- 1 Research Fellow I (management)
- 1 Research Fellow II
- 2 Nurse-Educators
- 1 Health Educator
- 1 Personal Secretary
- 2 Clerk/Typist
- 1 Clerk
- 2 Part-time Lecturers

c) Research

- 1 Research fellow Grade I (Sociologist/
Demographer)
- 3 Research fellows Grade III
- 1 Operations Research Specialist
- 1 Demographer
- 1 Biostatistician
- 1 Computer Programmer
- 2 Coders - Punchers
- 2 Grade I Interviewers
- 7 Grade II Interviewers
- 3 Grade III Interviewers
- 1 Principal Lab Technologist
- 1 Superintendent

3 Technologists
2 Lab Assistants
1 Lab Attendant
1 Assistant Personal Secretary
1 Typist
3 Clerks

- National Operations Division

- Deputy Director

a) SIFH Liaison

1 AEO Logistics
1 Senior Health Sister
1 Research Fellow Grade I
1 Research Fellow Grade I (physician)
1 Social Scientist
1 Statistician
1 Computer Programmer
1 Management Scientist
1 Personal Secretary
1 Clerk/Typist

b) Policy and Planning

1 Health Planner (at level Senior Lecturer
or above)
2 Research Fellow Grade I (economics and
management)

- 2 Research Fellow Grade II
- 1 Personal Secretary
- 2 Clerk/Typist

c) Consultation and International Health Affairs

- 1 Research Fellow Grade I (Public Health)
- 1 AEO Administration
- 1 Personal Secretary
- 1 Clerk/Typist
- 20 Part-time consultants

5. Facilities of the NIFH:

At present the clinical and socio-demographic facilities of the Institute of Child Health are in separate locations. It would be ideal to consolidate all the functional units of the NIFH into one building. This need not be very large, but it should provide adequate clinic, office, laboratory and training space for the diverse activities of the Institute.

6. Equipment of the NIFH

The present, the Institute of Child Health at Lagos has some of the basic equipment necessary

that would be required by the Administration, Management and Logistic Support Division and the Program Operations Division.

If the ICH becomes the nucleus of NIFH, then the operations can begin with a modest increase in equipment. The unit for the production of teaching materials will need photographic equipment and graphics materials.

Simple computer machines would be necessary for the analysis of research data. Audio-visual equipment and teaching aids would be required for the educational activities. The field health workers would require uniforms, leather bags, torch lights, rain boots and similar equipment. A minibus for the use of the field health workers would facilitate their work considerably. The National Operations Division would need to be equipped entirely. It would need office furniture and equipment. The library and information service would need considerable expansion, and funds for books reproduction, and mailing.

D. Organization and Structure of the State Institutes
of Family Health

Each of the twelve states would establish an Institute of Family Health, based on its already existing Institute of Child Health or its plan for such an Institute. In this section tentative descriptions are given of the functions, organization, relationships, facilities, staff and equipment of the SIFHs. The actual details will have to be worked out with all parties concerned.

1. Functions of the SIFH:

The SIFH would perform the following functions:

- Act as the primary advisor to the State Ministry of Health on all matters pertaining to policy, planning, and implementation of the Family Health Program in the state.

- Provide curative health services to the people living in the immediate area of the SIFH. This would be done through a Family

Health Clinic that would serve as a model demonstration clinic serving approximately 50,000 fathers, mothers, and children.

- Render preventive health care to the target population of 50,000 persons. This would be done by integrating these services with the curative health services at the SIFH operated Family Health Clinic.

- Develop and conduct training programs for all levels of Family Health personnel who would be involved in the statewide program, both rural and urban. These programs would be undertaken with the assistance and participation of the staff of the NIFH as needed.

- Design and implement research programs. These would focus on the particular health care problems of the state. They could involve basic research, laboratory studies, operations

research and evaluation studies, depending on the scope of work of the SIFH staff.

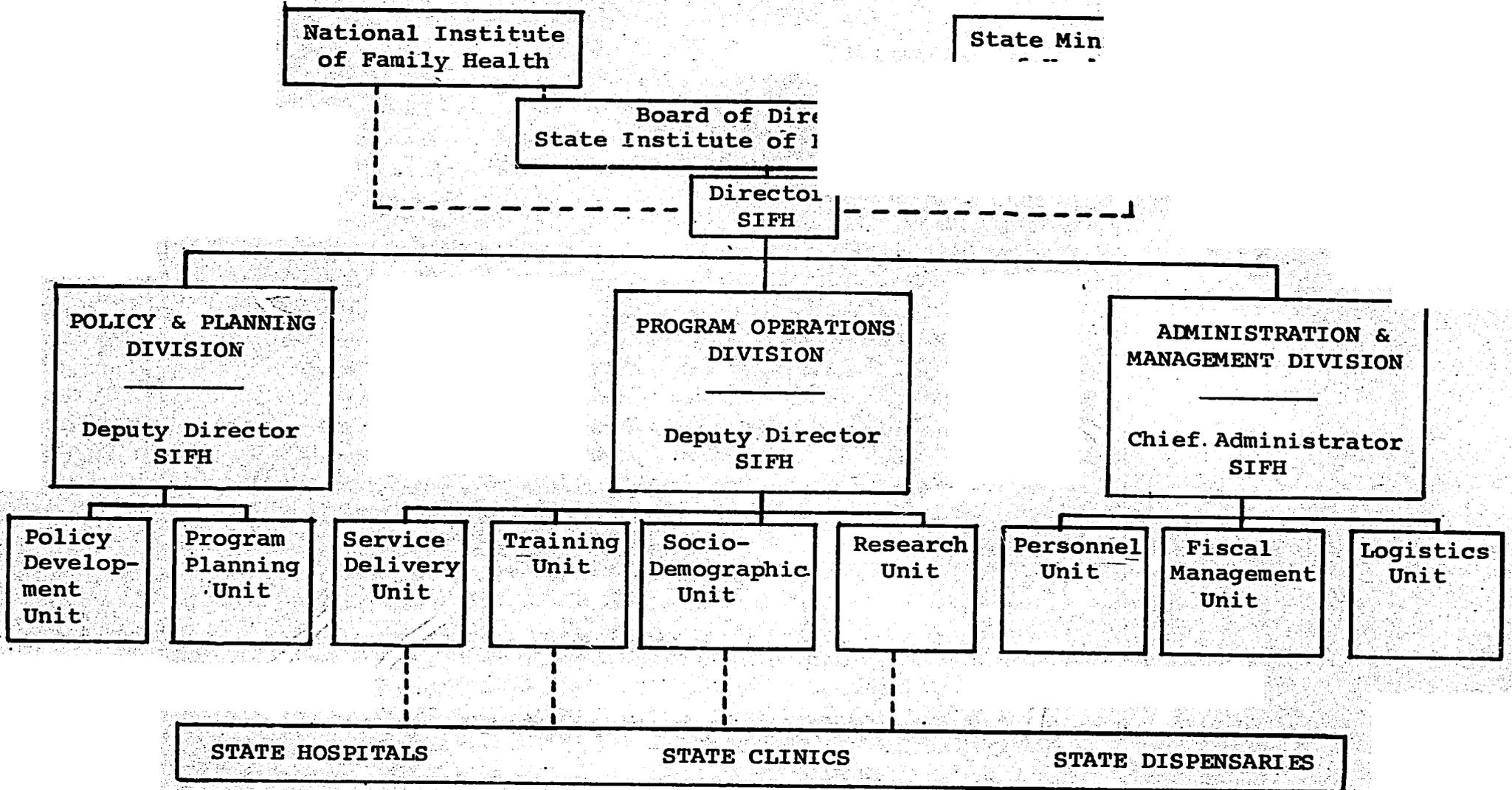
The SIFH would be able to call on NIFH for technical assistance, or for joint participation in studies.

2. Organizational Structure of the SIFH:

The organizational structure of the proposed SIFH is shown in EXHIBIT II. Briefly, the functions of the various components and major executive staff of the State Institute would be as follows:

- Board of Directors: The Board of Directors would be responsible for the overall supervision of the SIFH. It would oversee the development of policies, the implementation of programs and the administration of the Institute. The members of the Board would be chosen by the State Supreme Council for a 3 year term of office that could be renewed. The members of the Board should be selected from among persons

SUGGESTED ORGANIZATIONAL STRUCTURE OF A
STATE INSTITUTE OF FAMILY HEALTH



in the public and private sectors of the state. They should be distinguished citizens who have demonstrated their commitment to the welfare of their state and its people.

- Advisory Committee of the SIFH: This Committee would have the responsibility of providing professional advice and assistance on all technical and administrative matters to the Director of the SIFH. The Committee would be composed of a broad spectrum of professionals including:

- State Commissioner of Health
- Director of the National Institute of Family Health
- Member of the Armed Forces
- Member from at least one State Medical School
- Member from the Community Medicine, Pediatric, or Obstetrics-Gynecology faculty of a Medical School
- Member from the State Pediatric, Obstetrical-Gynecological and/or Community Medicine Societies

- Member from the state professional societies of such groups as the nurses, public health workers, and health educators.
- Member from such non-medical professional groups as the lawyers, dentists, and engineers.

- The Director: The Director of the SIFH would be the Chief Executive Officer of the Institute responsible for the development of its policies and programs, and the smooth management of its affairs. He would be appointed by the Board of Directors from a list of nominees prepared by the State MOH and the Director of the NIFH.

The Director should be a physician with the academic position of Associate Professor or equivalent in the University system. His qualifications should include specialty training in Family Health, Pediatrics, Obstetrics-Gynecology or Community Medicine. In addition, he must have successfully completed a course of training for administrators at the NIFH. Graduate work and/or experience in public health, health education or research would be desirable.

- The Deputy Directors: The Deputy Directors would be responsible for the day-to-day administration of the Program Operations and Policy and Planning Divisions. In the Director's absence, one should be Acting Director of the SIFH. They would work under the supervision of the Director and be appointed under contract.

The Deputy Directors should have medical degrees, health administration experience and positions, as Assistant Professors, within the University. Advanced training and experience in a relevant medical specialty, public health, health education and/or research would be desirable.

Chief - Administration and Management Division. The Chief of this Division would be responsible for the management and administrative functions of the institute including personnel, budgeting and logistics. He should be a full-time employee of the SIFH. It is essential that this person have administrative experience, but he need not be a physician.

We will now briefly outline the tasks and structure of each of the major divisions of the proposal SIFH. This outline should be taken only as a suggestion entirely subject to discussion.

- Program Operations Division: This Division would have responsibility for the operations of the various SIFH programs. This would include the health clinics, the research projects, the training activities and the socio-demographic unit.

In addition, this Division would be the SIFH's primary liaison with the state's hospitals, clinics and dispensaries. It would provide, as requested, technical assistance in health, research and training for those units of the state health system requesting such assistance.

- Policy and Planning Division: This Division would serve in a staff capacity to the Office of the Director of the SIFH. It would develop policies and plans for the Institute's Programs.

- Administration and Management Division: this Division would be responsible for the management aspects of the SIFH's activities. This would include personnel, facilities, logistics and supplies, as well as fiscal management.

3. Relationship of the SIFH to other organizations:

The SIFH would relate to several organizations including:

- State Ministry of Health.

Like the NIFH, the SIFH should be an autonomous non-governmental organization. It would, however, relate directly to the State MOH, as its principal advisor on Family Health matters. The SIFH activities would be supervised by the MOH and its funding would be through the MOH. The State Commissioner of Health would sit on the Advisory Committee of the SIFH, but neither organization would exercise decision making authority over the other.

- National Institute of Family Health.

The NIFH would supervise the technical aspects of the SIFH's programs. It would provide technical assistance on curative and preventive health care matters and on research problems. The NIFH would also provide training programs, educational materials and curricula to the SIFH, if requested. The SIFH would participate in joint research activities as agreed upon by the two organizations. SIFH would consult with the NIFH on funding matters, and would be assisted by the NIFH in discussions with the Federal and State Ministries of Health on budgetary matters.

- Universities:

The state universities could be involved in training activities related to SIFH manpower development programs. The two groups could share staff, facilities and equipment.

- Medical Schools:

Division

The SIFH and the Medical Schools would both be active in health education programs for the state. Hopefully, these organizations would work together to plan, design and implement health manpower projects aimed at alleviating the skilled health personnel shortages that are found in most parts of Nigeria.

Staff of the SIFH:

The following personnel would be required for each of the SIFHs:

- Office of the Director

Director

Executive Officer

Administrative Assistant

Executive Secretary

2 Secretary/Clerk

- Administration, Management and Logistics Division

- Chief of Division

a) Accounts Department

1 EO Accounts

1 AEO Accounts

b) General Administration

1 EO Administration

1 AEO Administration

c) Personnel Management

HEO Personnel

d) Passage and Transport

1 Driver I

2 Driver II

2 Messengers

e) Supplies

1 HEO Logistics

1 Storekeeper

1 Store Attendant

f) Information Service

1 Program Information Officer

1 HEO Librarian

g) Publications and Teaching Materials

1 EO publications

h) Clerical Assistance to the Division and
typing pool

1 Personal Secretary II/I

1 Clerk Typist

1 Clerk III

- Program Operations Division

- Deputy Director

a) Family Health Service

1 Senior research fellow (physician)

1 Senior Health Sister

2 Health Sisters

1 Senior Nursing Sister

5 Nursing Sisters

1 Staff Nurse

2 Senior Community Sisters

4 Community Nurses
1 Senior Clinic Assistants
1 Senior Technologist
1 Lab Assistant
2 Clinic Assistants II
2 Clinic Assistants III
2 Dispensary Assistants
2 Cleaners
1 Messenger
1 Senior Night Watchman
3 Watchmen
1 Driver III
1 EO Administration
2 Typists
1 Field Health Worker Supervisor
(interviewer supervisor)
1 Grade I Field Health Workers
(interviewers)
3 Grade II Field Health Workers
(interviewers)
1 Physiotherapist
1 Senior E.E.G. Technician
1 Laboratory Attendant
1 Nutritionist
2 Nutrition Officers
1 Senior Nutrition Assistant
1 Nutrition Assistant

b) Training and Education

- 1 Research Fellow I (management)
- 2 Nurse-Educators
- 1 Health Educator
- 1 Clerk/Typist
- 1 Clerk
- 6 Part-time Lecturers

c) Research

- 1 Research Fellow Grade III
- 1 Operations Research Specialist
- 1 Grade I Interviewer
- 2 Grade II Interviewers
- 1 Lab Assistants
- 1 Lab Attendant
- 1 Assistant Personal Secretary
- 1 Typist
- 2 Clerks

- Policy and Planning Division

- Deputy Director

1 Health Planner (at level Senior
Lecturer or above)

2 Research Fellow Grade I (economics
and management)

1 Assistant Personal Secretary

1 Clerk/Typist

5. Facilities of the SIFH:

The SIFH and its various components (clinics, training facilities, laboratories, etc) should preferably be housed in one building. The amount of space required need not be overly extensive but there should be scope for expansion. The major space requirements would be for clinic and teaching facilities and supervisors' offices.

6. Equipment for the SIFH:

The amount and type of equipment required would depend on the types of activities that the SIFH would undertake. It can be expected that at a minimum, equipment would be needed for training activities, field health workers, and clinic management.

E. Content of Services to Be Provided by the NIFH and the SIFHs

The NIFH and SIFH would be available as national sources of consultants and experts on family health. One of

the features of this proposed plan is the flexibility that it allows the federal and state governments in the planning and implementation of Family Health Programs at the national and local level. The NIFH and the states would be free to develop programs that fit the divergent needs of the different areas that would be served. Thus, the NIFH and SIFHs would support and conduct a different mix of activities involving service delivery, educational programs and research studies. These efforts would be coordinated through ongoing planning activities between the NIFH and the SIFHs. In addition, the Federal and State MOHs would be responsible for ensuring that NIFH and SIFH plans and programs were compatible with, and not a duplication of, federal and state efforts.

The following is a brief description of the content of the various NIFH and SIFH programs in health care services, training and education, and research.

1. Health Care Services:

The NIFH and each of the SIFHs will operate a Family Health Clinic for approximately 50,000 persons living in the immediate vicinity of the

Institute. The clinic will offer comprehensive curative and preventive health services for adults and children. These comprehensive services will encompass the following areas of priority interest on an ambulatory basis:

- health supervision of newborns and well babies (including growth surveillance)
- immunizations
- nutrition education and care
- detection and rehabilitation of handicapped children
- prenatal supervision and care
- post natal supervision and care
- child spacing
- primary care of ill infants, children, and adults
- premarital consultations.

The comprehensive service will also cover health education of mothers and fathers regarding such matters as:

- child growth and development
- nutrition and malnutrition (importance of breastfeeding, weaning diets, balanced nutrition for adults)

- prevention and causation of infectious diseases
(immunization, personal hygiene, etc.)
- child spacing
- methods of safe home delivery

In this way, the family will be treated as a whole, both at home and in the clinics. The emphasis of the clinic will shift away from episodic and acute care to continuous medical care.

A doctor with training in maternal and child health will be in charge of the clinic. A senior Health Sister will be responsible for the day-to-day running of the clinic and will supervise the work of the other nursing staff, and the non-medical auxiliaries working in the clinic. This family health clinic will not only serve a 50,000 population, but will be used as the prototype of family health services. It will undergo constant refinement of content and delivery systems and will serve as a basis for training.

Associated with the Family Health Clinic will be a Research Unit. Its function will be the collection of important data necessary for planning and managing the services for families and also for measuring the effect of the services provided for the population. This would include:

- Operations Research, especially functional analysis to identify needed improvements in health delivery.
- Vital statistics such as infant mortality rate, birth rate, perinatal mortality and morbidity rates, and maternal death rates.
- Incidence of various diseases in the community.
- The effect of health education in changing the attitudes, knowledge and practices of mothers and fathers to nutrition, traditional medicine, family planning, and home accidents.
- The growth and development of children in the community and how these are affected by various factors over a period of time. These factors could be social, economic or disease processes.

A sociologist/demographer should be in charge of this unit. He/she would be assisted by a Chief Field Health Worker who would be trained by the NIFH to take charge of the Family Health Workers. These persons would be trained to work in the community to conduct surveys, give health education in the homes, refer patients to the clinic and follow up clinic defaulters. They thus would combine clinic functions with research.

The research team will further consist of research laboratory technologists, nutritionists, a statistician and operational research scientist, and a computer programmer.

The NIFH is considering the development of another level of personnel - the outreach worker. This person would be recruited from the community and will be trained in the basic elements of health, nutrition, family planning, sanitation and infant/child care. The outreach worker would then be sent to his/her own community, usually a small town or village, to provide the first line of

health care. Their duties would be to give health education to families, first aid for acute illness or injury, and referrals to local dispensaries, clinics or hospitals.

We would like to stress the importance and unique features of this manpower staffing pattern. It is the key to our solution of the health manpower shortage in Nigeria. Our health care system is based on:

- Physicians who would have overall responsibility for medical care management, but who would be used only for difficult or complicated cases.
- Nurses who would be specially trained to make decisions and render treatment for common illnesses and preventive care.
- Family Health workers who would provide health education to families and collect health data at the community level.
- Community Outreach workers who would give some health care and health education, and who would be responsible for referring and following-up patients.

2. Training and Education

The NIFH would be responsible for the initial training of the various personnel to man the units of the Institutes, and later the training of their high level research workers and clinic superintendents in each state. It would also encourage and assist the states in establishing comprehensive maternal and child health clinics in various parts of each state so that the services could be brought to all children in urban and rural areas. Thus, the NIFH would provide training at several levels, including:

- Physicians
- Administrators
- Nurses
- Trainers of SIFH trainers

In addition, the NIFH would also develop curricula, training aids, and educational materials for use by all the SIFHs and other health training schools and colleagues in Nigeria and Africa.

The training of personnel in skills required to deliver health care to mothers, fathers and children would be undertaken by each State Institute of Family Health. It may not be necessary to train a new cadre of health workers, but those already engaged in the delivery services would be taught the newest methods of health care or be given refresher courses at appropriate intervals during their working careers. In this way, the Institute would ensure that the services to mothers, fathers and children were kept at peak efficiency.

Both in the case of NIFH and the SIFH, some of the training to be dispensed would involve upgrading existing personnel to fulfill new roles. But as health schools and medical colleges prepare their students for Family Health functions, the NIFH and SIFH would more and more be able to concentrate on post-basic and post-graduate courses.

3. Research:

The research programs of the NIFH and SIFH would be based on the data collected by each Research

Unit. As noted in a preceding section, this unit would develop information on families, their illnesses and their communities.

Various types of research would be conducted including:

- Basic research into the etiology and manifestations of disease.
- Operations research into the administrative and management aspects of the program.
- Evaluation research on the impact and outcome of the program on family health.

Such research would be conducted by the NIFH and the SIFHs. The exact scope of the research would depend on the health needs of the community served by each Institution.

The NIFH would be responsible for coordinating the research programs of the SIFHs. Collaborative research between the NIFH and the SIFHs, or

between SIFHs would be encouraged. The research units of NIFH and SIFH would also be available for contract research in the service of federal and state governments respectively. Furthermore the capability would be provided to the Institute to permit them to issue research contracts for specific research subjects which could be better performed by research groups in universities or by private bodies.

F. Plan for Implementing the Family Health Program

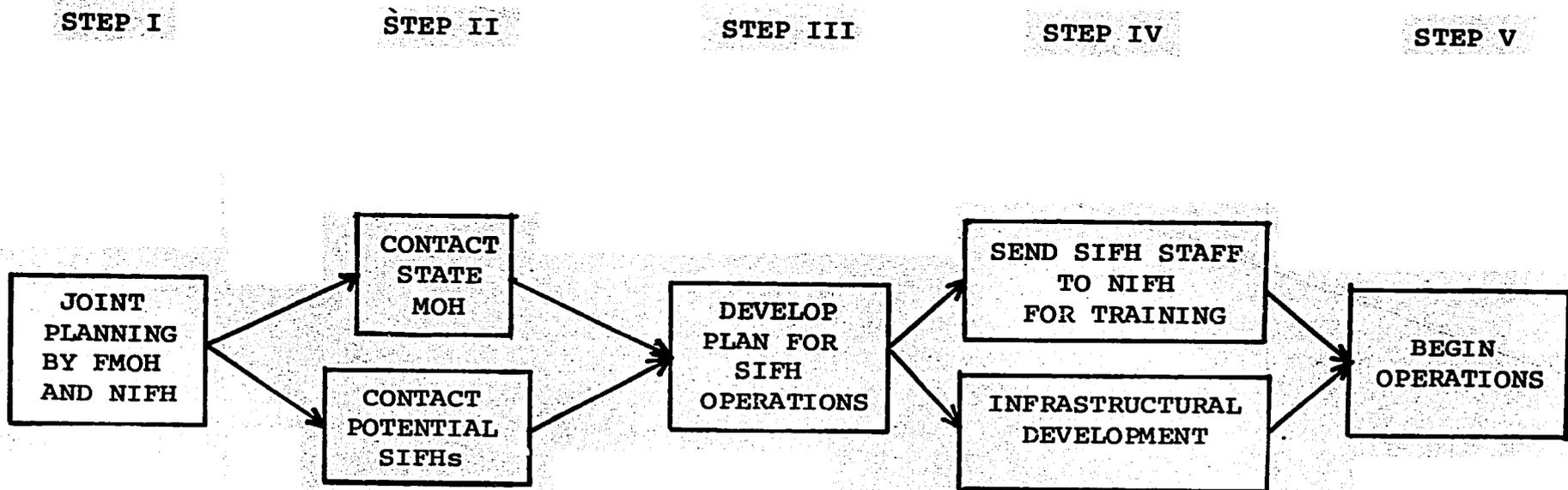
The following steps, described graphically in EXHIBIT III, would be taken to implement the Family Health Program on a nationwide scale:

STEP ONE: JOINT NATIONAL PLANNING

The Federal Ministry of Health (FMOH) and the National Institute of Family Health would begin to plan jointly for the national program. Their discussion should focus around:

- Program policy development
- Proposed program operations
- Organizational structure of the program

TASK PLAN FOR IMPLEMENTING THE FAMILY HEALTH PROGRAM



- Manpower requirements
- Resource requirements
- Facilities requirements
- Timetable for operations
- Desirability of transforming existing institutions into Institutes of Family Health

STEP TWO: CONTACT PARTICIPATING ORGANIZATIONS

The FMOH and the NIFH would contact the major participating organizations:

- State Ministries of Health
- Potential State Institutes of Family Health

The State MOH would be fully advised about the nature and scope of the proposed program. They would be encouraged to assist in the development and eventual support of their State Institute. Once the State MOH interest in such an Institute is known, the FMOH-NIFH-State MOH would also contact the potential SIFH's. These (the potential SIFH) would be assessed for capability, resources and willingness to participate in the program.

STEP THREE: DEVELOPMENT OF STATE PLANS

In this stage, the FMOH and the NIFH would work with the State MOH and potential SIFH's in the development of operational plans. This would involve development of:

- Policies
- Organizational structure
- Program operations
- Plans for manpower, facilities and equipment
- Timetable for operations.

STEP FOUR: INFRASTRUCTURE DEVELOPMENT

In this task, several activities would be undertaken simultaneously. They would form the basic infrastructure for the Family Health Program at the state level.

These subtasks would be:

- Identification of appropriate SIFH personnel (physicians, nurses, administrators) for training at the NIFH. This training would require 4 1/2 months for the nurses, and 6 weeks for the physicians and administrators. The training would be conducted at the NIFH as soon as the SIFH's operational plans were completed.

- Modification and equipment of the SIFH building chosen as the site of operation for the state Family Health Program. This would be done according to the plan previously approved by the SIFH and the State MOH.

- Survey of the state to determine health care problems and relevant socio-demographic data. This study would be conducted with the assistance of a sociologist/demographer from the NIFH, and would be performed about two months before SIFH operations were to begin.

- Survey by the program and policy planning unit, in conjunction with the State Ministry of Health, of pre-existing literature and ongoing projects on family health and health manpower in the State. The unit would make preliminary recommendations on service, manpower development, and research priorities on that basis.

STEP FIVE: BEGIN OPERATION OF THE SIFH

The operation of the SIFH would begin as soon as the basic staff training, information survey and building

modifications were completed. This would vary somewhat for each SIFH. It is important, however, that all SIFH's be operational within 18 months of the approval of the national plan.

G. Schedule of Operations

EXHIBIT IV indicates the projected timetable for accomplishing the various tasks described in the preceding section.

It should be noted that the overall schedule calls for the Family Health Program to be operational in Lagos and at least one state by the eighteenth month. It is understood that several states are already conducting some activities through their existing Family Health Units or Institutes of Child Health. The majority of states, however, are either in the early stages of planning or have not formulated plans as yet.

It should also be pointed out that some of the activities would run concurrently, depending on the state of development of individual SIFH's.

**SCHEDULE OF OPERATIONS
FOR
THE IMPLEMENTATION OF THE NATIONAL FAMILY HEALTH PROGRAM**

TASK	MONTH																		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	
1. Joint National Planning	█																		
2. Contact Participating Organizations				█															
3. Development of State Plans							█												
4. SIFH Infrastructure Development											█								
5. Begin Operations in One or More SIFH																		█	

III. MANAGEMENT AND ORGANIZATION OF THE PROPOSED PLAN

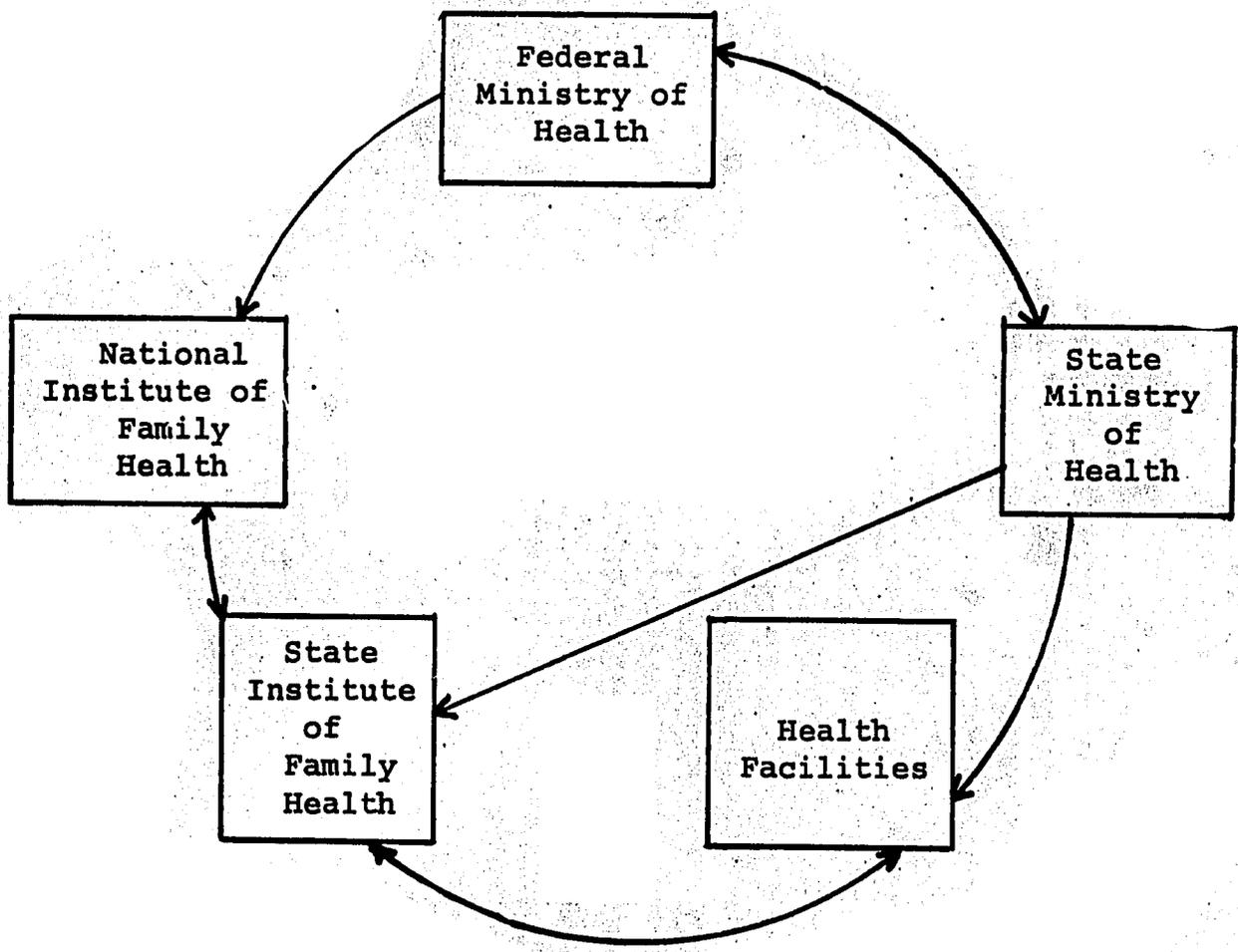
The development and implementation of this national program will require the active support and participation of many governmental and private organizations. Among these will be:

- Federal and State Ministries of Health
- Academic Institutions
- Medical Schools
- Professional Societies, both medical and non-medical
- Health service providers such as hospitals, clinics and dispensaries
- Armed services
- Federal and State Ministries of France
- Federal and State Ministries of Economic Planning.

Each of these organizations will have a different role in this program. This section will describe some of those roles.

The basic structure of the National Family Health Program is illustrated in EXHIBIT V. The Federal Ministry of Health has the overall responsibility within the Federal Military Government, for the program. It in turn

RELATIONSHIP OF THE VARIOUS
ORGANIZATIONS WITHIN THE
FAMILY HEALTH PROGRAM



relates to the other governmental agencies that might become involved (but are for simplicity of the drawing not shown) such as the Supreme Council, the Ministry of Financing, and the Ministry of Economic Planning. The Federal Ministry of Health will also work with the State Ministries of Health on this program.

The National Institute of Family Health will be established as an autonomous organization that reports to the Federal Military Government through the Federal Ministry of Health. The NIFH will act in an advisory capacity to the Federal MOH, and will in turn receive its financial support from the MOH.

The National Institute of Family Health will supervise the planning and implementation of the State Institutes of Family Health. This will be done in conjunction with the Federal and State Ministries of Health.

The State Institutes of Family Health will also be autonomous organizations, reporting to the State Ministries of Health. The SIFH's will receive their financial support for research and training from the Federal Government, and for services from State Ministries of

Health. The SIFHs will act as program advisors to their own State Ministries of Health. The providers of care - the hospitals, clinics and dispensaries - will relate to the Ministries of Health in their usual way. They will however, be able to draw upon technical assistance from the SIFHs. In case of need, the SIFH's may call on NIFH to help particular health facilities with specific problems in the areas of family health services delivery, training, and research.

IV. RESOURCES NEEDED FOR THE PROPOSED PROGRAM

The National Family Health Program will require manpower, facilities, equipment, supplies and funds for operation. This section will try to summarize, as realistically as possible, the resources that will be required to implement this program. The tentative budgets shown here are for the NIFH itself and a typical SIFH. These estimates are, of course, preliminary and subject to further planning and negotiations.

A. Resource Needs of the National Institute of Family Health

1. Personnel

<u>Title</u>	<u>Annual Salary</u>	<u>Total</u>
- Office of the Director		
- Director	₦14,000	₦14,000
Executive Officer	3,000	3,000
Administrative Assistant	2,000	4,000
Executive Secretary	4,000	4,000
2 Secretary/Clerk	3,000	6,000

<u>Title</u>	<u>Annual Salary</u>	<u>Total</u>
- Administration, Management and Logistics Division		
- Chief of Division	N10,000	N10,000
a) Accounts Department		
1 HEO Accounts	4,000	4,000
1 EO Accounts	3,000	3,000
1 AEO Accounts	2,000	2,000
b) General Administration		
1 EO Administration	3,000	3,000
1 AEO Administration	2,000	2,000
c) Personnel Management		
HEO Personnel	4,000	4,000
d) Passage, Transport, and Guesthouse		
1 Driver I	2,000	2,000
2 Driver II	1,500	3,000
2 Driver III	1,000	2,000
2 Messengers	1,000	2,000
1 Asst. Domestic Warden/ House Keeper	2,000	2,000

<u>Title</u>	<u>Annual Salary</u>	<u>Total</u>
1 Cook/Stewart	N 1,500	N 1,500
1 Porter/Attendant	1,000	1,000
1 Cleaner/Gardener	1,000	1,000
1 Night Watchman	1,000	1,000
1 Equipment & Maintenance	1,000	1,000
e) Supplies		
1 HEO Logistics	4,000	4,000
1 Storekeeper	1,500	1,500
1 Store Attendant	1,000	1,000
f) Information Service		
1 Program Information Officer	6,000	6,000
1 Assistant Program Officer	4,000	4,000
1 HEO Librarian	4,000	4,000
1 AEO Library Assistant	2,000	2,000
g) Publications and Teaching Materials		
1 Language editor	2,500	2,500
1 Graphics Artist	2,000	2,000
1 EO publications	3,000	3,000

<u>Title</u>	<u>Annual Salary</u>	<u>Total</u>
h) Clerical Assistance to the Division and typing pool		
1 Personal Secretary II/I	₦ 4,000	₦ 4,000
1 Asst. Pers. Sec.	3,000	3,000
2 Clerk Typist	2,500	5,000
1 Clerk III	2,000	2,000
- Program Operations Division		
- Deputy Director	11,000	11,000
a) Family Health Service		
1 Senior research fellow (physician)	8,000	8,000
3 Research fellow I	7,000	21,000
3 Research fellow II	6,000	18,000
1 Senior Health Sister	6,000	6,000
3 Health Sisters	4,000	12,000
2 Senior Nursing Sister	6,000	12,000
10 Nursing Sisters	4,000	40,000
1 Staff Nurse	5,000	5,000
4 Senior Community Sisters	6,000	24,000
8 Community Nurses	5,000	40,000
2 Senior Clinic Assistants	4,000	8,000
1 Senior Technologist	6,000	6,000

<u>Title</u>	<u>Annual Salary</u>	<u>Total</u>
1 Lab Assistant	N 1,500	N 1,500
1 Lab Attendant	1,000	1,000
4 Clinic Assistants II	2,500	10,000
4 Clinic Assistants III	2,000	8,000
4 Dispensary Assistants	1,500	6,000
4 Cleaners	1,000	4,000
3 Messengers	1,000	3,000
1 Senior Night Watchman	1,500	1,500
6 Watchmen	1,000	6,000
1 Driver III	1,000	1,000
1 EO Administration	3,000	3,000
2 Typists	2,500	5,000
1 Field Health Worker Supervisor (interviewer supervisor)	3,000	3,000
2 Grade I Field Health Workers (interviewers)	2,500	5,000
7 Grade II Field Health Workers (interviewers)	2,000	14,000
3 Grade III Field Health Workers (interviewers)	1,500	4,500
1 Physiotherapist	4,000	4,000
1 Senior E.E.G. Technician	4,500	4,500

<u>Title</u>	<u>Annual Salary</u>	<u>Total</u>
1 Laboratory Attendant	N 1,000	N 1,000
1 Senior Nutritionist	5,000	5,000
1 Nutritionist	4,500	4,500
1 Higher Nutrition Officer	2,500	2,500
2 Nutrition Officers	3,000	6,000
1 Assistant Nutrition Officer	2,500	2,500
1 Senior Nutrition Assistant	2,000	2,000
1 Nutrition Assistant	1,500	1,500

b)-Training and Education

1 Senior Research Fellow (physician)	8,000	8,000
1 Research Fellow I (management)	7,000	7,000
1 Research Fellow II	6,000	6,000
2 Nurse-Educators	6,000	12,000
1 Health Educator	5,000	5,000
1 Personal Secretary	4,000	4,000
2 Clerk/Typist	2,500	5,000
1 Clerk	2,000	2,000
12 Part-time Lecturers	2,000	24,000

<u>Title</u>	<u>Annual Salary</u>	<u>Total</u>
c) Research		
1 Research fellow Grade I (Sociologist/Demographer)	7,000	7,000
3 Research fellows Grade III	5,000	15,000
1 Operations Research Specialist	5,500	5,500
1 Demographer	6,000	6,000
1 Biostatistician	6,000	6,000
1 Computer Programmer	3,000	3,000
2 Coders - Punchers	1,500	3,000
2 Grade I Interviewers	2,500	5,000
7 Grade II Interviewers	2,000	14,000
3 Grade III Interviewers	1,500	4,500
1 Principal Lab Technologist	8,000	8,000
1 Superintendent	7,000	7,000
3 Technologists	6,000	18,000
2 Lab Assistants	1,500	3,000
1 Lab Attendant	1,000	1,000
1 Personal Secretary	4,000	4,000
1 Assistant Personal Secretary	3,000	3,000
1 Typist	2,500	2,500
3 Clerks	2,000	6,000

<u>Title</u>	<u>Annual Salary</u>	<u>Total</u>
- National Operations Division		
- Deputy Director	N11,000	N11,000
a) SIFH Liaison		
1 AEO Logistics	2,000	2,000
1 Senior Health Sister	6,000	6,000
1 Research Fellow Grade I	7,000	7,000
1 Research Fellow Grade I (physician)	8,000	8,000
1 Social Scientist	6,000	6,000
1 Statistician	6,000	6,000
1 Computer Programmer	3,500	3,500
1 Management Scientist	6,000	6,000
1 Personal Secretary	4,000	4,000
1 Clerk/Typist	2,500	2,500
b) Policy and Planning		
1 Health Planner (at level Senior Lecturer or above)	8,000	8,000
2 Research Fellow Grade I (economics & management)	7,000	14,000

<u>Title</u>	<u>Annual Salary</u>	<u>Total</u>
2 Research Fellow Grade II	N 6,000	N12,000
1 Personal Secretary	4,000	4,000
2 Clerk/Typist	<u>2,500</u>	<u>5,000</u>
<u>TOTAL PERSONNEL</u>	<u>740,000</u>	

2. PERSONNEL FRINGE BENEFITS (35%) = 259,000

3. TRAVEL

Domestic	= 20,000
International	= 25,000
Per Diem	= <u>30,000</u>
Total Travel	= 75,000

4. COMMITTEES

Honoraria for Board of Directors, Advisory Committees, Ad Hoc Committees	= 20,000
Travel for Committee Members	= <u>5,000</u>
Total Committee Costs	= 25,000

5. CONSULTANTS

Honoraria	=	200,000
Consultant Travel	=	20,000
Consultant Per Diem	=	<u>20,000</u>
Total Consultants		240,000

6. OTHER DIRECT COSTS

Motor Vehicles	=	30,000
Alterations to Vehicles	=	20,000
Vehicle Rental	=	30,000
Vehicle Maintenance	=	15,000
Staff Training	=	25,000
Conferences-International	=	10,000
Conferences-Domestic	=	6,000
Office Furniture	=	20,000
Research and Laboratory Equipment		40,000
Medications, Clinic Supplies	=	50,000
Printing, Duplication, Stationary	=	30,000
Books, Periodicals	=	10,000
Communications, Cables, Telephone	=	5,000

Advertisements	=	3,000
Entertainment	=	5,000
Other Costs	=	<u>11,000</u>
TOTAL OTHER DIRECT COSTS	=	₱310,000

SUMMARY OF FIRST YEAR NIFH OPERATING COSTS

Direct Labor	740,000
Personnel Fringe	259,000
Travel	75,000
Committees	25,000
Consultants	240,000
Other Direct Costs	<u>310,000</u>
Total	₱1,649,000

Second Year NIFH Operating Costs	=	1,896,000*
Third Year NIFH Operating Costs	=	2,180,000*
Fourth Year NIFH Operating Costs	=	<u>2,507,000*</u>
Total Four Year NIFH Operating Costs	=	8,232,000

Capital Expenditure (one year only) = 2,000,000

Total NIFH Four Year Operating Costs
and Capital Expenditures = **₱10,232,000**

*Includes 15% Annual Increase for Inflation
and Salary Raises.

B. Resource Needs of the State Institute of Family Health

1. Personnel

<u>Title</u>	<u>Annual Salary</u>	<u>Total</u>
- Office of the Director		
- Director	N11,000	N11,000
Executive Officer	3,000	3,000
Administrative Assistant	2,000	2,000
Executive Secretary	4,000	4,000
2 Secretary/Clerk	3,000	6,000
- Administration, Management and Logistics Division		
- Chief of Division	8,000	8,000
a) Accounts Department		
1 EO Accounts	3,000	3,000
1 AEO Accounts	2,000	2,000
b) General Administration		
1 EO Administration	3,000	3,000
1 AEO Administration	2,000	2,000

<u>Title</u>	<u>Annual</u> <u>Salary</u>	<u>Total</u>
c) Personnel Management		
HEO Personnel	N 4,000	N 4,000
d) Passage and Transport		
1 Driver I	2,000	2,000
2 Driver II	1,500	3,000
2 Messengers	1,000	2,000
e) Supplies		
1 HEO Logistics	4,000	4,000
1 Storekeeper	1,500	1,500
1 Store Attendant	1,000	1,000
f) Information Service		
1 Program Information Officer	6,000	6,000
1 HEO Librarian	4,000	4,000
g) Publications and Teaching Materials		
1 EO publications	3,000	3,000

<u>Title</u>	<u>Annual Salary</u>	<u>Total</u>
h) Clerical Assistance to the Division & typing pool		
1 Personal Secretary	N 4,000	N 4,000
1 Clerk Typist	2,500	2,500
1 Clerk III	2,000	2,000
- Program Operations Division		
- Deputy Director	9,000	9,000
a) Family Health Service		
1 Senior research fellow (physician)	8,000	8,000
1 Senior Health Sister	6,000	6,000
2 Health Sisters	4,000	8,000
1 Senior Nursing Sister	6,000	6,000
5 Nursing Sisters	4,000	20,000
1 Staff Nurse	5,000	5,000
2 Senior Community Sisters	6,000	12,000
4 Community Nurses	5,000	20,000
1 Senior Clinic Assistant	4,000	4,000
1 Senior Technologist	6,000	6,000
1 Lab Assistant	1,500	1,500
2 Clinic Assistants II	2,500	5,000

<u>Title</u>	<u>Annual</u> <u>Salary</u>	<u>Total</u>
2 Clinic Assistants III	N 2,000	N 4,000
2 Dispensary Assistants	1,500	3,000
2 Cleaners	1,000	2,000
1 Messenger	1,000	1,000
1 Senior Night Watchman	1,500	1,500
3 Watchmen	1,000	3,000
1 Driver III	1,000	1,000
1 EO Administration	3,000	3,000
2 Typists	2,500	5,000
1 Field Health Worker Supervisor (interviewer supervisor)	3,000	3,000
1 Grade I Field Health Worker (interviewer)	2,500	2,500
3 Grade II Field Health Workers (interviewers)	2,000	6,000
1 Physiotherapist	4,000	4,000
1 Senior E.E.G. Technician	4,500	4,500
1 Laboratory Attendant	1,000	1,000
1 Nutritionist	4,500	4,500
2 Nutrition Officers	3,000	6,000
1 Senior Nutrition Assistant	2,000	2,000
1 Nutrition Assistant	1,500	1,500

<u>Title</u>	<u>Annual Salary</u>	<u>Total</u>
b) Training and Education		
1 Research Fellow I (management)	N 7,000	N 7,000
2 Nurse-Educators	6,000	12,000
1 Health Educator	5,000	5,000
1 Clerk/Typist	2,500	2,500
1 Clerk	2,000	2,000
6 Part-time Lecturers	2,000	2,000
c) Research		
1 Research fellow Grade III	5,000	5,000
1 Operations Research Specialist	5,500	5,500
1 Grade I Interviewers	2,500	2,500
2 Grade II Interviewers	2,000	4,000
1 Lab Assistants	1,500	1,500
1 Lab Attendant	1,000	1,000
1 Assistant Personal Secretary	3,000	3,000
1 Typist	2,500	2,500
2 Clerks	2,000	4,000

<u>Title</u>	<u>Annual Salary</u>	<u>Total</u>
- Policy and Planning Division		
- Deputy Director	N 9,000	N 9,000
1 Health Planner (at level Senior Lecturer or above)	8,000	8,000
2 Research Fellow Grade I (economics and management)	7,000	14,000
1 Assistant Personal Secretary	3,000	3,000
1 Clerk/Typist	2,500	2,500

TOTAL PERSONNEL = 360,000

2. PERSONNEL FRINGE BENEFITS (35%) = 126,000

3. TRAVEL

Domestic	=	10,000
International	=	10,000
Per Diem	=	<u>10,000</u>
Total Travel	=	30,000

4. COMMITTEES

Honoraria for Board of Directors, Advisory Committees, Ad Hoc Committees	=	10,000
Travel for Committee Members	=	<u>3,000</u>
Total Committee Costs	=	13,000

6. OTHER DIRECT COSTS

Motor Vehicles	15,000
Alterations to Vehicles	5,000
Vehicle Rental	10,000
Vehicle Maintenance	10,000
Staff Training	10,000
Conferences-International	5,000
Conferences-Domestic	3,000
Office Furniture	10,000
Research & Laboratory Equipment	15,000
Medications, Clinic Supplies	30,000
Printing, Duplication, Stationary	10,000
Books, Periodicals	3,000
Communications, Cables, Telephone	2,000
Advertisements	1,000
Entertainment	3,000
Other Costs	<u>5,000</u>
Total Other Direct Costs	137,000

SUMMARY OF FIRST YEAR SIFH OPERATING COSTS FOR ONE SIFH

Personnel	360,000
Personnel Fringe	126,000
Travel	30,000
Committees	13,000
Other Direct Costs	<u>137,000</u>
Total	666,000

C. Total Program Costs

	<u>NIFH</u>	<u>SIFH</u>	<u>TOTAL</u>
First Year (One SIFH Operations)	1,649,000	666,000	2,315,000
Second Year (Five SIFHs Operations)	1,896,000*	3,830,000*	5,726,000
Third Year (Nine SIFHs Operations)	2,180,000*	7,929,000*	10,109,000
Fourth Year (Twelve SIFH Operations)	2,507,000*	12,156,000*	14,663,000
	<u>8,232,000</u>	<u>24,581,000</u>	<u>32,813,000</u>
CAPITAL EXPENDITURES	<u>2,000,000</u>	<u>3,000,000</u>	<u>5,000,000</u>
Total Four Year Operating Costs and Capital Expenditures	10,232,000	27,581,000	37,813,000

*Includes 15% Annual Increase for Inflation and
Salary Raises.