

**Combatting Childhood
Communicable Diseases,
Nigeria Program:
Management Analysis**

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PREFACE

This report was prepared by Craig V. Olson, a senior development management specialist at Development Alternatives, Inc. Dr. Olson spent the period of March 31 to April 4 in Nigeria where he worked with three other team members: Dr. Joe Davis, AFR/TR; Dr. Stan Foster, CDC; and Dr. Deborah Blum, PRITECH. Dr. Olson interviewed key personnel in USAID/Nigeria, the Federal Ministry of Health in Lagos, and UNICEF/Nigeria. He also spent one day interviewing government officials in Ogun State and in the Abeokuta Local Government Authority in Ogun State.

This report was prepared in the offices of Development Alternatives, Inc. in Washington, D.C.

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I. INTRODUCTION AND SUMMARY OF PRINCIPAL RECOMMENDATIONS

Introduction

The objectives of the Combatting Childhood Communicable Diseases (CCCD) project in Nigeria are noble and worthy, even glamorous. As in the rest of Africa, childhood mortality is unacceptably high. One of every five children born to a Nigerian mother will die before the age of five, one in ten before the age of one. Major causes of morbidity and mortality in Nigerian children include malaria, diarrhea, measles, whooping cough, and tetanus all of which are targeted diseases in the CCCD/Nigeria project. The technology and know-how to reduce significantly the death and suffering caused by these diseases -- immunization, ORT, and presumptive treatment of fever with chloroquine -- exists. If sufficient funding is made available for drug and pharmaceutical supplies, if health education and community mobilization is effective, and if immunization campaigns, cold chains, and information systems are well organized and well managed, there is little question that dramatic declines in infant and child mortality can be achieved.

The kicker is management. Management is decidedly unglamorous. The vision of young dedicated Nigerian medical school graduates instructing anguished mothers in home ORS preparations or of nurses lining up infants held in their mothers' arms for the third dose of oral polio vaccine is romantic. But behind the scenes, someone has to plan for the posting of the young doctors, ensure their transportation and pay their expenses. In similar fashion, someone has to order the polio vaccine, ensure that it remains refrigerated at the proper temperatures while in storage and delivery, and plan and administer the schedule of immunizations. For every child treated or immunized, there are a myriad of such management and administrative tasks that must be carried out.

This report was requested by AID as a reaction to the relative lack of attention given the management issue in an October 1985 proposal to initiate a CCC/D country program in Nigeria. At the request of the government of Nigeria (GON), a team of health specialists carried out, in the fall of 1985, an assessment of the feasibility of providing CCC/D assistance to Nigeria. The proposal that resulted from this assessment was reviewed in AID/Washington in December, 1985 and, while the proposal was neither accepted nor rejected, several issues were identified that would require resolution before further action could be taken. One of these issues involved the question of how the various project activities could be managed.

This report identifies and analyzes the principal management tasks and problems that CCCD/Nigeria will confront. It also analyzes the capacity of the government of Nigeria (GON) and of the United Nations Children Fund (UNICEF) to assist CCCD in project management. (The other issues raised by AID/Washington are covered in different reports.)

Summary of Principal Recommendations

The principal recommendations of the report are as follows:

1. For reasons of cost and technical oversight, responsibility for the recruitment and support of the various types of long- and short-term technical assistance should be assumed by UNICEF in Nigeria and to three AID centrally-funded projects:

- CCCD, through the Center for Disease Control (CDC) in Atlanta, Georgia;
- Technologies for Primary Health Care (PRITECH); and
- Health Communications (HEALTHCOM).

2. To assure coordination of technical inputs, the CDC program manager in Nigeria, in collaboration with the Nigerian project director, should be assigned supervisory responsibility over the other long-term specialists (except the UNICEF technical officer) and all short-term specialists.

3. To facilitate the administrative tasks associated with this supervisory responsibility, the CDC program manager should be authorized to hire a program assistant and an administrative assistant. The program manager should also be authorized to maintain a special operating account.

4. A Project Coordinating Committee composed of the AID/W project managers for CCCD (who would become the permanent chair), PRITECH, and HEALTHCOM and a representative from UNICEF/New York, should be established to assure coordination of project management at the level of the implementing agencies in the United States.

5. A special effort, involving a three-month consultancy of a CDC epidemiologist, will be required to organize a proposed Youth Epidemiology Service (YES).

6. In the first year or two, the YES activity should be limited to one five-state zone.

7. Procurement of U.S. source and origin commodities should be undertaken directly by AID/Washington; local procurement and Free World procurement for items for which waivers will have been secured should be undertaken by UNICEF.

8. USAID/Nigeria need not be involved in day-to-day program management, but should, in conjunction with the Federal Ministry of Health, play an active role in policy and program oversight.

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II. THE PROBLEM

The proposed CCCD program in Nigeria entails a set of management tasks that is complicated by three factors. The first is the rather large number of complex but interrelated activities that the project proposes to undertake. The second is the rather large number of institutions that will be involved in one way or another in the project. The third is the federal structure of government in Nigeria.

Proposed Program Activities

The October 1985 assessment identified three program areas in which the U.S. government could assist the government of Nigeria (GON) in the health sector:

- Expanded Program on Immunization (EPI), a program which in Nigeria is aimed at achieving and maintaining an 80 percent nationwide immunization coverage (B.C.G., Oral Polio, D.P.T., and measles) of children under one year old by the year 1990.
- Control of Diarrheal Disease (CDD), a program to promote oral rehydration therapy (ORT).
- Malaria management.

Within these program areas, the assessment proposed assistance in the following areas:

- Creation of a Youth Corps Epidemiologic Service (YES) through which selected medical school graduates will be assigned to the states to improve the quality and quantity of rural child services. YES personnel will be provided through the National Youth Service Corps (NYSC), a program of compulsory one-year public service for all Nigerian college graduates.
- Improving Health Planning and Finance. This intervention will provide short-term training and technical assistance for government officials at the federal, state and local government levels in the areas of health planning, budgeting, finance, and program monitoring and evaluation.

- Improving Health Education and Community Mobilization. The project will provide long- and short-term technical assistance to the Health Education unit in the Federal Ministry of Health in order to improve the unit's capacity to promote community education and mobilization for the EPI and ORT programs. Also proposed are the provision of educational equipment and materials and the organization of some 15 workshops on health education subjects for federal, state and local health professionals.
- Strengthening Pharmaceutical Supply Management. This component involves financial assistance for the procurement of program related essential drugs and pharmaceutical supplies as well as short-term technical assistance and workshops in pharmaceutical supply procurement and management.
- Improving Health Information Systems. This component involves assistance to various levels of government in identifying data needed to assess the effectiveness of primary health care activities and assistance in developing or improving systems to collect and analyze these data including the use of computers.
- Strengthening Operations Research. This component involves limited funding for research on topics that have the potential of improving the technologies and/or delivery systems of EPI, CCD/ORT, or the malaria program.

In sum, the project proposes to support Nigeria's health sector in a number of program and operational areas and in a variety of ways: long-and short-term technical assistance, commodity procurement, training and funding for research projects. Each of these activities entails carrying out a number of procedural and administrative tasks including planning, scheduling, budgeting, communications, logistics, record-keeping, vouchering, supervision, reporting, assessment, and follow-up. Beyond these activity-specific tasks, there is a need to coordinate the separate activities in a manner that will ensure their complementarity and overall contribution to program objectives. In short, the Nigeria program must be managed.

Institutions Involved

The problem of the management of this project is complicated by several institutional factors. First, the AID affairs office in Lagos, with only two direct-hire employees, is not adequately staffed to assume more than the minimum of management responsibilities. Second, there are a multiplicity of institutional actors that will be potentially involved in the project. These include three AID centrally-funded projects each of which involves several institutions.

1. CCCD. Managed in the Africa Bureau of AID/Washington, the purpose of this project is to strengthen Africans' ability to control childhood communicable diseases. The implementing agency for CCCD is the Center for Disease Control (CDC) in Atlanta, Georgia. Strong consultative relationships are maintained with Cooperation for Development in Africa (CDA), the World Health Organization (WHO) and the United Nations Children's Organization (UNICEF). Nigeria would be the thirteenth country in which CCCD has initiated country-specific programs.

CDC's proposed involvement is to provide two long-term experts: one a program manager to work in the Federal Ministry of Health in Lagos and the other an epidemiologist to be stationed in one of the northern states, probably Kaduna. CDC would also provide some short-term technical assistance and training and workshop expertise.

2. Technologies for Primary Health Care (PRITECH). Managed by the Science and Technology Bureau (S&T) of AID/Washington, this project aims at promoting proven disease control technologies on a world-wide basis. The prime contractor for implementation is Management Sciences for Health (MSH) which has subcontracts with the Johns Hopkins University School of Hygiene and Public Health, the Academy for Educational Development (AED), and the Program for Appropriate Technologies in Health (PATH).

The proposed involvement of PRITECH is to provide a long-term ORT specialist to advise the Epidemiologic Unit in the Federal Ministry of Health in Lagos in the planning and supervision of an intensified ORT program. PRITECH will also provide short-term technical assistance and training in ORT, particularly in local governments.

3. Health Communications (HEALTHCOM), an S&T-financed project aimed at improving communications between health service providers and health consumers. The prime contractor for implementation is AED. Principal subcontractors are the Annenberg School of Communications of the University of Pennsylvania, Applied Communications Technology, Needham Porter Novelli, and PATH. Six additional subcontractors are identified to provide specialized assistance as required; these include MSH and Johns Hopkins University.

It is proposed that HEALTHCOM provide two long-term advisors to the Health Education Unit in the Federal Ministry of Health, one in health communications, the other in educational materials development. As with the other projects, HEALTHCOM will provide short-term technical assistance and training as well.

Another institution that is proposed for a prominent role in the project is UNICEF. UNICEF will provide a technical officer financed by AID to be assigned to the northeast region and stationed in Bauchi. UNICEF will also assume responsibility for the bulk of the commodity procurement under the project. As explained in Chapter V. UNICEF is now the principal international organization assisting the GON in the health sector.

The Structure of Government in Nigeria

The management of the project is further complicated by the fact that Nigeria has a federal form of government similar to that of the United States. Each of the nineteen states, as well as the federal government in Lagos, has a full set of ministries, including a ministry of health. Whereas the federal ministries establish policies and provide substantial amounts of funding and technical expertise, it is either the state governments or Local Government Authorities (LGA) that are responsible for the provision and administration of public services, including primary health care. The management capacity of these various levels of government is described in Chapter V.

III. ANALYSIS OF MANAGEMENT TASKS

The management of the CCCD/Nigeria program may be separated into three categories corresponding to three categories of AID-financed inputs: technical assistance, training, and commodity procurement. Each of these categories entails a series of tasks that must be carried out. An overarching category is program management: how all inputs and AID-financed activities can be integrated to ensure their efficient contribution to achievement of the program objective.

Technical Assistance

The CCCD/Nigeria program is in large part a technical assistance (TA) program. The nearly 33 person-years of long- and short-term TA that has been programmed consumes the majority of the budget. Since host-country contracting is not contemplated, mechanisms must be identified to provide financial and administrative support to each of the long- and short-term specialists and to ensure that their work is integrated and coordinated in a manner that leads to the achievement of program objectives.

Six long-term specialists are proposed: a program manager, an epidemiologist, an ORT specialist, two health education specialists, and a zonal technical officer. The two health education positions are programmed for three years each. The other four positions are each for five years. All of these specialists must be provided with appropriate support. Support tasks include payment of salaries, arranging international and in-country transportation, provision of temporary and permanent housing, insurance payments, shipment of household and personal effects, processing travel vouchers, and providing office space, communications support and secretarial/administrative assistance.

In addition to the 26 person years of long-term TA, some 82 person months of short-term TA have been programmed in support of EPI, ORT, and other program interventions. The management tasks associated with short-term TA include arranging international transportation, payment of salaries and travel expenses, communications, scheduling, airport entry and departure facilitation, room reservations, in-country transportation, and in-country secretarial and report production support.

Recruitment and Support Options

Several models for the recruitment and support of these specialists have been discussed. One model would be to engage a single organization to recruit these specialists and to provide for all their support. Another model would be provide some or all of the specialists through a Participating Agency Service

Agreement (PASA) with CDC, a U.S. government agency. A third model would be to use the funding mechanisms and technical and administrative backstopping of existing centrally-funded projects. Another model would be to provide funding to an international organization to recruit and support one or more of the specialists. Yet another model would be to recruit the specialists through one or more of these mechanisms and to provide for their in-country support through the services of an independent organization.

Each of these options has advantages and disadvantages. The single organization option has the advantage of efficiency in that AID payments would only be made to one organization which would provide all TA support. However, this option would also entail delays in the contracting process, would be expensive because of the institutional overhead, and would to some extent duplicate already existing capabilities in the form of the centrally-funded PRITECH and HEALTHCOM projects. The main advantage of the use of PASAs with CDC is that CDC, as the principal implementing agency for CCD throughout Africa, is the organization which is most knowledgeable about the technical requirements of the project. However, the ability of CDC to provide administrative support to technicians in the field is minimal. As a U.S. government agency, CDC and its personnel abroad are entitled to the administrative support of embassy and AID missions; however, as pointed out previously, the capacity of the AID office in Lagos to provide this support is extremely circumscribed by its limited staff. Providing specialists through PRITECH and HEALTHCOM permits the use of an existing contracting mechanism and engages competent organizations to provide technical oversight; however, it disperses the technical assistance among multiple organizations, thus possibly compromising the efficiency of technical coordination. The use of an international organization like UNICEF has the advantage of leveraging an existing in-country administrative support mechanism but carries with it the partial loss of technical as well as administrative control over the specialist's services.

The use of an independent "logistics" firm to provide administrative support to specialists hired through other organizations provides, at first glance, the advantage of letting the technicians get on with their job without being burdened by administrative problems. However, experience with this model in other countries shows that the theory breaks down in practice over the question of competing loyalties and boundaries of responsibility. The logistics organization may provide some on-the-ground efficiencies, but also adds to the expense and organizational complexity of the project and may find itself providing services that overlap with or are redundant to those of the specialists' employers. The organization that employs a specialist cannot totally dissociate itself from administrative support, including salary payments, international travel, and shipment of household and personal effects. With respect to housing, whereas the logistics firm may be responsible for

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ensuring that household repairs are made, it is usually the specialist or the specialist's employer that is responsible for paying the housing bills. When problems arise, the employee thus has a natural tendency to turn to his/her own organization for assistance even though the "logistics" organization may bear first-line responsibility. It is in this manner that the model of two organizations supporting a single individual frequently causes more problems than it resolves.

Recruitment and Support Recommendations

After much discussion, the arrangements that have been proposed for the management of long-term technical assistance entail a combination of these models with a number of special administrative provisions.

Two of the long-term specialists -- the program manager and the epidemiologist -- will be provided through CDC. As CDC employees they will be entitled to administrative support by the U.S. embassy in Lagos, including housing and arrangements for in-country transportation. However, the administrative burden on the embassy for other support items for these two specialists will be at least partially relieved by several special arrangements. First, both specialists will be provided office space by the federal Ministry of Health. The program manager will serve as the counterpart to the Chief Consultant Epidemiologist (the head of the epidemiology unit) in the ministry in Lagos. (See organization chart, Chapter IV, Figure 2.) The epidemiologist will occupy an office in one of the ministry's special primary health care zones, probably Kaduna. (See Map and Chapter IV, Figure 3.) Both specialists will be provided with secretarial assistance by the ministry.

In addition, it is proposed that CDC provide the program manager with two local-hire special assistants. One of these will be a program assistant who will be responsible for carrying out all administrative tasks associated with the program manager's CCC/D Nigeria management responsibilities. These will include port clearance of commodities procured in AID/Washington, bookkeeping for local per diem and petty cash transactions, hotel and travel arrangements for short-term consultants, in-country transportation and temporary lodging arrangements for long-term specialists, scheduling and organizational arrangements for workshops, and processing of vouchers (for the CDC employees, local consultants, and YES staff.) These special assistants will be hired and paid through the U.S. embassy using project funds, but will report directly to the program manager. }

The second local-hire will be an administrative assistant, primarily with secretarial skills, who will be responsible for the typing and preparation of the reports of short-term consultants and maintaining the program files for the program manager and the ORT specialist. It is also proposed that CDC provide the

program manager with a special operating account, to be administered by the program assistant, to provide for special or unforeseen local currency expenditures, particularly for overflow typing services, emergency transportation needs, and the like.

The ORT specialist will be provided through PRITECH as an employee of MSH, the principal PRITECH contractor. The main reason for this arrangement is that PRITECH is considered to have specialized knowledge in ORT technology. As the ORT program is just getting underway in Nigeria, it is largely this program area that will require large amounts of short-term technical assistance and training. It will be the responsibility of the ORT specialist to program the short-term TA and training related to the CDD/ORT program. All short-term specialists in ORT will be provided through PRITECH.

The ORT specialist will occupy an office in the federal Ministry of Health and serve as the counterpart to the chief of the CDD/ORT unit (See Chapter IV, Figure 2.) The Ministry will provide secretarial assistance and the ORT specialist will benefit, as explained above, from the services of the two special assistants assigned to the program manager. MSH will be responsible for all other support of this specialist, including international transportation, shipment of household and personal effects, housing, insurance, allowances and per diem.

The two health education specialists will be provided through HEALTHCOM and will be employees of AED, the principal HEALTHCOM contractor. As with the PRITECH/ORT specialist arrangement, the main reason for involving HEALTHCOM in this manner is the special technical expertise of HEALTHCOM in the field of health education and community mobilization. In addition to their own technical responsibilities, the two long-term specialists -- one in health communications and the other in educational materials development -- will be responsible for programming 13-20 months of short-term technical assistance in such fields as market research, medical anthropology, behavior analysis, and instructional media design and for arranging 15 two-three week workshops. The short-term specialists will be provided by HEALTHCOM either through AED or through one of AED's subcontractors.

The two health education specialists will occupy offices in the health education unit of the federal Ministry of Health in Lagos and will be provided secretarial support. It has been proposed that an effort be made to recruit Nigerians for these positions, possibly university professors on leaves of absence. Should this occur, it would represent considerable cost savings since it would not be necessary, to provide for international transportation, household and personal effects shipments, or housing. The specialists would nevertheless become employees of AED for the three years that each is scheduled to occupy the positions and AED would be expected to provide all other support to these individuals.

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The sixth long-term specialist will be a technical officer assigned to one of the northern primary health care zones, probably Bauchi. (See Map and Chapter IV, Figure 3.) This specialist will become an "Associate Expert" with UNICEF. Under this arrangement, the expert's salary will be funded by the CCCD project but UNICEF will provide housing as well as all the normal personnel support that UNICEF provides its regular employees. Beyond the obvious cost savings to the U.S. government, the rationale for this arrangement is that the nature of the technical officer's duties -- primarily working with state and LGA health personnel in training and technical supervision of EPI and ORT interventions -- corresponds closely with UNICEF's own assistance program in Nigeria.

Training

The project has programmed a great deal of training centered mainly around in-country workshops in such areas as operations research and evaluation, training of trainers in ORT, health communications techniques for LGA community mobilization coordinators, instructional programming in health for broadcast producers, and the use of revolving drug funds for cost recovery. Most of the workshops are to be held at the state or LGA levels and, as such, will be held in several locations. In addition to these workshops, a special program is to be established to provide an annual three-week training program for YES doctors and the project may also provide short (1-2 month) certificate courses in health planning, budgeting, financial analysis, monitoring and evaluation for selected federal and state health professionals at a U.S. university.

Workshops

For the management of most of the in-country training, no special project resources will be required beyond the provision of the short-term specialists who will participate in the workshops. This is because, to the extent that the workshops respond to genuine needs, the federal and/or state governments can be counted on to do a good job of organizing them. As described in Chapter IV, the federal and most state governments already have well established and well run health delivery systems, including training facilities. As a result, the appropriate Nigerian authorities will take responsibility for convening, transporting and financing the costs of participants, of securing an appropriate location and of other such logistic arrangements. In addition, UNICEF has agreed to handle the payment (using project funds) of all other local costs associated with workshops. Thus, the only responsibilities of the long-term specialists with respect to these workshops will be in initial planning and, of course, participation. To the extent necessary, and particularly with regard to the provision of special training materials, the program assistant to the CDC program manager will be available to

assist with workshop organization. The procedures for recruiting short-term specialists to provide instruction or otherwise participate in the workshops will be the same as those described for recruiting short-term technical assistants.

Youth Epidemiologic Service

The training and deployment of Youth Epidemiologic Service (YES) doctors will take a special effort. To date, YES exists only at the idea stage although it has been informally endorsed within the federal Ministry of Health. However, the idea must be discussed and negotiated with the appropriate authorities in the National Youth Service Corps (NYSC) and with participating state authorities. Once the idea is accepted, it will be necessary to plan and organize the recruitment, selection, training and deployment of the first year's medical school graduates.

To accomplish these tasks, it is proposed that a CDC epidemiologist be brought to Nigeria for a period of approximately three months to concentrate exclusively on the organization of YES and, particularly, on planning the initial training. Ideally, this epidemiologist would be the same person who would become the CDC epidemiologist in Kaduna because, once taking up residence in Kaduna, one of the epidemiologist's principal responsibilities will be to supervise the activities of the YES doctors. To this end it is also proposed that in the first year or possibly the first two years, the YES activity be confined to the single five-state primary health care zone of which Kaduna is a part (the other four states in the zone being Sokoto, Niger, Kwara, and Abuja.) In this regard, the number of YES doctors to be recruited and trained in the first year should be reduced from the 30 proposed in the October 1985 assessment to 10 (two for each state in the zone.) The October 1985 assessment suggests that the project might pay for the training and travel costs of YES trainees. It is suggested that, if at possible, these costs be borne by the NYSC since they are probably not much different in kind or in amount than those of other NYSC programs and since they will also become a recurrent cost to the government if YES is institutionalized. However, if the project does pay part or all of these costs, they should be met through draw-downs on the special operating account administered by the CDC program manager and the program assistant.

If it is decided to provide certificate training in the United States, it is suggested that a representative from the proposed university, possibly Johns Hopkins, be sent to Nigeria to make all necessary arrangements. If, as suggested in the October 1985 assessment, Johns Hopkins University is selected for this task, no separate contracting mechanism will be necessary because Johns Hopkins is already a subcontractor to MSH under the PRITECH project.

Commodity Procurement

The grant agreement to be negotiated with the government of Nigeria provides for approximately \$8.7 million in commodity procurement and related costs. Most of these items will be local (shelf item) procurement and related local costs such as vehicle maintenance and printing costs of educational materials. About \$1.8 million will be used for off-shore procurement of such items as vehicles, medical supplies, ORS material, and educational equipment. Of this latter amount, \$882,000 will be for the procurement of items that are available only in the United States or which U.S. law restricts to U.S. source and origin. The remainder will be obtained on the basis of special waivers from Free World sources.

Most local procurement will be carried out by UNICEF on a cost reimbursement basis against budgets drawn up in annual or semi-annual planning sessions and approved by the CDC program manager and the Project Coordinating Committee in the United States (a member of which will be a UNICEF/New York official.) A small amount of local procurement will also be carried out directly by the CDC program manager from the operating budget provided by CDC.

Off-shore procurement of U.S. source and origin commodities, such as ORS solution and computers, will be undertaken by AID/Washington on the basis of PIO/Cs issued by the CCC/D project manager in Washington. These commodities will be consigned initially to the CDC project manager in Lagos through the U.S. Embassy. Arrangements for port clearance and delivery will be the responsibility of the program assistant.

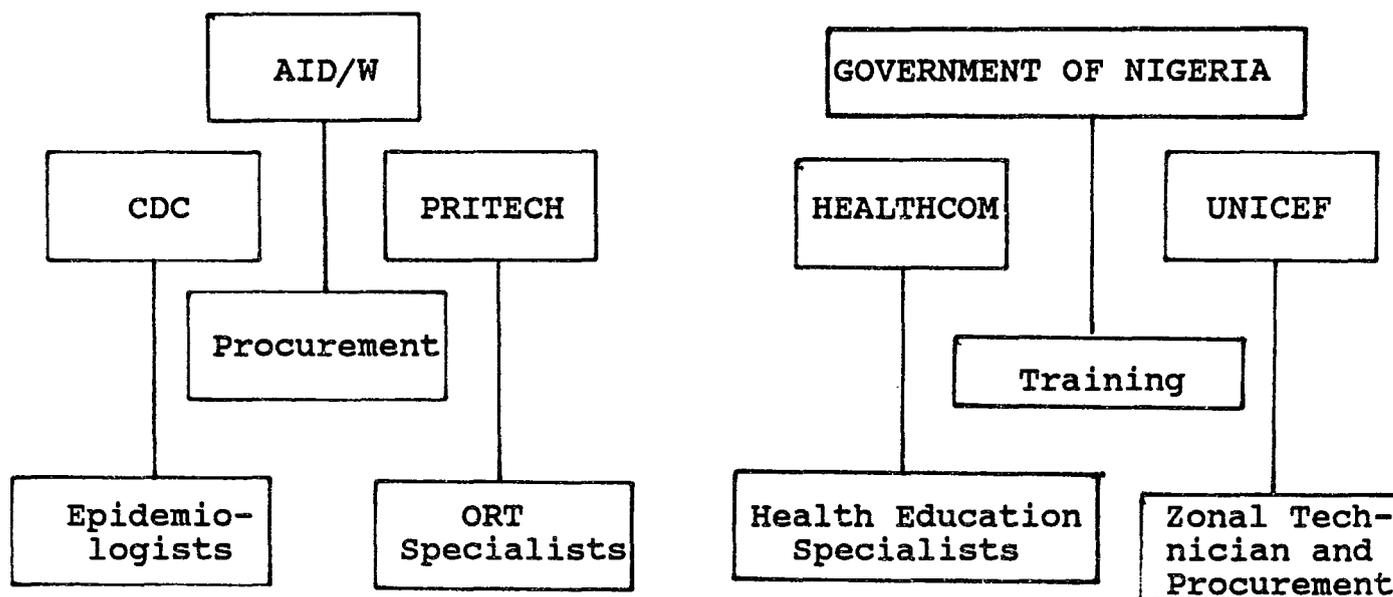
The remaining off-shore procurement, including vehicles and most of the medical supplies and equipment associated with the EPI program, will be effected by UNICEF. The actual procurement will be handled by UNICEF headquarters in New York on the basis of instructions from UNICEF/Nigeria. Payment vouchers will be submitted directly from New York to Washington and approved by the CCCD/project manager. The reason for delegating this procurement to UNICEF is that UNICEF has more experience than any other organization in the procurement of medical supplies for developing countries. In Nigeria, UNICEF is already acting as the procurement agent for medical supplies for most of the states and will, in 1986, begin to act as the procurement agent for the federal government for all vaccines. (A description of UNICEF's capacity in this regard is provided in Chapter V.)

Coordination of Inputs

The foregoing arrangements for TA recruitment and support, management of training activities, and commodity procurement are not neat and tidy, but represent a balance of competing consider-

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ations of management efficiency, technical expertise and cost. Perhaps the largest potential problem with these arrangements is the potential for loose, even non-existent coordination of inputs. As so far described and as depicted below, management arrangements are acephalous, with separate entities responsible for relatively independent management of program activities.



This arrangement is clearly unsatisfactory since it provides for no coordination of inputs and activities among the various sectors. In Nigeria, some mechanism must be found to ensure day-to-day coordination of program activities. In the United States, it will be necessary to coordinate the Nigeria-specific management of the three AID centrally funded projects and to arrange a project liaison with UNICEF headquarters in New York.

In Nigeria, it is proposed that the CDC program manager, in collaboration with the Nigerian Project Director, be responsible for the coordination of all AID-financed program inputs within the country. What this means is that all long- and short-term AID-financed technicians -- whether employed through CCCD, PRITECH or HEALTHCOM -- should report directly and regularly to the program manager, that the program manager should hold regular meetings among these technicians (preferably in conjunction with Nigerian counterparts) to review progress and plan for assistance in such matters as organization of training sessions and workshops, and that requests for short-term technical assistance or major changes in technician activities (a change in geographic emphasis or target population, for example) must be cleared by the program manager. (It will not be possible for the CDC program manager to have the same supervisory responsibilities

over the UNICEF Associate Expert since this would encroach on UNICEF's direct authority. However, as will be described below, it is proposed that a formal liaison with UNICEF be established in the United States.)

For all matters relating to policy and program coordination in Nigeria, the CDC program manager should report directly to the AID affairs office in Lagos which should assume the responsibility of assuring that project activities adhere to USAID country strategy for Nigeria. As it happens, the two current USAID/Nigeria direct hire employees are both health professionals, so are well qualified to monitor the program from a technical point of view.

A principal responsibility of the CDC program manager should be to maintain regular contact with those persons within CCCD (CDC), PRITECH, and HEALTHCOM designated as project coordinators for Nigeria. The role of the project coordinator in each organization should be to facilitate requests (for example, for short-term technical assistance) coming from the program manager. The contact between the AID program manager and the project coordinators can be maintained through AID cable or commercial telex. In addition, the CDC program manager should be responsible for preparing a quarterly progress report to be submitted to the CCCD project manager in AID/Washington who will disseminate the report to the AID/W PRITECH, and HEALTHCOM project managers and to UNICEF/New York.

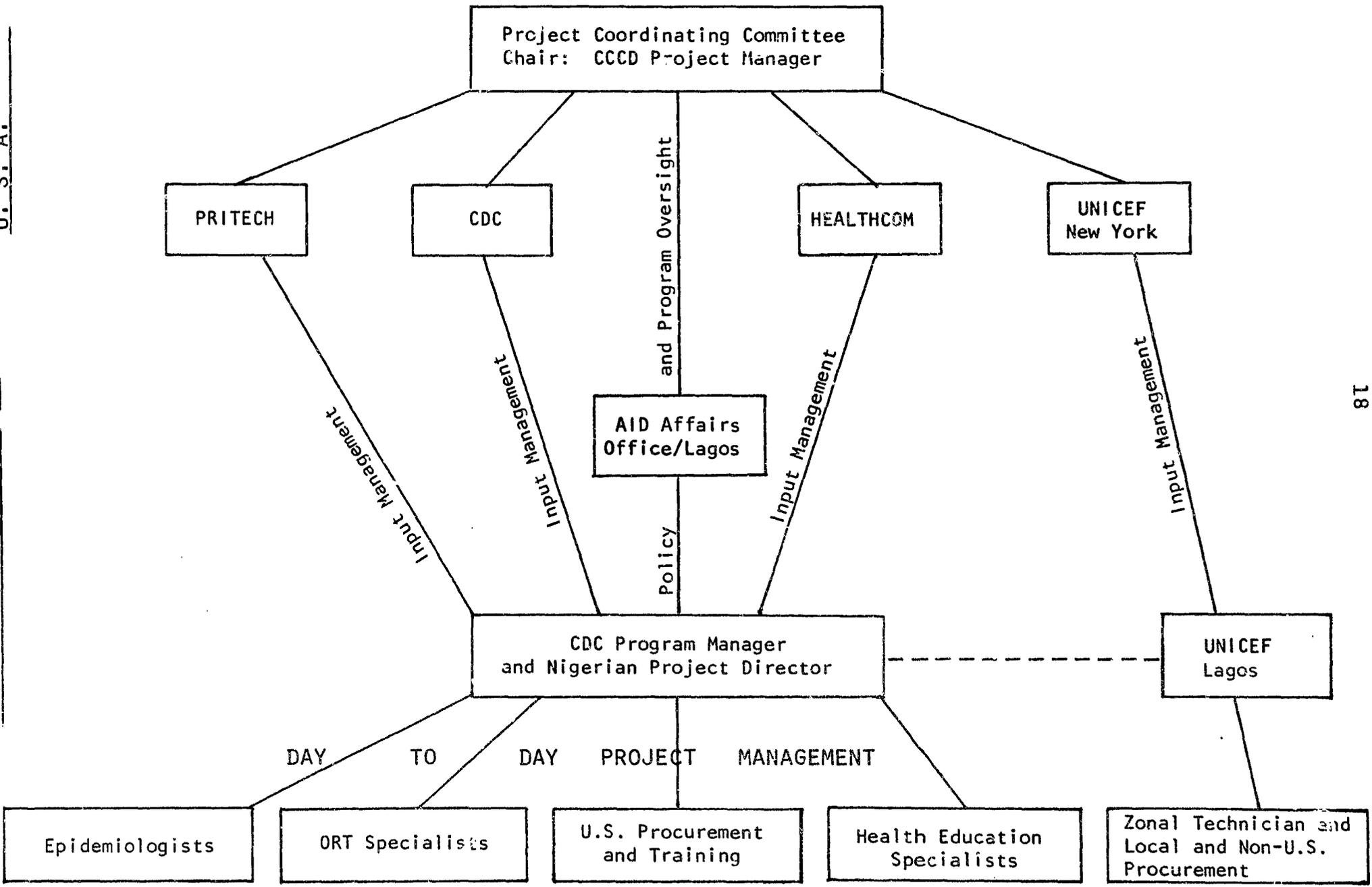
In the United States it is proposed that a CCCD/Nigeria Coordinating Committee be established composed of the project managers of the AID centrally funded projects and a person to be named by UNICEF in New York. The permanent chair of this committee should be the CCCD project manager. Regular quarterly meetings of this committee should be held to review project progress as reflected in reports from the CDC project manager, to program inputs for the next quarter, and to make whatever adjustments in the program in response to problems that arise during implementation. At least one of these quarterly meetings should be held in Nigeria to give the Coordinating Committee members a chance to meet with Nigerian personnel involved in the project as well as with the AID-financed technicians. The committee chair should convene meetings more frequently if the need arises.

These arrangements would create a project management structure depicted on the following page.

PROPOSED MANAGEMENT STRUCTURE FOR
THE CCCD PROGRAM IN NIGERIA

U. S. A.

N I G E R I A



IV. PROGRAM MANAGEMENT AT THREE LEVELS OF GOVERNMENT IN NIGERIA

Relative to other developing countries, Nigeria has well organized and well operated health care delivery systems. Primary Health Care (PHC) policies are well articulated and PHC programs such as EPI are well planned. Weaknesses crop up in the actual implementation of programs and, especially, in coordination for planning and implementation among levels of government. In general, however, the states and LGAs have adequate facilities (hospitals, clinics, maternities) and sufficient staff to carry out the programs that have been adopted at the federal level of government.

For these reasons, the strategy adopted by the CCCD program in Nigeria is to assist the various levels of government in carrying out already adopted PHC programs using existing facilities. No new programs and no new facilities are seen as necessary. Rather, CCCD/Nigeria has identified certain discrete areas in which the U.S. government can assist the GON in implementing its PHC program. These areas include funding for certain commodities and training and technical assistance in such areas as health information systems (HIS), operations research, and health education.

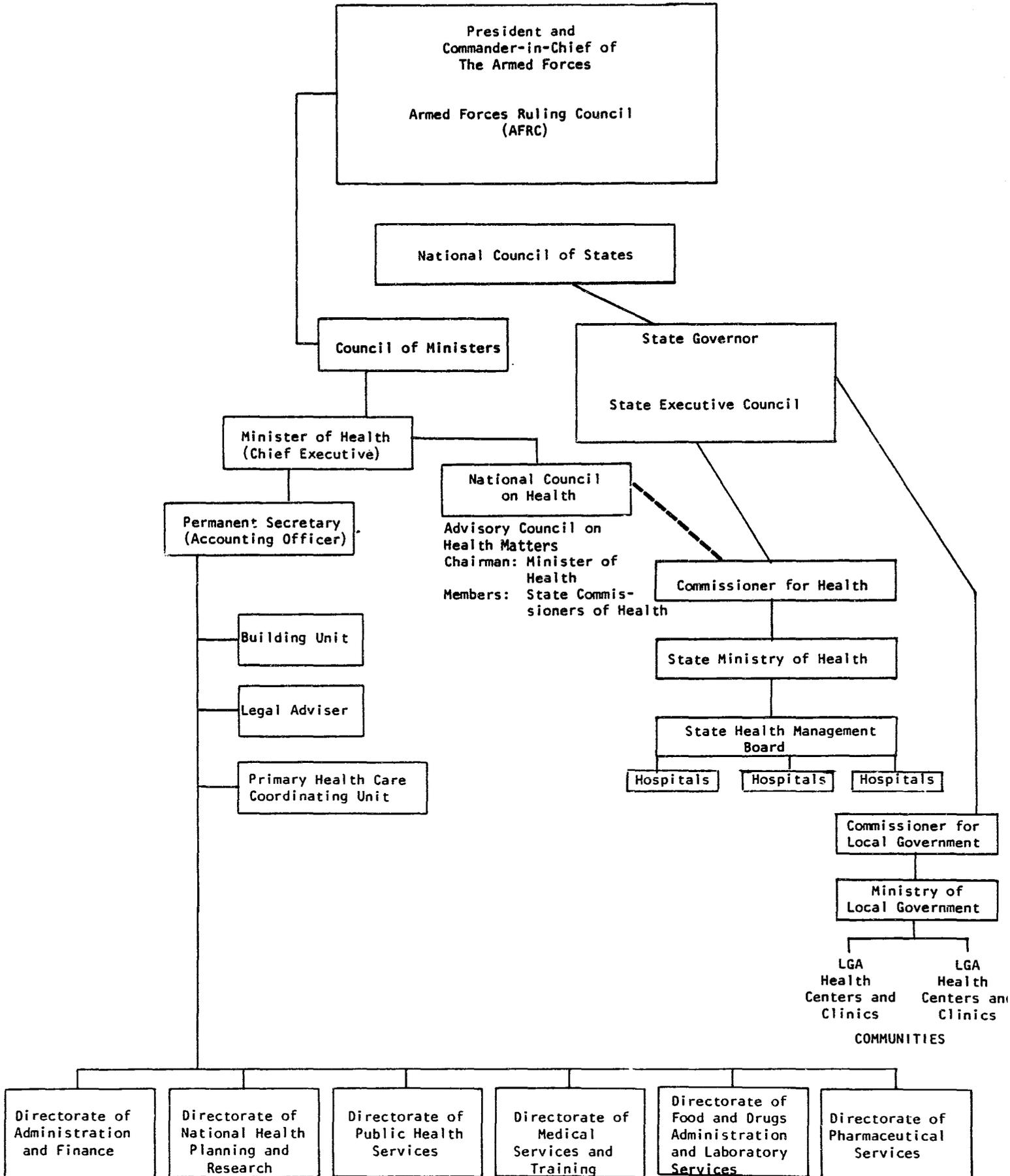
With a population of 100 million, Nigeria is by far the most populous country in Africa. It is also unique on the African continent in that it has a federal form of government composed of a federal government, nineteen state governments plus the capital territory, and 304 Local Government Areas. This Chapter provides a brief description of the capacity of the GON at the various levels of government to manage the CCCD program.

Federal Ministry of Health

The Federal Ministry of Health manages a handful of teaching hospitals, but otherwise has no responsibility for the administration of health care services at the level of the patient or beneficiary. Rather, the federal ministry is responsible for the development of national health care policies, for the standardization of training of health care practitioners, for budgeting and allocation of funds to state and LGA implementing agencies, for the procurement of vaccines, and for program monitoring and evaluation.

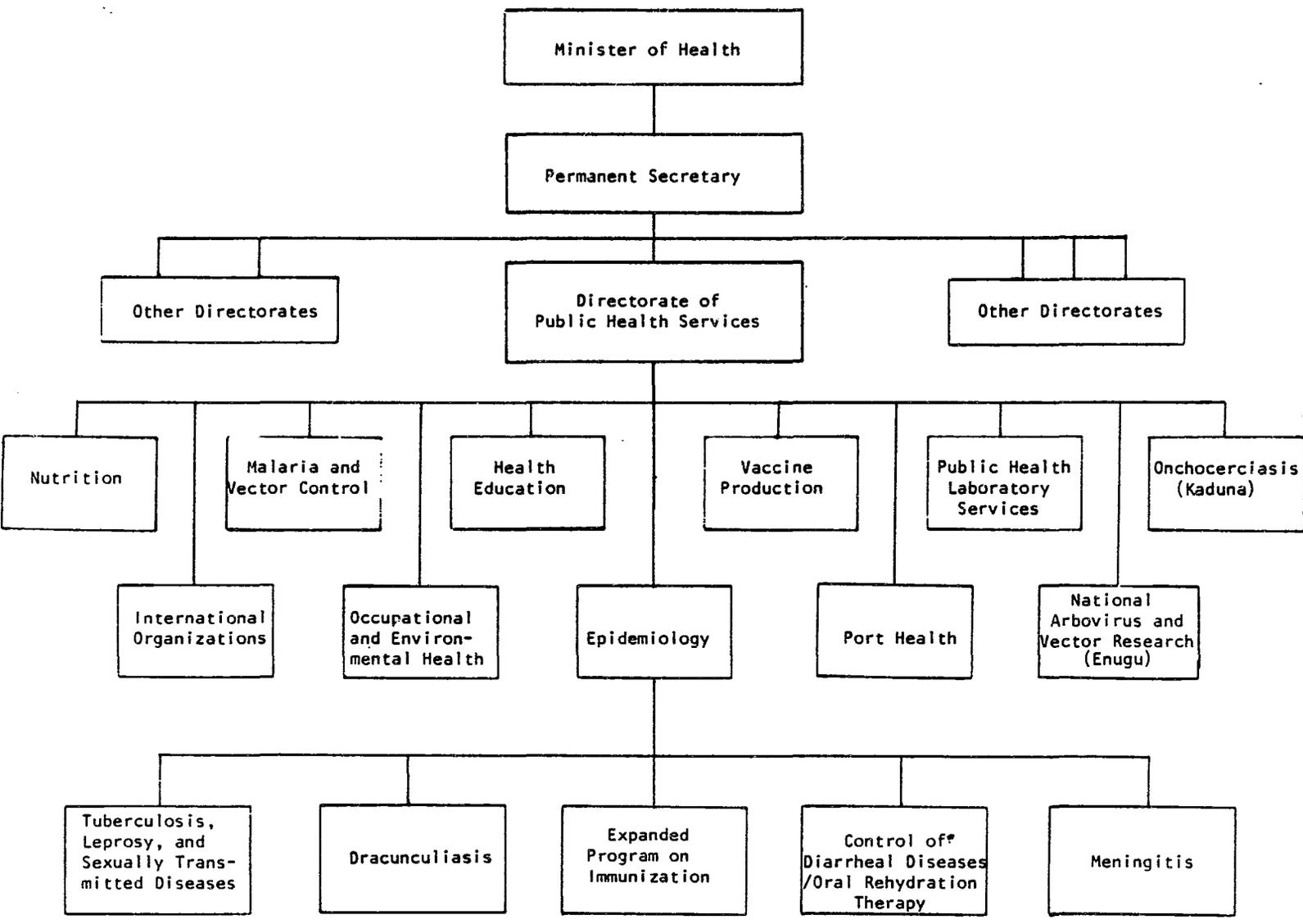
As shown in Figure 1, the federal ministry is organized into six directorates and a primary health care coordinating unit all reporting to the Minister through a permanent secretary. For the purposes of the CCCD program, the most important of these directorates is the directorate of public health services, the internal organization of which is shown in Figure 2. The total number of staff in the Directorate of Public Health Services is 835 of which 501 are at the senior and junior professional level.

FIGURE 1
FEDERAL MINISTRY OF HEALTH
ORGANIZATION CHART



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FIGURE 2
FEDERAL MINISTRY OF HEALTH -- NIGERIA
DIRECTORATE OF PUBLIC HEALTH SERVICES
ORGANIZATION CHART



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Within the Directorate of Public Health Services, two divisions figure prominently in the CCCD program. One is the health education division to which the two health education advisors will be assigned. At present, the health education division has 66 staff, 27 at the senior or junior professional level, including three doctors. The division contains four units -- school health education, community health education, training, research and evaluation, and communications. The basic responsibility of the division is to assist state health education agencies plan community health education activities, prepare community health messages, and develop health education materials. Although the staff of the unit appears adequate in terms of numbers, there are certain critical gaps in terms of training; no one in the unit, for example, has any formal training in the use of the mass media for health education. In addition, the plan of the division to place staff in the recently created zonal Primary Health Care offices is at least temporarily blocked by the federal government hiring freeze.

The other division within the Directorate of Public Health Services that is important for the CCCD program is the Epidemiology Division. As shown in Figure 2, the Epidemiology Division contains four units, including a unit consecrated solely to the Expanded Program on Immunization and another occupied solely with control of diarrheal diseases and oral rehydration therapy. Both of these units are directed by medical doctors as is the Division itself. Altogether the Division has 71 staff, 32 of which are at the senior or junior professional level, including seven doctors.

The Division is responsible for national planning and coordination of all epidemiologic activities including immunization campaigns and the procurement and distribution of vaccines and oral rehydration solution (ORS) ingredients. As shown in Table 1, a total of 2 million Naira has been allocated both in 1985 and 1986 through the Ministry's capital budget for the procurement of vaccines for EPI. To assist with these efforts, the CDC program manager will become the counterpart to the director of the Division who will become the Nigerian CCCD project director. The PRITECH/ORT advisor will be assigned to the CDD/ORT unit within the Division and will assist in the planning of national ORT policy and in ORT training in the states and LGAs. (It should be noted that a UNICEF staff member is already assigned full-time to the EPI unit to carry out similar functions.)

The staff and facilities for most other primary health care functions are located at the state and LGA levels. As such, the exact functions of the Primary Health Care Coordinating Unit (see Figure 1) are not clear. However, this unit may assume increased importance as the PHC zones (see Figure 3) become more fully staffed and operational since the zonal offices will basically operate as field units of the federal ministry.

TABLE 1

FEDERAL MINISTRY OF HEALTH -- NIGERIA
WITH DETAILS ON PROJECT-RELATED ITEMS

Capital Budget,
(in naira) ^{a/}

<u>Item</u>	<u>1985</u>	<u>1986</u>
Control of Communicable Diseases (vaccines)	2,000,000	2,000,000
National Malaria Control Program	150,000	400,000
National Institute for Production of Vaccines and Biological Substances	800,000	1,000,000
Federal Medical Store and Cold Room, Lagos, Port Harcourt, Kano, and Kaduna	50,000	1,000,000
All Other	<u>53,388,145</u>	<u>76,800,000</u>
Total	56,388,145	81,200,000

a/ 1 naira = 1 U.S. dollar

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FIGURE 3

PROPOSED PRIMARY HEALTH CARE ZONES

Federal Ministry of Health -- Nigeria

Zone	States	Number of LGAs ^{a/}
A	Benue	13
	Anambra	23
	Cross River	17
	Imo	21
	Rivers	11
B	Lagos	8
	Bendel	19
	Ondo	17
	Ogun	10
	Oyo	24
C	Kaduna	14
	Sokoto	19
	Niger	9
	Kwara	12
	Abuja	2
D	Kano	20
	Bauchi	16
	Borno	18
	Plateau	14
	Gongola	17

^{a/} LGA = Local Government Authority

State Ministries and Health Boards

Each of the 19 states has its own Ministry of Health which is responsible for policy and planning at the state level and each also has a State Health Board which is responsible for the administration of all health facilities, curative as well as preventive, at the state level. The relationship between the state and the health boards appears to vary from state to state. In most states, the health boards are fairly autonomous, but in others are run as agencies of the ministry. In Ogun State, the Health Board is said to be autonomous, but the chairman of the Health Board is the State Commissioner (Minister) of Health.

Organization for health care also varies from state to state. In Ogun state the Ministry has divided the state into four zones, each with a zonal coordinator who is administratively in charge of all facilities in that zone, including district and community hospitals and comprehensive and family health care centers. The EPI campaign in 1985, however, was run directly out of the Ministry (see Figure 4) perhaps because, consonant with national guidelines; 1985 was to be the first intensive year of the Revised EPI program targeting capital LGAs in each state.

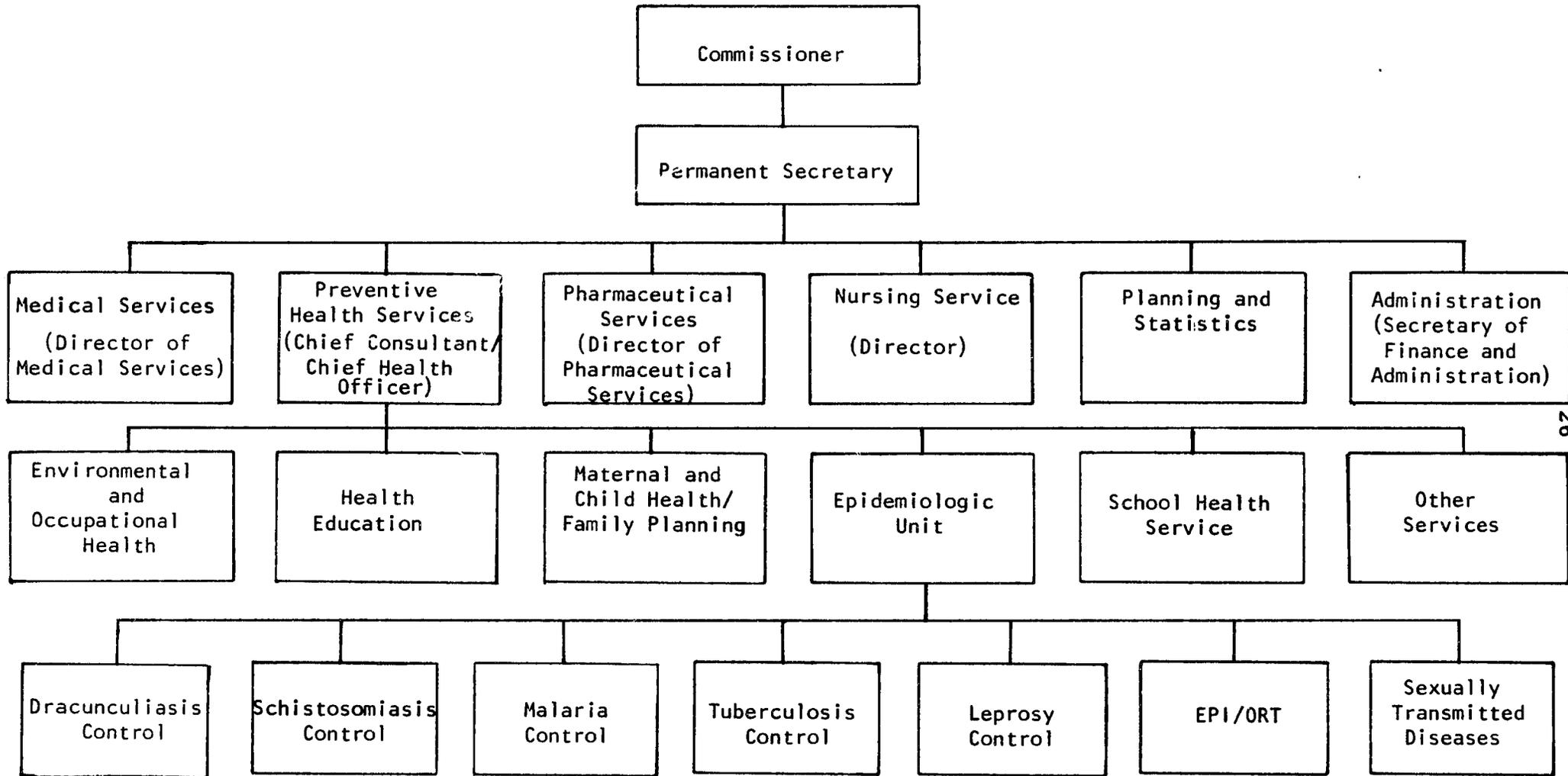
The facilities and record keeping of the EPI campaign in Ogun state (targeting Abeokuta LGA) are impressive. The central cold room at the Ministry is impeccably organized with detailed and accurate records of vaccine arrivals, storage temperatures (twice daily), and vaccine deliveries. Within the LGA, there are 21 immunization sites, mostly at maternities. The statistics office keeps detailed records on immunizations at each of these facilities and has also carried out surveys of defaulters to determine why some mothers failed to return for the second or third dose of polio vaccine or D.P.T.

Achievements in Ogun State, however, are less impressive. Despite the intensive campaign in 1985, coverage of under two year olds in Abeokuta LGA for B.C.G. was only 35.8 percent, for the third dose of polio and D.P.T. only 21.9 percent, and for measles only 16.8 percent. These figures are all below the national averages for all nineteen states.

One of the reasons for the low coverage in Abeokuta LGA may have stemmed from the policy of the state virtually bypassing the LGA itself in the EPI campaign. Planning for the immunization schedule and for the delivery of vaccines was organized entirely by the Ministry although the actual immunizations were carried out mostly in LGA facilities (maternities). On the day that immunizations occurred in a particular facility, Ministry staff brought the vaccines to the facility, supervised the immunizations, kept the records, and returned to the state cold room with unused vaccines at the end of the day. No vaccines were allowed to be stored in the LGA facilities which meant that any mothers

FIGURE 4

OGUN STATE MINISTRY OF HEALTH ORGANIZATION CHART
WITH DETAILS ON PREVENTIVE HEALTH AND EPIDEMIOLOGY



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who missed that day would have to wait until the next date. It would seem clear that there is room for a project like CCCD to help states and LGAs improve coverage through improved planning, coordination and social marketing.

Another area in which assistance is needed is in funding for commodities and equipment such as syringes, needles and vehicles. State governments, which are responsible for the procurement of these items, can and do raise their own revenues, but are, nevertheless, heavily dependent on federal allocations to meet their budget obligations. With the current economic crisis in Nigeria (provoked by falling oil prices), the federal government has been unable to increase its allocations commensurate with inflation (which is currently at about 20 percent). As shown in Table 2, the federal allocation to Ogun State in 1985 represented only 46 percent of recurrent revenue whereas in 1983, it represented 80 percent.

The example from Ogun State (Table 3) shows that state budgets -- both capital and recurrent -- contain separate provisions for preventive health and epidemiology. However, according to officials in Ogun state, the release of these funds is often dependent on the effectiveness of petitioning from the units involved to the State Ministry of Finance since the actual amounts of money available are frequently less than reflected in the budget.

Local Government Authorities

Local Government Authorities are responsible for operating the small facilities -- clinics, maternities, and dispensaries -- that make up the largest number of primary health care facilities in Nigeria. The staff of these facilities -- community health officers, dispensary assistants, midwives -- are the persons that have the most frequent contact with the mothers and children that are the targets of the CCCD program. As such they represent the primary target population for training in such areas as social marketing, health education, and health information systems. In Abeokuta LGA, Ogun State, 16 of the 21 facilities used for the EPI program in 1985 were LGA facilities (although, as mentioned, above, LGA staff were not sufficiently involved in the planning and coordination of the program.)

LGAs have their own sources of revenue. However, as shown in the example from Abeokuta LGA, (Table 4), LGAs receive more than half of their revenues from state and federal allocations. Of the Naira 12 million in the 1986 budget for Abeokuta LGA, Naira 1.3 million was allocated for health.

LGAs also have their own civil service. Before the most recent military coup d'etat in Nigeria, the head of the LGA was elected but is now appointed by the state governor. Abeokuta LGA has a total of 657 staff of which 321 work in the health sector.

TABLE 2

OGUN STATE - NIGERIA
SUMMARY OF RECURRENT REVENUE
1983-1985

(naira 000) ^{a/}

<u>Source of Revenue</u>	<u>1985 (est.)</u>	<u>1984 (approved est.)</u>	<u>1983 actual</u>
Taxes	72,760	54,512	21,751
Fines and Fees	6,098	7,197	2,410
Licenses	276	244	96
Earnings	12,441	7,832	1,476
Rent on Government Property	708	8,245	123
Interest, Repayments, and Dividends	21,390	14,490	439
Reimbursements	18,207	18,838	462
Miscellaneous	1,022	1,021	-
Allocation from Federal Government	<u>111,187</u>	<u>109,998</u>	<u>106,000</u>
TOTAL	244,089	222,377	132,757

^{a/} 1 naira = 1 U.S. dollar

TABLE 3

OGUN STATE - NIGERIA
CAPITAL BUDGET - 1985
WITH DETAILS ON HEALTH LINE ITEMS
(naira) a/

<u>Item</u>	<u>Amount</u>
State Health Board	3,367,300
Ministry of Health	6,588,500
of which Preventive Health	1,000
Other Ministries	<u>77,869,735</u>
TOTAL	87,825,535

RECURRENT BUDGET - 1985
WITH DETAILS ON HEALTH LINE ITEMS
(naira) a/

<u>Item</u>	<u>Amount</u>
State Health Board	19,434,400
Ministry of Health	12,326,482
of which Preventive Health	3,900
Epidemiology Unit	7,300
Other Ministries	<u>212,327,745</u>
TOTAL	244,088,627

a/ 1 naira = 1 U.S. dollar

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TABLE 4

ABEOKUTA LOCAL GOVERNMENT AUTHORITY
OGUN STATE -- NIGERIA

REVENUE ESTIMATES 1984-1986
(naira 000) ^{a/}

<u>Item</u>	<u>1986</u>	<u>1985</u>	<u>1984</u>
Rates	550	900	397
Licenses, Fees, and Fines	832	593	483
Earnings from Commercial Undertakings	876	836	507
Rents	18	16	16
Interest, Payments and Dividends	15	8	9
Grants	.03	--	--
Miscellaneous	<u>49</u>	<u>37</u>	<u>39</u>
Total Internal	2,340	2,390	1,451
Allocation from Federal Government	6,244		
Allocation from State Government	1,451		
External Loan	<u>2,000</u>		
TOTAL	12,035		

a/ 1 naira = 1 U.S. dollar

V. MANAGEMENT CAPACITY OF UNICEF

The UNICEF Program in Nigeria

The United Nations Children's Fund has assumed a leadership role among international organizations in Nigeria in the field of child health and child survival. Prior to 1984, the UNICEF program reflected a balance of efforts in the field of primary education and primary health care. However, beginning in 1984 a decision was taken to increase significantly the focus of program assistance toward actions with a direct impact on child mortality. For the period 1986-1990, the GON and UNICEF have agreed that priority should be given to interventions affecting infants between the prenatal period and two years old, and that the UNICEF program should focus on malaria, child and maternal malnutrition and under-nutrition, diarrheal diseases, measles, acute respiratory infection, neonatal tetanus, pertussis, and tuberculosis. These problems correspond closely to the focus of the CCCD program in Nigeria.

To pursue this policy, the strategy adopted by UNICEF and the GON was to begin all program assistance at the community level in selected rural areas so as to build workable models for national replication. To this end, the centerpieces of the UNICEF program in Nigeria are:

- A model EPI project in Owo LGA in Ondo State that increased immunization coverage of under two year olds from under nine to over 80 percent in less than one year. On the basis of this success, the GON launched the Revised Expanded Programme on Immunization that covered 100 LGAs in 1985.
- A model ORT demonstration unit at Massey Street Children's Hospital in Lagos the success of which led to the adoption of ORT as a national health priority.
- A model water and sanitation project in Imo State that has been adapted and expanded to Gongola and Kwara States.

With respect to EPI, the UNICEF/GON objective is, by 1990, to immunize 85 percent of Nigerian children 0-24 months old against the six EPI diseases (tuberculosis, diphtheria, pertussis, tetanus, polio and measles), and 85 percent of pregnant women with tetanus toxoid. With respect to control of diarrheal disease, the objective is to provide ORT to 80 percent of diarrheal cases by 1990. To achieve these objectives, UNICEF plans to assist the GON with commodity procurement, training at federal, state and LGA levels, community mobilization and public education, and strengthening planning, monitoring and evaluation capacities throughout the system.

UNICEF Staffing and Financing

Currently, UNICEF has a total of 79 employees in Nigeria. Of these, 28 can be classified as health or, more generally, development professionals. Half of these professionals are currently posted or soon will be posted to areas outside Lagos. Recruitment is underway to fill another seven to ten field positions. These field staff, to include epidemiologists, scientific officers, and ORT consultants, will be assigned mainly to the GON PHC zonal offices. A UNICEF epidemiologist is already assigned full-time to the EPI unit of the epidemiology division in the federal Ministry of Health.

To complement the UNICEF field staff, an agreement has been reached for CCCD/Nigeria to second a technical officer to UNICEF who will be engaged as an "associate expert" for a period of five years. CCCD would pay the technical officer's salary while UNICEF would provide housing and other in-country support. This arrangement entails substantial cost savings in that UNICEF is able to provide housing and other in-country support at considerably less cost than AID. The arrangement also has the advantage of forging a substantive link, in the person of the technical officer, between AID and UNICEF for the purposes of the the CCCD program in Nigeria. One disadvantage of the arrangement is that the associate expert would be subject entirely to UNICEF, rather than CCCD, administrative and technical supervision. However, since the objectives of the UNICEF program, as discussed above, and that of CCCD are virtually identical and since the relationship between UNICEF/Nigeria and AID/Nigeria is one of professional respect and collegiality, the dissipation of AID/CCCD control over the associate expert should not create insuperable problems.

The UNICEF/Nigeria budget for the next five years (Table 5) commits about US\$ 6 million per year to the Nigeria program. Of this amount one-third is for the EPI program, 11 percent for ORT and most of the remainder for complementary efforts in health education, and planning, operations research, monitoring and evaluation.

In addition to its financial and technical support, UNICEF provides the federal and state governments with important commodity procurement services. At the state level, UNICEF has entered into an innovative agreement by which UNICEF uses its foreign exchange to procure EPI supplies and equipment for the states and the states reimburse UNICEF in Naira which UNICEF uses to pay its local administrative and operating costs. All 19 states have participated in this arrangement and, as of January 1986, 2.2 million Naira had been deposited by the states in the UNICEF account in Lagos. At the federal level, UNICEF will, in 1986, act as the procurement agent for the Ministry of Health for national vaccine procurement; the value of this procurement will

TABLE 5

SUMMARY OF UNICEF INPUTS FOR PROGRAMME COOPERATION
IN NIGERIA 1986 -- 1990 (US\$000s)

PROGRAMME COMPONENTS	<u>1986</u>	<u>1987</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>TOTAL</u>	<u>%</u>
Expanded Programme on Immunization	1956	1989	2180	1910	2040	10075	33
Oral Rehydration Therapy Promotion	746	800	700	550	440	3236	11
Rural Water and Sanitation	2000	1750	1750	1500	1500	8500	27
Integrated Community Health and Development	206	552	550	1120	1453	3881	13
National Mobilization and Education	337	378	500	550	400	2165	7
Planning, Operational Research, Monitoring and Evaluation	204	224	220	297	292	1237	4
Contingency	83	116	200	478	600	1477	5
TAD Ceilings	5532	5809	6100	6405	6725	30571	100
f) Development of a Network of Educational Resource Centres							
g) Support for Training in Primary health Care.							
h) Support for Nutrition Programmes							
i) Support for the Development Support Communication Unit							
j) Development of a Local Government Information System							

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be about US\$2 million. It is primarily because of UNICEF's expertise and experience in health commodity procurement that the CCCD program in Nigeria has chosen to carry out the bulk of the program's local and non-U.S. off-shore procurement.

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