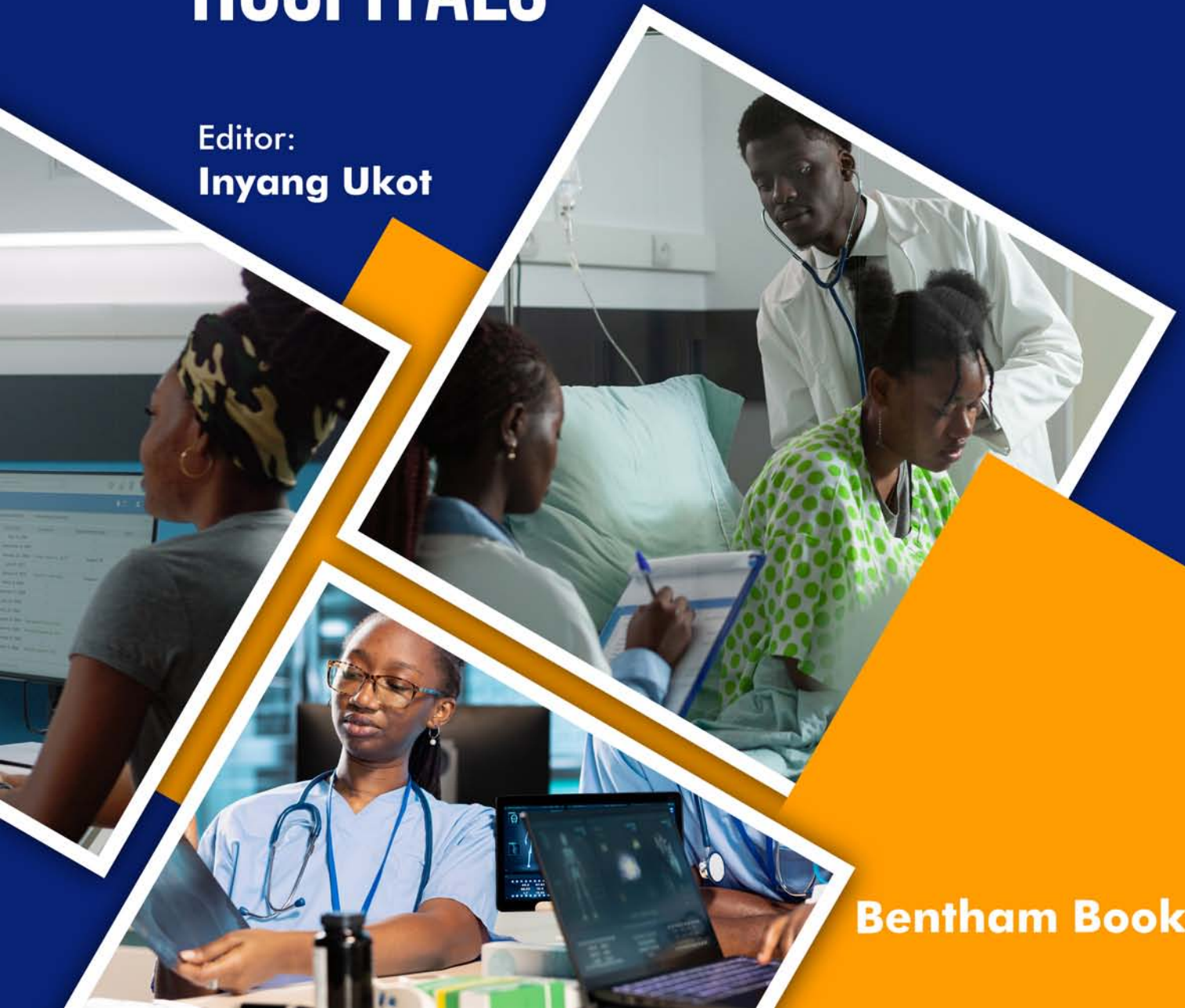


FUNCTIONALITY AND EFFICIENT SERVICES DELIVERY IN NIGERIAN HOSPITALS

Editor:
Inyang Ukot



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Functionality and Efficient Services Delivery in Nigerian Hospitals

Edited by

Inyang Ukot

RST Clinics Ltd.

Federal Housing Estate

Uyo, Akwa Ibom State, Nigeria

Functionality and Efficient Services Delivery in Nigerian Hospitals

Editor: Inyang Ukot

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FOREWORD

Dr. Inyang Ukot graduated from the College of Medicine of the University of Lagos, Nigeria, with a Bachelor of Medicine and Bachelor of Surgery (MB, BS) in 1981. He completed a residency in Family Medicine and is a Fellow in Family Medicine of the National Postgraduate Medical College of Nigeria (1991) and the West African College of Physicians (1995). He obtained the postgraduate Diploma in Occupational Medicine from the Royal College of Physicians of London in 2005. He was the coordinator of training in Family Medicine at the National Postgraduate Medical College of Nigeria between 1995 and 1999.

Dr. Inyang Ukot has extensive experience as a family medicine specialist and first contact specialist in the health care system, a career spanning about 40 years in Nigeria. This extensive experience and exposure covered health care systems in the North, South, East and West of Nigeria, a highly populated developing nation in Sub-Saharan Africa. In the first year of his career, Inyang worked in Eku Baptist Hospital, located in a rural area in the South-South part of Nigeria; and during his year of compulsory service (NYSC) in Nigeria, he worked in a State government secondary care medical facility in Birnin-Gwari in the North-Central part of Nigeria. During his residency in Family Medicine, he had a stint in a Presbyterian Church hospital in the South-South part of Nigeria, NKST Church hospital and two Catholic Church hospitals in Benue State (North-Central part of Nigeria). Dr Inyang Ukot was the first family physician to head the General Outpatients' Department of the University of Port Harcourt Teaching Hospital in the capital city of the oil-producing Rivers State in the early '90s. In the mid-nineties, he was one of the two specialists who led the medical services department of United Bank for Africa (UBA) in UBA House, Lagos Island, Lagos State. He worked in two busy, high-profile private hospitals in Ikeja, Lagos State, in the southwest of Nigeria between 1992 and 1996, and between 1998 and 2006, he was a staff physician for ExxonMobil in Nigeria.

Dr. Ukot's vast work experience covers primary, secondary, and tertiary health care and hospitals. He has worked in hospitals in rural areas, semi-urban areas, and cities in Nigeria for over 40 years. He is well aware of the details of the structure and function/malfunction of the health care system and hospitals in Nigeria. The contents of this multi-author book, with chapters authored by well-chosen specialists are a valuable resource for current and prospective foreign and local investors in healthcare, proprietors, professionals, policymakers, regulators of medical training and practice, and patients in any setting in any developing country. He commenced the writing of his first book in medicine one year after completing his postgraduate training in Family Medicine, a writing career with publishing dates in 1996 and 2023. Many medical students have benefited from his MCQ book.

Inyang is, therefore, well experienced in writing **Functionality and Efficient Services Delivery in Nigerian Hospitals**, a book I recommend to all stakeholders in the Nigerian healthcare system and other sub-Saharan countries.

Emmanuel Monjok
Primary care and Community Medicine
University of Calabar and University of Calabar Teaching hospital
Calabar, Nigeria

PREFACE

Functionality and Efficient Services Delivery in Nigerian Hospitals arose from the author's observations during his over-forty-years medical practice, which covers the north, south, east, and west of Nigeria. The summary of the observations is that while there have been remarkable improvements and advancement in almost every segment of their societies, the advancement in medical facilities and medical services in Nigeria and many developing countries has lagged significantly – and the degree of dropping back in comparison with the status in the advanced countries seems that there is no hope of catching up unless Nigeria and similar countries make a definite and deliberate attempt at addressing this sore thumb. Dr. Ukot and his team believe that this situation can be resolved and that is why they joined hands to pen this book in a way that is easy to read and understand its contents and implement the suggestions it proffers; this is because of its deliberate a small volume that makes this work “friendly” enough for every reader to read in its entirety. This book is a combination of “saying it as it is” and “crying and hoping to be heard” while keeping in mind the beneficiaries of the goings on in our hospitals – the patients and the employees.

The title of this book, Functionality and Efficient Services Delivery in Nigerian Hospitals, is specific and the book limits itself to that. This book intends to cover, and therefore only deals with, the area of the goings-on in medical facilities and the various influences or factors that determine the structure, function, and clientele of hospitals in developing countries using Nigeria as the prototype.

In this book, the word “Hospital” encompasses facilities as small as health posts and health centers and large ones like tertiary hospitals, of which teaching hospitals are good examples. It is difficult to write on even the teaching hospitals in Nigeria as they belong to different “generations” in terms of age, equipment profile, staff strength, land and facility sizes, level and structure of personnel, administrative focus and style, and the peculiarities and diversity of the patients and third parties that patronize the hospitals. It was, consequently, very difficult to choose the four hospitals whose stories are told in this book – two of them are teaching hospitals and the other two are private hospitals. Of the two teaching hospitals, one is a Federal government-owned hospital, while the other is owned and run by a Christian Mission. With reference to the private hospitals, one is a medium-sized hospital, while the other is a small hospital. Each of them has an interesting story and they provide us with examples of making things work in similar existing or future hospitals. It was not difficult to choose some of the authors because they readily saw the need for the project when they were approached; it was difficult to eventually obtain consent to write from others as many declined due to time constraints in writing to meet deadlines. The completed work reflects the original intention and it is hoped that this work will be of assistance to every reader as it has a message for everyone.

Inyang Ukot
RST Clinics Ltd.
Federal Housing Estate
Uyo, Akwa Ibom State, Nigeria

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When I approached the co-authors of this book, I was not certain that they would buy the idea considering the fact that the book is neither a novel nor a medical textbook; moreover, some of them are specialists in areas that are outside medicine. To my surprise, and their credit, they all agreed to contribute to this peculiar book. I am grateful to them for carving out time out of their busy schedules to enrich this work. The book has turned out to be a well-woven material that will benefit healthcare services delivery by managers/operators and the various professionals in medical facilities in Nigeria.

Being the Ultimate, I acknowledge God for providing the idea, good health and fortitude that enabled me not only to conceive this work but also to start the writing, coordination and organization of chapter contributions and eventual production of this book – overcoming the numerous challenges in between.

DEDICATION

To our immediate family members who have supported us in our professional and personal endeavors, our colleagues with whom we have grown over the years, our mentees who have accepted and benefited from the impartations from us, and our numerous patients to whom we have committed our best although we may not have saved all.

INTRODUCTION

Abstract: Hospitals are a key component of the system for health care delivery in any country. In Nigeria and other developing parts of the world, it is not different. Hospitals may be seen as the last part of a chain or cascade of institutions that are established to provide appropriate services for the well and the ill. “The well” is mentioned before “the ill” because until the populace, healthcare system designers, and operators remember or factor in this fact, we shall continue to be inundated with people with illness rather than prevent illness and promote health. When there is a combination of illness prevention and health promotion, service providers, hospital facilities, equipment, and consumables do not get overstretched.

The starting point in the healthcare delivery system appears to be imprecise. This author thinks that it could be the point of entry into medical schools and other schools that prepare and produce the wide variety of professionals we find in hospitals – and this variety is ever-increasing in number and sub-specialization. The starting point could predate entry into the training institutions and could be taken as the ideas, plans, and actions of various policy makers.

The World Health Organization (WHO), in its Overview on Hospitals, documented that “Hospitals matter to people and often mark central points in their lives. They also matter to health systems by being instrumental in care coordination and integration. They often provide a setting for education of doctors, nurses and other health-care professionals and are a critical base for clinical research.”[1] This book chapter, although written in the form of a story, addresses, in generality, the value of the contributions of hospitals to healthcare delivery systems, to the personnel in hospitals, to the clients who patronize hospitals (patients), and to research.

There are several ways to describe or classify hospitals. The following summarizes the classes of hospitals: “Hospitals may be classified by type of service, ownership, size by number of beds, and length of stay” [2].

The European Observatory’s work on health care delivery describes health care delivery thus: “Health care delivery forms the most visible function of the health system, both to patients and the general public. It concentrates on patient flows as well as the organization and delivery of all services dealing with the diagnosis and treatment of disease or the promotion, maintenance and restoration of health. It covers the principal areas of service provision such as public health, primary care, specialized care (often divided into secondary and tertiary care), urgent and emergency care, pharmaceutical care, rehabilitation/intermediate care, long-term care, services for informal carers, palliative care, mental health care and dental care” [3].

The approach adopted for this chapter is because every type of hospital is important and the author considers the smallest and the most basic set of hospitals the “foundation” of the system of health care delivery in any part of the world. The foundation of any building determines in incredibly significant terms the viability and safety of that structure, irrespective of how fanciful or attractive it is. The chapter covers hospitals of diverse types

and levels, their locations, their operators, and their clients. It concentrates on what happens and should happen in such medical facilities.

Hospitals should not just work, but their various practitioners must cultivate and maintain a culture of continuous improvement. What and who determines that hospitals are functional and rendering efficient services? It is the quality of service delivery that determines that hospitals work, and it is the beneficiaries of the services who can rightly determine that hospitals work. There is no need for the system designers, operators, and monitors to independently conclude that their system works without getting concurring input from the beneficiaries or users of the services and facilities in hospitals.

Keywords: Client services, Design and utilities, Distribution, Federal ministry of health and social welfare, Health insurance schemes, Healthcare personnel, Healthcare sector, Hospitals, Large hospitals, Location, Medium-sized hospitals, Ministries of health, Nigerians, Professional bodies, Public perception, Regulatory bodies, Small hospitals, Training, Work relationships.

HOSPITALS

In Nigeria and other developing countries, there is a diversity of hospitals and they are briefly described.

Types – In terms of diversity, there are health posts, health clinics, maternity homes, health centers, comprehensive health centers, cottage hospitals, general hospitals, specialist hospitals, federal medical centers, and university teaching hospitals. This list may not be comprehensive but suffice it to say that their categorization can be Primary healthcare facilities, Secondary healthcare facilities, and Tertiary healthcare facilities.

Design and Utilities – Facilities management is discussed in detail in Chapter 4. However, before the management of a hospital's physical structure, furniture, furnishing, and equipment, the building must be put up. Ideally, medical facilities should be designed as hospitals and constructed to meet the purpose. This means that detailed consideration should be given to the size of the hospital, projected population it would serve, types, sizes and number of floors of the building(s), and parking space. Various sections of the hospital must be planned to make sense in terms of relationships – the location of the mortuary must certainly not be in proximity to the kitchen or out-patients' department; there should be a natural relationship between the various out-patients' departments just as a similar relationship should be established between the maternity ward, labor ward, and the operating room/theater that serves that wing of the hospital. Such "natural" relationships should be seen in every large hospital and, therefore, be established at the design stage. Minute details must be paid to the walls, roofing, floors, doors, windows, ventilation, lighting, water supply, drainage, signage, ease of access and movement, refuse and sewage disposal, and other considerations. Safety and security considerations must be built into the structure just as provision should be made for expansion if the need arises in the future. Since everything must be factored in and designed to meet the standards of a hospital, it is certainly not good to hurriedly put up a hospital building or building complex; neither is it good practice to use "converted" buildings as hospitals or clinics. It is because of such conversion that a number of hospitals do not have patients' drop-off zones with ramps or ease of use of wheelchairs and

trolleys. Some large and busy hospitals do not even have dedicated entry and exit points for in-house and external ambulances to bring in patients and depart with ease. A well-conceived and satisfactorily-constructed hospital facility will have enough space within and outside to meet the needs of its patients, personnel, and third-party service providers. Green areas should be incorporated into the plan of hospitals.

A hospital must have a continuous water supply even if it does not have a continuous electricity supply – having both is ideal, and all developing countries should strive to make these available for their hospitals. In countries where health is taken as a priority indeed, continuous electric power and water supply are sine-qua-non.

Effective maintenance must be built into every hospital or there will be a predictably rapid deterioration of the facility.

Distribution and location – Using Nigeria as not only an example but also a reference, in terms of number, a cursory observation is that where most people reside is sometimes where there are the least number of functional hospitals. This statement sounds incredible at face value when one considers that University Teaching Hospitals located in either State capitals or major cities attend to a lot of patients on a daily basis. If a pregnant woman in a remote part of a state is in obstructed labor and cannot get attention in any nearby hospital and eventually has Cesarean section or instrumental delivery of a stillborn (or both mother and baby die), will the immediate family members count the clinics, medical centers, or general hospitals that they bypassed to get to the nearest Teaching Hospital to receive belated service as hospitals? They ordinarily should not.

For hospitals in Nigeria to demonstrate functionality, deliver efficient services to their clients, and exhibit continuous improvement they may not be evenly distributed but must be well distributed (appropriately distributed) in the entire country. The distribution should be based not only on population but also on proximity to current and prospective end-users in terms of time and space. It is counter-intuitive and improper to site a “big hospital” in a small community like a village just because of political considerations; this could be because the State governor, a senator, or some other politically relevant individual is from that community. Locating a medical facility such that it is isolated from the nearest referral medical facility could be counter-productive. Good intentions aside, that facility is subject to failure if utilities and facilities like public electricity, water, reliable telecommunication, roads, vehicular traffic, fuel stations, and rail systems are not available to readily link their patients who need a referral from the referring center to a referral center.

It defeats the purpose of a hospital for relevant authorities to approve a clinic or hospital to be sited within a shopping complex or business plaza just because such places receive and serve many people daily. It will not serve the intended purpose if a hospital is situated in a congested area such that the hospital does not have adequate car parking grounds for staff and patients. It is also not fair or appropriate to allow hospitals to be sited close to a flood-prone area, landfill, refuse dump site, abattoir, bus station, quarry, or erosion site.

Small hospitals – Small hospitals need not have all the features of large hospitals. They must be designed and equipped to render the services they intended to and are approved to provide and stick to them – or expand appropriately to add other services. One problem in many

developing countries, including Nigeria, is that there are not enough small hospitals. Small hospitals may be private clinics/hospitals, or they may be government-owned medical facilities. Ideally, small hospitals should be dotted around every part of a country; each of these small hospitals should be able to meet the needs of the residents in the communities where they are located. A small hospital may actually render primary health services while another small hospital can devote itself to providing high-profile, sub-specialty services; the former fits into rural and semi-urban areas while the latter is ideal for urban centers like large cities, State capitals and nations' capitals. Unfortunately, many small private hospitals are set up with the intention to provide every service – and have every facility. This means that such small hospitals do not see themselves as adequate without having the full diagnostic set-up in terms of the laboratory, radiology, ultrasonography, and operative capability, among other contraptions and services. This author believes that this needs not be. It could simply be because of this type of mindset that prospective investors are not encouraged to set up diagnostic centers within the reach of, say, ten or fifteen small private or government hospitals. If this challenge were not the case, standalone diagnostic centers would be able to run profitably while the small hospitals would not stretch themselves thin and lean, carrying a load beyond their professional, financial, and administrative capacity. The diagnostic centers could give the small hospitals that patronize them discounts based on the level of patronage, to the effect that both parties would benefit financially and professionally. Investors in small hospitals, if they followed this format of operation, would be able to start functional professional medical facilities that render good services with a reasonable budget. Coupled with the assurance of a reasonable and functional referral system they would save the lives of patients with emergency cases as such patients would be stabilized prior to referral. I believe and would recommend that, though these hospitals are private, State and Federal governments should provide such operators a reasonable incentive to site small hospitals in the periphery – rural and remote parts of all the states in the country. This recommendation is based on the stark reality that the cost of running an efficient hospital in a rural area is much higher than in the urban centers where electricity, water, roads, means of transportation and communication are available, even if they are “epileptic.” A good distribution of and support system for such hospitals would provide a healthcare service network that would work and save lives; we are witnesses that lives are currently lost unnecessarily before patients arrive at the nearest large hospitals that, in reality, are frequently distant.

Medium-sized hospitals – In-between small hospitals and large hospitals, discussed below, are medium-sized hospitals. In Nigeria, they could be private, company, or government hospitals. Their characteristics tend to be a mix of what is applicable in small and large hospitals. These hospitals are important in Nigeria.

Large hospitals – Large hospitals are being overwhelmed with patients that are supposed to be attended to at the lower strata of the healthcare delivery system; when this situation continues, these hospitals do not function optimally and the structural facilities and equipment are over-used, under-maintained, and rapidly run down. In terms of the buildings, it smacks of poor planning to have hospitals that are on four, five floors, and more and do not have lifts (elevators) – or, when existent, are unreliable or non-functional. When the external and internal walls of any large hospital, particularly government-owned hospitals, look old and dilapidated, it is discouraging to patients, their relatives, visitors, and hospital employees. Such a decrepit outlook of hospitals is not right, even if top-notch services are rendered within. A sad feature of the grounds of many of our large hospitals is their being dotted with

uncompleted building projects. In developing countries, uncompleted projects are not only an eyesore but also venues for unwholesome practices, including criminal acts. Security personnel in many of our public hospitals have enough work without the unnecessary addition of keeping an eye on these structures. Sometimes, it takes close to seven years before these projects get to completion – and some give the semblance of abandonment. Many people know of the “hospital smell” of certain hospitals – it is an unwelcome and, sometimes, foreboding smell for many patients, and the odor need not be as it can be prevented or eliminated if proper attention is given to good housekeeping as part of continuous care of the facilities.

Healthcare personnel –Background – The background of every personnel in a medical facility has an impact on the functional or sub-optimal functioning state of such facilities. This is because the output by these core professionals and support staff depends strongly on the mindset of the young people who were trained and eventually found themselves with a career in the healthcare delivery system. Some of us became who we are in this system because we admired one person or the other; had absolutely no idea how the system works, had a good idea of the expectations of the system, or felt constrained to join and stay in the system because we felt we could change the status quo – *i.e.* for people whose significant other like a parent, sibling, *etc.* did not receive what was expected to be the best from a hospital; scored good-to-excellent grades in the high school (secondary school) that qualified us to pick and eventually join any field of our choice in the healthcare sector, *etc.* Most of these reasons do not hold water by the time core hospital personnel start work and meet the unfortunate “realities” on the ground.

Healthcare personnel – Training vis-à-vis work relationships – Before a cleaner, security personnel, medical records officer, laboratory scientist, pharmacist, radiographer, nurse, administrative and management staff, or doctor starts work in any medical facility personnel would have obtained requisite education from various training centers. These training institutions may be at the secondary school (high school) level or university level – or their equivalent. Many of the higher cadre of personnel also have post-graduate academic and/or professional qualifications and have various professional bodies they belong to. It is well-known that the previous sentence holds true for some personnel in the course of service, and not necessarily prior to their being employed to work in hospitals. In spite of the various qualifications, how many of these workers have been specifically trained to work in a hospital setting – having teamwork, understanding of patients and patients’ relatives, *etc.* in their training curriculum? The training is usually focused on proficiency that is limited to the respective fields, with a concentration on technical issues. With regard to teamwork, consideration should be given to the fact that the entire hospital workforce must function as a cohesive team; this means that each department and each unit must also work as a team. Is it possible or easy to work as a team when each person has not been trained or received orientation to that effect? Lip service should not be given to this critical issue or allow the fact to be taken for granted. The cardinal role of team work has to be inculcated into the workforce before their joining hospital service or ensured at the earliest stage of every employee’s career.

If heads of medical establishments, like chief medical directors, medical directors, and medical superintendents do not see their doctors as colleagues, or all other cadres of employees as key members of their working team, how will a strong chain be formed and

maintained? If cleaners, security and janitorial staff or the core clinical personnel have not been trained to see themselves as part-and-parcel of a cohesive functional system, with each employee providing essential services, no hospital can function well consistently. Everybody is important and while some people can do others' work, they will not have the time to do so in the continual absence, inefficiency, or malfunctioning of the others. A doctor, nurse, or pharmacist can certainly do the work of a cleaner (and not *vice-versa*) but they cannot do and continue doing cleaners' work if most of the cleaners are sacked and not replaced or if a cleaner is the only one for the entire clinic, hospital unit, or hospital department. Top management staff, their assistants, heads of department, or supervisors must not harass their subordinates verbally, physically, or emotionally and expect to continue receiving respect, cooperation, and proficiency from them. The team will not function optimally, be it the entire hospital, a department, or unit – and clients will suffer, being on the receiving end of such a dysfunctional state.

Healthcare personnel – Client services – One area that separates good medical facilities from the not-so-good ones is client services. Client services is a crux in the life of a medical facility; a hospital must take and treat it as the heart of its practice and business. It is so fundamental that a hospital that pays scant attention to this pivot of medical services would find itself not growing or dropping in rating among its clients. According to the article “Hospital Customer Service: A patient-centered care,” “Patient service is key in healthcare in any medical facility. A good patient experience can greatly improve his quality of life, which is the cornerstone of the hospital's success. Accordingly, enhancing the patient's quality of life and focusing on how to improve the medical service provided to him is fundamental to achieving satisfaction.” [4]

Hospital customers are unwilling and sometimes unhappy clients. Healthcare personnel must realize that client services start from the time any client arrives at the hospital entrance and continue until they leave *via* the exit gate. Each personnel can, therefore, enhance or cancel the positive or negative services provided before clients contact physicians or after consulting the doctors. The article “Providing customer support at a critical time: Hospital customer service” rightly captures under “A different approach” the import of customer services in a hospital setting when it states, “Hospital staff are not typically thought of as customer service providers. But in reality, there are many similarities between them and other, more traditional customer service agents. People visiting hospitals require fair treatment, effective communication, and quick responses, just like in other customer service situations. The difference is that people who require hospital customer service are often in the midst of a health crisis, either personally or on behalf of a loved one, and are dealing with intense, emotional scenarios. That is why it is so important to provide customer service that is both efficient and empathetic.” [5]

Real patients are not criminals and, when at the gate, security personnel should not treat them as such; they are not dust or dirt that the cleaner sweeps or mops; they are not blood or urine samples that the laboratory scientist works on; they are not drugs that the pharmacist dispenses; they are not the management meetings that managers and heads of department hold; and certainly not the diagnoses that doctors make. We must all realize or remember that we are rendering humanitarian services – no matter how hefty the bill of a private hospital may be or how “affordable” the bill of a government-backed and subsidized service may be. It is when relations like spouses, children, parents, or even colleagues of hospital employees

become patients that you see a typical hospital worker switch into the expected normal mode for relating with and attending to a patient. This selectively good (ideally, normal) attitude towards service provision is what should characterize our services to all clients. There is undoubtedly burnout among many healthcare service professionals in developing countries; this, however, should not make us snap at our patients and their relations and treat them as objects as though they are our problems. Clients in the hospital setting can broadly fall under those who receive services from hospitals and those who provide services to hospitals. Those who receive services are the ones just described, while those who provide services include, but are not limited to, contractors who build and maintain structures and equipment and suppliers who deliver equipment and consumables regularly or on a needs basis.

Healthcare personnel – Public perception – In developing countries everyone has a perception of healthcare personnel, whether core professionals or support staff. The perception may be right, wrong, or warped. Whatever the perception is, it is important to know that something generated it. Some people hold a perception about a hospital or about its personnel generally or particular personnel even before setting foot on the grounds of the hospital or meeting the workers. This shows how sensitive the work of a medical facility and its personnel is. Of particular note is the not-so-correct impression that people who are outside the healthcare delivery system have about doctors and other hospital workers; many people hold the opinion that hospital workers are rich people but do not realize the amount of effort and sacrifices that hospital workers make. Hospital workers themselves may find that they are stuck in their profession and cannot convince anyone else that they are not who/what the outsider passionately believes that they are. Unfortunately, the hospital worker sometimes shoots himself in the foot by attempting to run the rat race with external professionals. Hospital personnel should resist the temptation of making additional money out of “vulnerable persons” while their perceived “competitors” are making money legitimately out of “goods.” The difference is always clear. If such a thing is practiced or encouraged, it breeds animosity towards hospital personnel. From a correct or biased public perception, it is sometimes difficult for the public to agree with and support doctors and other healthcare personnel when they “cry” over one challenge or another.

Organizations and institutions associated with hospitals – There are government organizations or professional bodies that have the responsibility of seeing to it that hospitals in Nigeria work efficiently. Some of these organizations of government include the Ministry of Health at the national and state levels. Hospitals owned by the government, like University Teaching Hospitals, Specialist Hospitals, and Medical Centers report to the Ministry of Health at national levels and hospitals owned by the various state governments report to the various State Ministries of Health. Many sub-national governments also have boards and institutions that go by various names; these manage hospitals under the Ministries of Health. Other institutions have been set up by national governments and they bear various names; in Nigeria, examples are the Medical and Dental Council of Nigeria, various Councils and Boards of specialties like Pharmacy, Nursing, Laboratory science, and Radiography. These apex bodies regulate the practice of medicine, dentistry, and other specialties that are found in the hospital setting.

The Federal Ministry of Health and Social Welfare lists regulatory bodies in the healthcare sector in Nigeria as follows:

- Medical and Dental Council of Nigeria (MDCN)
- Nursing and Midwifery Council of Nigeria (NMCN)
- Medical Rehabilitation Therapist Board (MRTB)
- Radiographers Registration Board of Nigeria (RRBN)
- Optometry and Dispensing Opticians Registration Board of Nigeria (ODORBN)
- Dental Therapists Registration Board of Nigeria (DTRBN)
- Institute of Public Analyst of Nigeria (IPAN)
- Community Health Practitioners Registration Board of Nigeria (CHPRBN)
- Pharmacists Council of Nigeria (PCN)
- Institute of Chartered Chemist of Nigeria (ICCON)
- National Institute of Pharmaceutical Research and Development (NIPRD)
- National Primary Health Care Development Agency (NPHCDA) [6]

Professional bodies are myriad and include the Nigerian Medical Association, Medical and Dental Consultants Association of Nigeria, National Association of Resident Doctors, Association of Nigerian Private Medical Practitioners, National Association of Nursing and Midwifery, Pharmaceutical Society of Nigeria, and unions like Joint Health Sector Union.

The idea behind all these organizations and institutions is to establish and run hospitals, regulate the practice of the various specialties in the healthcare sector, and allow the various practitioners to have special bodies they belong to. The entire thing is to ensure control, discipline, and good practice within acceptable national and international standards. It is, therefore, expected of the various state Ministries of Health to inspect and license all non-government-owned hospitals in their areas of authority and the national Ministry of Health to establish, equip, run and maintain the national government-owned hospitals and receive reports from the managers of those institutions on behalf of the national governments. The regulatory bodies are to ensure that individuals in each of the specialties are properly licensed to practice, keep a record of their professionals, ensure continuing professional development, as well as establish and implement disciplinary measures against professionals who are found wanting. The professional groups seek the welfare of their members and act as pressure groups to get whatever they consider equitable treatment. Unfortunately, there is almost no designated group that represents the clients of medical facilities. Patients should come under national or state Health Insurance Schemes, but there are many that do not come under such schemes due to low coverage in their countries; they come as individuals and pay for services out-of-pocket. Until both patients (clients) and medical institutions (service providers) are adequately represented and protected in the various health insurance schemes in Nigeria and similar developing countries, it will remain difficult to make things work.

When the chips are down, everyone benefits from hospitals in Nigeria working efficiently; conversely, if we do nothing (or not enough) and allow a slide in funding, structure, equipment, function, attitudes, and service provision in hospitals in Nigeria, making hospitals functional and working efficiently will remain a mirage.

CONCLUSION

It is essential that governments, businesses, schools, religious organizations, communities at all levels, and individuals recognize and treat hospitals as integral parts of society. Until that

happens, the chances of Nigeria or any other developing country moving forward to the point of actualizing their potential shall remain slim. This is because while Nigeria and these other countries are in the race for development and prosperity, the poor health of their people shall certainly stifle their efforts. Everybody should invest in health, for continuing to do otherwise is nothing less than putting the cart before the horse.

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List of Contributors

Emmanuel Kunle Abudu	Department of Pathology, University of Uyo, Uyo, Nigeria
Inyang Ukot	RST Clinics Ltd., Federal Housing Estate, Uyo, Akwa Ibom State, Nigeria
Osahon Enabulele	Department of Family Medicine, University of Benin Teaching Hospital, Benin City, Edo State, Nigeria
OmoOlorun G. Olupona	Bowen University Teaching Hospital, Ogbomos, Oyo, Nigeria
Raphael Sunday Olarewaju	Mother and Child Hospital, Lagos, Nigeria

CHAPTER 1

Functionality and Efficient Services Delivery in Nigerian Hospitals– An Overview

Osahon Enabulele^{1,*}

¹ *Department of Family Medicine, University of Benin Teaching Hospital, Benin City, Edo State, Nigeria*

Abstract: It was with great pleasure that this author accepted the book author's request to pen a general view on the title of this important book, **Functionality and Efficient Services Delivery in Nigerian Hospitals**. This title is appropriate and reflects a conscious effort by the author to galvanize efforts towards strengthening much of Africa's health system using the Nigerian health system and its hospitals as a template.

A cursory look at the title of this book may suggest that our hospitals (Nigerian hospitals, in this instance) are not working to deliver the expected efficient and quality healthcare services to their clients and patients. This deduction is similar to what seems like a general public perception that hospitals in Nigeria are not working.[1] Indeed, the poor state of hospitals is said to be one of the factors promoting outward medical tourism, characterized by frequent foreign medical trips by Nigerians, including top political and public office holders.

The above deductions and impressions notwithstanding, it is important to state at the outset that the situation may not be that gloomy, particularly as there are some hospitals in the public and private health sectors of Nigeria, nay Africa, that are still holding their own despite the perennial challenges besetting them. Some watchers may even argue that in the face of the general decay in Nigeria's public institutions, her public health institutions, including her public hospitals, seem to have fared better than some other institutions in the sustenance of their critical responsibility and mandate for healthcare service delivery.

In developing this chapter, the author leveraged their practice experience as a medical doctor and Consultant Family Physician, experiences as a Health and Civil rights activist, involvement in the processes that led to the enactment of Nigeria's National Health Act (NHA), and the practical leadership experiences within health systems at local, state, national, continental, and international levels. This is particularly true, having served as President of the Nigerian Medical Association (2012–2014), President of the Common Wealth Medical Association (2019–2022), and President of the World Medical Association (2022–2023).

* **Corresponding author Osahon Enabulele:** Department of Family Medicine, University of Benin Teaching Hospital, Benin City, Edo State, Nigeria; E-mail: osahoncmavp@gmail.com

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Inyang Ukot (Ed.)

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Keywords: Chief medical directors, Federal ministry of health, National health act, NHA-2014, Nigerian medical association, Policymakers, Strikes.

INTRODUCTION

Functionality and efficient service delivery in Nigerian hospitals depend on an understanding of and paying close attention to virtually every word in the title of this book. This chapter commences by describing the word “Hospital.” An extrapolation of the definition shows that it is not just a place but what happens in that place, who occupies that space, and for what purpose. For a hospital to exist it means that somebody, a set of people, an organization, or a government must conceive it. This chapter discusses these “conceivers.” Since an existing thing or entity does not need creating, it means that the conceiver must be thinking forward. It is this thinking forward that is a problem when it comes to a hospital, groups of hospitals, or a layer of hospitals. When something is right with the “thinking forward,” the results will show, and when something is wrong with the “thinking forward,” the results will also show. This is where functionality comes in. Functionality must be incorporated into the planning process. Otherwise, it becomes cumbersome or impossible to make practical modifications to achieve functionality if it is not considered, forgotten, or kept in the background. Efficient service delivery dwells mainly on the human beings in a hospital. Briefly and put simplistically, human beings are the patients and healthcare providers. The fact that a hospital is in existence and is equipped does not translate into efficient service delivery. There will surely be service delivery, but will it be poor, suboptimal, or efficient? The bulk of the responsibility depends on the healthcare providers and much less on the healthcare services beneficiaries (patients). The healthcare providers should be seen as the “powers behind” the existence of the hospitals or hospital system (proprietors, government, investors, *etc.*) and the “direct and indirect operators” who are the healthcare providers who consist of the core healthcare professionals and support personnel, respectively. Patients are very important, though their responsibility is less; they are important because if they do not play their role well, they may either contribute to inefficiency in the delivery of services or complicate it. In Nigerian hospitals, many patients—whether rightly or wrongly—bypass primary healthcare facilities and go directly to teaching hospitals, overwhelming their capacity and negatively affecting the quality of services provided.

Functionality and efficient service delivery in Nigerian hospitals also depend on variables outside the confines of the hospitals and the healthcare delivery system. These are all described not only in this chapter but also in the rest of this instructive book.

Definition of Terms

Before proceeding further, a concise definition of some operative terms is imperative.

Our: The Cambridge English Dictionary defines “Our” as:

(1) Of or belonging to us; (2) Belonging to or connected with us [2].

With the foregoing definition, the focus of this overview is on hospitals located in Nigeria, where I practice as a Consultant Family Physician and served as President of the Nigerian Medical Association (2012–2014).

Hospital: The same Cambridge English Dictionary defines a hospital as a place where people who are ill or injured are treated and taken care of by doctors and nurses [3].

The World Health Organization (WHO) defines a hospital as an establishment that provides short- and long-term medical care consisting of observational, diagnostic, therapeutic, and rehabilitative services for people suffering or suspected to be suffering from a disease or injury and for parturient women. It may or may not also provide services for ambulatory patients on an outpatient basis [4].

The WHO further states that hospitals are reservoirs of critical resources and knowledge that complement and amplify the effectiveness of many other parts of the health system, providing continuous availability of services for acute and complex conditions [5].

It is also important to note that aside from medical service delivery, a hospital may also provide education and training for its staff, health professionals, and students. It may also be involved in the conduct of biomedical research.

Brief Historical Excursion***Global Experience***

It is trite knowledge that before the emergence of hospitals, healthcare had always been extended to those in need (especially the sick and injured) in one form or another. Scriptural and historical accounts indicate that early physicians engaged in solo practices and visited the homes of sick ones, where they offered them treatment. In other instances, the sick were treated in the homes of early physicians, in some temples, or make-shift shelters, sometimes located in the fringes/outskirts [6]. Even Hippocrates (the father of modern medicine) and his

CHAPTER 2

The Place of Small Hospitals in the Healthcare System**Inyang Ukot^{1,*}**¹ *RST Clinics Ltd., Federal Housing Estate, Uyo, Akwa Ibom State, Nigeria*

Abstract: In Nigeria, there are all types of hospitals. The earlier and latter chapters in this book describe hospitals that may be described as small, medium-sized, or large – this attribution is a rough description and uses physical size as the only determinant. The type and level of services that a hospital provides, its location, and the size of its clientele are immaterial as far as the contents of this chapter are concerned. A primary care hospital may occupy large grounds, while some tertiary health care facilities are small in size.

Keywords: Challenges, Client services, Cost of care for patients, Distribution, Encouragement, Financial assistance, Government influence, Investment in hospitals, Leadership, Location, Nigeria, Ownership, Patronage, Payment for services, Physical access, Poor referral network, Power supply, Services, Small hospitals, Sustaining policies, Water supply.

INTRODUCTION

This book chapter, **The Place of Small Hospitals in the Healthcare System**, is not only about one type of hospital but also indirectly a description of the healthcare system in any developing country, using Nigeria as a veritable example. The type, number, ownership, personnel, level of care, and distribution reflect the importance of health and the impact of wealth on the state or nation [1, 2].

In this chapter, the word “Hospital” encompasses basic, small facilities like health posts, maternity homes, health centers, comprehensive health centers, and small hospitals (usually called clinics) that are high-profile, upscale medical facilities. While some of these are strewn across Nigeria, others are typically located in specific parts of the country. It is difficult to write about all types of small

* **Corresponding author Inyang Ukot:** RST Clinics Ltd., Federal Housing Estate, Uyo, Akwa Ibom State, Nigeria; E-mail: inyang.ukot@yahoo.com

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hospitals in Nigeria unless an entire book of a reasonable size is devoted to that purpose.

The state of a nation's public healthcare system has a correlation with the wealth of that country and the level of development enjoyed by its citizens and residents [3].

According to the US News and World Report, Canada is the country with the most well-developed public healthcare system, followed by Denmark and Sweden; the UK is sixth and Switzerland tenth. GDP per capita is GDP divided by midyear population. The GDP of Nigeria per capita in 2014 (\$3,201) was much better than the figure for 2017 (\$1,941.9), which represented a precipitous fall. Nigeria's GDP per capita in 2019 was 2,230 USD; for Canada, for the same year, it was 45,445.610 USD. The nation's GDP per capita has suffered an even worse fate after 2017 for it became \$1,621.1 in 2023. The poor performance of this otherwise great country (going by this economic index) is that Nigeria fared worse in 2023 compared with 1981 when its GDP per capita was \$2,187.9 [4].

The context in which "Small hospitals" is used in this book is any hospital that is physically smaller than a general hospital and also usually has a personnel strength of not more than fifty; the number of patients that such small hospitals attend is immaterial. They go by various names like clinic, comprehensive health center, health center, health clinic, health post, and maternity home.

These hospitals are, therefore, expected to fit into the healthcare delivery system of any developing country, including Nigeria. What role do they play in the healthcare delivery system in Nigeria? What impact do they make? Is the impact positive or negative [5]?

On the surface, they are the majority of medical facilities in a country like Nigeria, but where are they? Who operates them? Who patronizes them? What services do they render? What challenges do they encounter? What value do they add to peoples' lives and the economy?

Ownership

Statutorily, in Nigeria, public secondary care hospitals belong to State governments and public tertiary hospitals belong to the Federal government. Secondary care medical facilities are general hospitals and their equivalent. Tertiary hospitals are usually university teaching hospitals, but specialist hospitals belong to this group also.

With respect to hospitals discussed in this work, the ownership resides in private persons, groups of persons, communities, and Local governments. Other owners include Christian missions, *e.g.*, NKST church that operates mainly in north-central Nigeria, and government parastatals that render services to their employees, *e.g.*, Central Bank of Nigeria, and manufacturing companies that run industrial clinics on-site.

Nigerian National Petroleum Corporation Ltd. is exceptional in the sense that it does not just own a chain of big hospitals but they are well distributed in the country. In 2020, the Nigerian National Petroleum Corporation (NNPC) indicated its plan to build hospitals in 12 of the 36 States in Nigeria to the tune of N21 billion. These hospitals were to be sited in the six geopolitical zones of the country [6]. In 2022, it was in the news that this national oil corporation was interested in intravenous plant concession. ICRC is the Infrastructure Concession Regulatory Commission. To show the importance of health, the corporation's Medical Services Ltd. Plans to build five specialist hospitals and one intravenous fluid plant – these are to be sited in the six geopolitical zones of Nigeria [7]. So, in Nigeria, ownership of hospitals comes under a wide umbrella. The examples provided in this paragraph show that any individual, group, or organization that is interested in contributing to the healthcare sector in Nigeria would be licensed to do so if they meet the requirements of the licensing body of government and stick to the category of medical facilities they are accredited to operate.

Distribution

The Federal Ministry of Health and Social Welfare in Nigeria lists twenty hospitals as teaching hospitals in Nigeria [8].

However, in 2007, the Federal government tertiary hospitals, which include university teaching hospitals and specialist hospitals, were 151. They represented 0.88% of the hospitals in Nigeria. The State governments owned secondary care hospitals which were 8.11% of the hospitals in the country. Religious organizations owned secondary healthcare facilities, and theirs constituted 1.93% of the hospitals. A couple of Christian missions also own and operate university teaching hospitals. Private hospitals made up 43.20% of the 17,038 hospitals in the country in 2007, closely following the 7,580 hospitals owned by Local governments, which represented 44.41% of hospitals in Nigeria. As of 2024, the Federal Ministry of Health's Health Facility Registry (HFR) indicates that there are 38,813 operational hospitals and clinics in Nigeria [9]. More recent data shows that in Nigeria, the government owns and operates more health facilities (public) than the hospitals owned and operated by the private sector; this is

Efficient Human Resources Management in Hospitals

Inyang Ukot^{1,*}

¹ *RST Clinics Ltd., Federal Housing Estate, Uyo, Akwa Ibom State, Nigeria*

Abstract: In a typical hospital, nearly everything of significant interest—both living and non-living—relates to humans. The non-living things include the building (if it is a small hospital) or the buildings (if the medical facility is a large hospital at one site or a chain of hospitals in multiple sites). The other constituents of non-living things are the moveable, and installed and immovable equipment of diverse sizes and numbers. Living things are usually considered plants and animals. Plants could be a problem and could also be of great aesthetic value in the hospital setting, as this book shows in some of its chapters. Human beings come under the animal kingdom classification and are considered to be at the top of the ladder in that kingdom. Non-human animals are part of human existence, but they are not considered in this book as the medicine that applies to animals is veterinary medicine. In a characteristic hospital of any size, the consideration or focus is humankind.

This book is about human beings who are unwell and need to be given attention by other human beings (and gradually assisted by robots) to achieve restoration of health, prevention of disease, or promotion of health. In summary, one set of human beings needs help; another set of human beings provides help.

Keywords: Administration, Human resource management, Staffing, Workforce diversity.

INTRODUCTION

It is interesting on the one hand and incomprehensible on the other hand that some people who look at a hospital “from the outside” do not realize that hospitals, particularly the large ones, consist of one of the most diverse sets of employees and service providers. Having worked with a multinational-cum-global oil company and one of the largest banks in Nigeria with established presence in various parts of the world, this author is convinced that the diversity that is found among workers in a hospital is something that should be held dearly and positively beneficial for the employers, employees, patients, and in community a hospital is located.

* **Corresponding author Inyang Ukot:** RST Clinics Ltd., Federal Housing Estate, Uyo, Akwa Ibom State, Nigeria;
E-mail: inyang.ukot@yahoo.com

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What we find in Nigeria is that even the government at the three established levels fails to make use of the talents and potential of these remarkable people. In the private sector, the same pattern is applicable with significant exceptions in the oil industry.

The diversity and importance of human resources in a hospital can be simplified as follows:

- Direct healthcare professionals – These include, but are not limited to, physicians, pharmacists, nurses, radiographers, laboratory scientists, physiotherapists, occupational therapists, and phlebotomists.
- Indirect but essential support professionals – These are hospital administrators, lawyers, accountants, internal auditors, security experts, *ad infinitum*.
- Broad support personnel – There may be individuals or personnel of third-party contract firms. Personnel in this category are security personnel, and technical personnel like plumbers, electricians, horticulturists, carpenters, roofers, and more.

Understanding this wide range of top, middle-level, and lower-level professionals and personnel is especially important but exceedingly difficult. This is partly attributable to the fact that in many public hospitals, the usual yardstick of importance is what this author would simply call “the paycheck.” The value of an employee’s paycheck may cause at least two problems: a) It makes an employee feel superior to another employee with less on the paycheck; b) It makes an employer disregard the importance of the low-paid employees. Sometimes, it is not the employer but the employer’s representative (or high-level employee like the medical director, group medical director, director of finance, executive director – human resources) who choose to create an unbridgeable gap between the high-ups and “the rest.” Where this occurs, managing the human resources of a hospital could be the caterpillar that gradually eats the “leaves” of the hospital, or the pest that attacks the “roots” or “stem” of the hospital. It is by choice that this author is using non-human resources terms in this Introduction so hereby promptly explains leaves, roots, and stem. The “leaves” symbolize any hospital that has grown enough to develop leaves but not enough to produce fruits. The people who matter in handling employee issues may feel that the hospital “business” has flourished because of the satisfactory performance in terms of the financial standing – but they are wrong. The “stem” refers to the visible robustness of the establishment. In Nigeria, this is occasionally a façade and the proprietors of the highly physically visible hospital feel deceived when they send out adverts and are inundated with responses from prospective applicants. In Nigeria, the unemployment rate is remarkably high and continues to rise [1]. According to the Nigeria Economic Summit Group (NESG), globally, Nigeria,

with a combined unemployment and inflation rate of 36.9% in the first quarter of 2024, competes very favorably with the worst in terms of misery indices [1]. In Nigeria, less than 10 of the available opportunities are in the formal sector. This means that more than seventy percent of currently employed people hold jobs that are ipso facto vulnerable jobs [1]. How does it feel when today you leave your home for work and in about three months you are jobless, promptly back to the unemployment market? The situation is so bad that when they are paid, they are paid less and the working conditions are inconducive – there are main instances that there are no toilets attached to some workplaces and working hours could be unjustifiably long; these are features of the informal sector. Is it, therefore, surprising that when a job vacancy is posted for ten employees in any place of work that offers some stability in employment status, five hundred or more applicants may apply?

Employees in the informal sector often work without the protection or support of formal structures and benefits, or receive only minimal coverage [2]. The worker finds themselves in a quandary. Do they accept a job that is inherently dangerous, with little or no prospects, very fickle, with many other equally disadvantaged persons seeking similar jobs, or wait and hope to get a job in the formal sector that may equally not assure them of satisfactory or regular remuneration?

The rest of Chapter 3 is devoted to a brief presentation of the following topics; it contains the principles and practices of human resource management applicable in Nigeria currently, with some examples of the situation in the past.

Employment

In Nigeria, it is uncommon for a young university or college graduate to obtain an offer of employment within the first five years after graduation. A generation ago (and slightly earlier), it was possible for a graduate to have an offer of employment in the final year of school. This was so for many doctors and the vacancies were waiting to be filled. Commencing the one year internship (called “housemanship” in Nigeria) was mandatory and some students chose to travel abroad for a holiday before returning to take up the appointment. The process was bereft of any bureaucratic bottlenecks. For other graduates who did not require any internship, life was easier and faster, as they started with the compulsory National Youth Service Corps (NYSC) immediately after graduation. So, for a typical graduate from a tertiary school educational institution, the first employment was assured. Today that is not the case. Some doctors wait to have an opening for months before they can start their pre-registration service that statutorily lasts for one year employment (not from graduation date but from the date that the graduate receives an offer of employment). It, therefore, happens that

CHAPTER 4**Functional Structures for Efficient Service Delivery: Considerations for the Management of Health Facilities****Inyang Ukot^{1,*}**¹ *RST Clinics Ltd., Federal Housing Estate, Uyo, Akwa Ibom State, Nigeria*

Abstract: The development and management of hospital facilities should follow a systematic process, including, at a minimum, conceptualization, planning, design, construction, maintenance, provision for growth, and security considerations. This chapter is designed to cover these aspects. The contents are not exhaustive but are adequate to demonstrate considerations, challenges, and successes in achieving functional and efficient medical facilities management.

Keywords: Design medical infrastructure, Facilities management, Hospital planning.

INTRODUCTION

This chapter explores the challenges and successes in achieving functional and efficient medical facilities in Nigeria. The stories are actual stories of what has happened, used to happen, and is still happening in hospitals in Nigeria. The stories of many hospitals are discussed in this chapter to highlight successes and offer suggestions for enhancing the functionality of the medical facilities. The aim is not to criticize but to acknowledge that, while no facility is designed to fail from the outset, some may encounter flaws either at inception or during their operational lifecycle. Every medical facility in Nigeria is welcome, and more should be built and operated efficiently. The population of Nigeria is projected to continue growing, as it has yet to reach a plateau; this means that there shall be an increase in the pressure that is placed on medical facilities in Nigeria. These hospitals, as described in other chapters of this book, are varied and could be government-owned hospitals, faith-based hospitals, company hospitals, educational institutions, medical facilities, or private hospitals. Whatever the ownership is, a hospital may provide primary, secondary, or tertiary healthcare services (sometimes offering just the first two levels, and at other times, all three).

* **Corresponding author Inyang Ukot:** RST Clinics Ltd., Federal Housing Estate, Uyo, Akwa Ibom State, Nigeria; E-mail: inyang.ukot@yahoo.com

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Conceptualization

A physical structure is the product of the mind. The mind may be that of an individual or the mind of a group of people. If more than one person is involved, it may be that they are a couple, a family, friends, business partners, a company, an institution or an organ/arm of government, people of the same religious faith, and others. The more people involved in conceptualization, the more time and input are involved. When it is one person, there is usually a shorter time because numerous meetings that two or more people would necessitate would be obviated. In either case, there are challenges. One of the challenges with many people is the possibility that one or more of them could be dominant “voices” and may not listen to the opinion of even the majority, but one of the advantages is that all aspects of the matter in question are considered and the result stands a good chance of success. With one person, there may be the challenge of “myopia” that makes the individual not see “beyond their nose.” This tends to happen when this individual is the embodiment of everything about the concept, especially if the person is the financier in toto.

When it comes to a hospital, it is good for a doctor to be involved but it could be dangerous if that doctor does not listen to anybody but believes that being the professional and having the funds, they need no input from external sources. In this unfortunate situation, the result shows up like a sore thumb in the future, and onlookers and clients would wonder how and why that is the case. The reason is that conceptualization is really the unseen, intangible, and most important foundation of a medical facility and, indeed, any physical structure.

Planning

In this chapter, a simple approach was adopted to planning as outlined in *Business Jargon* [1]. With regard to planning a medical facility, the components of planning extracted from this interesting write-up are goal-oriented and futuristic. These two are considered the sine qua non. There must be a goal. What are you trying to build? Are you building it because you have so much money or because you have funds limitations? Do you have a clear idea of the hospital in your mind, or is the idea foggy or in flux? In terms of goal, do you know where you are going with this hospital? Where are you taking patients, employees, and third parties? Is your planning in consonance with the reality of the goal in your mind, or is the planning tangential to the goal? Regarding futuristic, are you living in “the now” only, or do you think about the future? Which is more important to you, now or the future? Are you sure that your planning for this medical facility is based on you, or is it based on another person or other people? Specifically, are you certain that you are not on a “competition trip” with your medical school classmates or

juniors? Is this planning for something that will last or will certainly fade away? Are you aware that many businesses do not survive beyond five years? Is your planning to put you in this class of the majority of businesses or in the elite class of the dogged businesses?

Design

The design of a building starts with having lucidity regarding the purpose of the structure; in this case, a hospital. It must be noted that the term “hospital” can refer to vastly different entities, much like the word “animal” can apply to both an ant and an elephant. So, which one are you asking the architect to design for you (the client)? Do you have any idea of your own that could be incorporated into this design? If you do, do you want to dictate everything regarding the design? Or do you extricate yourself (or yourselves) from the design and simply tell the architect, “Design a ten-bed hospital for me?” or “Design a seventy-five-bed hospital for us?” Which architect have you chosen, or are you considering choosing for this design? What experience does this professional have regarding designing hospitals? Are you engaging them because they are a family member, church member, club member, or some other sentimental reason? Is it because this architect successfully designed an office that caught your attention? Remember, a hospital is not an office, residential building, restaurant, or hotel; it encapsulates all of them.

Briefly stated, your proposed hospital must be designed to attend to the following: entrances, exits, water (and appropriate plumbing), power (and the best and most convenient outlets as sockets and lighting), heating, ventilation, and air conditioning (HVAC) [2]. Other important considerations are ease of movement, like corridors, verandas, ramps, and restrooms, among other features. A hospital is not a place designed for use by healthy people (although the healthy people are engaged as employees and third parties), but principally by the unwell, who must not be exposed to further hazards and inconveniences like uneven floors, multiple steps, absence of elevators/lifts/escalators where they should be incorporated at the design phase. The design of your hospital, therefore, constitutes an approved set of documents that detail the architectural, engineering, and technical characteristics of the building-to-be.

Construction

As briefly stated earlier in this chapter, a hospital, especially a large one, is a peculiar building and should be treated as such *ab initio*. The construction of a medical facility entails unique challenges. Apart from incorporating safety controls for everybody, particularly patients, the unseen challenge of infection must not be ignored but controlled or reduced significantly. Many hospital

Getting the Best Out of Hospital Employees

Inyang Ukot^{1,*}

¹ *RST Clinics Ltd., Federal Housing Estate, Uyo, Akwa Ibom State, Nigeria*

Abstract: The idea behind this Chapter, “Getting the best out of hospital employees,” is the reality that there are many hospitals in Nigeria that do not lack patients, but what they lack are hospital employees who, for one reason or another, do not or cannot give the best to their employers or patients. When and where this happens, the physical edifice of the affected government hospitals and the smaller facilities owned by individuals and organizations exist mainly to pay salaries and to “stay open” to the public. The clientele dwindles over time and such medical facilities become abandoned where the negative and unprogressive trend is not stemmed. Since it is difficult to repurpose a purpose-built hospital, particularly large hospitals (government or private) become liabilities rather than the assets they were intended to be. This scenario is presented first with the purpose being to discourage any employer or investor from allowing this to happen to them, their business, or social services project. Unquestionably, the best asset that any hospital has is the human resources. How to get the best out of hospital employees is consequently the best objective of any hospital, its management officials, and owners/proprietors.

Interestingly and almost peculiarly, a reasonably large hospital in Nigeria, in addition has features of a hotel, restaurant, bank, typical office or institution, school, land transportation outfit, and more. Hospital employees or personnel are, therefore, not only the core healthcare professionals like doctors, nurses, pharmacists, laboratory scientists, and medical records personnel but also administrative personnel, lecturers, teachers, security personnel, cooks and restauraners, janitorial staff members, employees of banks that have outlets in the hospital premises, drivers, and more. Sadly, carrying along sixty percent of these personnel does not give the institution a pass mark in the minds, eyes, words, and social medial postings of patients and their family members. This is because a patient may feel impressed right from the hospital’s entry and exit gates just because of the treatment that they receive the first time or every time they have cause to go to the hospital. On the other hand, they may become disgruntled at the point of entering the compound of the hospital or anywhere in between there and their leaving the hospital – and this could be the handiwork of one hospital personnel or more than one such employee. Despite the training that hospital employees (core personnel or support staff members) receive during training in their various schools, their attitude towards clients and the level of service they render are generally based on the individual. This chapter is to show that it ought not to be so; it should be institution-

* **Corresponding author Inyang Ukot:** RST Clinics Ltd., Federal Housing Estate, Uyo, Akwa Ibom State, Nigeria; E-mail: inyang.ukot@yahoo.com

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alized. Every hospital must establish the standards on which it wants its employees to function and, at the same time, know and remember that the treatment it gives to its employees goes a long way to determining what services it can extract from these employees. The immediately preceding sentence simply means that if employees' salaries are withheld for months, indiscipline is condoned, time for work is flouted with no consequences, leaders fail to show good examples, there is harassment in the workplace, fairness in handling personnel matters becomes an unnoticed or irrelevant "man overboard," there is lack of training and employees' progression in the workplace is irrational or inexplicable, or retired employees are not paid their benefits for months or years, it becomes very difficult to obtain from employees that commitment to work that is integral in rendering excellent services naturally.

Keywords: Accreditation process, ACLS, Advanced cardiac life support, Advanced practice roles, Advanced technological devices, Advanced trauma life support, American hospital association, ATLS, Attitude, Basic life support, BLS, Burnout, CGFNS, Client services, Clinical training exposes, Conditions of service, Developed countries, Developing countries, Emigration, Emotional support, Greener pastures, Health risk assessment, Inconducive work environment, Interactive case studies, Levels of equipment, National council licensure examination, NCLEX, Nursing and midwifery council of nigeria, PALS, Pediatric advanced life support, Personnel, Professional development, Retired nurses, Retirements and succession, Retiring nurses, Rural areas, Simulation, Shift work, Standardized documentation, Standardized nursing care, Task trainers, Training, Training, Virtual clinical tools, Young nurses.

INTRODUCTION

This chapter is on hospital employees; these consist of at least four groups, *viz.*: medical professionals, other healthcare professionals, administrative professionals, and support members of staff. Writing on every professional in these groups would take an entire book. This chapter does not attempt to start what it cannot achieve, and so its author has chosen to use the most ubiquitous personnel (in the sense that wherever they are not present, the facility may not be rightly designated as a medical facility). In the healthcare industry, the progress and impact made by the various professionals depend partly on the level and efficiency of the training that the future professionals receive in their years in school and the formative years during practice. The challenge of achieving and sustaining this ideal is immense. In advanced countries where training and practice are well structured and highly regulated, it is still a challenge; in developing countries where the struggle is multifaceted, the development of the healthcare sector and its professionals is a monumental challenge. These personnel are nursing personnel, and the reader should bear with the author in using them to represent every other personnel found in a typical hospital.

Training and Practice in the Nursing Profession

In the USA, for example, the American Association of Colleges of Nursing (AACN), in its 2024 fact sheet on salaries and instructional and administrative nursing faculty, documents that the mean ages of doctoral-prepared faculty at the highest levels ranged between 49.6 and 61.2 years; the age bracket was lower for nurse faculty with master's degree [1]. This shows that there is a shortage even in the USA. The healthcare burden is higher in developing countries, and very few have personnel at this elevated level to train nurse faculty who would engage in the training of nursing personnel at lower levels. Until the relevant authorities find and implement a solution for this challenge of teaching professionals shortage, the hope of achieving top-notch nursing services consistently and globally could prove to be a mirage. The challenge is even direr in developing countries. It is natural for employees to age, but this inevitably shortens the number of productive years available for nurses and other healthcare educators to teach and mentor the next generation. In Nigeria, for example, some accredited centers for training nurses are inundated with nursing students, and this could wear out the lecturers.

Regarding retirements and succession of nursing faculty between 2016 and 2025, this work by Fang and Kesten suggested that there is an impending departure by the retirement of about 33% of top nursing faculty that were in service in 2015 [2]. This would not only negatively impact the training of high-level personnel to teach upcoming nursing postgraduate and undergraduate students but could also threaten the future nursing workforce. As mentioned in the previous paragraph, any negative impact on healthcare professionals' training and practice in advanced countries tends to reflect a greater (and unreported or underreported) negative impact in developing countries. Unfortunately, in developing countries, the conditions of service are far from satisfactory, and when given the opportunity, these high-level academics would rather leave their countries for "greener pastures" or take up political appointments that offer higher remunerations and added perks of high office, these could permanently prevent them from returning to the "classrooms or lecture halls" after their tenure.

A further challenge is the remuneration imbalance between high-level nursing practitioners and high-level teaching professionals in nursing. While the median salary of nurse practitioners, nurse anesthetists, and nurse midwives in 2023 was \$129,480 (and the hourly pay was \$62.25), the pay of a professor for the corresponding period was less by about \$36,000 (at \$ 93,958) [3, 4].

At the time of the research by Anarado, Agu, and Nwonu that led to their publication in 2016, the results of the study that took place in the South-Eastern

CHAPTER 6

Growth and Transformation of Faith-based Hospitals: Bowen University Teaching Hospital'S Story of Focus and Resilience

OmoOlorun G. Olupona^{1,*}

¹ Bowen University Teaching Hospital, Ogbomos, Oyo, Nigeria

Abstract: One of the reasons for choosing Bowen University Teaching Hospital as a “case study” in this book is that it is a quintessential example of a hospital that started not with the aim of making profit but to render medical services to a poor and, at the time of its inception, a rural community but somehow survived the intricacies of medical practice in Nigeria and, today, is rendering primary, secondary, and tertiary healthcare services. The services of this hospital attract patients from nearby communities and nearby states in the South-Western geopolitical zone of Nigeria.

This is an interesting story with ups and downs, periods of uncertainty and joy, periods of support and virtually standing alone to believe in itself – and most importantly, periods of taking “a leap of faith” that has taken it to an enviable league of a tertiary hospital that trains medical students, postgraduate (resident) doctors, and undergraduate students in nursing.

The story of Bowen University Teaching Hospital should encourage any hospital irrespective of its ownership to aim for greater heights and to believe that when medical services are rendered from the mindset of running a marathon race and concomitantly satisfying their patients and communities consistently, only the future can tell what a hospital with a humble beginning can become.

Keywords: Bowen university iwo, Nigerian baptist conventionnational health insurance scheme, Ogbomoso baptist hospital, Ogbomoso, Southern baptist convention.

INTRODUCTION

In Nigeria, most faith-based hospitals are called “Mission Hospitals,” and the name seems to derive from missionaries who came to Africa (including Nigeria)

* Corresponding author OmoOlorun G. Olupona: Bowen University Teaching Hospital, Ogbomos, Oyo, Nigeria; E-mail: oolupona@gmail.com

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to propagate their faith, the Christian faith. Interestingly, these hospitals have lasted for more than half a century, and many are still operational although they have been handed over to their Nigerian equivalent or the communities where they are. In some instances, the government in various states unilaterally created laws that enabled them to take over some of these hospitals. The author of this book (not this Chapter) was born in one of these hospitals, and it is still functional. The story of Bowen University Teaching Hospital narrated in this Chapter, is about one such hospital, and one that has stood the test of time and is not only operational but also has been transformed into a tertiary hospital in Nigeria. It is in the southern part of the country. Another hospital (run by another Mission) is in the northern part of Nigeria and has contributed significantly to the health care of Northern Nigeria and, similarly, transmuted into a university teaching hospital.

Concept of the Medical Facility

The Southern Baptist Convention of the United States of America began its mission work in Nigeria when its first missionary, Thomas Jefferson Bowen, arrived in the country in 1850 and started work in Ijaiye, Lagos, and Ogbomoso [1]. The initial focus was the establishment of churches with self-governing congregations. In line with the tripod ministry of Jesus Christ, the mission work was later extended to the teaching and healing ministries. The first hospital to be established by the Southern Baptist Convention in Nigeria was Ogbomoso Baptist Hospital. It was established on 18 March 1907 with the arrival of Dr. George Green and his newly wed bride, Lydia, in Ogbomoso [2]. Dr. Green, who was born in London, was influenced by his godly parents. At the age of 22 years, he left London for Montreal, Canada, and in the following year, he took ill with the flu. He received compassionate care from a physician who was a member of his local Baptist Church and convalesced in the home of another member. These kind acts sowed the desire for him to become a medical doctor. In 1897, he relocated to Woodstock, Ontario, where he met the Sweet family and professors at Woodstock Baptist College, whose parents had served as missionaries in India. These godly people influenced his interest in missions and ministry work. Due to his ever-increasing passion for mission work, he sold off his flourishing book binding business and enrolled in Woodstock Baptist College, an affiliate of McMaster University. His excellent educational background enabled him to complete the course in one year. He was licensed to preach by the First Baptist Church, Woodstock, in 1899 and completed his college education in 1900.

Green relocated to the United States of America having been convinced of a call into the medical ministry; he sought admission and was admitted into the Medical College of Virginia in Richmond in September 1901. He received his degree of

Doctor of Medicine in May 1905. The Foreign Mission Board of the Southern Baptist Convention appointed him as the first medical missionary to Africa, and he was ordained into the ministry on 26 November 1906. He and Lydia were married on 09 January 1907 in Norfolk. The newly wedded couple went directly from the church to the wharf to board the steamer from Norfolk en-route to Lagos *via* Richmond, New York. They finally departed for Lagos on 19 January 1907. They arrived in Lagos on 04 March 1907 and finally in Ogbomoso on 18 March 1907 (Fig. 1). Dr. Green seized every opportunity he had whenever he went back home on furlough to improve his medical knowledge and skills. He obtained the title of Licentiate of the Royal College of Physicians and Surgeons of Edinburgh and Glasgow after passing the qualifying examinations. The success enabled him to join the British Medical Association in 1920.

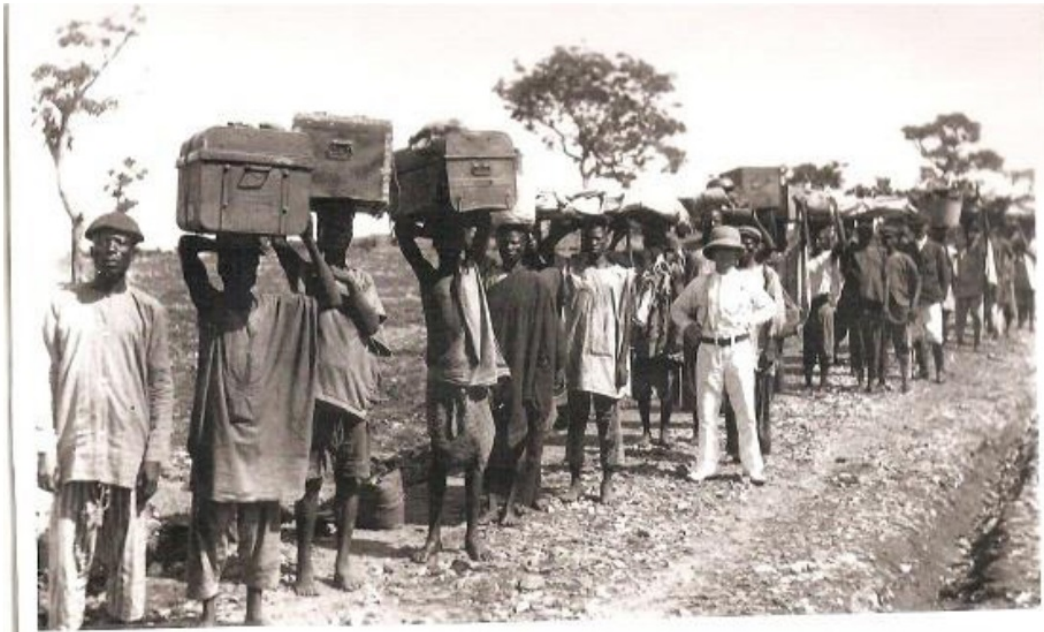


Fig. (1). Dr. George Green and his entourage en route to Ogbomoso (Photo credit – BMC archives).

Over the years, Ogbomoso Baptist Hospital made a name for itself for the quality and compassionate care it rendered to patients from near and far, irrespective of age, gender, religious or political orientation. It became a brand name not only in its immediate surroundings but even in distant places across Nigeria and in neighboring countries, especially where natives of Ogbomoso and its environs had migrated. For 102 years, the hospital remained a secondary health care facility. However, with the establishment of Bowen University Iwo (of the Nigerian Baptist Convention) and the accreditation of the university to run the program for

The Place of Government Tertiary Hospitals in a Developing Country: The Story of the University of Uyo Teaching Hospital

Emmanuel Kunle Abudu^{1,*}

¹ Department of Pathology, University of Uyo, Uyo, Nigeria

Abstract: The University of Uyo Teaching Hospital (UUTH), Uyo, is not one of the first-generation teaching hospitals. The story of this hospital is included in this book because it is a story of hope – hope in the sense that with determination, despite humble beginnings, something good, useful, and great can be obtained from something that appears small at the beginning. UUTH was not even conceived as a Teaching Hospital, but the foresight in setting it in a strategic location seems to have made the hospital attractive enough to the Federal Government of Nigeria to convert it into a Teaching Hospital of its university called the University of Uyo. This hospital has adequate grounds that have been fenced to provide security and discourage any form of encroachment. Physically, the hospital has not fully occupied the space available for the small initial hospital. Although it is not as established as the original teaching hospitals, UUTH has achieved a lot and, has weathered many storms and is still standing and getting stronger. It is the only teaching hospital in Akwa Ibom State (an oil-producing State in the South-South geopolitical zone of Nigeria.) The presence of this hospital has helped address the healthcare needs of residents in the 31 local government areas in Akwa Ibom State.

Keywords: Bill waivers, Equipment and consumables, Financial leakages, Firefighting services, Internship, Laundry services, Non-clinical services, Personnel, Renovation, Standard operating procedures.

INTRODUCTION

The University of Uyo Teaching Hospital (UUTH) is among numerous tertiary health institutions in Nigeria established to support manpower development through teaching and research. The target beneficiaries are the immediate community and the proximate ones. The objective of the Federal Government of Nigeria was, and remains, healthcare service delivery in a compassionate and

* Corresponding author Emmanuel Kunle Abudu: Department of Pathology, University of Uyo, Uyo, Nigeria; E-mail: ekabudu@yahoo.com

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dignifying manner; this objective reflects the mission of all teaching hospitals in Nigeria, and the specific mission that specific hospitals spell out reflects this core mission. In addition, each teaching hospital is set up as a modern health institution that should achieve high-quality healthcare delivery. The intention of the government is to equip each teaching hospital with excellent and modern diagnostic facilities aimed at providing qualitative training, research, and disease prevention.

The Akwa Ibom state government conceived the hospital in 1994, and it was originally called Sani Abacha Specialist Hospital. Clinical services started on January 22, 1996. The Federal Government took it over in 1997 and renamed it Federal Medical Center, Uyo. Following the establishment of a College of Health Sciences at the Federal University of Uyo, a Memorandum of Understanding (MoU) was signed in March 2001 between the Federal Ministry of Health, University of Uyo, and the hospital, making it the University of Uyo Teaching Hospital. This was done in order to enable the students to undergo clinical training.

It is of note that the instrument that accorded the hospital the status of a full-fledged teaching hospital was finally signed on 28 January 2008 by the then President and Commander-in-Chief of the Armed Forces of the Federal Republic of Nigeria, Alhaji Umaru Musa Yar'Adua.

Within a short period after assuming office as the first home-grown Chief Medical Director of the University of Uyo Teaching Hospital, the directorate of clinical services has achieved several achievements that have positively changed the impression of the populace on the quality of healthcare services available in the hospital. These are milestone achievements, though there are also worrisome challenges.

Achievements

The achievements include:

Renovation

The management has undertaken renovation of some buildings for effective healthcare delivery. One of the most significant is the front building, which now has a new look (Fig. 1).

Other achievements include a new doctors' lounge in the department of accident and emergency, general out-patient department toilets for patients and staff, an intensive care unit, a main theater, a public health block, an old amenity block,

medical wards, an old surgical block now occupied by the departments of Ear, Nose, and Throat (ENT), and ophthalmology, maxillofacial surgery, and burns and plastics units. The next two photographs (Figs. 2 and 3) show how the front building looked prior to renovation.



Fig. (1). The front building of the University of Uyo Teaching Hospital, Uyo.



Fig. (2). The front of the teaching hospital (right wing) pre-renovation.

CHAPTER 8**Targeted Specialist Medical Services by Private Hospitals: The Mother and Child Hospital Story****Raphael Sunday Olarewaju^{1,*}**¹ *Mother and Child Hospital, Lagos, Nigeria*

Abstract: The purpose of including Mother and Child Hospital is to show how a private hospital can provide essential and targeted medical services to patients who reside near and far from it. Mother and Child Hospital is neither a small nor a large hospital but, being a medium-size medical facility, it sits comfortably in-between these two types of hospitals. Like many small and medium-sized hospitals that are set up primarily for profit in addition to rendering medical services, this hospital is situated in the mainland part of Lagos State which is suitable for easy physical access to and financial affordability for its target population – mainly the middle class. The hospital started as an obstetrics and gynecology cum pediatrics outfit and has maintained this target as its clientele.

The story is brief and it demonstrates that any focused medical practice that operates with excellence and patience eventually makes a mark on its patients and patients' relatives. The word of mouth by beneficiaries of medical services in any hospital, especially in private hospitals, is so important that it can make or mar an upcoming or an established hospital. This hospital has been on the right side of history and patronage of its patients. Following the example of this hospital is a recipe for comprehensive success.

Keywords: Financial institutions, Gynecology, Health insurance, Infrastructural needs, Medical investors, Medical practice, Pediatrics, Regulatory agency, Traditional medical practice.

INTRODUCTION

As fact-checked by the editors of Encyclopaedia Britannica, a hospital is “An institution that is built, staffed, and equipped for the diagnosis of disease; for the treatment, both medical and surgical, of the sick and the injured; and for their housing during this process. The modern hospital also often serves as a centre for investigation and for teaching” [1, 2]. It is a place in which the sick and injured

* **Corresponding author Raphael Sunday Olarewaju:** Mother and Child Hospital, Lagos, Nigeria; E-mail: ralpholarewaju@yahoo.com

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are received and treated. A public or private institution founded for reception and cure or the refuge of persons diseased in body or mind or disabled or dependent. A hospital is a place where they are catered for either at their own expense or, more often, by government or charity. It is a place of succor for the sick, the infirm or the unhealthy.

In light of the above, many hospitals in Nigeria today are far from what hospitals should be. Nowadays, most of the medical centers in Nigeria are worse than what General Muhammadu Buhari described as “mere Consulting Clinics” when the Military took over power from the Civilian government in 1983 [3, 4].

The challenge today is how to get our hospitals working again. How do we make our health system become the envy of the world again? How do we attract foreign nationals to our hospitals instead of the current deplorable and unacceptable situation where Nigerians suffer undue hardships and also spend billions of foreign currency on medical tourism annually?

Furthermore, how can entrepreneurial doctors and investors in medicine ensure that they have good medical practice in terms of impact, profitability, and sustainability?

Opening and managing a medical practice can be very exciting and rewarding as owners and operators can make a positive influence on the community they serve while doing what they love. However, entrepreneurial doctors and other medical investors should be mindful of the fact that managing hospitals is also very complex and challenging. Establishing and managing medical concerns are also capital intensive while the returns are usually in trickles but may be enjoyed over a long period. Medical Services are not financial fast-track areas where investors can recoup their investments quickly. This is because medicine and medical practice are mostly seen as human rights and social service issues and everyone or every government involved feels the exorbitant capital outlay.

Medical practitioners by training are usually versed in the science of medicine but may be deficient in the business of medical practice. Establishing and managing a medical practice is a business and the uninitiated should not venture therein without relevant training and experience.

For many doctors who desire to combine medical practice with the business of medicine, the challenge is how to marry their clinical acumen with the management of business, finance, human and material resources to produce a successful and profitable medical practice. How should medical entrepreneurs manage the ever present problems of inadequate infrastructure, medical personnel and finance in developing countries?

It is this arduous task that I attempt to perform using my experience as a specialist medical doctor, a medical educator, and pioneer medical director of a successful private medical concern in Nigeria. The hope is that this modest effort will be useful to those who are bothered by the current deplorable state of our hospitals and want to contribute their quota to right this wrong.

Hospital establishment and management are very expensive and demanding projects that should not be undertaken with levity and unadvisedly. Some of the experiences that have been very helpful in our practice are highlighted in this chapter. It is necessary to reiterate that much of what follows was learned on the job after the commencement of the operation of Mother and Child Hospital (MCH). Because medical students do not learn medical business in schools, many doctors literally jump into medical business with little or no knowledge or experience about business. The lack of knowledge or adequate preparation makes many doctors struggle and labor without success. There is a world of difference between the medical management of diseases and infirmities and the business side of medicine.

The establishment of MCH is a life-long vision that was pursued with all vigor and determination till the commencement of operations in October 1996. The visioner was trained in one of the foremost medical schools in Nigeria. He had a post-graduate qualification in Obstetrics and Gynecology and was a Fellow of the West African College of Surgeons in the Faculty of Obstetrics and Gynecology. He was a medical educator and a consultant to a teaching hospital for years.

The business aspect of medicine was taken care of by working as a staff of a prestigious medical practice in Lagos where he rose to the position of Clinical Director and Consultant Obstetrician and Gynecologist. He attended a management course organized by Centre for Management Development and has a Certificate in Leadership and Management in Health from the University of Washington's distant learning program.

The following suggestions are some important but non-exhaustive factors that should be taken into consideration before any intending medical entrepreneur embarks on the voyage of establishing and managing a medical practice.

The Reason for Starting a Hospital

It is of utmost importance that one sets out clearly why one desires to establish and run a medical facility. Many practitioners would have fared better working in the public or government sector or with an already established practice instead of establishing their own medical practice. Jumping into the fray without counting the cost may bring a lot of regrets later on.

Challenges, Success, and Prospects of a Small Hospital: A Story of Rst Clinics Ltd

Inyang Ukot^{1,*}

¹ *RST Clinics Ltd., Federal Housing Estate, Uyo, Akwa Ibom State, Nigeria*

Abstract: “Small hospitals” is an expression that many prospective and current proprietors and operators of hospitals might avoid using. This is understandable in a country where it is believed that the bigger, the better. The author deliberately used this expression to buttress the point that “Small” is not synonymous with the quality, significance, or nature of service that a hospital provides. The purpose of using “Small” is also to encourage doctors and non-physician investors to take seriously the prospect of establishing and operating hospitals that are small in comparison with the usual and commoner expansive hospitals, space-wise. To write this chapter, the author conducted a detailed analysis from a search of hospitals and discovered that even the World Health Organization (WHO) and the various governments in Nigeria acknowledge and advocate “small hospitals.” In Nigeria, the government allows “Small hospitals” to be sited in remote areas, rural areas, semi-urban areas, urban areas, state capitals, and even the Federal Capital Territory. This alone shows that there is, indeed, a place for “Small hospitals” in Nigeria – and, by extrapolation, in other developing countries of the world.

Keywords: Clinics, Electricity, Employees, Equipment, Maintenance, Medical examination, Nigeria, Planning, Policies, Power, Pre-employment, Procedures, Roads, RST Clinics Ltd., Small hospitals, Utilities, Water.

INTRODUCTION

Impact Clinics Ltd. is a limited liability company that was established in 2007 with the name RST Clinics Ltd. It assumed its current name from 24 June 2025. Some doctors do not want to go through this detailed process that may require the services of an attorney to sail through the requirements of the Corporate Affairs Commission (CAC) in Nigeria. Search for availability of the name of a hospital (large or small) may undergo “rejections” as the same or a similar name may have been “taken” and used by another medical facility. This is just one hurdle. This

* **Corresponding author Inyang Ukot:** RST Clinics Ltd., Federal Housing Estate, Uyo, Akwa Ibom State, Nigeria; E-mail: inyang.ukot@yahoo.com

[#] *Impact Clinics Ltd. has since replaced the former company name RST Clinics Ltd.*

introduction includes this seemingly small detail as those who start a hospital may wish to watch the progress of the hospital over some time and then apply for registration of the name. Nigeria is a large country with over 200 million people and with thirty-six states and the Federal Capital Territory. Some of the states in Nigeria are as populous as some countries in Europe. It is at the point of application for registration that it becomes clear that the name is in existence in the same State or another State in Nigeria and the name cannot be used. Sadly, this is true even when the name is not a direct match but very similar to the requested or intended name for registration. In this case, the already known name must be jettisoned and another name may be sought. Depending on where the hospital is located and the clientele, people may raise questions as to the “sudden change in name.” The curious people may not only be existing individual or corporate clients but also neighbors.

RST Clinics Ltd. did not want to have the above experience and went through the registration process first. Starting off as a legally recognized entity adds a feather to the cap of a new hospital (especially if it is a “Small” hospital); this is because the hospital can solicit a business relationship with any company (large or small). In the case of RST Clinics Ltd., this new and “small” medical company was “retained” by two banks and, soon after, by a multinational oil company.

There is, therefore, an advantage in doing the right things at the right time and being known for diligence, expertise, and thoroughness. RST Clinics Ltd. has, despite its small size, stood the test of time and hardly any client has had a significant adverse experience with us.

The rest of this Chapter describes the challenges and successes of this unique small hospital.

RST Clinics Ltd. is a limited liability company registered with the Corporate Affairs Commission of Nigeria and its registration number is RC 713510. It was registered in October 2007 and started rendering services effectively on 02 January 2008. One of its objectives is the provision of medical services *via* a small medical facility. This company, however, also provides a variety of medical consultancy services when contracted to do so.

RST Clinics Ltd. is a company that operates a medical facility. Medical facilities go by different names and may be classified according to size, level of care that its employees provide, or ownership. “According to the American Hospital Association (AHA), hospitals are licensed institutions with at least six beds whose primary function is to provide diagnostic and therapeutic patient services for medical conditions; they have an organized physician staff; and they provide continuous nursing services under the supervision of registered nurses. The World

Health Organization (WHO) considers an establishment to be a hospital if it is permanently staffed by at least one physician, can offer inpatient accommodation, and can provide active medical and nursing care.” [1] In terms of facility size, RST Clinics Ltd. fits into “Clinic,” which belongs to the group that may be described as small hospitals.

Concept of the Medical Facility

There is a concept behind any business. The concept varies from one business to another and it may change over time. With medical facilities, the concept may vary based on the owners of the business, the target clientele, the location of the practice, availability of other hospitals or otherwise in the neighborhood, proximity to hospitals that may be similar in terms of areas of specialization of the practitioners or the major specialty(ies) that the facility is set up to concentrate on in service provision. The concept that gave birth to a hospital not only envisions the initial size of the hospital but also the ultimate size. The concept driving the hospital determines how much funds are injected into the project ab initio and how much funds continue to be allocated to it. The amount of income expected to be generated from the hospital also drives the concept.

Concepts dwell in the mind and how well they are configured and nurtured determines how realizable they become. A concept may remain in the mind; it may be short-lived for many businesses, or it may become a reality. The reality may meet the goals of the original concept just as it may exceed them.

RST Clinics Ltd. was almost a child of circumstance. This company was thought of after a sudden and unexpected loss of employment by its eventual medical director. The physician found an unpredictable contract employment at the University of Uyo Teaching Hospital (UUTH), Uyo, just about six weeks after disengaging from the relatively short spell at the multinational company he used to work for. He knew full well that this new employment was an uncertain job that was subject to loss or renewal even after the very first year. To ensure that there would be no room for regrets a second time and that unused time was adequately occupied engaging in medical practice the way he thought fit, the idea of establishing a clinic arose. What kind of hospital would not only be sensible but also attainable under the then uncertain circumstances compounded by limited financial resources?

Many questions were considered and each required obtaining reasonable answer options even if definite answers were not feasible. Would this be a hospital or a company hosting a hospital? Was this going to be just, or yet, another hospital? Would it make sense to locate this hospital in the state capital, Uyo? Since the physical hospital would most likely be in Uyo as the principal medical personnel

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Inyang Ukot

Dr. Inyang Ukot is a Chief Consultant in Family Medicine and a diplomate in Occupational Medicine. He holds two fellowships in Family Medicine from the National Postgraduate Medical College of Nigeria (1991) and the West African College of Physicians (1995). He also holds a diploma in Occupational Medicine from the Royal College of Physicians of London (2005). He is a graduate of the College of Medicine, University of Lagos, Nigeria (1981).

Inyang has been interested in medical practice even before commencing undergraduate medical studies or residency in Family Medicine (then called General Medical Practice in Nigeria) as an Assistant Lecturer at the University of Calabar, Nigeria. His experiences have been vast and varied compared with his peers; this is because many of his colleagues have either worked wholly in the private sector or served solely in the public healthcare sector within Nigeria or in the diaspora. Unlike them, Dr. Ukot has worked in every sector – from health posts and health clinics owned by missions to teaching hospitals owned and run by the government. He has also worked in fully private hospitals, mission hospitals in villages/rural areas run by four different Christian organizations, and multiple medical facilities in the petroleum industry owned and run by the Federal Government of Nigeria and an international oil corporation.

He has, therefore, worked directly in medical facilities in many rural areas, three state capitals, and the federal capital. The wide scope of his medical practice has prepared him to write the contents of a book that, although small, reasonably reflects the challenges and successes in the various types of hospitals in Nigeria. Unlike most of his books, he chose to make *Functionality and Efficient Service Delivery in Nigerian Hospitals* a multi-authored book that captures even the views of non-core medical professionals.