TITLE PAGE

CO-ORDINATION OF GOVERNMENT PROGRAMMES: A STUDY OF KADUNA STATE HEALTH MANAGEMENT BOARD

BY

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A thesis submitted to the Postgraduate School, Ahmadu Bello University, in partial fulfilment of the requirements for the award of Masters degree in Public Administration

Department	-	Public Administration
Faculty	-	Administration
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DECLARATION

I, Ali Umar Bindawa, hereby declare that this thesis was written by me and only me and that it was not copied from any past research work. Also, I declare that both published and unpublished books, articles or journals directly used in the thesis are appropriately acknowledged.

DEDICATION

To the two: Alhaji Ali Bindawa and Hajiya Maimunat my parents, for all they have done and a lot more to be done.

CERTIFICATION

This thesis entitled "Co-ordination of Government Programmes: A study of Kaduna State Health Management Board," by Ali Umar Bindawa meets the regulations governing the award of the degree of Masters in Public Administration of Ahmadu Bello University, and is certified and approved for its contribution to knowledge.

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ABSTRACT

The major concern of this study has been to examine the nature and level of co-ordination in terms of effectiveness or otherwise of health service programmes offered by the Kaduna State Health Management Board. It also attempts to determine the factors that mostly affect co-ordination of health service programmes of the Board, and how such factors influence the efficient delivery of services to the people.

The health of the people depends on the quality and quantity of the health services provided by the government, which in turn depend on effective management of the agency or machinery responsible for the discharge of these services.

The study essentially employed the questionnaire and interview methods for data collection. A stratified random sampling was used in selecting the subjects because the sample was not homogenous. Using this technique a total of 225 respondents were sampled for this study. The technique used in analyzing data are the statistical frequency distribution and simple percentages. The major hypotheses tested revealed that there is ineffective co-ordination of health services by the Board. Our analysis also indicated that co-ordination could be seen from the perspective of internal and external or vertical and horizontal dimensions.

On the factors the mostly affect co-ordination it was revealed that a combination of variables affect co-ordination in the Board. And the combined effects of delegation, informal groups activities and political forces were negative. In the study therefore efficient and satisfactory delivery of health services to the teeming population has been an illusion. Finally, suggestions for improvement were made and in this way the government will endeavour to fulfil its social responsibility for the sake of good life.

TABLE OF CONTENTS

		PAGE
Title Page	....	i
Declaration	....	ii
Dedication	....	iii
Certification	....	iv
Acknowledgement	....	v
Abstract	....	vii
Table of Contents	....	ix
List of Tables	....	xi
List of Figures	....	xiii
Abbreviations	....	xiv

CHAPTER ONE _ INTROUDCTION

1.1	Statement of Problem	1
1.2	Aim of Study	5
1.3	Justification of Study ,,,,	5
1.4	Scope and Limitation of Study	6
1.5	Hypotheses	7
1.6	Methodology	7
1.7	Definition of Concepts	10

CHAPTER TWO - LITERATURE REVIEW AND THEORITICAL FRAMEWORK

2.1	Literature Review	15
2.2	Theoritical Framework	26

CHAPTER THREE

3.1	The Administration of Health Services in Nigeria	....	34
3.2	National Health Policies 1975 - 1985	....	37
3.3	The Administration of Health Services in Kaduna State	....	39
3.4	Kaduna State Ministry of Health: Bureaucratic Structure and Functions	....	41
3.5	Preventive Services	....	43
3.6	The Evolution of Kaduna State Health Management Board	....	44
3.7	Structure and Functions	....	45
3.8	Curative Services and Hospital Administration	....	50

CHAPTER FOUR – ANALYSIS OF DATA AND PRESENTATION OF RESULTS

4.1	Response Pattern to Questionnaire	....	54
4.2	Empirical Test of Hypotheses	....	56
4.3	External or Inter-agency Co-ordination	....	64

CHAPTER FIVE – SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1	Summary	....	101
5.2	Conclusions	....	106
5.3	Recommendations	....	109

LIST OF TABLES

			PAGE
1.1	The Structure of Sampling Units	...	9
4.1(a)	Responses on the questions on functional role perceptions	...	57
4.1(b)	Responses on the question on functional role perceptions	...	57
4.2	Responses on the question on role-conflict in Organization	...	59
4.3	The effect of role-conflict on co-ordination of health services	...	61
4.4	Classification of responses on re-definition of existing functional roles	...	62
4.5	Role perception in the running of organisation	...	65
4.6	Classification of responses for inter-agency role-conflict	...	66
4.7	Whether there is competition to perform similar things between the Board and the Ministry of Health	...	68
4.8	Responses on the question on leadership styles in your organization	...	71
4.9	Classification of responses on the level of delegation	...	76
4.10	Classification of responses on the degree of freedom granted to informal groups	...	79
4.11	Effects of informal groups activities on co-ordination	...	81
4.12	Classification of responses on the statement on effects of political factors on co-ordination of health services	...	83
4.13	Classification of responses according to level of participation in major administrative matters of the organization	...	88

4.14	Classification of MLMS responses according to level of participation in 'running' of the organization	...	89
4.15(a)	Classification of responses on whether there is an intergrated approach to Health Care	...	94
4.15(b)	Classification of responses on dichotomy between professional-specialists and generalist - Administrators	...	95

LIST OF FIGURES

		PAGE
2.1	A simplified model of Political system	28

ABBREVIATIONS

				PAGE
W.H.O.	-	World Health Organization	...	23
H.M.B.	-	Health Management Board	...	46
M.L.M.	-	Middle Level Managers	...	54
T.L.M.	-	Top Level Managers	...	54

CHAPTER ONE

INTRODUCTION

1.1 Statement of Problem

In modern societies there are numerous agencies engaged in the provision of health services to the people. In Nigeria, for instance, there are many agencies responsible for the provision of those services. In a vertical authority relationship, there are the Federal Government's health institutions such as the university teaching hospitals, military and armed forces specialist hospitals. Secondly the State Governments' have general hospitals, health centres and clinics. Thirdly the Local Governments' have dispensaries which are scattered in rural areas. Besides these institutions there is the World Health Organization with its health programmes which do come through the Federal Government. The implementation of those programmes rest on almost all the health agencies mentioned above.

The health service programmes of these agencies therefore require effective coordination in order to reduce or eliminate duplications and overlaps on one hand and to maximize the provision of services at a minimum cost on the other. It is often commented over the newsmedia that Government programmes suffer from lack of coordination. But there is a constant need to pull programmes together, especially as new services are added or dropped, and policies and regulations changed. Thus coordination

addresses the delivery of services and seeks the time, quantity and quality that will best meet desired needs. Health services to the people depends to a large extent on the quality, quantity and effective management of the health service programmes provided by the government. The problem of coordination seems to transcend national boundaries for instance the regional Director African Sub-region, World Health Organization Dr. A. A. Quenum at a coordination committee meeting on Health in Africa in Yaounde, Cameroon 1973 called for a concerted action towards achieving effective coordination. He stated that:

> ..... Technical assistence has been an arena for futile rivalry to the prejudice of the clear interests of the communities we were supposed to be helping. Overlapping or duplication of activities and ill-intentioned competitiveness lead only to wastage of resources and a sense of frustration. The primary purpose of coordination is to ensure more effective execution of programmes and to improve the administrative efficiency of each participating agency and the system as a whole[1].

In Nigeria, the recorded socio-economic growth in the 1970's led to demands for more and better health services. This resulted in expansion in size and scope of health service programmes. In Kaduna State, for instance the area of glaring increase was in the construction of health centres and clinics which were undertaken by the Ministry of Health and Social Welfare. It appears that the proliferation of these health institutions was however not accompanied by commensurate increase in actual health services to the people. Therefore fine physical structures

stand as "white elephants." Because the structures were not properly coordinated with the available human resources. Health services were not even within easy reach to the people.

The Government in cognisance of this problem stated in the 2nd National Development Plan 1970-74 that:

> A healthy population is an economic asset since it assured the supply of a strong and healthy labour force . . . . . for development. Health needs liiust therefore keep pace with the growing needs . . . . of the people . . . . for this reason development in the health sector must be geared to targets which will ensure that health services and amenities are within easy reach of the people .

This pronouncement by the government readily brings these questions to mind. Have these services and health amenities been provided within easy reach of the people? If not what are the factors inhibiting the provision? Has ineffective coordination contributed towards government's inability to provide services?

As a response to those shortcomings the Health Management Board was created by an edict No. 7 of 1978. The Board was created to among other things ensure coordination and integration of the various health . services in the state. In addition the Board was responsible for curative services as well as managing health institutions under it. The Board has its headquarters at Kaduna and six zonal management committees strategically located all over the state.

However, inspite of the Board's creation eight years ago the problem of coordination of health services persisted.

The growing gap between expectations and the agency's performance made it evident that a problem exist. The problem of health "administrators" in the agency is how 'best' to coordinate health services in the state. This problem poses a challenge. The challenge today therefore is to reach most people with health care using limited resources at the disposal of government in ways that will yield the greatest possible benefits. To achieve this objective, there should be effective coordination. The questions this study direct itself to are: What is the level of coordination in the Board? To what extent has the Board achieved effective internal coordination of health services? What are the contributions of the Board in the external coordination of various agencies and Health institutions providing health services in the state? In line with the provision of the Edict establishing the Board, has coordination really been achieved? What factors inhibit or promote effective coordination of health service programmes by the Board?

For the government to provide her social responsibility for the sake of good life, the Board as a government agency is faced with the onerus task of managing the health services. Thus answers must be provided on how "best" to bring about effective coordination of government programmes by the Board and consequently the efficient delivery of health services to the people.

The effort of this study has been to provide these answers by explaining the present situation in the Board and pointing towards a new direction.

1.2 Aim of Study

Based on the statement of problem, the study is aimed at:

i) Examining the nature and extent of coordination of health service programmes by the Kaduna State Health Management Board.

ii) Examining the factors that mostly affect coordination of health service programmes of the Board, and how these factors influence the efficient delivery of health services to the people.

iii) Examining the mechanisms of coordination the Board employs to promote or achieve effective coordination of health services.

1.3 Justification of Study

This study has been inspired by an overt desire to fill a gap in knowledge in an area that has suffered neglect from scholars. Though many studies have been undertaken on health administration, as far the researcher was aware none has ventured in to study co-ordination of health service programmes.

A nation seeking to develop and continue to exist must be concerned with the problems of inadequate health services to all citizens irrespective of the differences in location. It has been reflected in many physical and management sciences literature that high mortality rate results into costs in time,, output, efficiency and

productivity. Having realized this, the Federal Government in the first National Development Plan 1962-68 stated that:

> A fully co-ordinated health programme is essential not only for the physical welfare of the nation but also to contribute to increase productivity which is essential for the success of the plan[3].

In the light of the above, it is not only justifiable but also vital for practical and effective management, to venture in to a research of this nature.

In a situation where the records of performance of Government agencies responsible for health care delivery leaves much to be desired, a study of this nature is justifiable. In fact, frustrations with gross deficiencies in co-ordination of health services and the growing gaps between expectations and performance have made it evident that investigation in this field of knowledge is justifiable in order to bring to light problems and gaps that require attention of administrators and policy makers.

1.4 Scope and Limitation of Study

This study covers a period of eight years from 1978-86. This reason behind this choice is to enable the study to cut across the "Systematic" changes Nigerian political scene had witnessed over the years. Changes from the Military administration to Civilian Presidentialism and back to the present Military Administration.

As a case study of the Kaduna State Health Management Board, it focuses mainly on the administrative aspect. Though there are many variables associated with

administrative aspect of Health services, such as Finance and Manpower this study limits itself to co-ordination as a managerial activity and its effects on an agency responsible for the provision of Health Services.

It is necessary to state that the collection of data required for this study met with unquantifiable hardship. This resulted from lack of co-operation and suspicion from some members of staff especially in the top management of the agency under study. The crux of the problem in the Board's Headquarters was the Secretary and Head of Administration (1985-86) whose suspicion and interpretation of research activity was negatively unwarranted.

1.5 Hypotheses

From the available facts and existing data, the following hypotheses were tested.

i) Effective co-ordination of the Health .Services depends on clear functional roles of an organization,

ii) Organizational climate affects co-ordination,

iii) Participative Management influences co-ordination.

1.6 Methodology

Basically there are three methods of data collection viz the observational method, the interview and the questionnaire methods. Essentially this research employed the interview and questionnaire methods for data collection.

In the questionnaire method most of the items were closed ended or fixed alternatives.

The questionnaire was administered to selected health institutions and zonal Management Committees of the Board, as well as other agencies responsible for the provision of Health Services with which the Board relates. By this method information was obtained on co-ordination of the external environment, that is to say the Board's relations with other agencies providing or aiding in the provision of health services in the state.

The face to face interview method has also been extensively used to collect facts which could not be obtained using questionnaire method.

Principal Officers in the Health Management Board were interviewed to obtain data on the level of co-ordination of the internal environment, and its effects on performance. Information on the co-ordinative mechanism of the Board was als tapped from the sample used in this study.
The interview method was used to assist the researcher in corrobtating data collected from the questionnaire method. Also to clarify certain issues and ask certain questions considered sensitive and therefore not suitable for the questionnaire. The questionnaire method comprised both open-ended and close-ended questions.

Any meaningful research undertaking in the humanities would require the use of sampling technique. A stratified random sampling was employed in choosing the subjects because the sample was not homogenous and the advantage of this method of stratification rested on the fact that each section of the population stood a chance of adequate representation. This teachnique also minimized the persistent

traditional African research problem of lack of co-operation from among the survey population.

A total of 225 people were sampled for the purpose of this research. The reason responsible for the stratification included differences in areas of specialization for instance, professionals, para-medical and administrative personnel. Vertical management position in terms of top level managers and middle level managers. Therefore the population was divided into units/strata and from each strata a random sample of required size was chosen. The classification is shown in table 1.1 below.

TABLE 1.1

THE STRUCTURE OF SAMPLING UNITS

Sampling Units	Vertical Mgt. Position and salary GL.		
	Middle Level Managers GL 08 - 10	Top Level Managers GL 12 & above	Total
Health Mgt. Board Head-quarters	20	13	33
Kaduna Zone Health Insts.	16	14	30
Katsina Zone Health Insts.	20	15	35
Kafanchan Zone	8	7	15
Zaria Zone Health Insts.	6	4	10
B/Gwari Zone Health Insts.	4	3	7
Daura Insts.	6	4	10
Min. of Health Kaduna	-	21	21
TOTAL	80	81	161

On data analysis the principal technique employed in this research work was that of frequencies and simple percentages.

1.7 Definition of Concepts

This portion is devoted to both theoretical and operational definitions of concepts employed in this study.

Co-ordination: Is the harmonious combination of actions of agents towards given or certain objectives; it is bringing people (personnel) to ends (objectives) and parts (organizational structures) to each other.

For any agency to fully achieve effective co-ordination, "there must be among others, co-operation, organization, planning, control and leadership."[4]

Performance: Job accomplishment with positive results and achievements within stated time period by an agency or a group of agencies.

Control: The exercise of power through the use of instruments of rules and regulations and informal constraints.

Controlling: "Is the adjusting of operations so that they conform to predetermined objectives."[5] This definition is less concerned with controlling personnel but with goals.

Planning: Decision concerning future action. Broadly defined "planning is the working out in broad outline, the things that need to be done and the method for doing them to accomplish the purpose set for the enterprise" or (agency).

Delegation: Operationally defined here to mean the process by which a superior in a hierachy grant to a subordinate the authority to act on his or her behalf.

Co-operation: Working together in order to achieve a common purpose or the organizational goals. (in other words spirit of team work).

Integration: A process of bringing otherwise independent administrative, technical structures, functions and diverse mental aptitudes into a co-herent whole.

According to Umar Shehu of the W.H.O. 'an integrated" health* service is normally operated on the basis of team work, such that the greatest possible use of skills could be made[1]. In this study therefore integration and co-operation would be used interchangeably.

Leadership: "A social process where by one or more (emphasis mine) individual (s) attempt to influence others.'[0] Leadership in an

organization has the prime tasks of harmonizin parts to each other and peoples (personnel) to ends (objectives).

Leadership Style: This is the total pattern of leaders' action in relation to their followers. That is, the leaders attitudes towards the employees.

Organizational Climate: The human environment within which employees perform their tasks. This include the internal and external settings. The internal setting comprises of those variables such as leadership style, informal group activities e.t.c. that exert a direct and usually immediate influence on the organization. The external setting however contains variables such as the political and socio-economic systems, government policies and other forces that interact with and influences the organization directly or indirectly.

Agency: A body corporate or incorporated established by the government vide a decree, edict or law to perform specific functions or services.

Organization: Government establishment charged with authority and responsibility for specific services. This study shall use agency and organization interchangeably.

Top Level Managers: Staff occupying top management positions in an agency or organization. This study uses all those staff on GL 12 and above.

Middle Level Managers: Employees occupying middle level management position. The staff which forms the linkage group between the top management and junior staff cadres. This study uses the category of staff GL 08 - 10.

Participative Management: Refers here to a situation in which members of an organization who are involved in, or who will be affected by administrative decisions are permitted or even required to participate in deliberations (not necessarily as members of the committee or management) leading up to the decision. In other words direct and/or indirect participation in decision making process.

Health Services: Consists of all services being rendered for medical care.

Preventive Care: Emphasise control of an impending disease before occurance.

Curative Care: Treatment of person(s) affected by disease.

Board: Government agency established by decree, law or edict to facilitate efficient delivery of stated services or functions authorised by the legal provision, establishing it. In this study Board means the Kaduna State Health Management Board.

FOOTNOTES

1. A. A. Quenum, The Health Development of African Communities. Afro-Technical Papers No. 15, W.H.O. Brazziville Press 1979, p. 101.

2. Federal Republic of Nigeria, Second National Development Plan 1970 - 1974, Federal Government Printers, Federal Ministry of Information, Printing Division, Lagos 1970, pp. 247 - 249.

3. Federal Republic of Nigeria, First National Development Plan 1962 - 1968, Federal Government Printers, Printing Division, Lagos 1962, p. 23.

4. Dimock and Dimock, Public Administration, 4th ED. Holt Printers. NewYork 1969, pp. 80-84.

5. L. C. Howard and J. B. Mackinney, Public Administration Balancing Power and Accountability. Moore Pub. Co. Illinois 1879, p. 209.

6. Faludi Andress, A Reader in Planning theory, Pengramon Press, N. Y. 1973. p. 327

7. Umar Shehu, Health Care in Rural Areas. Afro-Tech Papers, No. 10, W.H.O. Brazziville Press 1975, p. 28.

8. R. M. Stodgill, Leader Behaviour, its Description and Measurement, Columbia, Ohio State Univ. Bureau of Business, 1980, p. 19.

CHAPTER TWO

LITERATURE REVIEW

Co-ordination as a management concept is one of the most interesting but indeed controversial managerial concept which attract attention and comments from administrators and managers in both public and private agencies.

It has often been regarded as an all-inclusive managerial activity. In public administration practice, co-ordination is necessary because of a number and complexity of programmes. In fact because of the importance attached to the concept, quite a substantial literature has been writte about it.

To grasp the idea of co-ordination, it is necessary to realise its pervasiveness in government operations. Dalton and E. Mcfarland defined co-ordination as:

> That process by which managers achieve integrated pattern of group and individual effort. To co-ordinate is to develop unity of action in common purposes[1].

Whereas Dimock and Dimock defined co-ordination in this way: "Co-ordination is the harmonious action of agents or function towards a given objective"[2].

Tyagi defined it as follows:

> Co-ordination means bringing about consistent and harmonious action of person with each other towards a common end[3].

From the above definitions, the common feature to all of them are "common action, purpose and ends". These definitions seem inadequate as they did not indicate precisel what co-ordination in organizations seeks to achieve. If co-ordination brings about "common action or purpose," one

may still ask common action for what. However, Howard and Mckinney provided an explanation to our searching question about what co-ordination seeks to achieve. They argued:

> Co-ordination addresses the delivery of services and seeks the time, quantity and quality that will best meet client needs.[4]

From this argument it becomes evident that co-ordination is important in public agencies not only to meet client needs but also to satisfy the constant need to pull government programmes together. From the foregoing an acceptable definition for this study is further provided by Howard and Mckinney in the following lines:

> Co-ordination attempt to combine action of a number of muscles.... and in administration the harmonious combination of actions of agents or function toward a given objective, and the process of under lining, unifying and integrating managerial functions, actions and operations.[5]

The emphasis to note in the above definition is on people (personnel) to ends and parts (organization structures) to each other. It also discusses the harmonious combination of functions establishing linkages and overcoming administrative procedures - inhibiting progress - within an organization. In summary therefore, co-ordination requires teamwork, every collective activity no matter how simple need co-ordination and it is mostly pronounced in complex organization. In Nigeria Government programmes in particular health service programmes have become so numerous to a magnitu that they cannot be put under one umbrella. Co-ordination of these programmes is therefore essential for efficient delivery and maintenance of these services.

The trend of this literature review would however take a geographical pattern rather than chronology. The review would therefore continue by examining the relevant available studies or research works conducted in Nigeria. This would be followed by other works done on the African Continent and finally the rest of the third world nations. The reason for this format is to offer a critical review of works done in areas of the third world often regarded as having similarities of problems in certain aspects like political histories of domination, socio-economic and developmental problems.

The limited literature on the administration of Health Services and Health care delivery system in the developing countries in general and in Nigeria in particular that comes close to this study in terms of topical relations was that of Aliyu, who conducted a study on the Administration of Health Services in Kano Metroplitan areas. In his study Aliyu contended that:

> Ministries are the central organs of government administration in every country the world over. The ultimate aim of the ministry is to achieve the set goals and objectives. These include the ability of the administrators to do the right things at the right time which are in conformity with the ministry's objectives. This lack of effort to implement the right things at the right time adds to more administrative problems especially when it comes to implementing the proposed projects[6].

The above contention is sound and reasonable but did not attempt any indepth analysis to empirically prove the reasons behind the administrators lack of effort to implement things so as to achieve ministerial and/or agency objectives.

Moreover, Aliyu's premise lay essentially on the administrative problems involved in the provision of health services to urban-based people of Kano metropolis. His area of coverage is very limited such that what happens outside the metropolis was not within his scope.

In addition Aliyu's research was generic superficially touching on the major aspects of administration and his conclusions are also general with less clarity as to the specific administrative problem or problems the study intended to reveal so as to enable other readers trailing along his path to grasp. Despite these ambiguities Aliyu's pioneering move is a pointer to an area of research still so new to be fully investigated. Another pioneering study in the field of the administration of health services was that of Ukpong who conducted a research on the "Administration of Health Services in Calabar Municipality."[7] Ukpong's study establishes the relationship between the peoples standard of living and health on one hand and their level of productivity on the other. He further expantiated on the vicious cycle of poverty first identified by Gunnar Myrdal in his work, "The Asian Drama." Ukpong therefore recommended the need for concrete action to break this vicious cycle especially in the area of preventive and social medicine. Ukpong concluded that there is no "clear cut health policy in this country in general and in the Cross River State in particular."[8] He blamed the Cross River State Government for inadequate allocation of funds to the Health Sector.

These conclusions broad as they appear, seems to ignore other forces affecting government allocation of resources to the health sector. Firstly Nigeria to my mind has a

health policy both preventive and curative although emphasis was recently put on preventive. In fact as a member of World Health Organization, it has incorporated the policy of "Health for all by the year 2000 AD." On the issue of resource allocation to the health sector, Ukpong seems to isolate the forces of corruption and fraud by some actors in the health agencies in Nigeria. Furthermore interest groups' activities which are inimical to the actual utilization of the scarce resources allocated to the health sector for the benefit of all the people were ignored in Ukpong's conclusions.

The researcher however shares Ukpong's stand that health and national development are bound to each other. His recommendation to the Cross River State Government to establish a Health Management Board to relieve the Ministry of some of its functions which inhibits the efficient discharge of responsibilities are logical however, the variables used in the study are general administrative aspects which are different from this research. Similarly Ukpong scope is urban based and did not cover the entire State.

Inspite of the distinction between Ukpong's and this research; the former's contribution to knowledge in this "barren" area has been worthy of a review.

In another study conducted by A. I. Ahwona " Politics and Health: colonialism and health in Northern Nigeria 1900-1960", under-development/dependency theoritical framework was employed to analyze the effects of colonial health policies upon the colonised peoples of Northern Nigeria. In the study he asserted that:

> Health care system should not be seen in isolation of all other economic, political cultural and environmental factors in society. An analysis of Health and health care system in a society should focus on all facets of society in general and in particular the control or non-control of the apparatus for policy making and of which specific interest predominates in society. For the final analysis it is those in position of authority that make policies which are authoritative and all-embracing policies as to who should have access or no access to health and wealth in society. Thus the link between politics or rather art of governing and health.[9]

The essence of the above extract is to motivate an indepth study on the effects of decision-making on co-ordinatio on the one hand and to see whether or not participation in decision making enhances co-ordination and therefore improves the administrative efficiency of an organization. In Ahwona's study he concluded that:

> The colonial health policies especially the development of the health sector and the distribution of medical facilities were greatly influenced by the economic interest of the British Colonizers.[10]

To expantiate further Ahwona implied that colonial health policies were antimasses and urban-based with a clear cut neglect of the rural areas. These conclusions are quite relevant and drawn from an empirical research. While no responsible government wherever it may be can pretend ignorance of the importance of health as an essential resource and health care as an essential social service, the colonial government was only interested in the economic exploitation of their colonies. Thus the health situation of the colonized people 'intrude' when the economic interests of the colonizers coincide with the necessity of a healthy labour force.

Although Ahwona's study analyzed the effects of colonial health policies on the Health Sector, there are however distinct differences between it and this research. He analyzed a different political setting with different actors (colonial administrators - cum - Military machine) from our present set-up. Finally, his analysis seems to strickly adhere to the political economy-cum-Marxist approach, while this approach would lend credence to political economy alone emphasis would strictly be on management theory or theories in Public Administration.

Whereas some studies like Ahwona's perceived Health and Health care delivery system in relation to the socio-economic, political and cultural environment, Ralph Schram[11] however, employs the historical/descriptive approach to the study of Nigerian health services.

Schram's work laid emphasis on the chronology of who does what and how from the earliest times - colonial occupation of West Africa - through to Nigeria's political independence in 1960.

This researcher's main observation of Schram's work was that he did not attempt an indepth analysis of the reasons for colonial unequal distribution of health care delivery. Rather he blamed this inequality on the problems of logistics which as earlier briefly pointed elsewhere in the previous paragraphs was not convincing; for the fact that the colonial military machine penetrated the thick swampy forest of coastal West Africa for the sake of conquest and domination when their economic interests dictated such moves. Hence to blame the delay in the provision of Health

Services to what was until recently (1957) known as Northern Region of Nigeria on logistics problems is untenable.

In another work Okello analyzed the relationship between imperialism and the health sector of third world nations. In it Okello traces the growth of European capitalism and its impact on health within and outside Europe. Furthermore he explained "how health and capital were in profound conflict and the ways in which the interest of capital were served by the capitalist in order to save capital more."[12]

Okello contend that the business of manufacturing drugs and health equipments for export to the developing countries was taken-over by the trans-national corporations with headquarters based in Europe and America. Consequently he reported that:

> Having adopted the strategy of local assemblage of drugs Transnational corporations (TNCS) find another set of allies among policy makers..... who may have interest in opportunities to make money from awarding contracts.13

In the above extract Okello exposes a fundamental relationship between imperialism, health sector and its actors in developing nations, a relation of accumulation at the expense of the health of the majority. Okello's conclusions suggested a solution to this conflicting relationship of health and capital, which according to him rest on 'a gigantic political struggle for the control of the state and its apparatus for policy making.'[14]

In a survey conducted in Kenya caption "KENYA SURVEY": Financial constraints dominated health debate, it was observed that Kenya was going through a period of economic uncertainty

and at independence Kenya inherited a health service geared to Nairobi - the country's capital and some major towns, hence like so many of its peers in Africa Kenya has never really managed to meet the extra-ordinary costs of running these hospitals as well as try to expand services more equitably. The survey pointed out the structural arrangement of health care delivery in Kenya. It reads:

> Structurally health care delivery is divided into regional zones with a limited autonomy granted each district. The Ministry of Health in Nairobi holds the purse strings and constantly appeal for funds are heard from all quarters.[15]

This survey exposes the problems of finances and management of health institutions; in particular the effects of centralization of bureaucracy which no doubt has tremendous effects on co-ordination in public agencies. For instance, Kenyatta National Hospital like most of its counterpart in Africa witnessed a dangerous drift in standard of a teaching hospital. Such hospitals have too much administrative palaver and insufficient medical care. Similarly financial constrint often affect these hospitals. The survey indicated that Kenya is facing up to a classic African problem. It is trying to play its part in health for all. A challenging task which require careful and proper management if services are to be provided and maintained. This challenge is not restricted to Kenya alone but many African countries such as Nigeria.

Umar · Shehu (at the moment of writing, the W.H.O. Regional Co-ordinator branch office Lagos) found it important to conduct a study on "Health care in Rural Areas". His data largely collected from Nigeria led to the following findings:

> Although services are provided by a number of organizations - Governmental agencies, Local Authority and voluntary agencies there is little co-ordination betwen the various sectors which makes it difficult to establ ish priorities and plan programmes..... the system is therefore inefficient and uneconomical and often lead to duplication of services in some areas and complete absence in others.[16]

From his findings, as quoted above, Shehu conclusively suggested that delivery of health care to rural areas must be based on an "integrated approach" so that there is adequate administrative and technical link between all units.

Shehu's work has direct relations with this research which aims at analyzing the linking of people or personnel to ends and parts or organizational structures to each other in a harmonious way with the purpose of improving or at least maintaining services. Because the fundamental health problems of rural areas cannot be solved automatically through the political gimmick of hospital or health centre constructions. The actors in the health sector must accept and appreciate the necessity for a team work through co-ordination.

In another survey conducted in the Gambia to assess health facilities, programmes and personnel, a plan of action was formulated focussing on the national and child health programmes. This plan pre-supposes that there was a primary link between infants, children and pregnant women and the health services provided. The plan divided the country into 3 zones of approximately 200,000 people each, where expansion of immunization services was phase one. The objectives of the immunization programmes were:

i) To reduce morbidity and mortality by 50 percent within 3 years of full operation.

ii) To develop the immunization programme within existing health delivery system.

iii) To establish a programme that will continue after the donor had withdrawn support.[17]

Thus after 2 years in which the programme has been in operation the percentage of the children covered has steadily increased reflecting the success of the integrated team approach and the procedure adopted. Reported figures of reduction of morbidity rates for measles according to the survey for the period from 1979-1981 were as follows:

> 1970 before introduction of programme no. of children 2,610.
>
> 1981 after introduction of programme no. of children 184.[18]

Apparently one can see from the reduction rate between 1979 - 1981 the programme was successful. This success could reasonably be attributed to the flexibility, functional design, method of operation and effective co-ordination of personnel and resources.

This survey therefore had proved that improvement of organizations and the administration of health services by adopting an integrated (co-ordinative) approach could meet the needs of the population in a reasonable amount of time and at minimum cost. To buttress this argument the Regional Director African Sub-Region of the W.H.O. Dr. A. A. Quenum commended the Gambian immunization programme and further appealed to the African member countries. He stated that:

> Integration of the health services into the general health infrastructure could significantly facilitate co-ordination.[19]

It is important to note here that the above survey has direct relevance to this research for the fact that Nigeria and the Gambia have many things in common such as

similar colonial history, common colonial "Masters" and at independence similar characteristics of a developing nation.

Whereas these similarities exist we are not unaware of silent differences between both countries. Indeed in both the Gambia and Kaduna State of Nigeria health service, is a specific service and the desire of the people to achieve good health in both countries is not conflicting.

Finally, the effort of this literature review has been to present other people's works and to critically analyz what differences and similarities that exist between such works and this research.

Although quite a number of literature has been written on co-ordination there seems as far as the researcher is aware, to be few researches on Health Services programmes. Nevertheless it is often observed that the road trodden by pioneers in any human endeavour is neither smooth nor easy, it is in recognition of this fact that the contribution of these author's reports and researches in various but related fields are fully appreciated.

2.2 Theoretical Framework

The multifarious factors which influence and indeed determine the co-ordination of government programmes especially the co-ordination of Health services would be meaningfully analyzed within the framework of the systems theory.

This theory would serve as the analytic 'box' into which all data can be arranged with a view to arriving at meaningful conclusions and recommendations.

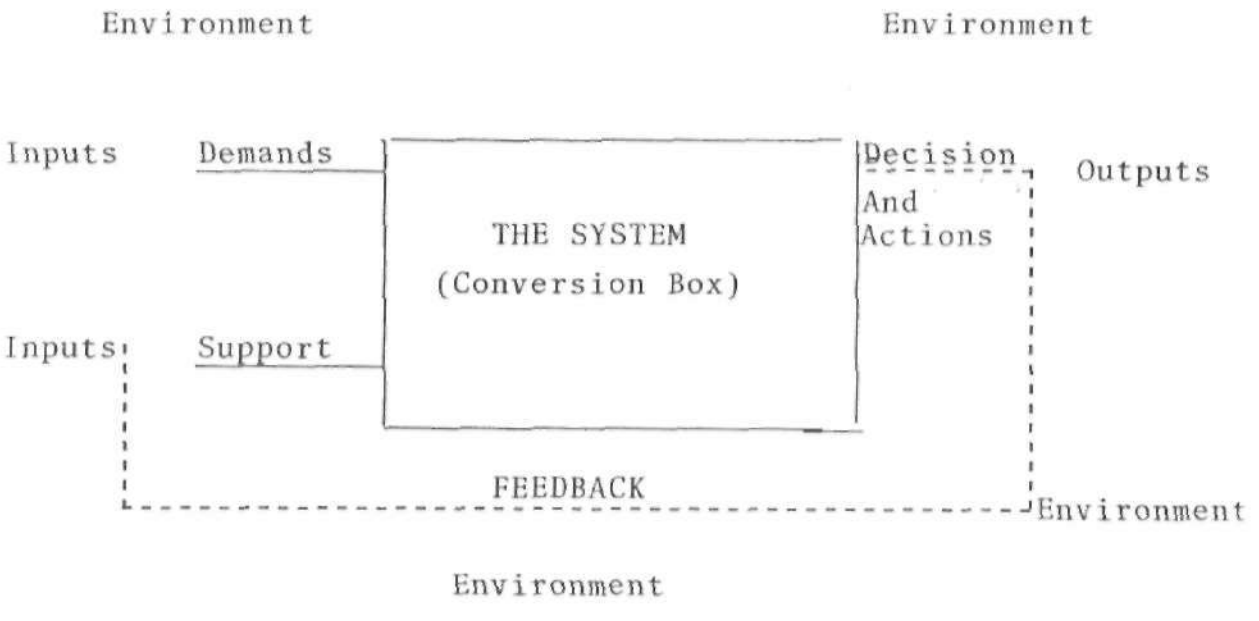
Health care system should not be seen in isolation of economic, political, cultural and environmental factors in any given society.

Gunnar Myrdal[20] points out the relevance of research into health in relation to development processes and plans in the developing nations. Thus an analysis of health care system in society should focus on all facets of society in general. It is in cognisance of this relevance that this study would analyzed certain variables like the political setting of the Health Services, Leadership style, delegation and informal group activities which are collectively considered as essential variables related to the organizational climate.

The study of the art of government is concerned with understanding how scarce resources are allocated between conflicting demands, how authoritative decisions are made and executed in and for society or societies. The science of administration emphasises the action-part-of-government which is continously being practiced in public agencies. Thus David Easton[21] explains that if we hold the system of political action as a unit before our mind's eye, as it were, we can see that what keeps the system going are inputs of various kinds in the form of demands from the people of the environment. These inputs are converted by the processes of the system into output in form of decisions and these decisions in turn have consequences both for the system and for the environment in which the system exists. From the feedback "given" by the environment

other inputs are generated further in form of support or fresh demands. Hence, the need for continuous co-ordination of the system with its environment both to maintain the system, prevent it from disintegration and to provide effective and efficient services by way of or through decision making and their implementation. The study would therefore use Easton's system theory of input-conversion - and - out-put process as its guide to analysis. Easton's model is reproduced below.

Figure 2.1: A simplified model of Political System



SOURCE: Adapted from D. Easton's "A Framework for Political Analysis in Jack Denis. Socialization to Politics: A reader. John Wiley Inc. N. Y. 1969 p. 32.

What then is a system? What are the properties of a system? And what is the rationale for using or adopting the theory for this research work?

A system is an organized unit that consists of two or more interdependent parts or sub-systems and can be distinguished from the environment in which it exist by some identifiable boundary.[22] For our analytical purposes this definition serve as our working-definition. The properties of a system include among others, organized independent unit, social structure(s) and an environment. It is applied to the study of organization by modern theorists.[23] Who have realized that social structures consist of 5 basic parts viz:

> The individual - who come into the organization with a particular personality structure - Secondly, the informal organization with its structural hierarchical set up each of which carry authority and responsibility. Thirdly, the informal organization which makes demands to the individual within an organization and to remain a member the person must behave appropriately. Fourthly, the fusion process which reveals give-and-take situation in the organization. Finally the environment.[24]

Systems theory is therefore concerned with viewing society and agencies as being made up of different sub-systems which are interrelated to one another and dependent on the environment within which they exist. Each sub-system has its norms, values and particular goals it seeks to achieve. The elements of sub-systems interact and relate to one another, a process (and maintenance) of this interactions can logically be considered as the administration of the system as a whole.

The rationale for adopting the systems theory to the study of co-ordination of government programmes as related to health services, lay in the fundamental assertion that nowhere in the world is it meaningfully. possible to study problems of health - whether administrative or technical in isolation from the environment in which the problems exist. Some may wish to argue that system theory is merely an approach strickly for political science but this argument has been resolved by theorists in both Public Administration and Political Science. For instance, John Pfiffner expressed the inter-relationship between politics and administration in the following lines:

> There is no denial that in a considerable number of instances questions of policy will be closely intermingled with administrative action.[25]

Furthermore Marshal Dimock reaffirmed this inter-connectedneess by stating that "the two processes of administration and politics or policy are co-ordinate rather than exclusive".[26]

Therein lies the link between the science of administration and that of political science, so too is the rationale for adopting this theory to our study.

It could therefore be hypothesized that if a structured system is to maintain itself, it must provide mechanisms whereby its members are integrated or induced to co-operate in some minimal degree so that they can make authoritative decisions and implement same in a harmonious manner to yield maximum result to beneficiaries and achieve satisfaction for performance by the organization.

Thus, the inextricable link between co-ordination and systems theory. Since co-ordination pre-supposes the presence of social structure in an environment, it therefore involves bringing peoples to ends and parts to each other in other words it addresses the delivery of services to meet peoples demands in a harmonious way.

Finally, while there is no one royal road that can be said to be either absolutely correct or the best it is only what appears at the given level of available knowledge to be the most useful that is considered. At this moment or stage it appears that system theory with its inputs - output exchange between a system and its setting; offers a fruitful approach, and a way of organizing presently disconnect data into a co-ordinated whole. In a study like this one, systems theory provides a useful guidance in analyzing the phenomenon of co-ordination in government agencies.

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CHAPTER THREE

3.1 The Administration of Health Services in Nigeria

A study on co-ordination of government health services programmes cannot easily be accomplished without tracing the history of Health Services in the country in general and Kaduna State in particular.

This is imperative because it will not only show the scope of the study but it will also delineate the different areas of co-ordination such as vertical, horizontal or lateral co-ordination of Health Services. It is through these areas that we can perceive the complexities of co-ordinatio and the presumed problems accompanying these complexities in government's effort to provide health services. In fact there are so many agencies currently engaged in the provision of health services in Kaduna State in particular, and the nation in general; such that it is difficult to pin-point who does what at a glance.

The history of modern Health Services could be traced back to the colonial period. The colonial health service structure relatively patterned on the systems in Europe was intended to cater for commercialised and urbanized societies. Such colonial medical services were concentrated in few selected towns where the colonialist have trading and commercial interests. Thus the colonial Medical and Health Services structure was intended to serve the colonial administrators, colonial military machine, and traders.

The infrastructures for medical services were first "seen" in Lagos, when the first Military Hospital was built in 1873.[1] Schram pointed that "no attempt was made to treat indigenous population."[2] Hence the indigenous population had to contend with the traditional medical service long in practice before colonialism.

In the same centuary (19th centuary), the missionaries first started the extension of medical and health services to the indigenous population along side with schools. Thus Ishaya Audu aptly stated that:

> A system of doctors, dispensaries and hospitals in colonial Nigeria developed in two separate directions. The Government Medical Services and the Missionary Medical Services.[3]

However, when Nigeria became formally a British colony, the entire Colonial Medical and Health Services structure essentially meant to serve the colonial masters began to distribute medical service to the people. Audu further stated that:

> As the local population began to seek medical assistance, what were called African hospitals were established..... and were meant to cater specifically for the African population. The earlier established "Nursing Homes" (i.e. British Administrators hospitals) continue to cater for the expatriate Colonial Civil Services and their families.[4]

As a result of Colonial Government's recognition and consequent extension of medical and health services to the indigenous population, the providers of such services to the population started to gear their attention to less urban areas.

However, on the whole, colonial health policy was deliberately designed with particular emphasis on curative care, massive importation of drugs, materials and medical

personnel. In addition, the policy deliberately created the imbalance in the distribution of health facilities between the urban and rural areas in favour of the urban areas.

It was therefore, not surprising to find that Nigeria at independence October, 1960 emerged with an inadequate doctor-population ratio which necessitated her dependence on foreign medical personnel, equipments, materials and drugs etc.

Independent Nigeria continued with the imbalance in the distribution of health facilities between urban and rural areas even after the departure of the colonialists. In Northern region, Kaduna and other major cities benefited from this imbalance to the embarassing neglect of the rural areas. Moreover, the emerging ruling class at independence followed the footstep of the colonial masters in designing a national health policy. Thus the imbalance in the distribution of health facilities continued.

Organizationally, the Health and Medical Services structure evolved with the establishment of a National Ministry of Health in Lagos and the Regional Ministries of Health at Ibadan, Kaduna and Enugu.

The creation of states in 1967 led to the development of State Ministries of Health in each of the 12 States. During the Murtala/Obasanjo's administration, the states - structure were increased from 12 to 19. Each of the 19 states has a Ministry of Health and at the Federal level, the Federal Ministry of Health act as the overall Government Ministry responsible for all health matters including the

"preparation" of National Health policy.

3.2 National Health Policies 1975 - 1985

The National Health policies from independence in 1960 to date have not been static. This research discusses the National Health policies of the period from 1975 to 1985 to cover the last two National Development Plans (3rd and 4th). This section would lay the foundation for the subsequent analysis on whether there is co-ordination of the external environment in the Health Management Board.

Prior to the third National Development Plan, the National Health Policy put more emphasis on curative services. This emphasis placed priority on the provision of hospitals, drugs and training of doctors to man these hospitals and render curative services to patients. In fact, during the plan period, "health policies were directed to meet areas of deficiencies in health care with no specific goals or target."[5]

This unspecified nature of our health policy first created by the colonialists aggravated the existing imbalance in the distribution of health facilities and health care in the country. If one closely examines the development of health service in other countries of the world for example Brazil and Argentina in Latin America, Philipines in Asia and Kenya in Africa, one finds that in their initial stages, they placed emphasis on curative services. As these services became more and more costly, the need for highly trained doctors and nurses to staff the hospitals increased the cost, hence it constituted a problem.

Therefore, the Governments of those countries shifted emphasis on preventive health services. In Nigeria, the government ha been very slow in the shift of emphasis to preventive care.

The 3rd National Development Plan 1975-80 however directed our health policy towards correcting the inadequate health services created first by the colonialists and maintain the ruling elites. The plan deliberately attempted to widen the National Health Policy.

The policy statement depicted a clear shift in emphasis from the curative to preventive services. Similarly in the 4th National Development Plan (1980-85) the National Health Policy was oriented towards preventive care. It stated:

> Overall philosophy and principle of state policy of the nation which was based on the principles of democracy, social justice and the ideals of freedom equality of status and opportunity. 6

Health care during the political days of the 2nd republic was considered a fundamental right of all and preventive care was given priority.

Thus, the philosophy for the National Health Care (1980-85) was based on the following principles:

1) The Government of the Federation should be responsible for the health care of citizens.

2) Information on health shall be dessiminated to enable each individual citizen to have greater responsibility for his own health.

3) Health care requires joint effort of all social and economic sectors.

4) Emphasis shall be placed on preventive and promotive measures which will be integrated with treatment and rehabilitation programme in a multidisciplinary and multi-sector approach.[7]

From the above one can safely conclude that the emphasis of Government's health policy during most of the period under study (1980-85) was on preventive services.

The goal therefore was to establish a comprehensive health care system, that is promotive, restorative and rehabilitative as a right to every citizen of the country within the available resources; so that individuals and communities are ensured of productivity, social well being and enjoyment of living.

3.3 The Administration of Health Services in Kaduna State

Administration could sometimes involve getting things done within stated schedule using the most effective skill in order to achieve desired results. Therefore administration involves co-ordination.

The philosophy of universal health care especially, that of the United Nation's "Health for all by the year 2,000 A.D", has to some extent affected the administration of Health Services in Nigeria.

Respective governments along side some voluntary agencies have intensified their role as health providers. The National Council of health the highest policy making body for health matters of the nation has the function of co-ordinating the states and federal health service programmes.

In a proper managed administration there is a vertical co-ordination in governmental operations between the Federal, State and even Local Governments.

The task of vertical and horizontal co-ordination of government programmes is mostly performed by certain actors in organisations such as the Health Management Board and

even the Ministry of Health to mention a few. These actors are referred to as the Civil Servants or Bureaucrats.

The Bureaucrates are vehicles through which government expects to realise its policies. Thus in the administration of Health Services bureaucrats play a significant role. Nevertheless the role of bureaucrats when compared with the actual services rendered in terms of quality and coverage leaves much to be desired.

The World Health Organization for instance estimated a standard doctor-population ratio of 1:10,000 people. Similarly in the Fourth National Development Plan (1980-85) it was stated that the urban centres have 90 percent of the registered medical practitioners yet just 20 percent of the population resides in the few cities. Also the manpower ratio for Pharmacists and Dentists is as follows: 'Pharmacist 1:29,720 persons and Dentist 1:307,140 persons.'[8]

Such manpower shortage is also reflected among sub professional and para-medical health personnel. It is therefore apparent that the above ratio cannot guarantee adequate health care services for Nigeria.

From the foregoing one can safely assert that the availability and provision for health services in most developing countries, Nigeria inclusive is far below the standard considered acceptable by the World Health Organization, of an estimated doctor - population ratio of 1:10,000 people.

In fact it is alarming to note that only about "35 percent of the Nigerian population is presently covered by any form of modern health care services."[9]

This low coverage underscores the magnitude of the health related problems facing the nation in general and Kaduna State in particular. What seemed persistently wrong in the health sector in Kaduna State is the problem of management. Government has been attempting to minimize certain problems through financial allocation but apparently the problem of health planners and administrators is how best to manage health resources and what long term measures are necessary to effectively utilise and channel these resources to the areas in need.

The administration of health services in Nigeria in general and Kaduna State in particular has manifested that the management of health care needs are not properly integrated, co-ordinated and decentralized from the ministries of health through Health Management authorities to individual institutional level.[10] These are some of the problems that affected proper vertical co-ordination from the ministries to the Health Management Board.

3.4 Kaduna State Ministry of Health: Bureaucratic Structure And Functions

The Ministry of Health is a hierarchical organization. The authority to perform specific functions comes from the top-down in a descending order.

The Commissioner is the political head of the Ministry whereas the Permanent Secretary is the Chief Executive as well as Chief adviser to the Commissioner.

Other administrative and professional head of divisions are accountable to the Permanent Secretary.

The State Ministry of Health is a complex bureaucratic structure divided into three main functional units as follows:

1) Policy and Management - This incorporates general administration and accounting matters.

2) Public Health Department - It comprises all medical services such as preventive and supervision.

3) Social Welfare Department.

All departments are expected to work in collaboration with each other towards achieving the basic objectives.

The Permanent Secretary has authority on all matters affecting the Ministry, but authority in this respect is supposed to be delegated alongside with responsibility to other divisional heads who would, in turn, perform certain functions and delegate others as appropriate. Under the Permanent Secretary, then the Principal Secretary and down the ladder of the organizational chart there are the executive officers and clerks.

The Public Health Department is headed by the Chief Medical Officer who is answerable to the Permanent Secretary. Under the Chief Medical Officer, are assisting staff like the Co-ordinator Primary Health Care, the Principal Medical Officer Planning etc.

The Pharmacy Department is headed by the Chief Pharmacist who is answerable to the Permanent Secretary in the discharge of his duties.

Finally the social welfare department has the Chief Welfare Officer as its head with his supporting staff. This officer is also answerable to the Permanent Secretary.

It is not within the scope of this study to discuss in detail the functions of these officers in the ministry. Nevertheless it is worth noting that this team of bureaucrats are responsible for translating government health policies into concrete action. What are the State Government's Health Policies? What kind of Health Services does the Ministry undertake? The State Government health policy is not significantly different from the National health policy discussed elsewhere in the preceding paragraphs.

The cornerstone of the state government health policy is to reach all citizens of the state with health care services at a minimum cost but with maximum benefits. The citizens have a right to health care services.

The national goal of comprehensive health care system geared towards offering promotive, protective, restorative and rehabilitative services are the concern of Kaduna State Government's health policy. This policy is essentially preventive and the state ministry of health is directly responsible, for its provision.

3.5 Preventive Services

Since the emphasis on preventive services in the 1970's by the Federal Government, the Kaduna State Government through the Ministry of Health has been pursuing the preventive policy rigorously.

It is an accepted fact that it is more economical to prevent than to cure many tropical infectious diseases which constitute our main health problems. Preventive health services incorporates all health related measures aimed at

preventing or controlling the occurance or spread of disease. Examples of preventive services include health education, environmental sanitation, nutrition lectures, immunization and inoculations. Essentially, the existing national 'package' for preventive health service provided to the state government contained the comprehensive health service scheme. with the basic health service scheme as its corner stone.

The basic health service scheme is the model through which the preventive policy could be achieved. The objective of the model is the provision of adequate and effective primary health care for the entire population. The State Government intend to use the local government areas as the implementation units of the scheme. The Kaduna State Ministry of Health had already started operating the scheme using the zoning system of one or more local government areas for example Zaria zone comprises Hunkuyi, Makarfi and Zaria.

While the ministry takes full responsibility of preventive services, the Health Management Board caters solely for the curative services, the latter should be discussed under the boards functions in the next section.

3.6 The Evolution of Kaduna State Health Management Board

The Health Management Board was established vide an Edict No. 7 of 1978. Sequel to the then civilian government (Executive) declaration of health care delivery as a cardinal aspect of its policy; the Board became operational on 1st April 1980.

The Board was made autonomous so that it can operate free of bureaucratic red-tapism. Thus, ensuring despatch in health care delivery. The Board was also charged with the responsibility of operating and maintaining health institution or establishment such as general hospitals, clinics and maternity centres of the state. Prior to the establishment of the Board, the Ministry of Health was responsible for all health care operation, running of hospitals, clinics and health centres. But with the 'inception' of the Board the Ministry was left with only preventive care, manpower training of para-medical staff and policy formulation.

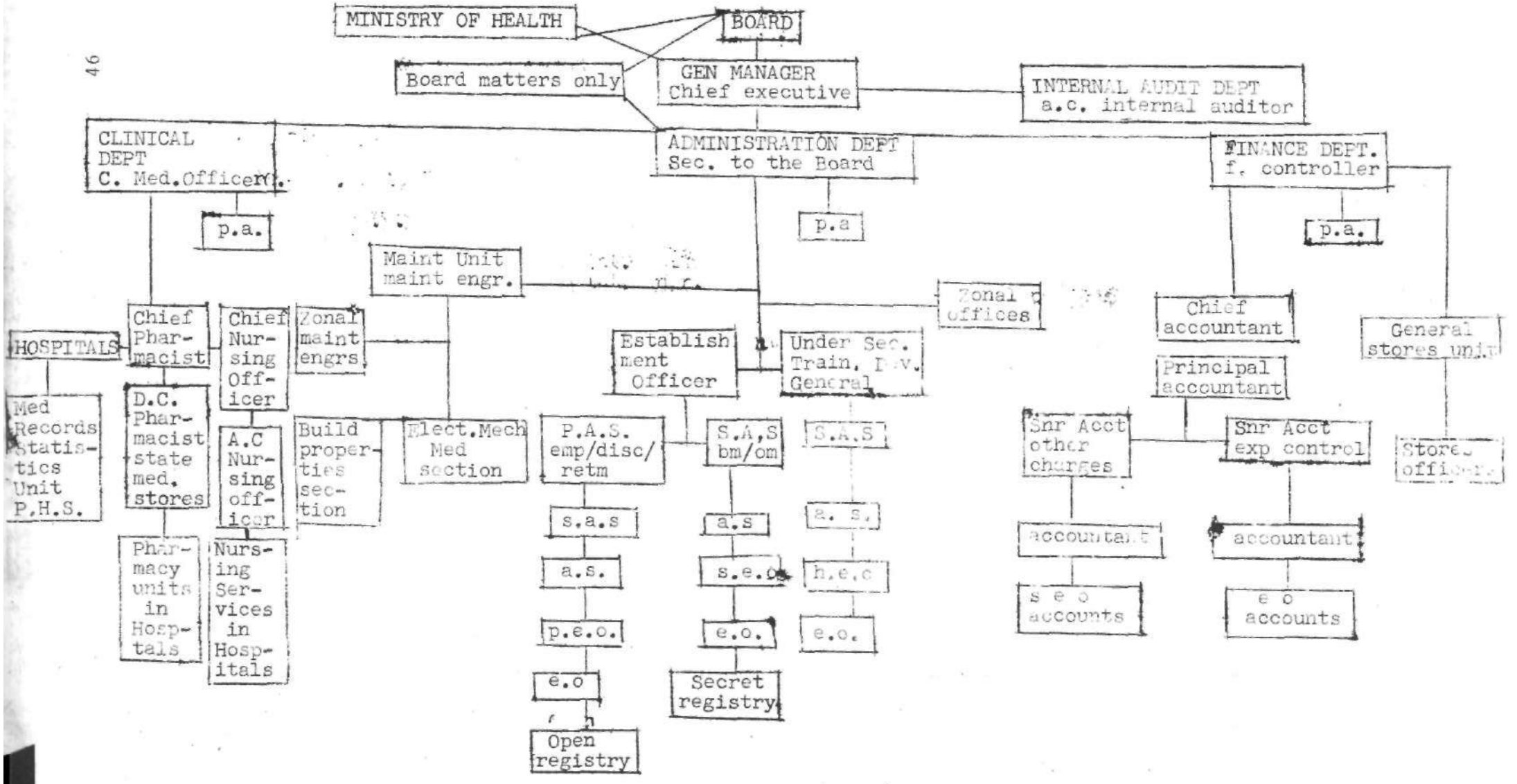
Inspite of the Board's autonomy it still has interconnections with the Ministry of Health so much so that vertical and external co-ordination could occur atleast on policy and administrative matters. For instance health policies from the Executive Council of the state came to the board through the ministry. Moreso the subvention of the Board from the Ministry of Finance is channelled through the Ministry of Health to the Board. One can assert that; at the moment of writing the Ministry of Health is the supervising agency of the Board.

3.7 Structure and Functions

The Health Management Board is self accounting and is responsible to the State Government through the Commissioner of Health.[11]

The organisational chart shows authority flow from top - down, in a descending order (see organizational chart on page 46).

KADUNA STATE HEALTH MANAGEMENT BOARD ORGANISATIONAL CHART



NOTES : a. health management board was established by edict no. 7 of 1978.
b. h.m.b is a self accounting board responsible for curative functions.
c. h.m.b has three (3) departments viz: administration clinical and finance.

Administratively the General Manager is the Chief Executive of the Board and is accountable to the Board of Governors in the discharge of his duties. The General Manager is the overall head of the Health Management Board. The General Manager perform the role of supervision, co-ordination and directing the official affairs of the Management Board. There are departments and sub-divisions each designed with specific functions to perform and the departmental heads are all answerable to the General Manager.

In recognition of the importance of good and efficient administration certain changes were introduced in 1984 and 1986 respectively. The first fundamental change was the restructuring of the Board to remove the Executive Chairman system and "Substitute it with a more realistic post of General Manager and Chief Executive who is a civil servant and not a political appointee as it were the case of Executive Chairmanship."[12] The explanation for this action was to "remove the dictatorial tendencies inherent in the Executive Chairmanship."[13]

The other fundamental change was in the appointment of the Secretary to the Board, which was hitherto the pre-rogative of the Governor which has now been delegated to the Board members. Tied to these changes was the introduction of four departments as opposed to three as shown in the notes of the organisation chart. The departments are Administration, Clinical, Finance and Internal Audit.

The Secretary to the Board is the Head of the Administration Department. As the Chief Administrative

Officer of the Board he is responsible for general administration, supervision and co-ordinating the Board's activities.

His immediate supporting staff include the under secretary; in charge of Training and Development, general administration, passages and housing matters. On the same positional level is the Establishment Officer; in charge of staff and all establishment matters.

In addition; the administration department take full responsibility of Zonal Officers Management, maintenance and planning units. The second but most important department is the clinical department headed by the Chief Medical Officer.

The Chief Medical Officer is responsible for the management of clinical activities and co-ordinating the activities of professional medical staff.

The main division of the department is the hospital services division. At the Board's headquarters this division is further sub-divided into Pharmacy and Nursing Units, each headed by a Chief Pharmacist and Chief Nursing Officer respectively. Whereas at the periphery the hospitals, health centres and clinics are directly under the Clinical Department.

The clinical department is the most vital of the Board's department essentially because it is the practical service department in the area of health care delivery. The Finance department headed by the Financial controller takes charge of all financial and accounting matters of the Board. It is better described as the "spring water" of the Board.

Finally, the Internal Audit Department headed by the Chief Internal Auditor. The department is responsible to the Board of Governors unlike what is shown in the organisation chart. Nevertheless, it is linked up with the office of the General Manager. The Audit Department keeps an eye over all the Financial dealings of the Board with a view to detecting and preventing any financial irregularities.

The structure of the Board as earlier mentioned depicts authority and responsibility to perform assigned functions. These two concepts of authority and responsibility according to C. I. Bernard are interwoven to the extent that one cannot function without the other.[14]

The main functions of the Board as per Edict No. 7 of 1978 establishing the Board include among others:

i) To carry out the Board directives on health services laid down by the Ministry of Health and Social Welfare;

ii) To promote, co-ordinate and evaluate activities and programmes.

iii) To develop strategies for the execution of general health policies.

iv) To ensure that progress is in accordance with approved objectives, targets and budgets and that services are being provided with efficiency and economy and to ensure that....standards in all the institutions controlled by the Board are of the highest standard.

v) To delegate to Zonal Management Committee executive responsibilities for the delivery of health care in the districts.

vi) To ensure co-ordination and integration of the various health services in the state and in turn, their co-ordination with those of the local government.[15]

3.8 Curative Services And Hospital Administration

The Board is essentially responsible for the provision and management of all curative Health Services in the state. The term curative services is referred to all efforts to treat person(s) affected by disease. This include the management of diseases and personnel providing those services towards achieving effective health care delivery.

Prior to this section, it had been indicated that the Ministry of Health takes charge of all preventive services, nevertheless a recent official communication stated that the functions of the ministry should include "Supervision and provision of curative services through the Board.[16]

The latter indicated the inter-relationship between governmental agencies, hence the need for external or inter-agency co-ordination in the provision of health care delivery. This shows the relevance of our discussion of the ministry of health in this study. In addition, the discussion will provide the foundation of our subsequent analysis on co-ordination of the external environment, that is, from the Board to other agencies providing health care.

On hospital administration, it is pertinent to begin by explaining how it relates to public administration in general. Hospital administration like any other practice of public administration, involve the co-ordination of individuals and group effort to carry out public policies in the sphere of health services. This co-ordination is characterised by firstly, the organisation of roles and functional responsibility designed to carry out policies.

Secondly it is also characterised by establishment of pattern of skills, responsibilities and authority that will permit co-ordination and unity of purpose through supervision.

The link between hospital administration and public administration can be seen in the essential ingredients of public administration which are found in hospital administration. Such ingredients include patterns of skills, responsibilities, authority, supervision and above all co-ordination.

Moreover, in hospitals just like any other public agency it is public affairs that are being managed and the "actors" or civil servants managing the affairs should possess profound knowledge and experience of the public administration discipline. Hospital administrators should be problem solvers as well as initiators of activities.

The Board, at the moment has, 16 General Hospitals, 2 Maternity Hospitals, 1 Psychiatric Hospital, 3 Rural Hospitals, 1 Leprosarium, 4 Dental Centres, 3 Eye Clinics.[17] (See Appendix I Map of the distribution of health institutions according to locations).

In addition, there are six Zonal Management committees at Kaduna, Zaria, Katsina, Dutsin-ma, Kafanchan and Funtua. Each is headed by a Zonal Chairman. The essence of zoning is to decentralise the management of the health services and provide for effectiveness and efficiency in health care delivery. Despite, the provisions of health institutions, the critical factors influencing the effectiveness of our network of hospitals remain the geographical distribution of these hospitals which is urban-based. Thus, there is limited access to which majority of the people have to these hospitals.

In our subsequent analysis of data in the next chapter it would be shown how this imbalance in the distribution of health facilities affects the level of co-ordination of health services by the Board.

The day to day administration of health institutions such as the general hospitals is the responsibility of the medical officers in charge.

The medical officers have supporting staff who are mostly heads of departments and divisions; such as Principal Nursing Officers, the Principal Pharmacists, Statisticians etc

The task of the Board is to provide curative services, a task which pos es a challenge to the administrators of health services. The challenge today is to reach the majority of people with health services using the most efficient methods and skills at a minimum cost to the government. A challenge which requires effective co-ordination.

One may ponder on the following questions. What is the level of co-ordination at the Board? In line with the provision of the Edict establishing the Board: has co-ordination really been achieved? What are the factors responsible for co-ordination or the lack of co-ordination? The answers to these and many other questions shall form part of our analysis in the next chapter.

FOOTNOTES

1. R. Schram, The History of Nigerian Health Services, University of Ibadan Press 1969, p. 19.

2. Ibid, p. 59.

3. Ishaya Audu in Durrenda Nash, The Role of Traditional Doctor in Nigeria Health Services, Ph. D unpublished thesis 1979, p. 13.

4. Ibid, p. 21.

5. Federal Republic of Nigeria, Second National Development Plan 1970 - 1974, Federal Government Printers, Federal Ministry of Information, Printing Division, Lagos 1970, P. 3.

6. Federal Republic of Nigeria, Fourth National Development Plan 1980 - 1985. Federal Government Printers, Federal Ministry of Economic Planning, Printing Division, Lagos 1980, pp. 3 - 4.

7. Ibid, p. 4.

8. Ibid, P. 275.

9. Ibid, p. 272.

10. Federal Republic of Nigeria, Federal Ministry of Health, Draft of the National Health Policy October 1982, Directorate of National Health Planning and Research, Lagos, p. 9.

11. Kaduna State Health Management Board, Organization Chart, Health Management Board Planning Division, Kaduna.

12. Kaduna State Health Management Board, Annual Report 1984, Government Printers, Kaduna, p. 4.

13. Ibid, p. 4.

14. C. I. Bernard, The Functions of the Executive, Howard Univ. Press 1968, p. 48.

15. Kaduna State Health Management Board, Edict No. 7 of 1978. Government Printer, Kaduna, p. 17.

16. Ministry of Health Kaduna State, Approved Function of Ministry of Health, Kaduna State, an official letter No. MHSW/1117/Vol.1/62 of 27/11/86.

17. Kaduna State Health Management Board (1984), op. cit., p. 8.

CHAPTER FOUR

ANALYSIS OF DATA AND PRESENTATION OF RESULTS

The previous chapter was devoted to a discussion of the historical perspective of the Nigerian Health Services and Policies, the functions of the Health Management Board and its relations with other agencies.

In this chapter the data collected would be presented and analyzed in the light of the hypotheses stated in the introductory chapter. The researcher used both primary and secondary data in testing the hypotheses. The primary data was collected through a survey of the Kaduna State Health Management Board and other health institutions or establishments under the Board.

In order to test external co-ordination of the Board, the State Ministry of Health and Social Welfare was surveyed using questionnaire and interpersonal interview techniques.

4.1 Response Pattern To Questionnaire

The Health Management Board just like the Schools Management Board of the Ministry of Education is a complex organization hence a total of 225 questionnaires were distributed for this study. Out of the 225 questionnaires 120 were designed for the Middle Level Managers (MLM) of the Board, and 80 were designed for the Top Level Managers (TLM) of the Board, and the remaining 25 were to cover the Top Level Managers of the State's Ministry of Health and Social Welfare.

Out of the total of 200 questionnaires distributed to the Board, 158 were returned. Out of the 158 questionnaires 11 were not fully completed while 7 were returned blanked giving a total of 140 valid questionnaires.

From the 25 questionnaires distributed to the Ministry of Health 21 were returned and the remaining 4 were not fully completed.

The study therefore used a total of 140 questionnaires from the Board and 21 from the Ministry. The classification of the administered questionnaires was as follows:
60 questionnaires for the Top Level Managers of the Board
80 questionnaires for the Middle Level Managers of the Board
21 questionnaires for the Top Level Managers of the Ministry of Health.

It is worth stating here that co-ordination in complex organisation is a managerial activity, the junior staff cadre are not responsible for co-ordination. Thus, the choice of managers as the sample for this research is not arbitrary. Similarly the division of the sample into Top and Middle Level Managers is not arbitrary for the fact that co-ordination is analyzed from internal and external dimensions.

The set of questions in Section 1 of each questionnaire were to be answered on the point scale ranging from a 3 - point to a 4 - point. Although each point scale is presented on the tables as appropriate but for simplicity of the analysis the responses of a 4 - point scale are often merged to form two groups as shown below.

(a) Very High (b) High (c) Low (d) Very Low

Responses 'a' and 'b' are often considered as 'high' while responses 'c' and 'd' are grouped as 'low' in the discussion.

In addition presentation of results from tables, is followed by analysis and general discussions of issues related to the variable(s) being analyzed. In the discussion and where appropriate the findings of the study are related to the general supporting theories and relevant research findings of other people.

4.2 Empirical Test Hypotheses

One of the aims of the study is to examine the extent of co-ordination of government health service programmes by the Health Management Board.

As earlier pointed out in the statement of problem, the challenge facing government and governmental agencies responsible for the provision of social services like Health Service, is to reach most people with such services using limited resources at the disposal of government in ways that will yield the greatest possible benefits. To face the challenge and achieve governmental objectives means to effectively co-ordinate.

The first hypothesis of the study states that effective co-ordination of health services depends on clear functional roles of the organisation.

To test this hypothesis, the functional roles of departments which is reflected through the functions and

duties assigned to incumbent officers of the organisation is being considered for analysis. Specific questions were asked to this effect and the responses are presented in Table 4.1 below:

Table 4.1(a)

i) How do you percieve your role in the "running" of your organization?

ii) How would you rate the perception of functional roles by your immediate subordinates?

Category of Respondents	Responses Grading	1st Question Number	1st Question Percentage	2nd Question Number	2nd Question Percentag
T. L. M.	V. clear	12	20%	3	5%
	Clear	40	61%	24	40%
	Diffusely Clear	6	10%	20	33%
	Not clear	2	3%	13	22%
	Total	60	100%	60	100%

Source: Survey by the researcher

Table 4.1 (b)

Rank the understanding or perception of functional roles of your superi ors.

Category of Respondents	Responses Grading	Number	Percentage
M. L. M.	V. Clear	14	18%
	Clear	45	56%
	Diffusely clear	21	26%
	Not clear	0	0
	Total	80	100%

Source: Survey by the researcher

In table 4.1 (a) the responses of the subjects to the first question indicated that 87 percent expressed clear self perception (i.e. we combined the responses for 'very clear' and 'clear' to mean 'clear') while a marginal 13 percent indicated that their perception of role is not clear.

To ascertain the TLM's claim the MLM's were asked to rank the functional role perception of their superiors. The data was presented in table 4.1 (b). From the table a total of 74 percent of the respondents confirmed that the role perception of the TLM's is clear while only 20 percent expressed a contrary view. In order to find out the role perception of the MLM's the researcher sought for the information from the TLM's. In table 4.1 (a) the responses to the second question showed that 55 percent of the respondents indicated that the MLM's role perception is not clear, and 45 percent answered on the contrary.

Role clarity here refers to the person(s) perception of the degree of explicitness of his or others understanding of his or their assigned functions in the organization.

From the results of the tables the variations in role perception between the two categories of respondents is understandable. The reason for the differences in favour of clear role perception by the TLM may not be unconnected with their wealth of experience and high level expertise in official procedures.

The study wanted to find out whether or not there exist role conflict in the organization. The data is presented in table 4.2.

Table 4.2

Do you observe any role conflict in discharging your duties in the organization?

Items	Category of respondents and scores			
	TLM		MLM	
	Number	Percentage	Number	Percentage
Yes	30	50%	44	55%
Cannot decide	4	7%	14	17.5%
No	26	43%	22	27%
Total	60	100%	80	100%

Source: Survey by the researcher

From the table, 50 percent of the respondents in the TLM's category observed that there exist role-conflict. Whereas 43 percent opined that it does not exist and only 70 percent could not decide.

From the MLM's row score, 55 percent observed the existence of role-conflict and 27 percent had a contrary view, while 17.5 percent could not decide.

Of significance is the fact that majority of our respondents indicated that there exist role-conflict in the organization. Conflict in an organization can be generated by the operations of staff specialties whose jurisdictions are unclear to them. Katz and Kahn asserted that "role conflict relates to a situation of conflicting or incogruent role expectations."[1]

Therefore, the problem of official role conflict transcend levels in organizations. It is more of the action-part of official engagements.

From the table, the results of the TLM's score of 50 percent in agreement with the existence of role conflict might be explained from the fact that the TLM's have to protect the organization's image regardless of the nature of that image, also the traditional secrecy surrounding official government operations might lead to such an average score.

In order to get more information on the issue an interview was conducted on selected members of the TLMS. For instance when asked about the possibility of role conflict, the researcher was told that there seems to be role-conflict in the Board's Headquarters. Administrators do interfere in professional matters but whenever a stalemate occur the General Manager steps in to decide and provide continuity.

But Mcfarland argued that, "intra organizational conflicts arises from a lack of shared perceptions and attitudes among members at different echelons"[2]. This statement buttress not only the results in table 4.2 but also agree with the findings in table 4.1 which show unclear perception of roles by the MLM's.

The study further progressed to find out the effect of role-conflict on co-ordination of Health Services.

Table 4.3

What is the effect of role-conflict on co-ordination of health services in your organization?

Items	Category of respondents and scores			
	TLM		MLM	
	Number	Percentage	Number	Percentage
Positive	0	0	4	5%
Negative	31	52%	40	50%
Unchanged	5	8%	8	10%
No response	24	40%	28	35%
Total	60	100%	80	100%

Source: Survey by the researcher

Table 4.3 shows that 52 percent in the TLM's category indicated that role conflict has a negative effec t. While 50 percent of the MLM's indicated that role conflict produces negative effect and a marginal score of 5 percent opined that it has a positive effect.

Of significance is the correlation between the responses of the TLM's and MLM's in tables 4.2 and 4.3. The responses indicated that those who observe role conflict in table 4.2 ranges from 50 - 55 percent. Similarly the percentage of those who indicated that role-conflict produces negative effect ranges from 50 - 52 percent. Therefore role-conflict in the organization yield negative effect and this was further proved from interview conducted. From the latter, it was discovered that stalemate frequently occur

in the Board and the General Manager has to step in to break the stalemate in the interest of continuity. Stalemate creates a period of in-action which is dangerous to an agency responsible for life and death.

Closely related to the previous aspect discussed above, is the re-definition of functional roles. In table 4.4 the study wanted to find out the view of respondents on re-definition of functional roles. Since it has been shown in the previous paragraphs that there exist role-conflict as a result of unclear perception of roles by majority of the actors in the agency who are responsible for co-ordination of the health services.

Table 4.4

Do you subscribe to re-definition of existing functional roles in order to minimize or eliminate role-conflict in the organization?

Items	TLM		MLM	
	Number	Percentage	Number	Percentage
Yes	14	23%	46	57.5%
No	43	72%	19	23.75%
Cannot decide	3	5%	15	18.75%
Total	60	100%	80	100%

Source: Survey by the researcher

A comparative analysis of this table shows that majority of the respondents in the TLM's category did not subscribe to re-definition of functional roles,

this was reflected by the 72 percent score. Whereas the MLM's category majority of the respondents (57.5 percent) subscribed to re-definition of roles. From the results we can infer that the TLM are determined to maintain the statusquo inspite of certain problems that exposes confusion in the organization, which require changes. On the other hand the MLM by virtue of their positions of providing the linkage between top management and subordinates they welcome initiatives which could lead to changes in an organization. It could be noted that absence of conflict in organizations, often indicates the success of statusquo interests. However, ambiguity of roles is a major source of conflict in organizations. From the results in tables 4.1 (a) - to 4.4 there is a pattern which consistently show that the TLM have clear role perception unlike the MLM. In this regard, they demonstrated remarkable commitment to the survival of the organization which was shown to be threatened with confusion due lack of clear perception of roles by majority of the linkage group or MLM in the organization.

Our findings therefore lead to the conclusion that there is ineffective internal co-ordination of health services by the Board. Indeed if we lend credance to Biddle's definition of official functional role as, "the codified official sum of tasks"[3] we find that in the Board there was no manifestation of codified official sum of tasks from the major actors (MLM) involved especially in co-ordinating the internal environment. In fact, fine organizational structures cannot guarantee effective

co-ordination if the actors to operate the structures do not have clear perception of functional roles.

Howard and Mckinney argued that managers must constantly provide the linkage between what people actually do in the organization and what they are expected to do in achieving stated objectives.[4] The emphasis on Manager here is more on the MLM's who are the linkage group between the upper and the lower level of any organization. They re-affirm the above statement, that it cannot be taken for granted that the existence of a statement of mission or a hierarchy will automatically result in co-ordination.

Thus, the study's findings that there is ineffective co-ordination of the internal environment due to lack of clear perception of functional roles by majority of the "actors" responsible for co-ordination leads to the acceptance of the hypothesis that effective co-ordination of health services depends on clear functional roles of the organization.

4.3 External or Inter-agency Co-ordination

Co-ordination is a requirement of government at all levels and between levels. While co-ordination pre-occupies administrators and managers at middle level, those at the top level approach it with unique concern. In general top level managers co-ordinates the affairs of an agency with other agencies and/or bodies. This analysis therefore focuses on the activities of the top level managers of the Board in relation to another agency - the Ministry of Health and Social Welfare. The top level

managers of the ministry were therefore asked about their functional role perception in order to make a comparative analysis with the Board TLM's responses on similar question presented in table 4.1 (a). The responses of the ministry's TLM's are presented in table 4.5 below.

Table 4.5

How do you perceive your role in the 'running' of your organization?

Items	TLM	
	Number	Percentage
V. Clear	1	4.8%
Clear	17	80.8%
Diffusely clear	2	9.5%
Not clear	1	4.8%
Total	21	100%

Source: Survey by the researcher

From the table it shows that 85.6 percent of the respondents have a clear role perception while a marginal 14.3 percent found their roles unclear.

To compare table 4.1(a) with table 4.5 it can be found that in the former 87 percent of the Board's TLMS indicated clear role perception while 85.6 percent of the respondents in the latter table expressed similar opinion.

Of significance is the fact that both TLMS expressed a high rating of role perception. Perhaps the explanations of these results might be due to their wealth of experience and high acquaintance with official procedure.

Table 4.6 shows the reactions of respondents as to whether there is inter-agency role conflict in the provision of health services.

Table 4.6

Besides the Ministry other agencies like the Health Management Board, A.B.U. Teaching hospitals provide health services in the state. Do you observe any role conflict between the Ministry and those agencies?

Category of Respondents	Responses	Number	Percentage
Min. of Health	Yes	3	14
TLMS	Undecided	2	10
	No	16	76
Total		21	100%

Source: Survey by the researcher

From the table 76 percent of the respondents opined that there is no inter agency functional role-conflict in the provision of Health Services while 14 percent expressed that it exist. A marginal of 10 percent were undecided.

An indepth interpersonal interview was conducted to gather more information on the issue from the TLMS of the Board and the Ministry. The Boards TLMS informed the researcher that there is a demarcation of functional responsibilities between Ministry of Health, the A.B.U. Teaching Hospitals and the Board. The Ministry according

to them is responsible for preventive services, while the Teaching Hospital provides training as well as specialist services. The Board on the other hand is responsible for curative services. In addition the researcher was informed that there exist some form of inter agency alliance in the "referral" system, whereby critical cases are referred from the Board's health institutions or hospitals to the ABU Teaching Hospitals. This according to them facilitates co-ordination.

However, official conflict in this study is described as a situation in which groups disagree over means or ends and try to establish their views in preferance to others. Role conflict occur among groups due to competing objectives or missions and at times in the desire of managers or administrators interest to protect jurisdictions or in a situation when the areas of jurisdictions are unclear to the actors in the agencies.

In this context an interview revealed that there are instances of conflicts between the top level managers of the agencies concerned, but most of it revolves around personality clashes. Official conflicts within or between agencies are often so severe, so long lasting that they drain off energy and resources that could be devoted to achieve results.

The study ventured to find out whether competition to perform similar functions is common between agencies engagaged in the provision of health services.

The responses are presented in table 4.7 below

Table 4.7

Competition to perform similar things in terms of provision of health services is common between the Ministry of Health and the Health Management Board.

Items	TLM - Board		TLM Ministry	
	Number	Percentage	Number	Percentage
Strongly agree	-	-	-	-
Agree	8	13	-	-
Undecided	12	20	2	10
Disagree	40	67	19	90
Total	60	100%	21	100%

Source: Survey by the researcher

Table 4.7 shows that respondents of both agencies are of the opinion that there is very low tendencies towards competition to perform similar things. This was reflected by a high percentage of disagreement to the question in table 4.7.

When the researcher sought for further information through an interview conducted with a cross section of the respondents, the researcher gathered that each agency is familiar with its area of jurisdictions hence such competition for scarce resource allocation from government do occur but it is usually resolved at budget-preparation level in which both staff of the Board and the Ministry deliberate on their proposals before submission to the government. During this exercise duplication of requests are usually resolved.

The researcher's interpretation of the near absence of inter-agency conflict and competition between the Ministry and the Board is that there is rotation of Top Level Staff from the Ministry to the Board and vice-versa because the former was still the supervising Ministry of the latter, hence most of the staff are conversant with the operations of both agencies.

From the findings the contribution of the H.M.B. in aggregate co-ordination of the external environment is therefore effective, essentially because the TLM responsible for co-ordinating the external environment have clear perception of functional roles of the agencies concerned. Thus, this confirms the hypothesis that effective co-ordinatio depends on clear functional roles of the organization.

Another aim of study is to determine the factors affecting co-ordination of Health Services by the Board since in the preceding paragraphs, the first hypothesis tested has shown that effective co-ordination of the internal environment is lacking. The second hypothesis set to explore the organization (HMB) to find out the factors responsible for the lack of internal co-ordination. The hypothesis states that organizational climate affect co-ordination. This study delineate what it refers to as organizational climate in the following paragraphs.

Health care system should not be seen in isolation of the context in which it exist. Gunnar Myrdal shows the relevance of research in health in relation to development process of developing nation.[5]

Organizations are man-made and they exist and interact with the human environment, they are therefore a product of a complex eco-system with structural, political, social and economic variables. In this connection organizational climate provides a focus for analyzing in relation to managerial activities such characteristics here considered as variables of organizations. The frame of Easton's systems theory would be used as a guide in the analysis of this interaction of organization and its environment on the one hand and the organization and its mechanisms on the other.

A. Leadership Style

The first variable being considered under this hypothesis is leadership style, because leadership constitute part of the managerial activity essential to co-ordination.

Stodgill defined leadership as "a social process whereby one or more (emphasis mine) individual(s) attempt to influence others."[6] In organizations leaders work with and through people. They have a task of creating a true whole that is larger than the sum of its individual parts. Thus, leadership in organizations had the prime purpose of harmonizing parts to each other and peoples to ends. In other words, it has a prime role in co-ordination process of an organization. Druker in analyzing the tasks of leaders, compare it with that of a conductor of symphony ochestra through whose efforts, vision and leadership individual instrumental parts that are independently unpleasant become collectively musical.

However, the existence of a leader 'per-se' does not guarantee co-ordination unless the leadership is effective. Although the direction of this study is to find out the leadership style that could guarantee a conducive atmosphere for co-ordination nevertheless there are several theories of leadership. For purposes of clarity therefore, the study would consider two extremes of leadership styles viz democratic and authoritarian. But to offer the liberty of choice respondents were asked to choose from 5 types of leadership styles followed by a separate interview in order to gather more information.

The responses were presented in table 4.8 below.

Table 4.8

Which of these styles appropriately describe the leadership style in practice in your organization?

	TLM		MLM	
Items	Number	Percentage	Number	Percentage
Persuasive	3	5%	5	5.25%
Democratic	27	45%	29	36%
Care free/ Leissez-faire	10	17%	15	19%
Authoritarian	14	23%	22	27.5%
Autocratic	6	10%	9	11.25%
Total	60	100%	80	100%

Source: Survey by the researcher

From the table 45 percent of the respondents in the TLMS category indicated democratic style while 23 percent expressed that the style is authoritarian. 17 percent indicated laissez-faire/care free while 10 percent expressed autocratic. A marginal 5 percent opined that the style is persuasive.

In the case of the MLMS 36 percent expressed that the style is democratic while 27.5 percent indicated authoritarian style 19 percent expressed that the style is persuasive.

As earlier stated the study would use two extremes of leadership viz democratic and the authoritarian. The democratic style is associated with socio emotional orientations, the leader practising this style uses consultation to achieve desired goals. He makes constructive use of subordinates ideas and have confidence in them.

The authoritarian style of leadership is associated with high concern for production and is task oriented. Tannabaum and Schmidts pointed, to the use of authority to make decision and announces it without any consultation with subordinates as a characteristic of this style.[7] Authoritarian leader get things done through actual or implied threats, often takes credit and blame failures on subordinates.

From the responses in table 4.8 it is clear that majority of the respondents have indicated that the style of leadership is democratic. This is represented by 45 percent from the TLMS category and 36 percent from the MLMS category. An interview conducted showed that majority of

the respondents opined that the democratic style is appropriate

Based on Stodgill's definition of leadership the concept of power as the capacity to influence is central to the understanding of organizational leadership styles. Based on this premise the researcher employed French and Raven's five major sources of power in a personal interview on selected managers of the Board in order to corroborate the results from the questionnaire.

According to French and Raven the leader's ability to influence others depends on all or any of these five sources of power. These are legitimate, reward, coersive, referent and expert powers.[8] Using French and Raven as a guideline the sample was asked to explain the tools or techniques that their management uses to get things done through people. Majority of those interviewed explained that the management uses more coersive than reward power in the running of the organization.

Reward power implies the management or leadership ability to bestow money, praise or promotion, while coersive power implies management or leadership ability to apply punishment or withold rewards.

Of significance is the fact that both types of power (coersive and reward) are tools often employed by authoritarian and autrocratic leadership styles to get things done. One would have expected that any other type of power but coersive would be employed by management in order to qualify that as a democratic style of leadership.

It can be seen that a mixture of authoritarian and autocratic styles are in practice being employed in

the administration of the Board, even though majority of the respondents as seen in table 4.8 have indicated a democratic style.

The explanations for this high percentage in favour of democratic style might be associated with the respondents familarity with the term "democratic" as against the other terms that constitute the alternative choices in the question.

Another reason might be the medical professional-specialists biases in terms of training and official actions, for instance, the professional-specialist interpretation(s) of his/their official interaction with others especially those who are not of the same profession, should be consultative hence democratic. Whereas his actions or decisions on professional matters are in most cases authoritarian or even autocratic, because consultation on professional matters according to his/their interpretation(s) might be read to mean incompetence on the job. Thus the medical professionals might choose 'democratic style' but on close observation, they could be found to act in an authoritarian or autocratic manner.

Finally, the traditional secrecy of bureaucracy could greatly attribute to the high percentage in favour of democratic style.

It is worth noting that research findings have never been absolutely conclusive, in some cases there appear to be serious contradictions. For example whereas

democratic style was perceived to be positively associated with effective leadership in this and in other studies such as Agyris (1957)[9]. An earlier study conducted in Nigeria by Paul Hersey in 1965 revealed that autocratic leadership style is more effective than democratic style.[10] Whichever way the responses in table 4.8 are interpreted, the significance of the results still remain that the majority of respondents have indicated that the democratic style appropriately described the leadership style of the Board.

It is therefore, this study's submission that this style (if practically employed) is capable of creating a condusive atmosphere for effective co-ordination.

B. Delegation

The study wanted to find out the effect of delegation as an organizational variable on co-ordination of the internal environment.

In an organizational set up delegation involves the assigning of duties, granting permission to act and creating the obligations for satisfactory performance from subordinates to whom authority is delegated. Mcfarland asserts that:

> In general authority flows downward from its source at the top. However, this downward flow is not smooth and continuous for the events that determine this flow are discret. The distribution of authority throughout an organization does not occur automatically, it usually depend on managers planned discretion.[11]

Thus, delegation of authority in an organization as much as it is a desired tool for modern management depends on managers discretion.

Respondents were therefore asked to rate the level of delegation of authority in the organization. The responses were presented in the first row of table 4.9.

Table 4.9

The Board has zonal management committees in selected Local Government Areas of the state. Please rate the level of functional administrative responsibility that has been transferred/delegated to the zonal management committees of the Board.

Category of respondents	Responses	Number	Percentage
	V. high	5	3.5
TLM	High	55	39
and	Low	68	48.5
MLM	V. low	12	8.5
Total		140	99.5

Source: Survey by the researcher

From the table it shows that 57 percent of the total sample (comprising "low and V. low" scores) expressed that delegation in the Board is low while 42.5 percent indicated there is a high delegation of authority in the Board.

In Section 11 the open-ended section of the questionnaire respondents were asked to explain their views on delegation of authority as it operates in the Board. Majority of the respondents indicated that it is a good management tool but that it is not sufficiently practised in the administration of the Board.

Furthermore in the open-ended section of the questionnaire, respondents were asked to comment on any of the choices whether the Zonal Committees have powers over some major administrative policies or they are just responsible for implementing policies as they come from headquarters. Majority of the respondents indicated that the Zonal Committees implement administrative decisions as they come from headquarters because they do not possess sufficient authority to deal with matters of policy.

To gather more information an interview with the General Manager confirmed that there has not been sufficient delegation of functional authority and responsibility to Zonal Committees as it is supposed to be as per the edict No. 7 of 1978 establishing the Board. According to him "lack of qualified personnel at the zonal levels to whom powers could be delegated" is the reason for the "insufficiency" of delegation. But the calibre of staff e.g. Zonal Secretaries are on GL. 12 and above, some rose through the ranks while others are graduates, and therefore competent to utilise delegated powers as appropriate.

Similarly, the Internal Auditor also confirmed that there is lack of delegation of authority. In his explanation he cited cases in which members of staff from different zones have to leave their stations to come to headquarters to pursue their annual leave grants.

Medical officers in charge of hospitals have to come to Kaduna to obtain clearance before purchasing a simple operation materials like cotton lints, blades, antiseptics etc which otherwise could be purchased using

revenue generated, in hospital with revenue generating units attached to them like the attached Dental Clinics. On the other hand, Zonal Secretaries interviewed complain ed of too much reference to headquarters for alot of things.

However, it is the researcher's contention that effective managers do not hesitate to delegate authority to even the weaker subordinates, so as to challenge and develop their abilities.

The General Manager's reason for insufficient delegation due to lack of qualified personnel is untenable, because a group is never wholly perfect and it is part of managers job to teach subordinates. Such techniques pay dividends, for when the subordinate acquires experience the delegator is relieved of burden-some details. In the final analysis performance of the subordinates is improved, through conscious checks on how delegated authority is utulised.

While there are so much benefits in delegation of authority which is also essential to effective co-ordination, the findings in this study point toward insufficient delegation of authority, which affects the co-ordination process of the Board.

C. Informal Group

Deep says "Whenever the established communication network of the formal organization proves inadequate, informal groups emerges.[12]

This study ventured to test informal group activities in relation to co-ordination in the organization. It is worthy to note that as part of the formal organization

informal group emerges and these informal groups emerges for among others, the need for co-ordination and collaboration in many tasks which formal organization network often over-look.

This study sought for information on the existence and activities of the "informal group(s)" in the Health Management Board. The subjects chosen for analyzing data on this issue are the Middle Level Managers (MLMS) only. Because they constitute part of the informal groups. Top Level Managers are more often than not excluded from the 'informal' or pressure group(s) like the Nigerian Nursing Association, Pharmaceutical Association of Nigeria etc. A specific question was asked to this effect and the summary of the responses are presented in table 4.10.

Table 4.10

To harmonize the working environment means to give freedom and recognition to employee informal-group-relationships (e.g. Pharmaceutical Association of Nigeria, Nigerian Nursing Association etc.). How would you rate the level of freedom given by management to "informal group" activities in your organization?

Category of Respondents	Responses Grading	Number of percentage
MLMS ONLY	High	-
	Average	31 (33.75%)
	Low	32 (40%)
	Nil	17 (21.25%)
	Total	80 (100%)

Source: Survey by the researcher

From the table 40 percent of the respondents expressed that the freedom given to informal group activities is low while 21.25 percent indicated that there is no freedom at all. But 38.75 percent expressed that there is average freedom granted to informal groups.

Of significance is the fact that none of the respondents expressed that management grant high level of freedom to informal groups, because it was not given to the degree relative to allow for effective functioning.

To corroborate the information an interview was conducted with selected members from the Top Level Managers' category. All of those interviewed do not consider granting freedom to "pressure - groups". In fact one interviewee at the headquarters, said they (informal groups) are "a headache to management". He cited the Nursing Association as an example of trouble shooters who are capable of paralyzing the smooth running of health institutions like General Hospitals.

The management according to my informant "try to satisfy the demands of informal groups not as a matter of conviction but in order to curb the consequences of not doing so."

This study assumes that pressure groups could affect co-ordination in its collective action at bargaining for something, hence in table 4.11 the study attempted to find whether or not informal groups have negative effect on co-ordination of government health programmes. The sample used were the TLMS because they alone can objectively assess the effect of informal groups ac tivities on the organization, since they are independent observers and not members of the informal groups.

Table 4.11

The development of dynamic human relations among employees is stimulated by the work environment or 'climate.' Does "informal group" or pressure groups (e.g. Pharmaceutical Association of Nigeria, Nigerian Nursing Association, Nigerian Medical Assocation) have any negative effects on co-ordination of government health programmes in your organization?

Category of Respondents	Responses	Number	Percentage
TLM	Yes	34	57
	No	26	43
	Total	60	100

Source: Survey by the researcher

From the table 57 percent of the total respondents indicated that the informal groups have negative effect while 43 percent considered their activities as not having such effects.

The realiability of this result was buttressed by information gathered from interview in which majority expressed that informal groups should be banned from organizations in charge of life and death because according to my informants, they can and infact do paralyze hospital routine. They cited the 1985 Katsina General Hospital Staff Nurses sit-down strike over non-payment of salary arrears to qualified staff nurses who had spend 6 months as qualified staff nurses but without corresponding salary of GL. 08. Even at the

moment of writing this research findings there are some qualified staff nurses who had spent 6 - 9 months but still receiving student-nurse allowances.

There seems a general consensus amongst management staff that informal groups are subversive and seek to counteract management goals. However, recent research finding has shown that informal groups can co-operate with management of formal groups to meet or even exceed management's expectations in terms of productivity and performance. For instance Sayle examined 300 informal groups in 30 industrial plants. One of his major findings constitute what he called "Conservative groups"[13] who are basically co-operatively - oriented with management.

Thus informal groups can provide a pattern of interpersonal relations and set acceptable standard of conduct in the working environment that cannot otherwise be defined in job description or job analyses. What matters today is to avoid confrontation with informal groups and replace it with thorough dialogue. However, the findings in this study consistenly indicated that there is no conducive atmosphere for informal group(s) activities and one of the reasons for its emergence as stated in this sub-section's opening paragraph is therefore defeated.

D. Political Factor

Organizations exist within the larger system of the society. The interaction of organizations with their environment is the source of influence of the former on the latter.

The study uses David Easton's system theory to analyze the effect of the external environment on an agency. The influence of the external environment provides the in-puts to the agency while the agency serve as the conversion box. The out-put constitute the Health Services to the people. This interwoven processes could affect co-ordination process of the Board.

In this regard, the study wanted to find out the effect of political factor, specifically political fluctuations of the staff and the nation on co-ordination. In table 4.12 the data is presented.

Table 4.12

Fluctuations in the political setting of the state affect policy continuity and therefore weakens effective co-ordination of health service programmes by the Board.

Category of Respondents	Responses	Number	Percentage
	Strongly agree	52	37.4
TLM	Agree	72	51.4
and	Disagree	16	11.1
MLM	Strongly disagree	-	-
	Total	140	99.9

Source: Survey by the researcher

It can be seen from the table that 88.8 percent of the total respondents agree, that fluctuations in the political setting or environment of the state affects policy continuity, while a marginal 11.1 percent disagree.

Besides this indication of political influences on policy, the researcher gathered from majority of those interviewed that the needs of the government in power determine policy continuity and execution. In other words, there are alot of governmental influence on the Board's activities. These findings neatly tie up with Robbin's statement that:

> The Government in developing Health Programmes at the Macro level significantly influence decisions, behaviour of managers and even the general management of the organization.14

In the final analysis organisations are only a system within a larger system - society as a whole. Decisions made by managers in organisations must reflect this dependence on the larger system. This phenomenon reflect a profound interaction between organisational policies and programmes on the one hand and the environment on the other.

This interaction and effects of fluctuations of the political environment on policy continuity is documented as factual in the 4th progress report of the 3rd National Development Plan, Kaduna State programme. It read thus:

> The year 1978/79 marked some improvement in the execution of the projects in the programme, it is hoped that though the present military administration would hand over the reign of power to elected representatives, the remaining projects, especially those which had been committed would be allowed to be executed.15

Not long have these fears been expressed the then civilian government under the 'ticket' of the defunct PRP took over office in October 1979. The then Governor Rimi of Kaduna State remarked that:

> The PRP government took over office and found some conditions in the state to its disadvantage..... for instance a Federal Government and House of Assembly hostile to the major programmes of the Government.[16]

This conflict between the executive and the legislature led to a long period of stalemate in which health projects and programmes were either delayed or even abandoned.

These occurences exceed the limits of organised and planned hand-over of reigns of power, but continue in a series of military coups and counter-coups as witnessed in our body-politic.

Another important aspect is the imbalance in the distribution of health facilities between the urban and rural areas. Even the government observed that:

> The health facilities are inadequate and maldistributed. They are concentrated in urban centres with just 20 percent of the population to the neglect of rural areas.[17]

While the above statement is a fact of our life, another alarming revelation is that only "35 percent of Nigerian population is presently covered by any form of modern health care services.[18]

When the researcher attempted to find out the reason(s) for this imbalance, he was informed by majority of those interviewed that political consideration rather than rationality play a big role in the distribution of health facilities. Also lack of basic infrastructures like 'pipe borne water', electricity and road networks were some of the reasons advanced for the imbalance.

The reason above is not concrete or tenable unless if we consider the medical doctors' training in Nigeria which is based on the use of a high technology as oppose to creative attempt to overcome the limitation of rural life. Okello et. al asserted that:

> Such a doctor, trained to be a consumer of medical technology not suited to an African or Nigerian rural environment which is without running water, without electricity and is therefore helpless. .. outside of technology loaded urban hospital.[19]

In the final analysis the discussion of problems of co-ordination of government health services here is a discussion of political power and of which interests dominate in society. Since as earlier stated organisations are a system within the larger system and the consequences of governmental policies must be reflected in the organization

E. General Discussions of Issues:

Of all the variables tested above only leadership style which had a high score in favour of democratic style - is positively associated with co-ordination. The other variables tested have been found to affect as well as hinder co-ordinati of health services, for instance, delegation of authority has been proved to be low in the HMB. Functional authority delegated to Zonal Management Committees has been proved to be low as well. This is more evident from the facts gathered at the interview in which the researcher gathered that the peripheral staff have to travel to headquarters for almost everything. Even the General Manager indicated that functional authority was not delegated as per the Edict's full requirement.

This shows that the channel of communication between the Board and Health institutions outside the headquarters (hospitals) has ignored the Zonal Committees, thereby creating a communication gap.

The activities of informal groups have been closely analyzed and it was proved that there freedom to act is very limited; in fact the management of the Board consider them a "headache" to the organisation which is responsible for Heal Services.

However, as part of the formal organisation informal groups emerged for among other things, the need for co-ordination and collaboration in many tasks which formal organisation network often overlook. Hence, the activities of informal groups in modern organisation positively contribute towards achieving co-ordination.

In the final analysis the variables tested in this study have been proved to affect and to certain extent hinder co-ordination of health services in the organization under study and this confirms the hypothesis that organisational climate affects co-ordination.

The other aim of study is to examine whether the HMB effectively employs certain co-ordinative mechanisms to achieve co-ordination and what type of influence does such mechanisms have on co-ordination. For an organization to achieve its objectives, it has to evolve a co-ordination machinery through which different units would operate harmoniously. Therefore, co-ordinative functions in an organization are imperative especially in complex organization. In this regard, the third hypothesis; participative management influences co-ordination would be tested. Briefly, participative management emphasises the importance of ideas, suggestion, feelings, and opinions from the appropriate members of the organization towards achieving co-ordination and organizational goals.

Participation is generally in form of interaction in the organisation, either between the individual and the manager or groups and the manager.

To test the above hypothesis the results from data in tables 4.13 and 4.14 are treated closely and sequentially. In table 4.13, classification of responses according to frequency of participation in major policies and activitie of the organisation is presented.

Table 4.13

Please rate the frequency of your direct or indirect participation in major administrative matters in your organization e.g. policy, decision-making, planning, goal setting and so on.

Items	TLM		MLM	
	Number	Percentage	Number	Percentage
Frequent	49	82	29	36.25
Not frequent	11	18	51	63.75
Total	60	100	80	100%

Source: Survey by the researcher

The results from the table indicates that 82 percent of the TLMS participate frequently in policy decisions, goal setting or planning in the organization, while a marginal 18 percent rarely participate. However in the MLMS row score 36.75 percent do not participate frequently either directly or indirectly.

From the data available we can note that participative management in the Board is illusive, for the fact that a large number of the respondents in the MLMS category, who

are the linkage group between top management and the lower level staff do not adequately participate in basic administrative aspects of the Board. Rather they merely implement what ever is conceived and hatched by the TLMS as policy decisions. Further explanation on this issue from results of an interview with some of the TLMS revealed that they do not have to involve the MLMS in major decision making because most of the time they have the information required for taking decisions and sometimes the MLMS are not experience enough to participate in major policy matters, infact it is not their responsibility to do so. The TLMS impression here is not tenable because the MLMS are competent enough to provide inputs to decision making processes.

However, this disagrees with one of the postulates of M. P. Pollett's 4-principles of organisation. Under the principle of "co-ordinating as a continuing process." she argued that:

> An executive decision is a moment in a process. So many people contribute to the making of decision that the concept of final or ultimate responsibility is an illusion.[20]

In table 4.14 below, the MLMS were asked three related questions on participation in the administration of their departments.

Table 4.14

i) Are your suggestions often sought for in the administration of your department?

ii) Are your suggestions or opinions taken seriously and translated into action?

iii) Do you have a feeling of belonging in the 'running' of your department?

Category of Respondents	Responses	1st Question Number	Percentage	2nd Question Number	Percentage	3rd Ques. No.	%
	Yes	23	28.75	12	15	33	41.
MLM	*Rarely	6	7.5	27	33.75	5	6.
	No	51	63.75	41	51.25	42	52.
	Total	80	100%	80	100%	80	100

Source: Survey by the researcher

* Rarely: This study uses the theory of probability to reduce the level of error in the analysis. The study assume that "Rarely" is inclined to the negative response scale because the theory makes anything less than .5 to have an unlikely chances of occurance.

From the table, the first item whether the MLMS suggestions are often sought for, in the administration of their department 28.75 percent indicated that they are consulted. Whereas 63.75 percent expressed a contrary opinion 7.5 percent indicated rare participation.

On whether their suggestions are taken and translated into action, 15 percent expressed in the affirmative whereas 51.25 percent indicated contrary opinion, 33.75 percent expressed rare participation.

On whether there is a feeling of belonging in the "running" or managing of their organisation 41.25 percent answered in the affirmative whereas 52.5 percent expressed a contrary opinion, 6.25 percent indicated rare feelings. Since the opinions and ideas of the majority of the MLMS are neither sought for nor seriously taken, the importance

of opinions and feelings from the appropriate members of the organisation towards achieving co-ordination does not prevail in the HMB.

However, of significance is the information from an interview with selected MLMS; that they enjoyed adequate participation in the "running of the organization during budget proposal exercise which occurs once a year, hence MLMS adequate participation is therefore temporary.

To verify the findings, the MLMS were also asked whether they enjoy departmental representation in the 'running' of the Board. Majority of them informed the researcher that such representation is the exclusive preserve of the top management.

However, management for upper and middle level managers is supposed to reflect more participation in decision making, wider sharing of authority and responsibility. But consistently the results from both tables and information gathered from interview conducted points toward non-participatory stle. Thus, our findings do not tally with Coach and French findings and conclusions from a research using 3 experimental groups. Their conclusions that total participati has about the same effect in kind, as representative participati but former has a stronger influence.[21]

However, the result of items 3 in table 4.14 - MLM's feeling of belonging in which 52.5 percent opined that they do not have such feelings consequently leads to unfavourable atmosphere, in which majority of the MLMS also feels that management has made representation in major activities its

own exclusive right (refer interview mentioned above). These findings seem to agree with research findings of Argyris, March and Simon which concludes that:

> Subordinates react favourably to experiences which they feel are supportive and contribute to their sense of importance. Conversely persons or subordinates react unfavourably to experiences which are threatening and decrease or minimize their sense of dignity and personal worth.[22]

These findings are supported by research on group behaviour Cartwright and Zander who concluded that each of us wants a feeling of accomplishment. We want to feel that we have a place in the world and in particular in our organization.[23] ("emphasis mine).

While some of our findings do not tally with other research findings, others are in perfect agreement with certain research works. Yet, one fundamental issue still remains unresolved. That is how deeply and specifically management styles affect or influence organsational operations; research findings of Likert indicate that:

> Organisations that enjoy Participative Management style have high productivity, greater involvement of individuals and better labour - management relations than those who do not.[24]

Management who use this style are often referred to as high producing managers. Scholars like Likert in 1958, Mann and Dent in 1954 and Katz et. al in 1951 showed that the general pattern of high producing managers tend to differ from that of managers of Mediocre, and low producing units by showing certain characteristics; like the use of participation to get the full benefits

of the technical resources of the classical theories.[25] Therefore, the use of participative management style in complex organisations point towards a positive correlation between the style and co-ordination as revealed by research findings above, while the use of non-participative management style point to a negative correlatio This was confirmed by the researcher's observation of some MLMS reactions ranging from apparent delay to refusal to execut e directives simply because they feel they were not adequately represented in the process of the decision leading to the policy directives of the Board. For instance, the decision late in 1985 to temporarily suspend the payment of Doctors-call allowance by the Board was a case in point. This constitutes a negative effect on co-ordination of Health Services.

However, from the data, this study's findings revealed that major decision making in the HMB is the exclusive - preserve of the top management and participation of majority of MLMS is not adequate except during budget proposal exercise. The MLMS ideas were neither highly sought for nor translated into action. Above all there seem to be a feeling of alienation by majority of the MLMS who are the linkage group between upper and lower cadres in the organization.

Based on the data and findings, one can infer that the Board employs non-participative management style, the effect of this on co-ordination is therefore found to be negative. Thus, the hypothesis, participative management influences co-ordination in the HMB stands

accepted. The study also revealed that there is a positive correlation between participative management style and co-ordination.

The other variable related to participative management and which is also a co-ordinative mechanism being tested in this study is integration.

Integration

The process of integration is aimed at bringing otherwise independent administrative and technical structures, functions and diverse mental aptitudes in such a way as to combine these into a coherent whole.

An integrated health service normally operated on the basis of teamwork, such that the greatest possible use of professional skills could be made. To test this variable two questions were asked - one to the MLMS; the other to the TLMS. The responses were presented in table 4.15 (a) and 4.15 (b) respectively.

Table 4.15(a)

Your organization consist of both administrative and professional staff. In your candid opinion do you observe teamwork between the medical, para medical and administrative staff in your organization?

Category of Respondents	Responses	Number	Percentage
TLM	Yes	21	26.25
	*Rarely	27	33.75
	No	32	40
	Total	80	100

Source: Survey by the researcher

*Rarely: This study uses the theory of probability to reduce the level of error in the analysis: The study assumes that "Rarely" is inclined to the negative response of the scale. Hence it has a value of less than .5 chances of occurance. Relevant data has been used to analyze this column in the discussion.

Table 4.15(b)

It is assumed that technical or professional-specialists are at a distance i.e. there is dichotomy between them and the generalists - administrative staff.

Category of Respondents	Responses	Number	Percentage
TLM	Agree	43	71.6
	Disagree	10	16.6
	Undecided	7	11.6
	Total	60	98.8%

Source: Survey by the researcher

From table 4.15(a) it shows that 26.25 percent of the respondents (MLMS) are of the opinion that there exist teamwork between the Medical, Para-Medical and Administrative staff in the organisation. Whereas 33.75 percent of the respondents observed that teamwork rarely exist in the organisation, 40 percent are of the opinion that it does not exist. The latter represents the highest percent of the responses.

To confirm this result, the researcher relates it to his observation of an incident of professional disagreement over the procedure to curb further spread of meningitis

in Katsina township and its environs which occured in 1985. The disagreement was between the Medical and preventive departments of the General Hospital. The incident temporarily strained the relations between the departments concerned and this led the receipi ent of the Health Services to suffer during the stalemate.

But it is this researcher's contention that the staff of a hospital are a team and they should have a 'morale' which at its best has mutual sense of zest, industry and dedication but at its worst corporate feeling of sloth, futility and frustration. These feelings are often a direct consequence of lack of integration which characterise the Board as per the study's findings.

From table 4.15(b) above, the result shows that 71.6 percent of the TLMS agreed that there is dichotomy between tl professional-specialists and generalist - administrators whereas a marginal score of 16.6 percent disagree. 11.6 percent were undecided on the issue.

The results from this table is as startling as it shows a marked antagonism between the generalists and the specialists - as shown in the sample of this study.

In order to gather more information on the issue, the researcher conducted an interview with both administrative and professional staff. The medical-specialists unequivocally 'blamed' the administrators especially those at the headquarters for lack of understanding of the technicalities involved in health care delivery. While the generalist administrators interviewed informed the researcher that professional - specialists always over-emphasize the importance and necessity of their ideas and often leave no room for compromise.

But of importance is the fact that all those interviewed recognised the need for teamwork and integration in the provision of health care delivery.

The problem in the researcher's opinion is how to achieve integration of professional-specialists and generalists administrators in the interest of effective co-ordination of government health service programme.

It should be noted that the complex nature of present day's organizations exhibits characteristics of specialized skills and professionals which makes it almost impossible for the manager to make the best decision based on the best technical facts by himself alone. Similarly the problems are so complex that no one subordinate or middle level manager has all the technical information required. Therefore to marshall all the relevant information bearing on a decision it is usually necessary to involve experts from different fields. For instance; from the decision to perform a surgical operation on a patient in the hospital - the Medical Surgeon must require the co-operation of the anaesthetist, the nurses, etc to a major policy decision on drug purchase and distribution which must require the co-operation of the generalists-administrators, pharmacists and a host of experts that constitute the Board members. Hence this illustrates the need for co-operation and integration in health care delivery.

However, the findings in this study reveals a dichotomy between the professional-specialists and administrators which is interpreted to be the source of lack of teamwork

and integration. This has negative effects on the co-ordination of health services by the Board. These findings neatly agree with the Public Service Review Commission, Udoji which looked into the public services in Nigeria and reported that:

> The relationship is one of acrimony and antagonism in a conflict rather than partnership in an enterprise with resultant lack of teamwork necessary for modern management.[26]

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CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This study was conducted in an attempt to provide answers to the following questions which also constitute the major aspects of the research problem: Has the Kaduna State Health Management Board achieved co-ordination in its efforts to provide health services? What is the level or extent in terms of effectiveness or ineffectiveness of co-ordination? What factors inhibit or promote effective co-ordination of health service programmes by the Board? How do these factors influence effective delivery of health services?

Based on stratified random sampling a total number of 161 subjects participated in the study. The study utilised the following sets of questionnaires; a set of questionnaire was administered to 60 top level managers of the Board and Health Institutions under the Board. While 80 middle level managers were also served with another set of questionnaires. Another set of questionnaires was administered to 21 top level managers of the Ministry of Health. Furthermore, an interview was conducted to clarify certain issues and obtain information that could not be obtained through the questionnaire method.

The results of the investigation revealed that there is ineffective co-ordination of health services at the Health Management Board due to lack of clear perception

of functional roles by a large majority of the sampled population. Effective co-ordination was also discovered to be influenced by a number of variables classified into organizational climate. Similarly the results also showed that in the board participative management style was not being employed to achieve co-ordination. This style of management has been accepted as a pre-requisite for effective co-ordination by management writers like Likert (1958) Argyris (1957) and Howard and Mckinney (1977).

Functional role perception was examined first from the perspective of the top level managers (TLMS). As presented in table 4.1(a) the result indicated that 55 percent of the respondents in the middle level managers (MLMS) category did not have clear perception of their functional roles, while 45 percent expressed a clear perception of functional roles. However, the MLM'S viewpoint about the role perception of the TLM'S showed that 74 percent of the respondents confirmed that the TLMS have a clear role perception while 26 percent expressed a contrary opinion.

Though the variations in role perception between the TLMS and the MLMS is as interesting as it is understandable, the results from data indicated that majority of the sampled subjects that also constitute the linkage group between the upper and lower cadre of the organization do not have a clear perception of functional roles.

The concept of role is however, of considerable utility in the study of co-ordination of government programmes, a study that involves social interaction among and between middle and high leverage managers in any complex organization.

Another variable considered, along with functional role perception was role conflict. When this was examined the results revealed that there exist role conflict (table 4.2). On the effect of such conflict on co-ordination of health services, the result showed that it has a negative effect (table 4.3). It follows therefore that efficient delivery of health services is not realised.

When role conflict was examined in relation to re-definition of roles in order to minimize or eliminate conflict the results showed that 57.5 percent of the respondents in the MLMS category were in favour of re-definition of roles. When compared with the TLMS response on the same issue 72 percent were not in favour of re-definition of roles.

From the evidences gathered one can conclude that majority of the MLMS have consistently shown their lack of clear perception of functional roles which logically leads to their expressed desire for re-definition of roles. Similarly majority of TLMS have consistently shown that they have a clear role perception and hence do not subscribe to re-definition of roles.

From the results therefore one can conclude that effective co-ordination depends on clear perception of functional roles of an organization. This is more so because good and qualified task performers can just make an ambigious structure work but they can certainly work better where roles are clarified.

The study also revealed that a combination of variables affects co-ordination of health services. When these variables were tested delegation, informal group

activities and political forces were found to affect co-ordination more than the leadership style. How these factors influence co-ordination has been shown to be negative and this inhibit efficient delivery of health services.

The effect of delegation of authority and responsibility was shown in table 4.9. The result showed that 57 percent of the total respondents were of the opinion that delegation of authority was low, which hampers effective co-ordination. The findings of this study in respect of this factor is not consistent with Onasode's (1980) report on parastatals which concludes that the greatest strength of management .... is the speed with which decisions are taken, communicated and implemented. This happens because well-defined responsibilities are carried out to specific levels.... Sufficient authority is then delegated to each level of management and every manager is held accountable for the results which he achieved under the system.

On the effect of informal group activities the study revealed that the Board's management considered informal groups as a headache to the organization and their activities inimical to effective co-ordination. These findings are not consistent with the findings of Sayles (1958) who pointed out that informal groups can be co-operatively oriented with the management of an organization. Hence, they are capable of influencing co-ordination positively, through a system of group behaviour.

On the effect of political factor on co-ordination, the study revealed that political fluctuations as it relates to policy on health services in the state affect co-ordination. Table 4.12 presented the evidence that 88.8 percent of the total respondents confirmed that political fluctuations affects policy continuity or discontinuity depending upon the desires of the powers that be. The findings were in perfect agreement with Robbins (1978) who pointed out that governments in developing health programmes at macro level significantly influence the decisions and even the general management of the organization in charge.

When the variables associated with organizational climate were collectively examined the combined effect of delegation, informal group activities and political forces were found to be more than that of leadership style; which the total respondents indicated was democratic (table 4.8) hence positively associated with a conducive atmosphere for effective co-ordination.

It was also shown that the combined effect of these variables inhibit rather than promote efficient delivery of health services to the teaming populations.

Finally the result also showed that participative management in the Board is illusive. This is evident by the results presented in table 4.13 in which 63.75 percent of the respondents in the MLMS category confirmed that their direct or indirect participation in major administrative matters such as planning, goal setting, policy decision process is rare. Even representative participation is exclusively for the top level managers. This result is

not consistent with Follet (1964) who postulated that an executive decision is a moment in a process so many people contribute to the making of decision that the concept of final, ultimate or exclusive responsibility is an illusion.

Furthermore, on closer examination of the variables of participative management, the MLMS who are the linkage between top management and the junior cadre of an organization confirmed that their suggestions, or ideas, were not sought for in the management of the organization. Consequently, over 52.5 percent of the respondents expressed the feeling of alienation in the "running" or management of the organization (table 4.14). This result is not in agreement with the findings of Cartwright and Zander (1960) who postulated that each of us want a feeling of accomplishment we want a feeling that we have a place in the world and in particular in our places of job. It follows that participative management style enhances co-ordination if practically employed by an organization. Findings from this study have shown that in the Board this management style is illusive, hence it is not being sufficiently employed in the administration of the Board and consequently there is ineffective co-ordination of health services.

5.2 CONCLUSIONS

The main aim of this research was to determine the extent and/or level - in terms of effectiveness or ineffectiveness of co-ordination of government health programmes in the Kaduna State Health Management Board. It was also to determine the factors affecting co-ordination and the influence of such factors on the efficient delivery of health services to the people.

Co-ordination is a requirement of governments at all levels, between levels and within individual programmes. This is so because many public programmes and services involve more than one level within the organizational hierarchy. While every collective action needs co-ordination; however co-ordination is essential to the success of any complex organization. Similarly to achieve results every public program requires the mobilization of organizational forces viz personnel and materials. It is relevant to perceive health service and national development as complementary, for it is an accepted fact that any effort towards national development must require a healthy population. The latter imply a healthy labour force which in effect is a pride of any nation. Therefore, it follows, that responsible governments seek to establish agencies to shoulder the responsibility of the provision of health services. This task requires co-ordination due to the complex nature of the agencies charged with such responsibilities as in this case study the Kaduna State Health Management Board.

In line with the aims of study therefore the researcher hypothesized as follows: Effective co-ordination depends on clear functional roles of an organization, organizational climate affects co-ordination and lastly participative management influences co-ordination.

The phenomenon of co-ordination was therefore examined from the perspective of functional role-perceptions of the sampled subjects of the organization; organizational environmental factors such as leadership style, delegation,

informal group activities and political forces; finally from the participative management perspective. The results revealed that there is ineffective co-ordination of health services in the Board.

From the major evidence shown that the majority of the sampled population in charge of co-ordination did not have clear perception of functional roles (table 4.1(b) and the prevalence of organizational role conflict due to variations in skills or qualifications was also revealed (table 4.2). This in effect affect the efficient delivery of health services to the people.

Finally from the findings of this study and in cognizance of the Board's objectives, it is safe to conclude that the problems of health care delivery system lay not so much on finance, or manpower but on ineffective co-ordination of these services for the benefit of the teaming population. Health sector for instance has so far been the third besides agriculture and education in order of sectorial allocation of funds by the government, while manpower although still a problem but it is not the fundamental problem as shown in a seminar paper on Basic Health Service Scheme delivered by Prof. O. Ransome Kuti (now Minister of Health) in 1977. The paper comparatively explained that Lagos alone has a population of 1 doctor to 500 and Kaduna town has an average doctor population ratio of 1:1000.

5.3 RECOMMENDATIONS

In the light of the findings of this research, it is the opinion of this researcher that to achieve effective co-ordination of government health programmes and to provide health services to the people with maximum efficiency at a minimum cost. The following recommendations are worthy of consideration by policy makers and administrators.

From the findings of this investigation, the variable of functional role perception was found to be central to the theme of co-ordination in the Health Management Board.

The fact that research findings showed that majority of the sampled subjects do not have a clear perception of functional roles implied certain consideration of this factor. The agency should make a deliberate effort to design and clarify functions, lines of authority and eliminate ambiguities and overlaps. Through this the working environment can be placed in such a perspective that everyone knows who is to do what, who is responsible for what and which department is responsible to what, which in effect would make it easy to evaluate employee-cum-departmental performance. To further clarify the working environment of any ambiguity, employees should be encouraged to acquire skills in basic tenets of management through training.

Secondly, the Board should delegate sufficient authority and power to zonal management committees to enable them perform efficiently and effectively.

Thirdly, the government should establish a co-ordinating unit in each ministry or agency like the Board, where such units have not been established. Such units would co-ordinate the activities of the ministry or agency both at the internal and external dimension.

Fourthly the government should officially recognise and encourage traditional medicine research centres to promote and co-ordinate the services of traditional practioner with that of 'Western' medicine. Government should also modify pharmacy laws to integrate traditional medicine. Through these measures, government can supplement the existing imbalance in the distribution of health facilities between urban and rural areas. Fifthly, an integrated approach to health care delivery should be adopted by government. This approach presupposes that health personnel must work as members of a team sharing in, and assisting with one anothers' activities rather than narrowly pursuing their individual functions.

Lastly, from the findings of this investigation, participative management style was found to be positively associated with effective co-ordination when employed in an organization. Based upon its principles and practices, management can make full use of the potential capacities of its human resources, only when employees in an organization are allowed certain degree of participation in the 'running' of their organization.

Meaningful and appropriate ideas and suggestions by the employees should be seen as part of creativity and efforts to developmental activities. Essentially participation

reduces alienation of employees and minimize their chances of frustration. It is therefore recommended that the Board should employ participative management style to achieve effectice co-ordination. Health authorities have to realize that modern management principles must be used if adequate health services are to reach the people with minimum costs and at maximum benefits. In this way the government will fulfil its social responsibility for the sake of better life. For there nothing so good that cannot be made better.

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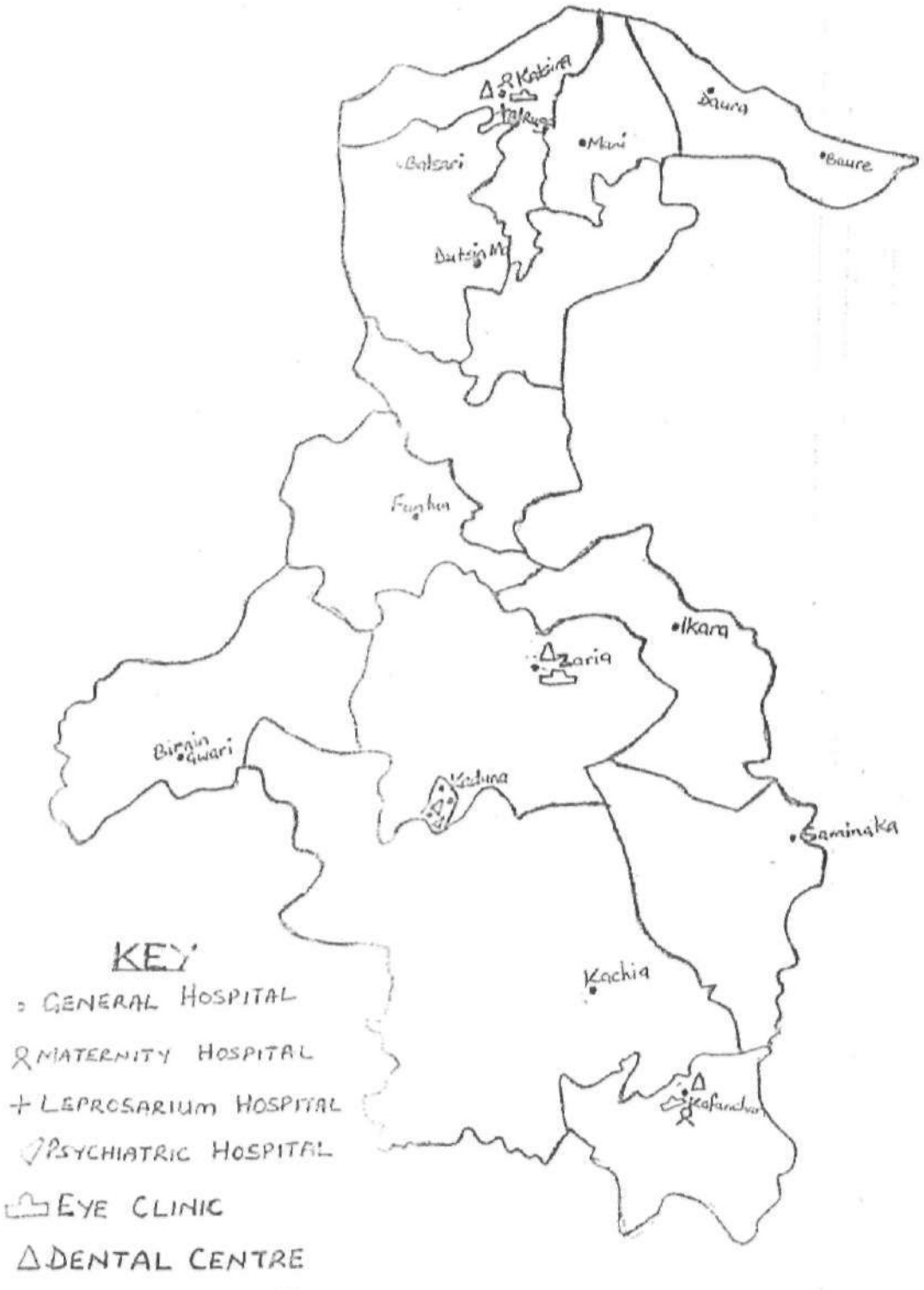
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KADUNA STATE HEALTH MANAGEMENT BOARD
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Military Governor's Office,
Kaduna State,
Private Mail Bag No. 2002,
Kaduna.

7th November, 1985

The Permanent Secretary,
Ministry of Health &
Social Welfare,
Kaduna.

The General Manager,
Health Management Board,
Kaduna.

MPA DEGREE THESIS: MAL. ALI UMAR BINDAWA

The bearer is Mal. Ali Umar Bindawa a student of Ahmadu Bello University Zaria collecting data for M.P.A. Degree.

I am therefore directed to request you to assist him with all the data be requires for his assignment please.

(SGD)
(SAMA'ILA S. HASSAN)
for Secretary to the Military Government and
Head of Service.

Department of Public Administration.
Institute of Administration,
Ahmadu Bello University,
ZARIA.

February, 1986

Dear Sir/Madam,

CO-ORDINATION OF GOVERNMENT PROGRAMMES: A STUDY OF THE KADUNA STATE HEALTH MANAGEMENT BOARD.

I am an M.P.A. student conducting research on the above subject; in order to learn more about co-ordination of government programmes and its effects on performance of government agencies.

Please you are being requested to complete the questionnaire attached.

This exercise is purely for academic purposes, therefore all information collected will be treated in strict confidence.

The names of respondents are not required please.

Yours sincerely,

(SGD)

(UMAR ALI BINDAWA)

Appendix II

TOP LEVEL MANAGERS (STAFF) QUESTIONNAIRE OF THE HEALTH MANAGEMENT BOARD AND HEALTH INSTITUTIONS UNDER THE BOARD

Instruction

i This questionnaire contains two sections. Section I consist of a set of questions to which respondents should indicate answers with a tick against his/her choice from the choices provided.

ii Section II consist of a set of questions to which respondents are required to write in spaces provided. Please use extra sheet of paper if necessary.

Rank or Title of Respondent _____

Sex: Male or Female: _____

Year of joining the Services: _____

Do you consider your organisation as:

a) Small scale (b) Medium scale (c) Large scale

To which of the following cadres do you belong?

a) Professional (medical and/or technical)

b) Administrative

1. At which of the following levels do you perform your role in the 'running' of your organisation?

a) Initiation of policy (b) Policy execution
(c) Programme and project implementation
(d) Project evaluation (e) General Administration.

2. How do you perceive your role in the 'running' of your organisation?

(a) V. clear (b) Clear (c) Diffusely clear
(d) Not clear

3. How would you rate the perception of functional roles by your subordinates?

(a) V. clear (b) Clear (c) Diffusely clear
(d) Not clear

4. Do you observe any role conflict in terms of specialisation and in the discharge of your duties in the organisation?

   (a) Yes (b) No (c) Cannot decide

5. (i) If your answer is 'YES' what is the effect of such role conflict on co-ordination of health services in your organisation?

   (a) Positive (b) Negative (c) Unchanged (d) No response

   (ii) Do you subscribe to re-definition of existing functional roles in order to minimize or eliminate role-conflicts?

   (a) Yes (b) No (c) Cannot decide

6. Competition to perform virtually similar things common between the Board and the Ministry of Health

   (a) Agree (b) Disagree (c) Cannot decide

7. Which of these styles appropriately describe the leadership style in your organization?

   (a) Persuasive (b) Democratic (c) Carefree/ Laissez faire (d) Authorita-rian (e) Autocratic

8. Project implementation technically and administratively requires supervision. Please rate the degree of supervision in project implementation and general administration in your organization.

   (a) High (b) Average (c) Low (d) Cannot decide

9. How would you rate the degree on which power and authority to perform tasks are delegated to subordinates in your organization

   (a) Very High (b) High (c) Low (d) Very low

10. Concentration of power among management staff have positive effect on co-ordination due to competence of this cadre to exercise power

    (a) Strongly disagree (b) Agree (c) Neutral (d) Disagree (e) Strongly disagree

11. The Board has zonal Management Committee in selected Local Government Areas of the State. Please rate the level of functional administrative responsibility that has been transferred/delegated to the Zonal Management Committee of the Board

    (a) Very high (b) High (c) Low (d) Very low

12. (i) Please rate the degree of communication *flow from buttom-up in your organization*

(a) High (b) Average (c) Low

(ii) Please rate the degree of communication flow from top-down in your organization

(a) High (b) Average (c) Low

(iii) Please rate the degree of lateral or horizontal communication flow in your organization

(a) High (b) Average (c) Low

13. The development of dynamic human relation among employees is stimulated by the work environment or 'climate' Does "Informal groups" (e.g. Pharmaceutical Association of Nigeria, Nursing Association, Nigerian Medical Association have any negative effects on co-ordination of government Health programmes in your organization

(a) Yes (b) No

14. Fluctuations in the political setting of the state affect policy continuity and therefore weakens effective co-ordination of health services programmes by the Board.

(a) Strongly agree (b) Agree (c) Disagree
(d) Strongly disagree

15. Please rate the frequency of your direct or indirect participation in major administrative matter e.g. policy decision-making, planning or goal setting in your organization.

(a) V. Frequent (b) Frequent (c) Not Frequent

16. How would you rate the degree of co-operation amongst employee when it comes to getting things done?

(a) High (b) Average (c) Low (s) Nil

17. It is assumed that technical or professional specialists staff are at a distance (i.e. there is dichotomy between them) with the generalists-administrative staff

(a) Agree (b) Disagree (c) Undecided

SECTION II

1. Please explain how the department you belong co-ordinate its activities with other departments.

---

2. To maximize the delivery of health services in the State other Organizations like A.B.U. Teaching Hospital are engaged in health care delivery, how does the Board Co-ordinate its activities with those Organizations?

---

3. Recently the World Health Organization launched the programme of "Health for all by the Year 2,000" through which of the following does the Board receive such programmes:

   a) The State Government

   b) The State Ministry of Health

   c) The Federal Government

   d) The Federal Ministry of Health

   e) Directly

4. Does the Board has co-ordinating unit to co-ordinate its activities?

---

5. Explain the differences in areas of responsibility between the Board and the State Ministry of Health.

---

6. Explain your views on delegation of authority as a management tool for speedy action.

---

7. Organizations like the Health Management Board exist and interact with its immediate environment. What is the effect of political forces of the state and the nation on the policies of the Board in terms of continuity and coverage.

---

8. Participative Management is a style of management that permits adequate employee participation in organizational activities. Please explain the extent to which this is applicable in your organization.

---

9. What problems are you facing in the performance of your duty?

---

10. What suggestions would you make towards improving health services in the State?

Appendix III

MIDDLE LEVEL MANAGERS (STAFF QUESTIONNAIRE OF HEALTH MANAGEMENT BOARD AND HEALTH INSTITUTIONS UNDER THE BOARD

Instructions

I. This questionnaire contains two sections. Section I consist of a set of questions to which respondent should indicate answer with a tick against his/her choice from the choices provided.

II. Section II contain a set of questions to which respondents are required to write in space provided. Please use extra sheet of paper if necessary.

Name of your Organisation/Health institutions --------

Rank/Title of respondent ----------

Sex: Male or Female ----------

Year of joining the Service ----------

Date of last promotion ----------

Would you say the staff welfare in your organization is:

(a) Adequate (b) Average (c) Inadequate

To which of the following cadres do you belong?

(a) Professional (medical and/or technical)

(b) Administrative

1. At which of the following levels do you perform your role in the 'running' of your organisation?

   (a) Policy execution (b) Project and Programme implementation (c) General Administration

2. Rank the understanding or perception of functional roles of your supervisor

   (a) V. Clear (b) Clear (c) Diffusely clear (d) Not clear

3. Do you observe any role - conflict in terms of specialisation and in the discharge of your duties in your organisation?

(a) Yes (b) No (c) Cannot decide

4. If the answer above is 'Yes' What is the effect of such role-conflict on co-ordination of health service in your organisation?

(a) Positive (b) Negative (c) Unchanged
(d) No response

5. Do you subscribe to re-definition of existing roles in order to minimize or eliminate role-conflict?

(a) Yes (b) No (c) Cannot decide

6. Which of these styles appropriately describe the Leadership style in your organisation?

(a) Persuasive (b) Democratic (c) Carefree/ Laisse-Faire (d) Authoritarian (e) Autocratic

7. Project implementation technically and administratively requires supervision. Please rate the degree of superviision in project implementation and genera administration in your organisation.

(a) High (b) Average (c) Low (d) Cannot decide

8. How would you rate the degree in which power and authority to perform tasks are delegated to subordin in your organisation?

(a) V. High (b) High (c) Low (d) V. Low

9. The Board has Zonal Management Committees in selecte Local Government. Please rate the level of administ tive responsibility that has been transferred to the Zonal Management Committee of the Board.

(a) V. High (b) High (c) Low (d) V. Low

10. (i) Please rate the degree of communication flow from bottom-up in your organisation.

(a) High (b) Average (c) Low

(ii) Please rate the degree of communication flow from top-down in your organisation.

(a= High (b) Average (c) Low

(iii) Please rate the degree of lateral or horizont communication.

(a) High (b) Average (c) Low

11. To harmonize the working environment means to give freedom and recognition to employee informal group relationships or (e.g. Pharmaceutical Association of Nigeria, Nursing Association etc) How would you rate the level of freedom given by Management to informal group activities in your organisations?

(a) High (b) Average (c) Low (d) Nil

12. Fluctuations in the political setting of the State affect policy continuity and therefore weakens effective co-ordination of health services programmes by the Board.

(a) Strongly agree (b) Agree (c) Disagree
(d) Strongly disagree

13. Please rate the frequency of your direct or indirect participation in major administrative matters e.g. policy decision-making, planning or goal setting etc)

(a) V. Frequent (b) Frequent (c) Not frequent

14. (i) Are your suggestions often sought for in the administration of your department?

(a) Yes (b) Rarely (c) No

(ii) Are your suggestion or opinions taken seriously and translated into action?

(a) Yes (b) Rarely (c) No

(iii) Do you have a feeling of belonging in the "running" of your department?

(a) Yes (b) Rarely (c) No

15. How would you rate the degree of cooperation amongst employees when it comes to getting things done?

(a) High (b) Average (c) Low (d) Nil

16. Your organization consist of both administrative and professional staff. In your candid opinion do you observe teamwork between the Medical, Para-Medical and administrative staff in your organisation or Health Institutions?

(a) Yes (b) Rarely (c) No

SECTION II

1. Please briefly explain the functions of your department in the Board.

---

2. What is your role in realizing those departmental functions?

---

3. Other health institutions such as the A.B.U. Teaching Hospital, Ministry of Health Clinics, government special Clinics are engaged in the provision of health services. How does the Board co-ordinate its activities with theirs in order to maximize delivery of health care without any duplications?

---

4. Do you offer Mobile clinic service to rural areas? If yes please explain the operations of such clinics.

---

5. The Board has Zonal Management Committees in selected Local Government Areas in the State. Do these committees enjoy sufficient delegated power to act within their areas of jurisdictions?

---

6. How do the Hospitals under Zonal Committees communicate their problems to Headquarters?

---

7. Leadership of an organisation depend on the perception of employees. Please name or explain the leadership style of your organisation?

---

8. There are several ways of making management aware of subordinates conditions. Explain the role of informal groups like Nursing Association of Nigeria, Nigerian Medical Association in pursuing employee's demands without endangering the organizational goals.

---

9. The Board exist and interact with its immediate nvironment, what is the effect of political forces of the state and the nation on the board?

---

10. How would you asses the participation of middle level managers in policy decision making in the Board?

Apendix IV

TOP LEVEL MANAGERS (STAFF) QUESTIONNAIRE FOR KADUNA STATE MINISTRY OF HEALTH AND SOCIAL WELFARE

Instructions

1. This questionnaire contains one section. It consists of a set of questions to which respondent should indicate answers with a tick against his/her choice from the choices provided.

Rank/or Title of Respondent ----------

Sex: Male or Female: ----------

Year of Joining the Service: ----------

To which of the following cadres do you belong?

(a) Professional - medical/or technical

(b) Administration

1. At which of the following levels do you perform your role in the 'running' of your organization.

   (a) Initiation of Policy (b) Policy formulation (c) Policy execution (d) Programme and project implementation (e) General Administration

2. How do you perceive your role in the "running" of your organisation?

   (a) V. clear (b) Clear (c) Diffusely clear (d) Not clear

3. Besides the Ministry other agencies like the Health Management Board, A.B.U. Teaching Hospitals provide Health Services in the State. Do you observe any role conflict between these agencies?

   (a) Yes (b) No (c) Undecided

4. Competition to perform virtually similar things in terms of health services is common between the Ministry and the Health Management Board.

   (a) Strongly agree (b) Agree (c) Disagree (d) Undecided