EDITORIAL

Dear Colleague and collaborators,

It is wisely said, “When you dream while sleeping and you want to realize the dream, get up from your slumber and put it into action. Otherwise, your dream will never be realized”. The vision, Mission and Broad objective of MBACEA are our stimulus. We can never go to sleep because we are obliged to realise the purpose for our existence as an international body-MBACEA.

Let’s keep our pens flowing with our hospital management experiences at our job sites for the continuity of our cherished Newsletter.

Are you challenged that you need to submit write-up for this newsletter publication? If YES, do it, and if NO, Why not?

As you read this publication, I wish you all the best and thanks for your continuous commitment to MBACEA’s growth both at your country and International levels. Stay Blessed!

Mr. Eseme Elias Tong
MBACEA International President

EDITORIAL

Dear Friends and Alumni,

This year we celebrate the 20th birthday of our HNU on October 23rd. This is a day when everyone can experience the HNU and see what we have reached since our foundation in 1994. In keeping with the motto “Designed to be different”, the HNU looks back on 20 years and shows what it is today: an international, family-friendly, practice-based and research-oriented university of applied sciences.

We have been particularly successful in the field of internationalization. I’m proud that HNU students can study at almost 60 partner universities worldwide. And in return, the HNU has become an international university through being host to a number of international students. But the best thing – and I am looking forward to this – is that our postgraduate Master’s degree programme in Health Information Management has started successfully. This degree is a special one. In this programme students from Germany, Kenya and South Africa come together and study in one of the home countries; in this way, the HNU is experiencing another form of internationalization.

Happy reading!

Best wishes,
Prof. Dr. Uta M. Feser

INFORMATION

The part-time study course MBA Management in Healthcare has started. 20 students are enrolled. The course is offered by HNU (Germany) in collaboration with the University of Eldoret (Kenya).

Appointment

Country meeting in Malawi 2014
Alumni-Conference on 26th October to 1st November 2014 in Dar es Salaam, Tanzania.

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Since 2005 the alumni have participated in a range of different courses and formats from the International Leadership Training (ILT) to the Specialized Course and the Blended Learning of the Hospital Management for Health Professionals (HMHP). The trainings were implemented as part of the German Development Cooperation on behalf of the Federal Ministry for Economic Cooperation and Development (BMZ).

Change agents for better healthcare

At the start of the alumni conference on Sunday afternoon, the alumni met classmates from their own courses and encountered many new colleagues. Monday was packed with information on alumni networking and with two lecture and discussion sessions on income generating activities and on strategic planning for hospitals. In the afternoon the conference was open to guests from partner organizations from the host country, Kenya, as well as from Cameroon and Tanzania. Welcome speeches were given by Lars Wilke of the German Embassy in Nairobi, Hendrik Linneweber, GIZ Country Director, and by Dr. Ruth Kitetu and Dr. Pacifica Onyancha of the Kenyan Ministry of Health (MoH). All speakers stressed the importance of further cooperation to strengthen African health systems and to strive for quality services in health for the whole population.

Human Capacity Development

Looking back on nine years of Human Capacity Development (HCD) programmes for hospital managers, Dr. Kleinschmidt of GIZ and Prof. Burk of the Ulm University of Applied Science (HNU) reported on the experiences and outcomes. All different formats had in common their comprehensive and practice-oriented approach and one common goal: to offer knowledge and competencies for the effective, efficient and needs-oriented management of hospitals. Success factors were a thorough needs assessment, the careful selection of qualified participants and a tailor-made curriculum with modern teaching methods for adult learning. A regional approach of South-South learning as well as very productive exchange with German counterparts and the multi-disciplinary composition of the groups added to this innovative approach. The HNU, longtime academic partner of GIZ, developed close links with several African universities and institutions, and was able to offer to many alumni the opportunity to continue studying for a MBA degree.

Speakers of the eight different groups of participants reviewed their experiences as learners. They reported on their impressions, commenting on German punctuality and working spirit, on finding friends and on facing winter time with snow and ice for the first time. Above all, the trainings contributed to the personal development and professional excellence of the alumni. As one speaker put it: „We were returning back to our homes as changed persons. There was new confidence and energy within us.”

Good Practice

On the last day of the conference, good practice examples demonstrated the potential of the trainings and their alumni. Ten projects were highlighted through presentations and market place sessions. All areas of hospital management were represented, i.e. quality management, human resources, information technology, leadership and financial management. The project presented by Dr. Peter Dattani on „Improving user fees collection” resulted in a four to five-fold increase of revenue to his hospital in Tanzania by implementing IT-based new processes. The project of Christine Sammy on „Training staff on how to handle maternal & newborn emergencies” has considerable reduced neonatal mortality in her county and is now regarded as a model for the whole of Kenya.

Panel Discussion

The concluding highlight of the event was a panel discussion on “Private and public provision of health services” moderated by Dr. Heide Richter-Airijoki (Principal Advisor Health, GIZ Kenya). Panelists were Dr. Lilian Kochola, (MoH Kenya), Dr. Amit Thakker (Kenya Healthcare Federation), Mrs. Hilda Mungure (Kilimanjaro Christian Medical Centre, Tanzania), Dr. Thompson Njie (Bamenda Regional Hospital, Cameroon), Mr. Michael Udedi (MoH Malawi) and Beatrice Uwayezu (Rwanda). The panelists agreed on the positive contribution that private sector providers can make in the health sector. High quality standards should be followed by all facilities, public, faith-based or for-profit. Many questions remain in all partner countries concerning financing mechanisms, public-private cooperation or partnerships, and the need for regulation and standards, to name but a few.

BMZ – Healthy Developments
ALUMNI SEMINAR: ‘FINANCE & IT IN THE HEALTH SECTOR’

The MBACEA Alumni seminar took place from 23rd – 28th of June 2014 at HNU. On the first day different activities and achievements of the local country meetings were presented. Afterwards the participants were introduced to the Alumniportal Deutschland (ADP) on a webconference by DAAD.

Lecture: Finance & IT in health

The health sector in Africa requires well thought out financing mechanisms in order to meet the various needs of health and to improve the health status of its population. An interactive lecture was given by Dr. Mwaura-Tenambergan where various concepts were explored and participants gave comments and their experiences. The main topics covered were:

- Description of a health system
- What does health financing provide
- Functions of health financing mechanism
- Sources of health financing

A very interesting lecture was delivered about information management by Prof. Swoboda that challenged some commonly known truths about technology. The key topics explored were:

- Basics and examples
- Data structures
- Functions and processes
- Components / Architectures
- Data-Quality

Excursion: Siemens Healthcare

Siemens is one of the large manufacturing companies in the world market today, dealing with health, energy, infrastructure and cities plus industrial sectors.

The group had the opportunity to listen to a presentation from Siemens Marketing manager, Mr. Manfred Kraft. He started by explaining briefly on the history of x-rays and further discussed the various technological advancements made in imaging and radiological diagnostics to date.

After the presentation, the group visited the assembly/production unit for MRI. The sections visited were; storage unit which is run by the supplier only materials taken from the storage are costed to Siemens. The second unit was the coiling unit where the temporary magnet coils are put together and the third one is the test unit that ensures quality after the assembly. The fourth part was the heating unit where the coils and other parts are heated together. The fifth part is a testing unit to ensure quality after heating. The sixth unit is the permanent magnet put together with the temporary magnet then Helium is filled up in the unit. The seventh unit is the production unit for receiving antennas. The last unit is the finishing part and transportation unit; at this unit labelling of the country to which the equipment will be transported is done.

Mutual Health Insurance

The topic was facilitated by Mr. Dimitri Biot as an expert in this area. He has experience in health insurance, as he has worked in different countries in Africa and Asia. The overall goal of this subject was to guide the health experts, in learning from a case study of Cameroon MHOs and thus come up with the best practices that will inform decision makers on Mutual Health Organization.

To be able to learn from this case study, 2 methodologies were used: the participatory and play role methods. Therefore each participant has played a role as if he/she was one of the components for MHO system in Cameroon.

In a nutshell, the lecturer highlighted the best practices, however his conclusion emphasized that there is no best Mutual Health Organization Model that each country can adopt. Situations in countries are quite different. Individual countries need to think twice and develop their own Models. Finally, MBACEA Rwanda is stressing that Africans should think of home grown solutions that respond to specific issues of health care for each country, and then share the best practice.

Health Care Financing

Dr. Kihombo, Mzumbe University Tanzania, addressed the following questions:

- Why talk about health care financing?
- How is health care financed?
- Available health financing options and their challenges?

Alumni Day

At the end of the six days seminar an evaluation was conducted and the way forward of the MBACEA Alumni network discussed. All Alumni gained new knowledge, which they want to apply in their workplace. Getting together with all fellows and exchange information and ideas are one of the success and motivation factors of this unique Alumni programme.

MBACEA
Today (on the right). Prosper has been given his sight. He can now smile. We look forward him doing well in class and at home.

CATARACT AND ITS IMPACT ON EDUCATION

When it comes to education, sight is very necessary, except for the blind that are trained differently. Blurred vision is not the best in education. No matter the much you struggle, there will still be an effect in your education. It affects you as an individual, the family at large but most especially, the immediate family. This was the case of Asongen Prosper. Despite being seven years old, he was still in primary one due to congenital cataracts which were only diagnosed by Acha-Douala outreach team at Ekona. He was transported to Acha-Douala Eye Hospital, hospitalised, operated and given post-operative medicines free-of-charge. His vision was restored.

Problem description

The performances of Asongen Prosper in school have always been questionable. His behaviour at home in terms of movement and doing things wrongly have always baffled the parents, most especially the mother. The teachers have been complaining that prosper is backward in education and could not see the blackboard from a distance but no one paid much attention to all these important remarks. Little was it known that he had vision problem as a result of congenital cataract. At the age of 7, Asongen Prosper’s was brought by his grandfather at Presbyterian Church Ekona, on the 7th of June, 2013 during a routine outreach consultation of Acha-Douala Eye Hospital where he was diagnosed of operable bilateral cataracts.

Amazingly enough at this age of 7, he is still in primary one. He struggled with the Nursery School for long, before managing to enter into primary one. Though in this class, he failed all his tests and examinations. The mother has been very much worried about the child’s condition and had this to say:

"In class, my child does not see the blackboard though positioned at the front row bench. He fails all his tests and examinations. At the age of 7, he is still in primary one. He does not identify objects easily. When he washes dishes, they are hardly clean".

Worth noting is that pre-operative vision acuity right was 3/60 and left 4/60. This is detrimental for a child to progress academically.

Solution approach

While at the screening camp, the parents of prosper were counselled. They were informed that the chances of Prosper seeing again well were slightly compromised given that the eyes have become lazy. Meaning, they have not been used to light since birth. If not operated now, he may become blind for ever. With their consent, they were freely transported to Acha-Douala. The child was hospitalised, operated and given post-operative medicines free-of-charge. Thanks to the support of Right To Sight (an NGO that is out to eradicated needless blindness) no leaving out the expertise of Dr Patel Rajesh (an Indian Ophthalmologist) working in this hospital.

Conclusion

Education goes hand-in-hand with good vision other things being equal.

Prosper became backward in education and even at home because of cataracts effects to his vision. Diagnosing and taking quick action salvages the vision of a child. Prosper was diagnosed, transported and operated of congenital cataracts and can see again. Hopefully other parents will lean from this. Thanks to the quality service delivery of Acha-Douala eye hospital.

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OUTSOURCING: IS IT THE BEST OPTION FOR DELIVERY OF NON-CLINICAL SERVICES IN OUR HOSPITALS?

An organization that outsources certain services does it by sub-contracting that it to a third party company, which is selected through procurement. This article analyses and evaluates the current pattern of contracting out of non-clinical services within the central hospitals in Malawi. It highlights current problems and challenges followed by indicating the efficiency gains if hospitals are to embrace this approach.

Introduction

Even though hospitals have outsourced some of the non-clinical services, currently there is no policy for hospitals to outsource the support services, but they have been encouraged by the Ministry of Health to do so if it is beneficial and cost effective. These services include: cleaning, security, catering, laundry, and maintenance of medical equipment, etc. But is contracting out a solution to the inefficient, costly and often poor quality services manifested in most public hospitals as compared to what the private sector can offer in delivery of the above mentioned services?

Problem Description

The efficiency and quality of non-clinical services in central hospitals in Malawi in the past were hindered by the uncontrolled expansion of services to match the patient demands as well as lack of adequate supervision and discipline among junior staff led to junior personnel display high level of absenteeism rates, late reporting for duties and early departure from work. Also, low numbers of security staff to cover all strategic areas for 24 hours saw rampant theft of hospital property.

Challenges of contracting out in Africa

Even where a contract for a particular service is justifiable and affordable, there are obstacles to effectively contracting out which include:

First, there is low capacity in the public sector to manage the contracting out process in terms of making appropriate decisions, negotiating a fair contracts and monitoring the performance of the contractor. For example at Zomba Central Hospital (ZCH) it is believed that the catering services nearly choked out all other services because it was costing 60% of their monthly expenditure to provide “hotel type” meals to its patients. Secondly, in many cases, contracting out is perceived as a threat to jobs. If management ignores dialogue with workers to convince them that contracting out is in the best interest of efficient services delivery, industrial strikes crops in. Furthermore limited competition can lead to dominance of one contractor who holds monopoly of the market. In this situation, the risk of serious exploitation by contractors is significant with unfair pricing.

Rationale to outsource non-clinical services

Hospitals were encouraged to outsource some of their non-clinical services based on theory that with contracting out, hospital services will improve both in terms of efficiency and quality. It is argued that countries that have outsourced their services have generated efficiency gains through cost reductions, given that the contractor is able to provide a similar or higher quality at a lower cost. The contractor may have skills, capacity or resources, not available to the government or that may not be a core competency of the government, e.g. the provision of catering and laundry services is not a core function of a hospital. Finally, the hospital may wish to contract out some service, allowing it to focus on specific hospital services and relieving them from the burden of service management.

Conclusions

In summary, outsourcing has allowed the hospitals to focus its energy and efforts on core patient care activities. Contracted out services have improved quality services however, NOT at lower cost. Besides, there is a lot of anxiety among lower cadre staff partly because they see contracts as a threat to their jobs.

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A prime example for non-clinical service: catering

OUTSOURCING: IS IT THE BEST OPTION FOR DELIVERY OF NON-CLINICAL SERVICES IN OUR HOSPITALS?
The District Hospital Abong Mbang is a state owned hospital located in the East Region of Cameroon in Upper Nyong Division. It is a reference hospital with a capacity of 50 beds.

**Problem statement**

This hospital was created in the year 1940. With the gradual onset of economic crises in the later years this hospital that covers an area of 6 hectares harboring 23 isolated buildings did not have enough means to maintain this entire infrastructure and equipment in a proper functional state.

I was posted to this hospital in January 2007 as the hospital director / chief medical officer. After serious reflection and consultations, I convened a meeting involving the hospital administration and the community representatives represented here by the hospital management committee (HMC) to make a situation analysis and development plan for the hospital. This was the situation of the hospital in 2007:

**Services and infrastructure:**

The hospital had 23 buildings dispersed over a surface area of about 6 hectares of which only 13 were functional. The remaining structures were in advanced state of dilapidation, abandoned and invaded by grass, rats, snakes and at times a harboring site for thieves. The 13 functional structures hosted the following services or departments: Administrative bloc, Outpatient department (OPD), Maternity, internal medicine, surgical theatre, surgical ward, pediatric ward, laboratory, HIV/AIDS treatment centre, pharmacy and post mortem unit. There was no security in the hospital as it had no fence and people living in the community could trespass pass through the hospital premises to their homes.

**Human resource:** The personnel situation was insufficient in quality and quantity. Most of the personnel were demotivated, indulged in parallel drug sales, corrupting patients, absenteeism and so on. Their financial motivation from revenue set aside was not paid for the past 3 years.

**Material resources:** The medical equipment or plateau technique was insufficient. Some of the equipment were so old and obsolete for example: operating table, patient’s beds, delivery table, microscopes, hot air sterilization machines, no autoclave, no X-ray machine, no ultrasound machine, worn out mattresses, poor lighting in the wards and no stand by generator.

**Financial resources:** The government running credit was insufficient, low revenue collection for the 50 bed hospital. Disperse revenue collection as a consequence funds disappear in some unscrupulous staff who turned their department in to private clinics within the state hospital.

After this situation analysis in 2007, we embarked on a certain number of measures to improve the working condition within the hospital such as:

- Reorganization of services and redeployment of personnel
- Open a second pharmacy so that access to essential drugs will be covered on a 24 hour basis.
- Follow up and pay the accrued debts of staff motivation from revenue set aside.
- Maintain the broken beds and rehabilitate their mattresses.
- Maintain the mortuary, ambulance and purchase small equipment
- Purchase a medium stand by generator to cover the theatre and emergency units during periods of power cuts.
- Organize staff quarterly meetings and end of year staff party where we award prizes to best units and outstanding staff for the year.
- Reinforce the hygiene and sanitation within the hospital and continues sensitization on infection prevention practices.
- Lobby for investment projects from the hierarchy and partners in collaboration with the administrative authorities and community representatives.

**Conclusion**

At this moment, December 2013, the entire project which started in 2010 is about 90% completed. In fact, the time frame for completion of this project is overdue because of many difficulties encountered by the project team such as: administrative bottlenecks, land disputes with neighbours, inaccurate planning and so on. Plans and negotiations are ongoing at the higher state level in collaboration with the first lady- Chantal Biya foundation (CERAC) to visit the hospital for inauguration of the project and of course celebration.

Dr Denis Nsame
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IMPROVING QUALITY OF SERVICES THROUGH HOSPITAL PERFORMANCE MEASUREMENT WITHIN THE CAMEROON BAPTIST CONVENTION HEALTH SERVICES

Quality in healthcare organizations can be evaluated in three different ways namely: structure (how care is organized); process (what is done by health professionals); and outcomes (the results achieved).

Measurement is central to the concept of quality improvement. It provides a means to define what hospitals actually do and to compare that with the original targets in order to identify opportunities for improvement. ‘Performance’ must be defined in relation to explicit goals reflecting the values of various stakeholders (such as patients, health professionals, regulators, insurers). In reality however, very few performance measurement systems focus on health outcomes valued by patients. In most cases, ‘measurement’ implies objective assessment but does not itself include judgment of values and quality. Hospital performance should be defined according to the achievement of specific targets, either clinical or administrative. Ultimately, the goal of health care is better health, but there are many intermediate measures of both processes and outcomes. Targets should relate to hospital functions such as diagnosis, treatment, care, billing, community care, public health and patients perception of services.

The overall goal (expected outcome) of the project is to serve ‘satisfied patients receiving high evidence – based care delivered by motivated staff’. A Performance Measurement Logic Model has been developed showing connections between hospital resources, activities, outputs and outcomes.

Data collection on existing processes and outcomes has been the first step in this project. Data collection methods include the following: document review (registers, files, reports); direct observation (procedures, events); surveys (clients, employees). Considering that standardization is essential for measurement within hospitals and critical for measurement between hospitals, various teams have been constituted in all areas of hospital life to analyse data collected and standardize processes. When processes shall be standardized, a performance measurement system shall be designed which will enable feedback on all hospital performance and patients perception of services.

While recognizing the fact that African hospitals lack a culture of documentation of processes and expected outcomes, and in some cases performance standards are only in the minds of managers, the call is to African Hospital Managers to embrace the concept of designing Hospital Performance Measurement Systems in their quest for quality improvement in health care delivery.

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