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Focus on:

CHAK Annual Health Conference 2017

Also in this issue...

CHAK Annual General Meeting 2017 and launch of CHAK Strategic Plan 2017-2022

Conference Theme: "Re-engineering Faith Based Health Services Business Model towards sustainable quality healthcare"

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Contents

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Re-engineering the faith based health services business model

CHAK held its Annual Health Conference and Annual General Meeting on May 2-4, 2017 in Nairobi. The conference with the theme *"Re-engineering Faith Based Health Services Business Model towards sustainable quality healthcare"* brought together over 200 CHAK members and partners to discuss sustainability issues facing faith based health facilities.

Why the theme on "Re-engineering Faith Based Health Services Business Model towards sustainable quality healthcare"?

1. Global shift from MDGs to Sustainable Development Goals (SDGs)

SDG Goal 3 focuses on good health and well-being. The sub topics under this SDG are:

- 3.1 Child health
- 3.2 Maternal health
- 3.3 HIV/AIDS, Malaria & other diseases
- 3.4 By 2030, reduce by one third premature mortality from non-communicable diseases
- 3.8 Achieve universal health coverage, including access to affordable essential medicine
- 3.c Substantially increase health financing and the recruitment and training of the health workforce
- 17.17 Encourage and promote effective public, public-private and civil society partnerships

2. The dynamic context of the health sector

- Health is a constitutional right and the government considers it their obligation to provide health services.
- Devolution of health services has shifted health system management and service delivery to the counties
- Competition for health workers, resources and services
- Burden of multiple regulators with heavy regulations
- Expansion and improved equipment in public county health facilities
- Rapid expansion of private sector health facilities and services
- Re-classification of Kenya as Lower Middle Income Economy
- New model of stand-alone specialized medical services
- Partnerships and mergers of health facilities
- Franchising and branding of health facilities and services
- Labour unrest in the health sector with the coming on board of health professionals' unions
- Challenge of performance based management of health care workers

3. Limitations of the traditional FBO health services business model

The model targeted the poor and marginalized to promote justice and equity and was based in the rural areas and urban slums.

- It was dependent on volunteers, donations and workforce trained on the job.
- It was largely focused on basic primary health care.
- The model was motivated by religious faith and sense of selfless giving or service.
- Additionally, it was built on trust around individuals and not systems.
- The model was exempted from strict regulation and taxation.
- It enjoyed natural trust and appreciation by the users.

Most of these charesteristics of the faith based model no longer hold true. For example, faith based health services are today not exempted from strict regulation and taxation. Doing business under this model is therefore no longer viable.

4. Faith based health facilities must therefore address the following issues:

- Business viability – undertake feasibility studies (is our product relevant/needed in the market?)
- Business efficiency and profitability
- Governance and leadership for performance
- Performance based management of human resources for health
- Accountability through automation of HMIS and performance tracking
- Brand building, niche development and marketing
- Strategic expansion – urban ministries, franchising and mergers/ partnerships

5. What must faith based health facilities do in order to re-engineer their services?

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New CHAK Strategic Plan launched at Annual Health Conference 2017

The CHAK Annual Health Conference and Annual General Meeting 2017 was held on May 2-4 at the All Africa Conference of Churches (AACC) Desmond Tutu Guest House & Conference Centre, Waiyaki Way, Westlands, Nairobi

The conference whose theme was "Re-engineering faith based health services business model towards sustainable quality healthcare" provided a rich forum for sharing of experiences by the CHAK network and partners on sustainability models and the use of technology to enhance efficiency.

CHAK Chairman Rev. Dr. Robert Lang'at delivered the devotion and welcoming remarks at the conference.

Health sector partners were on hand to deliver insights into the subject of delivering quality health care sustainably.

Insights into delivering sustainable health care

Safaricom's Product Manager, Social Innovations, Violet Njuguna, gave an insightful presentation on the top company's role in providing solutions for the health sector. Among the solutions currently available are m-health, m-tiba, among others.

Dr. K. Gakombe from the Kenya Health Federation gave insights from the private sector on success drivers in sustainable health care.

Representatives from the National Health Insurance Fund (NHIF) took participants through a presentation on FBOs' partnership with the fund for universal health coverage. Mr Ambrose Lugho took the conference participants through the 11 benefit packages from NHIF and urged CHAK health facilities to continue partnering with the health insurer. The NHIF package has a total of 11 benefits. An overview of the Linda Mama maternity financing programme was also given.

On health informatics and research, Dr Peter Cherutich from the Ministry of Health stressed on the need for a good governance system to guide the rapidly growing sector and added the government was already working on a personal health ID for every Kenyan.

CHAK departments and programmes took the opportunity to share on their achievements and partnerships over the last one year.

Several CHAK member hospitals also talked on their efforts towards

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Re-engineering faith based health services

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- Change of mindset to expand our horizon as regards our potential
- Shift to long term strategic planning and strategy building
- Our foundation, vision and mission may remain the same but we must change our strategies to align with the realities of the prevailing context
- Embrace modern technology in diagnostics, information management, e-learning and e-health
- Focus on customer/client needs, satisfaction and efficiency
- Transparency, accountability and participation
- Have an open mind to learn and adjust at anytime

Partnership opportunities

Among the partnership opportunities that are working and can work for church health services are:

- Government for enabling policy and resources. Resource mobilization for health requires multiple funding sources.
- Technology, innovation and research are best sourced from the private sector
- Partnering with academic institutions will support research, medical education and sharing of knowledge
- Financing institutions like NHIF and technical partners
- Media is key in marketing, public education, mobilization, advocacy and service monitoring

The CHAK network would therefore use the conference to discuss fresh ideas on how to achieve transformation of the faith based health facilities business model for sustainability and growth.

New strategic plan launched at AGM

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sustainability and re-engineering their services as follows:

- Medical education and diversification of specialized services – Tenwek Hospital
- Brand building and cross country outreach – AIC Cure International Hospital
- Re-engineering infrastructure, governance, management, services and HMIS – Maua Methodist Hospital
- Providing accessible, quality, specialized services to vulnerable children – BethanyKids
- Towards making specialized services accessible – NCCK Jumuia Hospitals
- Urban centres service outlets – AIC Kijabe Hospital
- Lab quality accreditation benefits – AIC Kijabe and PCEA Chogoria hospitals
- Quality improvement systems – AIC Litein and PCEA Chogoria hospitals

Mission for Essential Drugs and Supplies (MEDS) took the opportunity to do a survey on the quality of their services by distributing a questionnaire to the conference participants. A good chunk of CHAK member health units buy drugs and medical supplies from MEDS. Dr Jane Masiga from MEDS shared the results of the findings with the conference participants and urged the CHAK network to continue supporting MEDS by increasing the quantities they purchased. MEDS is jointly owned by CHAK and the Kenya Conference of Catholic Bishops (KCCB).

The Annual Health Conference discussions will be compiled into a report to be shared widely with CHAK members and partners.

Annual General Meeting

During the AGM held on May 4, 2017, Rev. Dr. Robert Lang'at was re-elected to continue serving as CHAK chairman for another two-year period while Mr William Shimanyula was re-elected to continue serving as Treasurer for another two-year period. Additionally, Ms.

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Rev. Dr. Robert Lang'at delivered the devotion and welcoming remarks at the conference.

CHAK Chairman leads Trustees in the launch of the strategic plan 2017-2022.

CHAK Trusteees from left: Pst Jonathan Maangi (SDA), Rt. Rev. Joseph Wasonga (ACK), Rev. Dr. Robert Lang'at (AGC, Chairman), Dr Samuel Mwenda – General Secretary (Ex-Officio) and Rt. Rev. Michael Sande (ACK) hold up copies of the new CHAK Strategic Plan 2017-2022 during the launch.

Drivers towards sustainability of health services in FBO facilities

PRESENTATION BY DR. K.K. GAKOMBE, MBCHB, MBA - CHAIR, KENYA ASSOCIATION OF HOSPITALS

Introduction

The right to health is recognised as a universal human right. However, it is constrained by economics whereby limited resources have to be used on endless needs.

Healthcare practice is also constrained by political, financial, social technological, regulatory and ecological factors. The healthcare investor or manager has multiple customers with different and at times irreconcilable needs.

The health care triangle

The health care triangle deals with three different customers - the patient, the payer and purchaser.

- The patient wants the very best and cost is only a secondary consideration
- The payer wants to retain maximum value and quality is a secondary consideration
- The purchaser wants to spend as little as possible on health care benefits in direct and indirect costs. Cost is secondary but full value for money spent is critical

Health care financing options

A number of healthcare financing options exist. These are:

- General taxation
- Private insurance or risk pooling
- Occupational or employee based schemes
- Medical savings accounts
- Social insurance: multiple or single scheme
- Out of pocket expenditure
- Donations including harambee insurance

Key strategic questions for FBOs

- What is the Church's role in healthcare? Is health care a source of cash, souls or both?
- Should the Church profit from health care?
- How can one to fund growth and build an ecosystem?
- Is devolution an opportunity or a threat?

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New strategic plan launched at AGM

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Christine Kimotho was re-elected vice-treasurer while Mr. Samuel Maati was re-elected as the Nyanza/South Rift region chair.

The AGM also received the Chairman's report and Association's financial report. Mazaars (CPAK) were re-appointed CHAK auditors for the next one year.

Launch of CHAK Strategic Plan 2017-2022

The new CHAK Strategic Plan 2017-2022 whose theme is 'promoting universal access to quality health care in the devolved health system in Kenya through advocacy, capacity building, health systems strengthening, partnerships and innovative health programs' was also launched.

The six-year plan has its core activities organized into five strategic directions:

1. Health service delivery
2. Health systems strengthening
3. Capacity building and research
4. Advocacy and partnerships
5. Sustainable financing and resource management

CHAK's vision is ***'Quality Healthcare for all to the glory of God'*** while the mission is '***To facilitate provision of quality health services through health systems strengthening, innovative health programs, training, advocacy and partnerships as a witness to the healing ministry of Christ***'.

The Association's values have been identified as follows:

- Integrity
- Transparency
- Accountability
- Professionalism
- Innovation
- Equity

Success drivers in sustainability

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- What about the public private partnerships law? What are the opportunities? Will counties outsource service provision?
- What are the hospital charges? Is the hospital providing hotel services or clinical care? What does the patient look for and want? What does the patient spend on? On which does the hospital earn a return? Is it possible to find a balance?
- Partnering with managed care: Is influence and pressure from insurance companies/NHIF always bad or is there room for compromise? Does pressure lower quality of care? What is the role of the peer review mechanism in clincial practice? Would they lower the quality of care if given a leeway?
- What is the role of ICT?
- Is the global shortage of health workers a threat or opportunity?

Dr Gakombe delivering his presentation at the CHAK Annual Health Conference 2017.

Key management considerations

Emergencies

How do we fund the cost of emergencies? Whose responsibility is it? Should other patients shoulder the cost? Does government have a responsibility? Should hospitals underwrite costs that should be borne by others? How far can or should the hospital go? The healthcare triangle is a key consideration here.

Rising costs

The main culprits in rising hospital costs are wages, supplies, competititon from the public sector, global competition for staff and patients.

Other factors that may cause costs to rise are wasteful and redundant procedures, procurement, loss and theft. Productivity management and optimal care may lead to workable solutions for rising costs.

NHIF

What is the role of NHIF? What are the risks and opportunities that it presents?

Potential solutions for financial management

- Formulary to regulate identification and stocking of brands and generics
- Procurement systems should control consumables purchase and pricing.
- Adoption of managed care principles including setting and monitoring price/cost targets per visit.
- Forward integration to enjoy a higher share of the patient value chain.
- Clinicians are the cost drivers. They must be involved in any cost management effort.
- Changing business model from fee for service to fixed pricing. This will mask the cost of inputs thus allowing the provider to reduce the cost of inputs without reduction in charges/revenue.
- Unbundling of services to enable the provider to charge for professional services such as dispensing. Banks have done this successfully following reduction in interest rates.
- IT has a role to play in costing, pricing, monitoring, work flow processing, decision support and clinical care.
- Cost management which may involve elimination of redundant processes and administration overheads.
- Specialisation and economies of scale and scope including monitoring average costs of care, cost per visit, cost per admission and reducing costs in certain areas

What is the hospital's core business?

Is the business a hotel or hospital and does this really matter?

The concept of value added service is one that FBOs need to think

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Success drivers in sustainability

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deeply about. This concept indicates that customers only willingly and regularly pay for services perceived to be of a value higher than the price charged.

In looking at the concept of hotel vs hospital, there is the challenge of tangibility and differentiation. Hotel services are tangible and thus enable providers to differentiate their offering. The need to maintain one's social and home lifestyle while in hospital demands differentiated hotel services for different clients.

For a long time, mission hospitals were seen as offering heavily subsidised or free health care. However, FBOs need to realise that the free healthcare concept discourages people from planning for their healthcare needs and puts a lid on hospital charges.

Management options for hospital charges

Some of the options available to FBOs for management of charges include:

- Shift from fee for service model to fixed price costing
- Shift care to the lowest safe level in order to cut cost of service without compromising quality.
- Focus on high margin specialised services with high perceived value such as day care surgery, paediatric surgery/care, cardiac surgery, elective surgery, high value diagnostics, diseases of affluence.
- Unbundling/itemised billing that captures each professional services rendered
- Medical tourism to cater for international high paying market

• The free healthcare concept discourages people from planning for their healthcare needs and puts a lid on hospital charges

Caring for emergencies

Every industry has business risks which must be factored into its pricing and risk management policies. Risk can be avoided, prevented or its impact reduced or mitigated.

The central and local governments have a responsibility to take care of their citizens.

Hospitals should be compensated for managing emergencies in a number of ways which include tax concessions and breaks, grants, case specific re-imbursement e.t.c. Some hospitals are exempt from income tax while others are exempt from VAT.

Some schools of thought argue that not for profit hospitals should provide charitable services equivalent to their income tax liability.

Hospitals subsidize the insurance industry by providing free services to RTA and accident victims. Mechanisms for re-imbursement can be pursued at industry level. The road levy should also be used to cover some of the costs of road use, emergency care, research on road design and accident reduction strategies.

Some hospitals have responded to the risk by closing A & E services and focusing on elective services. Better penetration of accident and medical insurance can reduce emergency care losses

However, until some of above measures are implemented, each hospital has to manage accident loss risk. Hospitals can also derive marketing mileage from inevitable emergencies in terms of corporate social responsibility.

Challenges of partnering with managed care

- Exclusions management
- High administrative demands
- Pre authorisations
- Membership administration
- Medical reports
- Claim administration
- Debt collection
- Clinical oversight
- Financing cost and burden including financial risk and cost of credit facilities
- Business risk due to potential loss of clients

Managing the relationship in managed care

First, we need to understand that managed care can only exist where there are health care providers. We all practice managed care principles on case by case basis especially with self-funded/cash paying clients. It is also important to acknowledge that insurers and scheme administrators have lower credit risk than individuals.

The hospital can introduce service level agreements setting out mutual obligations. In such cases, it is necessary to understanding each other's business models including things like average cost per visit, average annual visits, average cost per admission, value chain sharing.

Fixed price packaging such as capitation is a critical aspect of managed care. The hospital needs to understand the important role of ICT

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Lessons in brand building from AIC CURE International Hospital

About Cure International

CURE International is a non-profit organization that operates charitable hospitals and programs in 30 countries worldwide where patients experience the life-changing message of God's love for them and receive surgical treatment regardless of gender, religion, or ethnicity.

CURE International was founded in 1996 and, two years later, CURE's first hospital opened in Kijabe, Kenya. The CURE International network has so far been able to perform over 200,000 life changing surgeries.

Introduction

Faith based health facilities have for a long time delivered subsidized and charitable services to communities around them. But the reality is that free services do not exist. Somebody somewhere has paid the cost of the services for the needy to be able to enjoy them.

It is therefore time that CHAK facilities began thinking business to deliver mission. In

Factors of successful brand building

recent years, Kenya has moved up to become a middle income country. This has implications for donor funding and development support from the traditional sources in North America and Europe.

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Success drivers in sustainability

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in communication and administration. Communication channels such as SMS, Email and claims processing systems are a necessity today.

Managing the ballooning human resource cost

The high costs in this area are driven by public pay rise and international competition. The pay offered by hospitals is lower than that of many other industries for the same qualification. The lower wages are partly due to lower productivity in terms of revenue per employee, inappropriate use of qualified staff and the labour intensive nature of industry. Additionally, regulator restrictions make it difficult for hospitals to utilise human resources optimally.

Options available to hospitals in managing the cost of human resources include:

- Raising charges
- Better deployment of technological innovations for administration, finance, clinical and nursing systems
- Innovative deployment of staff; hospitals in western countries use up to 60 per cent of non-formal trained staff
- Process re-engineering and total quality management
- Diversifying into training for local and international market

AIC Cure's brand building journey

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Brand building

This can be described as creating awareness, establishing and promoting an institution using a clear set of strategies and tactics. A brand strategy is a long-term plan for the development of a successful brand in order to achieve specific goals. A well-defined and executed brand strategy affects all aspects of a business and is directly connected to consumer needs, emotions, and competitive environments.

The future of healthcare in Kenya is not in the size of institutions but in quality services. Patients in Kenya enjoy a variety of choices in health care both at home and abroad. Mission hospitals need to establish their place in this matrix.

Matthew 5: 14-16: Neither do people light a lamp and put it under a basket. Instead, they set it on a lampstand, and it gives light to everyone in the house. In the same way, let your light shine before men, that they may see your good deeds and glorify your Father in heaven.

Why is branding important?

- A brand is the visual voice of the company
- It clearly differentiates the institution from others in the same market and helps bring out the uniqueness of services. Branding should answer why a patient would choose to come to you and not another facility.
- Branding is becoming a promise of quality and reputation

CURE International Hospital Kijabe's branding journey

Faith based institutions need to be the pace setters in the way healthcare is provided in Kenya. AIC Cure decided to do an aggressive branding campaign after realizing the market did not know of its existence.

The hospital began by acknowledging quality as the core of its programmes. A clear definition of the vision and mission and development of a strategic plan to ensure sustainability over the next five years were essential.

Staff were seen as the main brand ambassadors. The hospital therefore came up with concrete motivation and retention strategies to ensure they played this role effectively.

Another area that required urgent attention was resource planning. The marketing and business development office was set up to cater for this area.

Stakeholder and partner mapping and engagement meant the hospital was able to identify and segment its partner base, leading to improved strategy.

Cross county approach

For AIC Cure, healthcare delivery is not just about brick and mortar (physical infrastructure) but quality service delivery.

The hospital therefore works within existing facilities, thus cushioning itself against massive investment in infrastructure. Cure pursues very intentional partnerships and relationships, both internally and externally. A key partner for Cure is county government hospitals.

Nairobi clinic

Market research identified a need for orthopedic services to cater especially for sports injuries. However, this service had to fit into the hospital's vision of catering to children born and living with disabilities. The hospital's private work is a means to healing more children who cannot afford to pay for their surgeries.

At the Nairobi clinic, private patients pay for a child to walk free. Market segmentation is key and the hospital has a diverse portfolio of patient categories ranging from the very needy to the super rich.

Nairobi was selected to host the clinic because it is the biggest market in Kenya and chances of success or failure are equal.

Marketing and resource mobilization efforts

- We choose to see opportunity in all our stakeholders including needy patients.
- The hospital has a clear strategy on resource mobilization and realistic targets have been set.
- A rich portfolio of partners helps mitigate risk
- The hospital uses different media to raise awareness on available services and raise funds.
- Transparency and accountability to all our partners

Conclusion

Church health services cannot continue to do things the same way and expect different results in a changing environment. In business, one cannot stay at the same level; it is either you progress or die.

With the current health financing policy, church health services have the best opportunity to grow but we need to be ready.

Role of technology in re-engineering health services in church facilities

Maua Methodist Hospital's experience with the CHAK HMIS software

Presentation by Ken Gitonga – Maua Methodist Hospital

Maua Methodist Hospital is an agency of the Methodist Church of Kenya located in Maua area of Meru County. The facility offers out-patient, in-patient, community health, CCC, outreach clinics, specialist clinics among many other services to Meru and other surrounding counties. On average, Maua Methodist Hospital serves 200 to 250 outpatients per day

ICT in Maua Hospital

Maua Methodist Hospital has a fully-fledged ICT unit which consists of three full-time employees (IT manager, deputy IT manager and IT assistant). The hospital has invested heavily in the unit to facilitate effective service delivery.

Some of these investments include:

- Modern servers and server room
- Well-equipped training room
- New computers
- Wifi connectivity
- Fiber cable structure

The unit is accorded maximum support by the hospital management

Health Management Information Systems

Maua Methodist Hospital's journey to acquire an Electronic Medical Records system began in 2003 with procurement of Integra HMIS. However, a decision to abandon the system was made in 2015 after 12 years of use.

Reasons for moving on were:

a. Fox Pro is an obsolete platform that is no longer being developed.
b. Support: Program vendors ceased to support the system.
c. The system failed to satisfy changing hospital needs.

In January 2016, implementation of Care 2X started and is ongoing to date.

Active areas include:

- OP
- IP
- Lab
- Finance
- Stores management

However, some of the stated areas are partially active because they are still being worked on. While Maua appreciates the effort put in by the CHAK team, we have missed the implementation timeline which was projected to be 3 months from January 2017.

Challenges of CHMIS

Support

This is the biggest challenge at the moment. Online/phone support is inadequate to deliver a fully working system that is able satisfy user requirements especially in the first phase of implementation.

Reports

The system is not giving adequate reports as required for financial planning and audits. This is being worked on but should be prioritized.

However, despite these challenges, CARE 2X is a great idea in providing CHAK affiliated institutions with a robust EMR.

Contrary to a common perception, CARE2X is not free. Massive investment has been put in to get it where it is today. A similar system would cost not less than Ksh3 million in the market currently.

A lot of work and resources and effort have been invested in the software and there is no room for turning back.

Way forward for CHMIS

In order to achieve better results with the software, Maua suggests that:

a) Institutions chip in some contribution to the development of the system, probably annual subscription

Benefits

i. These funds would enable CHAK to strengthen the team supporting the system.
ii. Hospital management organs would take a more active role in development of the system if there was a cost involved
iii. It would eliminate the false notion of 'free system' and encourage keen concentration by hospital leadership

b) CHAK considers signing service level agreement (SLA) with member hospitals

Benefits

i. It would increase the level of responsibility on both parties

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Maua's experience with CHAK software

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ii. It will give the project a more professional dimension

c) CHAK considers halting further new installations to allow the IT team to fully concentrate on unfinished work in member hospitals.

Benefits

i. Well-functioning system will lessen the work they have to do in subsequent installations.

d) CHAK strengthens the field support team to take solutions closer to the hospitals using funds from member subscriptions. This will allow the key programmer to concentrate on refining the system.

Benefits

i. The mentored support team will in turn help to 'grow' the system even further

e) Revision of implementation methodology, i.e. Increasing contact time with client institutions

Benefits

i. This would enable the programmer to clearly understand the individual needs of the different CHAK member units.

ii. The programmer would also be able to deliver a more comprehensive and refined system and solutions

iii. It would also reduce time spent solving after-implementation problems online.

Member hospitals need to forge closer ties to help one another in resolution of common problems. They could form a consortium with regular meetings to address emerging challenges.

Additionally, these facilities may want to take a more proactive role in development of Care2X, by for example, considering in-house personnel empowerment for localized support and system advancement

Participants at the AGM follow the proceedings keenly.

Maua is positive that CARE2X provides a good starting point in provision of a sufficient EMR for CHAK affiliate members mainly because:

i. Being Open Source, hospitals have access to the source code which they can use for individual customization

ii. No license is required as is the case with premium versions hence less cost

CHAK should give careful consideration to the concerns that have been raised in order to deliver an efficient system and therefore draw maximum returns on investment (ROI).

About the CHAK HMIS Software

CHAK has embraced advancements in information technology and developed a responsive customized Hospital Management Software built on the CARE2X and WebERP open source systems that has been named CHAK Hospital Management Software (CHMS).

This innovative software was initiated to respond to a demand by member hospitals who were frustrated by the cost, inadequate performance and lack of dependable support for other solutions that were offered off-the-shelf.

There is growing demand for CHMS uptake by MHUs. CHAK is thus challenged to march capacity with the demand while ensuring high quality. The need to build sustainability from domestically generated resources has also been discussed.

Cost sharing installation, training and maintenance fees were discussed by EXCO following recommendation from CHAK Management. These will gradually be introduced from 2017.

OpenMRS

CHAK has also continued the process of developing another hospital software based on OpenMRS in conjunction with AIC Kijabe Hospital. The software has been developed to a point where the first modules have been piloted at Kijabe Marira Clinic in Uplands.

Role of information technology in health facility management

PCEA Tumutumu Hospital spoke on the benefits of ICT during the conference.

Introduction

PCEA Tumutumu Hospital was started in 1909 by the Church of Scotland missionaries as a dispensary. In the 1960s, it was taken over by the Presbyterian Church of East Africa, when the Scottish missionaries ended their mission work in Kenya. It has a registered bed capacity of 203 beds. The Hospital is located in Nyeri County and serves people within the counties of:

1) Nyeri

2) Murang'a

3) Kirinyaga

4) Laikipia

Vision

To be a leading Christian Hospital in providing holistic quality health care in Kenya.

Mission

To bear witness of the Gospel of Jesus Christ, through provision of quality, accessible and affordable health care to patients, as well as train skilled human resources.

Hospital units

1) The main hospital provides all patient care services including:

- Obstetrics/Gynaecology
- Internal medicine
- General surgery
- Cataract surgery
- Urology
- Orthopaedics, among others

A four-bed critical care unit is scheduled to start operations in January 2018.

2) Training college: The PCEA Tumutumu Hospital School of Nursing has been training nurse assistants since 1929, Enrolled Nurses since 1949 and Enrolled Community Health Nurses since 1989. The college began training Registered Community Health Nurses in 2006. The college will begin offering diplomas in medical laboratory, nutrition and dietetics in 2018. The college also plans to begin offering diplomas in Business Management, Information Communication Technology and Bachelor of Science in Nursing in 2019.

Participants listen keenly to the proceedings at the CHAK Annual Health Conference and Annual General Meeting 2017.

3) The guest house has been operational since 2004. A cafeteria was added to the guesthouse in 2010 and through this arrangement, guests can benefit from for accommodation, breakfast, lunch, dinner, snacks and conferences.

4) Comprehensive Care Centre

The CCC set up in 2004 has:

- 1,796 patients active on ARVs
- 1,804 patients on care
- 3,245 on care and treatment

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Benefits of information technology

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Its annual budget stands at Ksh19.4 million.

5) Haemodialysis

A three-bed renal unit was started in November 2015 and expanded to five beds in January 2017.

Hours of operation

Each machine does a maximum of two sessions per day. Patient numbers have grown from an average of six per month in November 2015 to the current 134, mainly due to the NHIF comprehensive cover of Ksh9,500 per session per session.

Challenges

- Turning away patients due to operating at full capacity
- Lack of funds for new machines and employment of more personnel

Future plans

- Purchase of more machines
- Recruit more personnel for the unit

Use of technology

to offer 24 hour services.

Focus is on the automation of hospital processes, involving services offered to patients. Outpatient is paperless from registration to triage, consultation, payments to investigation. CCTV has been installed in all critical service points to enhance security.

Inpatient procedures are input into the patient accounts as the system does the costing. The system is used by virtually all staff in operations and decision making. Among the systems used are CHMIS, eHospital, Limsoft. The hospital also uses Mpesa pay bill and KCB agents.

CHAK has played a key role in Tumutumu's journey journey in the use of technology.

Why should health facilities use technology?

Technology must be reliable, cost effective and efficient. According to Gikemi (2009), church health facilities must be run as sustainable business entities governed by the principle of competitiveness.

Church health facilities must have the ability to offer a service that the client will purchase instead of that from your competitors, thereby retaining old customers while gaining new ones

Competiveness can also be offering the same service as fellow industry players at less cost. This works towards Prof. Michael Porter's generic strategies on cost leadership for gaining competitive advantage.

Benefits of HMIS to a hospital

a) Good image

Automation is critical in adding value to your service and builds trust. Most corporate clients will be comfortable with a hospital that generates, sends and receives patient data electronically. It is unimaginable to send hand written bills, investigation results and prescriptions in this day and age. Keep in mind that most clinicians have a "very clear handwriting".

b) Enhances profitability

It is easier to track revenues, since they are captured at the point of service. e.g. lab, drugs, etc. Additionally, there can be no service without pay and data entry hence less revenue leakage.

Reduced costs due to increased operational efficiency as a result of less human intervention, less staff for more work also enhance profitability. Costs are also reduced due to decreased paper work, less errors and less repeat jobs in support services.

c) Confidentiality

Access to the system is restricted to authorised users with different users having different rights. Access to patient information is thus on a need to know basis, locking out idlers, "busy bodies". Additionally, an automated system has the ability to trace the leak to a specific cluster of employees.

d) Improved decision making

Because there is better access to data for authorised users, It is possible to recheck test results at the click of a button. Fast and accurate reports are available directly to decision makers and no manual intervention needed in analysis.

e) Availability of audit trail

Data is stored for future review, dating back to the period defined as per set policy of the user. For this purpose, regular backups and storage protocols are key.

Where data security has been ensured, the data cannot easily be erased, unlike the manual system where data can be obliterated.

f) Better patient care

As departments are interconnected through a local area network, there is faster access of patient records from one department to the other. This reduces the amount of time expended in ferrying documents, thus saving on time taken to serve one client. This ensures improved work efficiency for quicker investigation, quicker treatment and faster recovery.

Taking a closer look at the health information landscape in Kenya

PRESENTATION BY DR PETER CHERUTICH - HEAD, DIVISION OF STRATEGIC HEALTH INFORMATION &RESEARCH, MINISTRY OF HEALTH

The health sector in Kenya is guided by the WHO framework and the Kenya health systems Health Policy.

The Kenya Health Policy:

- Defines the health goals, objectives, principles, orientations and strategies aimed at achieving the highest standard of healthcare in Kenya
- Outlines a comprehensive implementation framework
- Delineates the roles of different stakeholders in the sector
- Provides the structure to harness and give synergy to health service delivery
- Defines the M&E framework to enable tracking of progress made

Scope of health sector M&E

Purpose

The purpose of health sector M&E is to improve technical accountability in health.

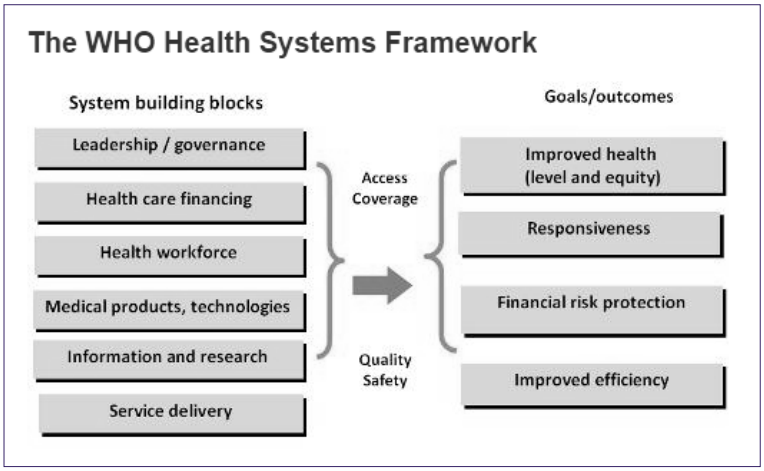
Focus

Strengthen county capacity in information generation, validation, analysis, dissemination and use through:

1. Improving facility reporting systems
2. Scaling up birth, death and cause of death reporting
3. Strengthening capacity for health research
4. Scaling up disease surveillance and response
5. Carrying out critical health surveys

Stewardship goals

1. Support establishment of a common data architecture
2. Enhance sharing of data and statistics
3. Improve performance monitoring and review processes



Challenges in health information and M&E system in Kenya

- Weak demand: Data is not trusted or used for policy making at country level.
- Weak health information system: There is limited capacity to generate and analyse data.
- Donors focus on their own data needs: There is little investment in Health Information Systems.
- Decision making is based on sectional interests, donor demand, inertia etc.

Role of FBOs

In a meeting held in Nairobi on May 16-19, 2016, health sector stakeholders committed to have one monitoring and evaluation framework for Kenya in order to accelerate achievement of universal health coverage. In a communique developed from the meeting, FBOs committed to:

1. A common health sector M&E framework
2. Continuously promote demand for data use through social accountability mecha-

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Kenya's health information landscape

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nisms at all levels.

3. Participate in all TWG meetings and dedicate resources to the implementation of the common M&E framework
4. As health service providers, provide data according to national and county requirements and standards
5. Provide data and information to the country M&E framework and information systems

Scaling up E-health

Historical overview

The journey towards e-health in Kenya began in 2005. Between 2005 and 2008, three EMR assessments were done to understand the landscape of EMR implementation in Kenya and three different reports generated from these assessments.

The assessments were supported by HIS/MOH, CDC/NASCOP and WHO. In 2009, the three assessment reports were harmonized into one document that collated their findings.

It was in the process of this compilation that it was discovered that the reports did not have a standard criteria for comparison. This began the process of developing EMR guidelines and standards.

In 2010, the EMR standards and guidelines were finalized and launched. However, these were HIV domain-specific EMRs.

In 2013, the EMR standards and guidelines were revised to include PHC, EMRS, PIS and LIS and ICT standards developed. In 2014, interoperability standards were developed and the HIS certification process started.

In 2016 m-health standards were developed and the second HIS certification meeting held.

In 2017, the Ministry is conducting review of HIS certification framework against international practices and will have the final HIS certification review before adoption.

There has been overwhelming commercial interest in providing HIS solutions in the country.

Governance

"One of the key challenges in the Kenyan health sector identified in the First Medium Term Plan of Vision 2030 is weak health information systems". (Kenya Health Policy, 2014 – 2030)

The policy identified several weaknesses but relevant to the scope of enterprise architecture was the "lack of integration/interoperability, many parallel data collection systems, and poor coordination".

As such, the process of developing enterprise architecture in the health sector began.

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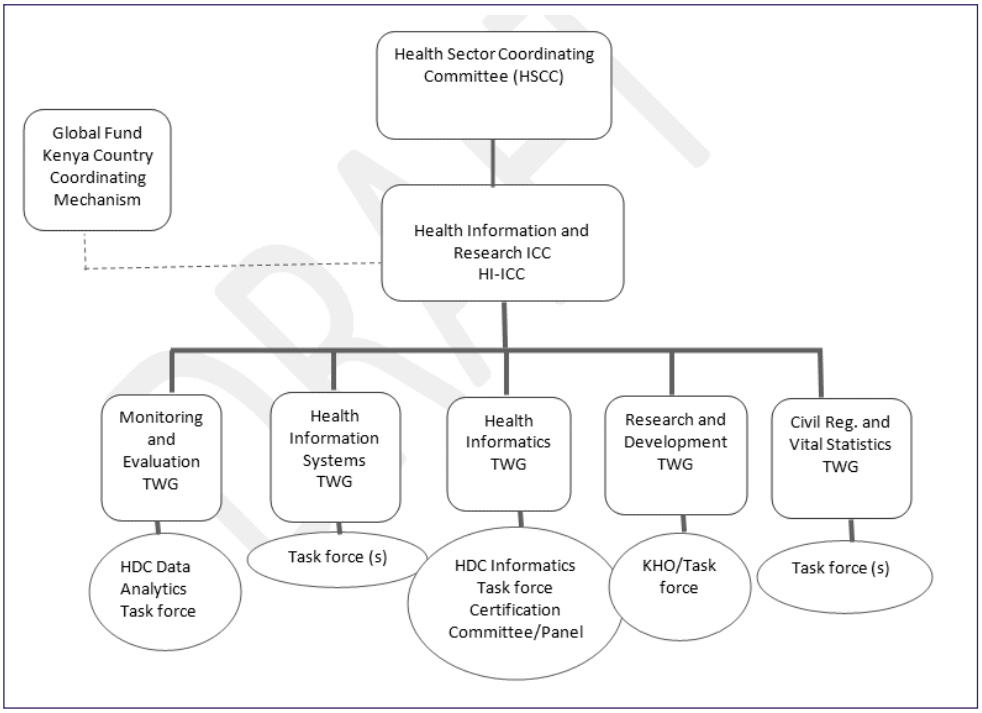
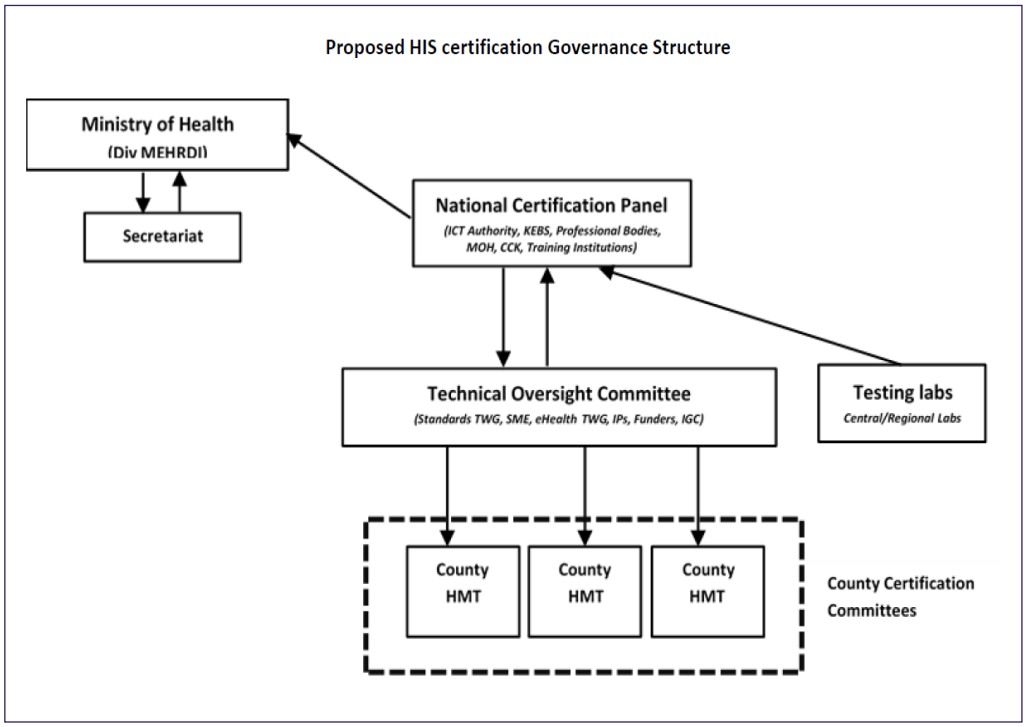


Proposed health informatics governance structures

Kenya's health information landscape



The Certification committee structure. A certification panel will look at all technologies coming into the market especially given that there has been overwhelming commercial interest in providing HIS solutions in the country.

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Architecture vision

The vision is client focused, thus it is expected that a client will access services through defined and managed channels.

Overview of DHIS 2

Strengths of DHIS2

- Ability to collect aggregated data
- Ability to collect individual records
- Ability to track registered entities
- Mobile apps with offline capabilities
- Ability to generate summary reports from individual records

Individual data records

DHIS 2 enables one to collect, manage and analyze transactional, case-based data records using:

- Tracker capture which allows tracking of an entity
- Event capture to collect single event records

Key features of DHIS 2

- One can collect transactional data, set up automated aggregation queries and populate the aggregated data warehouse directly.
- The system can also enroll individuals into longitudinal and chronic programs, schedule visits, set up automated SMS reminders, track missed appointments to improve retention.
- A user can define own programs with stages, decide what to collect at each stage, all through the user interface.
- You can also generate daily or weekly visit schedules (work plans) for your facility or community health workers.
- Tools for tracking and following up patients who do not come to scheduled visits are included.

Tracking "entities"

This started as functionality for enrolling people in health programmes and following them up over time. These included pregnancies and chronic conditions.

It was later expanded and turned into a generalized functionality to manage status for many types of "entities" including equipment, commodities and laboratory samples.

Individual data records implemetation in Kenya

Its main use is to collect data for surveys such as:

- SARA
- Beyond Zero Survey
- Trachoma Survey
- Inpatient morbidity and mortality

It is also used in the mother and child programme and registration of birth.

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Kenya's health information landscape

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Data analysis tools

DHIS 2 has advanced features for data visualization such as:

- Data set reports
- Standard reports
- Charts
- Web pivot table
- GIS
- Custom apps: This allows for development of custom information products. Custom DHIS2 apps include:

a) Standard reports

- IDSR weekly bulleting report
- IDSR weekly summary report

b) Custom apps

- Estimated Method Use App for Family Planning
- Score Card
- WHO Data quality App

Kenya needs to rally stakeholder support around a common M&E framework

The future

Kenya needs full automation that ensures the interoperability of systems (automated import) from other systems like MFL, EMR/EHR, HRIS, logistics etc.

There is also need for expanded use of geographical information systems, e-based learning and telemedicine.

A Unique Personal Identifier which is a health ID applicable across sub-sectors, geography, service delivery points, and time is key as is case-based reporting in real time and longitudinal follow up.

How to get there

- Raise the SDG profile and the global effort to strengthen country-led platforms for information and accountability among MoH officials, partners and stakeholders
- Rally stakeholder support around a common M&E framework, ensuring a clear plan for long-term support of coordination/governance mechanisms
- Implementation of common priority HIS/M&E actions and getting high-level commitments from partners for aligned support
- Support counties to set up robust M/E Systems

Acknowledgements

a) United States Government

- CDC
- USAID

b) Implementing partners

- Palladium
- ITECH
- UoN

c) All divisional staff

d) Health Data Collaborative

e) National disease programs

Focus on....

Bethany Kids

Accessible quality specialized care for vulnerable children

Mission statement

We are a Christian compassionate medical mission transforming the lives of African children with surgical conditions and disabilities through: pediatric surgery, rehabilitation, public education, spiritual ministry and training of health care professionals.

Facilities

- 74 Beds including eight-bed HDU, burns treatment room and isolation rooms

Services

- Tuesdays: Neurosurgery outpatient clinic
- Wednesdays: pediatric surgery clinics
- Mobile outreach clinics in 15 sites
- Doctors training in pediatric surgery (accredited with PAACS & COSECSA and neurosurgery

Some surgical conditions treated at the hospital are:

- Hernia repairs
- Anorectoplasty
- Colostomy closures
- Hypospadias
- Orchidopexy
- Curative Laparoscopy
- Hirschsprung
- VP Shunt, EVT,CPC
- Craniotomy
- Encephalocele repairs
- Spina bifida repairs
- Tethered chord release
- Cleft lips & palate repairs (Fully paid for by Smile Train)

Widening access to essential health services through national health fund

Introduction

The National Health Insurance Fund (NHIF) is a state corporation established under NHIF Act No 9 of 1998. The health insurance fund is now 50 years old, having been established in 1966 as a department of the Ministry of Heath to provide a contributory health Insurance.

NHIF works to secure financial risk protection against the cost of healthcare services for all Kenyans through pooling of resources. Contributions are from both the formal and informal sector. The fund has a coverage of over 20 million Kenyans while principal contributors are 5.9 million.

The functions of the Fund, as outlined in the Act are to:

1. Register and receive all contributions and other payments
2. Make payments out of the Fund to declared hospitals
3. Set criteria for declaration of hospitals and accredit them
4. Regulate contributions payable to the Fund, benefits and other payments to be made out of the Fund
5. Protect the interests of contributors to the Fund
6. Advise the Government on the national policy with regard to national health insurance

Vision

To be a world-class social health insurer

Mission

To provide accessible, affordable, sustainable, equitable and quality social health insurance through optimal utilization of resources to the satisfaction of stakeholders

Ambrose Lugho, Director of Strategy and Operations at the NHIF makes the presentation at the CHAK Annual Health Conference 2017.

Our core values

- Honesty, integrity and accountability
- Professionalism
- Dedication and commitment

The Fund's strategic intent is to increase value to stakeholders through:

- Access
- Equity
- Affordability
- Coverage
- Quality
- Strategic partnerships

The NHIF has two types of schemes:

- The national scheme which is for all Kenyan residents who contribute to the Fund
- Managed schemes which include:

1. Government and donor funded programs
   - Health Insurance Subsidy Program (HISP) for Orphans and Vulnerable Children
   - Health Insurance Subsidy Program (HISP) Elderly and people living with severe disabilities
   - Free maternity
   - Sponsored programmes

2. Employer based schemes
   - Civil servants scheme
   - County government schemes
   - State corporations schemes

NHIF financial pooling framework

Funds inflow comes from the formal sector, informal sector and sponsored programmes. This inflow is in the form of contributions and penalties

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Widening access through NHIF

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and investment income. The funds are used for purchase of benefits and administration costs (outflow).

NHIF benefits package

1. Outpatient cover
2. Inpatient cover
3. Maternity package
4. Renal dialysis
5. Kidney transplant
6. Rehabilitation package for drug and substance abuse
7. Overseas treatment
8. Oncology: chemotherapy and radiotherapy
9. Radiology: MRI, CT scan
10. Surgical package
11. Chronic illness including diabetes and hypertension

How is the benefits package implemented?

a) Outpatient: This is paid according to capitation set at Ksh1,200 for basic care facilities and Ksh1,400 for tertiary care facilities. The outpatient package has no limits but is controlled by the payment model.

b) Inpatient and foreign treatments are paid for through rebates. Rebates for inpatient range from Ksh1,500-Ksh4,000 while that of foreign treatment has been capped at Ksh4,000 per day. A patient can be admitted for up to 180 days in a year.

c) Maternity, dialysis, kidney transplant and radiology are catered for according to the respective package rates. Normal child delivery package is at Ksh10,000 while ceaserian section is at Ksh30,000. Dialysis rate is Ksh9,500 per session while kidney transplant is capped at Ksh500,000 per member. For MRI, the package stands at Ksh15,000 per image while a CT scan is at Ksh8,000 per image.

Benefit Package	Rates	Limits
Surgical	**Minor surgeries** • KES 40,000 (Level 5&6) • KES 30,000 (Level 3&4) **Major Surgeries** • KES 80,000 (Level 3&4), KES 130,000 (Level 5&6) **Specialized surgeries** • KES 500,000 (Level 5&6 and Overseas HCPs)	3 per family per year 2 per family per year 1 per family per year
Oncology	**Radiotherapy** KES 18,000 five sessions per week **Chemotherapy** Basic level KES 25,000 per cycle Complex level KES 150,000 per cycle	Max 5 sessions per week, Total 20 sessions 6 cycles per family 4 cycles per family
Drug & substance abuse rehabilitation	KES 60,000 Per member	One session per year

NHIF benefits package for surgical, oncology and drug and substance abuse.

Benefits utilization trends

Revenue has risen steadily since 2013 as follows with the increased revenue coming from enhanced rates and increased membership.

- 2013/2014 – Ksh9.3 billion
- 2014/2015 – Ksh12.4b
- 2015/2016 – Ksh29.4b
- 2016/2017 (projected) – Ksh33.3b

Administration expenses, on the other hand have been on a downward

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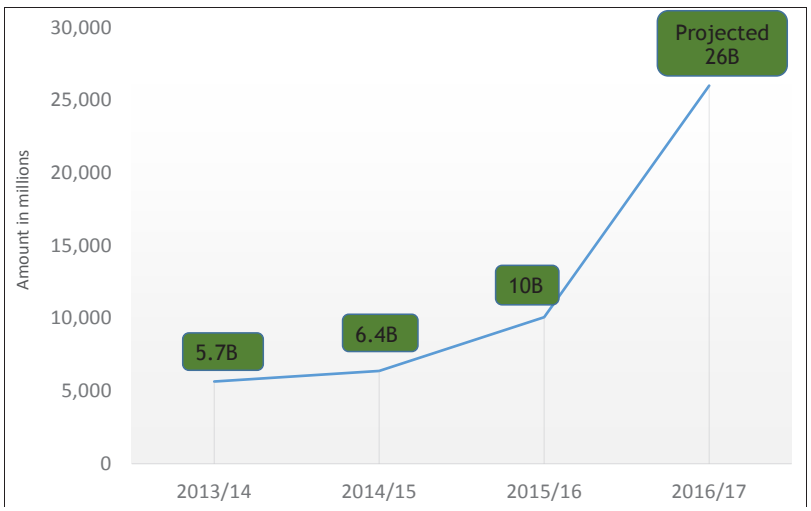
Benefits paid out



Widening access through NHIF

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trend as shown below:

- 2013/14: 27 per cent
- 2014/15: 24 per cent
- 2015/16: 13 per cent
- 2016/17: 10 per cent

Challenges faced

i. Adverse selection: Many people subscribe to the fund when at risk.

ii. Delays or lapses in submission of contributions by the informal sector

iii. Sustainability of contribution by members who suffer job losses/ exit formal employment

iv. Low penetration due to misunderstanding of social health insurance model. This is a similar scenario to Kenya not being a savings society.

v. Emergent health workforce unrest reverses gained benefits instituted through packages

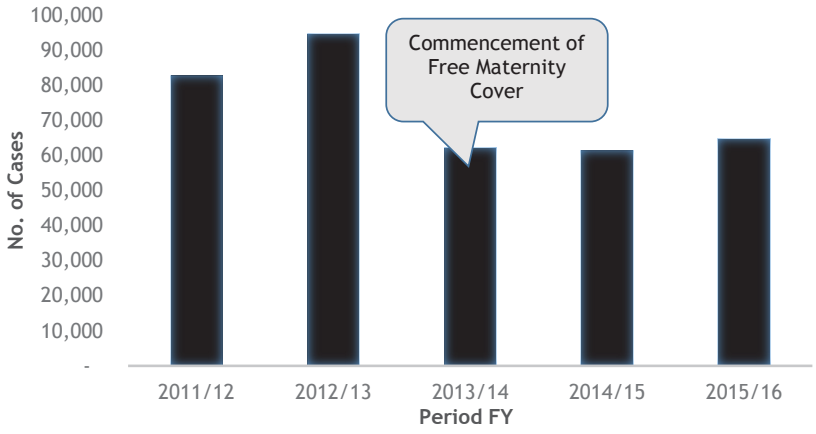
vi. Fluctuating costs of health services

Areas for collaboration

The NHIF is keen to collaborate with CHAK hospitals in the following areas:

- CHAK hospitals are an extensive provider network and have expanded the coverage of NHIF benefits.
- Adopt the Hub & Spoke model (for portability of benefits)
- CHAK members are key in member recruitment and education
- The Fund appeals to the hospitals to ensure accurate data entry and use of disease codes.

Maternity package utilization



- Elimination of fraud: CHAK hospitals need to ensure that all claims are genuine and effectively screen clients.
- Adherence to contract

Linda Mama programme

The Linda Mama programme is a free maternity cover by NHIF. All pregnant women who are Kenyan citizens are eligible for registration with the programme.

Platforms for registration of beneficiaries

- Mobile platform – *263#
- NHIF website
- The health facility can do a web application
- NHIF service centres: These are about 94 country wide.
- Huduma Centres which are about 40 country wide.

Registration requirements:

- Pregnant women of age 18 years and above will be registered using their national identity cards and ante natal

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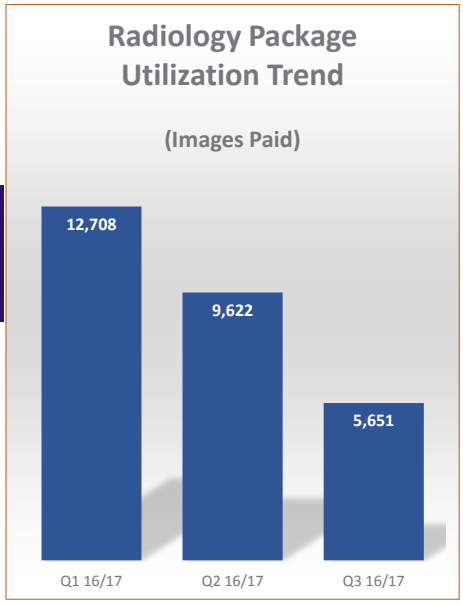

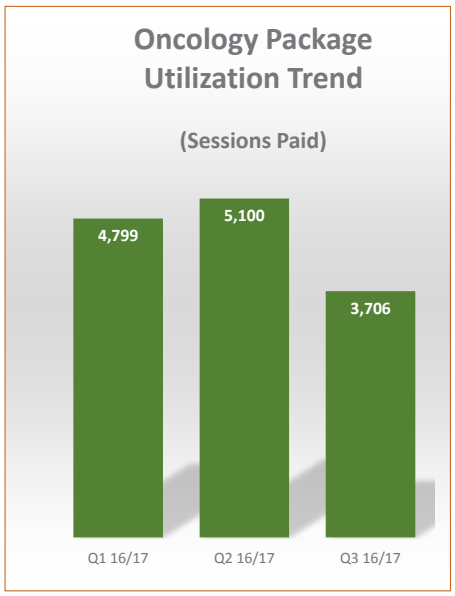

Innovative mobile solutions in support of quality health care

PRESENTED BY VIOLET NJUGUNA - PRODUCT MANAGER, SOCIAL INNOVATIONS, SAFARICOM

Safaricom focuses on the following areas in M-Health.

- Access to quality health care
- Maternal, Newborn and Child Health
- Healthcare financing
- Health systems strengthening, monitoring and evaluation

Lamu Telemedicine

This solution is aimed at leveraging connectivity to improve health care access in remote locations and enhancing the quality of care leading to reduced or timely and accurate referrals, training, better follow-ups and sit by patient consultations.

A video telemedicine service more efficiently provides health expertise to rural areas.

Remote consultations and training strengthens health systems, improving efficiencies and better utilizes limited resources.

Features

1) Easy-to-use multi platform video conference software.
2) Technology to connect facilities that works at low internet speeds (e.g. 3G), reliable and is affordable.
3) Cloud-based web portal for managing referral queues and doctors to edit medical records to improve efficiency.

Jamii Smart

Jamii Smart covers maternal, newborn and child health and is also web based

Jamii Smart is the Kenya Integrated Mobile Maternal and Newborn Child Health Information Platform aimed at improving access by modeling on existing sustainable mobile technology.

It is aimed at strengthening Kenya's community health and referral systems by linking households, community health workers, and health facilities in a real-time health information system that tracks pregnancies, birth preparedness, births,maternal and newborn health parameter and deaths.

It employs target-based health messaging for mothers and their families including updates and reminders for timely interventions.

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Widening access through NHIF

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care records.

- Pregnant women under 18 years will be registered using their guardians' national identity cards and ante natal care records.
- Pregnant women without national identity cards or guardians will be registered using ante natal care records

Phase one will cover deliveries in private and faith based Hospitals.

Linda Mama benefits package

Facility Level	Normal Deliveries	Caesarean Section Deliveries
Level II & III	3,500	N/A
Level IV-VI	6,000	17,000

Innovative mobile solutions

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Jamii Smart is currently seeking a partner to enable it to scale up nationally and disseminate learnings

M-tiba

Currently, M-tiba usage is as follows:

- Over 500,041 users currently on M-TIBA
- Over 192,475 Clinic visits recorded on M-TIBA
- 4,000 People signed up on M-TIBA everyday.
- 350 M-TIBA healthcare facilities signed up across the country.

Fafanuka

This is a platform designed to give information on selected NCDs from detection, diagnosis, care and management through a mobile phone.

Toto Health

This programme targets maternal, newborn and child health)

The application provides messages to mothers to help them monitor the development of their pregnancy or the child and to improve nutrition.

The solution aims to revolutionize maternal and child health with a simple idea: empower parents with credible and targeted child and maternal health care information based on the stage of pregnancy or age of the child.

Users are required to send a text message to 20209 to subscribe to the service.

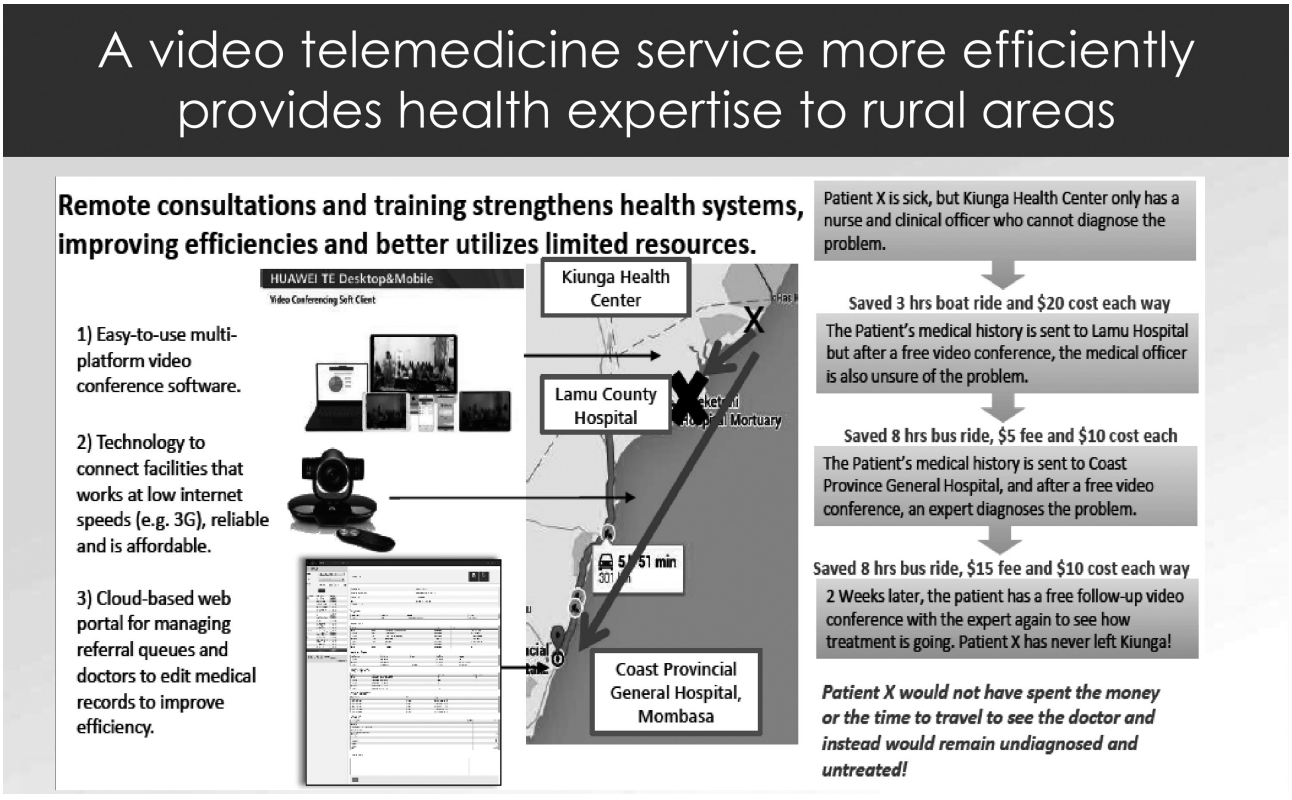

Illustration of how the Lamu telemedicine initiative works.

Achieving a competitive edge through continuous quality improvement

There are various ways to describe quality. It can be defined as:

- A degree of excellence
- Conformance to requirements
- Delighting customers
- Totality of characteristics which act to satisfy a need
- Being free from defects, deficiencies and significant variations
- Meeting customer requirements every time

What is a Quality Management System (QMS)

This term can be interpreted as follows:

Quality: Continuously improving service to patients

Management: With data and profound knowledge (documentation)

System: everyone is involved

Quality Management Systems in Kenya

There are various systems available in Kenya:

- Continuous Quality Improvement (CQI)
- KAIZEN
- Total Quality Improvement (TQI)
- Kenya Quality Model for Health (KQMH)
- ISO 9001 (Quality Management Systems)
- SLMTA (Strengthening Laboratory Management through Accreditation)/ SLIPTA (Stepwise Laboratory Quality Improvement Process Toward Accreditation)

Quality systems are useful for improving quality of services.

The basic principle of any quality system is Plan (P) – Do (D) – Check (C) – Act (A) or PDCA cycle. It requires that you:

- Plan what you want to do
- Follow that plan
- Monitor, measure and analyse the execution of that plan
- Improve your plan

Quality is everyone's responsibility.

Quality in health care

Service	Requirements	Characteristics
Health Care	Correct Diagnosis	Qualified doctor Experienced doctor
	Minimum waiting time	Effective flow of services (reception, consultation, laboratory, payment etc.)
	Cost	Correctly functioning finance system, service charter,
	Patient Safety	Right medication Right Diagnosis Infection Prevention Control

The basic principle of any quality system is Plan (P) – Do (D) – Check (C) – Act (A) or PDCA cycle.

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Continuous quality improvement

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Continuous Quality Improvement: PCEA Chogoria Hospital Experience

Presented by Millan Ochieng Otieno

Background information

PCEA Chogoria Hospital is situated within Chogoria town in Tharaka-Nithi County. It is about 200km north of Nairobi city along the Embu - Meru highway. The Hospital was established in 1922 by Scottish missionaries and transferred to the Presbyterian Church of East Africa (PCEA) in 1956. The Hospital has a bed capacity of 295 and focuses on the provision of curative, preventive and promotive health care services. It also serves as a referral and teaching hospital.

Quality improvement journey

The hospital's quality improvement department was established in October 2015 in partnership with CHAK. Institutionalization of continuous quality improvement is now part of the hospital's implementation of its strategic plan.

The journey began with the appointment of a quality officer and reconstituting the Quality Improvement Team (QIT). The hospital has been implementing its quality management system according to KQMH and ISO 9001:2015.

Plans in 2016/17

The hospital had the following plans during this period:

- Organizational baseline survey in service utilization
- Quality documentation, follow up and audits
- Quarterly patient feedback and suggestion box feedback review as well as annual staff feedback review

Achievements

Out of these plans, the hospital has been able to achieve the following:

- Approval of the terms of reference (TOR) for the quality improvement team
- The annual baseline survey has been done.
- Scheduled process and clinical audits
- Quality documentation has been done including quality manual, quality policy and control of documents.
- Several departmental Standard Operating Procedures (SOPs) have been developed and staff trained.
- The hospital is currently doing a 5S (Set – Sort – Shine – Standardize – Sustain) audit every three months.
- A hospital equipment list has been developed.
- Review of hospital organogram
- Quarterly patient surveys and feedback are being done.
- Medical Error Reporting has been established.

ISO certification

Benefits of lab ISO accreditation

The Chogoria Laboratory has also been ISO-certified with the following advantages being seen following the involving but successful process:

- Confidence in results
- Better controlled laboratory operations
- Accreditation has better equipment management and maintenance
- Improved quality of clinical care
- Increased management involvement in laboratory services
- Recognition by African Society for Laboratory Medicine
- The Chogoria laboratory is now a referral facility for the region.
- There has been a 37 per cent increase in laboratory tests following the accreditation.

Lessons learned

- Quality is not cheap butit is necessary
- Quality is everyone's responsibility and hence people involvement is critical.
- There has been resistance to change and improvements.
- A key pillar in the success of quality management is the involvement of facility management.

Continuous Quality Improvement at AIC Cure International Hospital

Presented by Elizabeth Shonko

What was planned?

AIC Cure's quality improvement goals were as follows:

- Finalize organization of documented information
- Create more awareness to the staff regarding the relationship between the strategic plan and quality management systems
- Compliance to statutory regulations e.g. DOSHS
- Increase institutional visibility

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Role of governance and management in re-engineering FBO health services

PRESENTATION BY DR SALVADOR G-DE LA TORRE – CEO, MAUA METHODISTH HOSPITAL

The need to re-engineer FBO health services is mainly as a result of the sustainability challenges they face today.

These sustainability challenges stem from the old business model in use by most FBO facilities. This outdated business model is characterized by a failure to recognize that times have changed in the health care sector. For the FBOs, the major changes in their operating environment that have greatly impacted on their sustainability include but are not limited to:

- Most mission partners are long gone. The FBO facilities now have to ensure they innovate to sustain their operations.
- Support from partner churches is decreasing.
- Globally, the information has brought about great revolution in the way things are done. Technology plays a key part in the information age, yet most FBO health facilities are still using outdated technology. For the FBO health sector, the technology gap is wide, with great impact on their operations.
- The FBOs are facing more regulation, especially with the introduction of county governments and demands from professional bodies.
- Clients have more demands and expect value for money. The clients are also better informed and able to demand quality services.

Key elements in re-engeering operations

The FBO facilities face challenges in finding ways to sustain services.

1. What worked well in recent past?
2. What is not working well?
3. Make a plan or strategic plan or action.
4. Monitor achievements/variances and make course corrections.

Evidence shows that to survive, FBOs must be run as "private and business-like operations".

A case study of Maua Methodist Hospital

The hospital was facing multiple challenges that hampered its efforts towards sustainability. Among these challenges were:

- A dysfunctional governance structure
- Inadequate oversight
- Inadequate planning
- Inadequate financial controls
- Inadequate documentation and adherence to policy and procedure
- Aging physical plant and equipment
- Inadequate ITC infrastructure

The result of these challenges was:

- Financial deficit: In the financial year 2015, this deficit stood at Ksh15 million.
- The payroll was taking 73 per cent of the hospital's operational income.

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- Pursue ISO certification
- Regular audits

What was done?

Documented information including procedures and work instruction manuals were finalized, approved and made available to the staff in the departments.

Following intense awareness creation, interaction of the strategic plan and quality management systems is now clear to the staff, standing at an average of 85 per cent.

Registration with DOSHS has been done, the OSH committee trained and awareness training for all staff conducted. Safety audits, risk assessment and fire safety audits have also been done.

Quarterly management reviews have been very helpful for the management to evaluate the effectiveness of the quality management system.

Internal audits have been implemented and a pre-assessment has resulted in better preparedness of the staff in general.

Branding and marketing have been successfully carried out and the hospital is in the process of applying for ISO certification by June 2017.

Challenges

- Changes in the organizational structural have slowed down implementation of quality management in the facility.

Role of governance and management

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- The hospital was struggling to attract and retain staff.
- High professional staff turn over
- Poor staff morale especially due to delay in salaries.
- Inadequate cost structure

Re-engineering health services at Maua Methodist Hospital

To turn the hospital around, a key step that needed to be taken was to strengthen governance at all levels.

- A functional Board was first put in place.
- A functional and focused hospital administrative team was also established.

These governance organs helped to promote transparency and accountability and strengthening oversight.

- Documentation was also strengthened and compliance with policy and procedure enforced.
- ICT infrastructure was improved.
- Equipment was replaced as necessary.
- To strengthen donor confidence, reporting and documentation was improved and Board members involved in the process.

Results

One-and-a-half years later:

- The staff are paid on time by the 29th of each month.
- Cost control is being implemented through budget management. Each head of department must own his/her budget.
- In the financial year 2016, the hospital reported a financial surplus.

Maua Methodist Hospital CEO Dr Salvador at the CHAK Annual Health Conference 2017.

Infrastructure

There has been Investment in ICT and an architectural refitting plan is being implemented with CHAK support. Old equipment is also being replaced.

Partner relations

Timely reporting and compliance, effective governance including a functional Board have seen partner relations improve.

A functional and engaging Hospital Administration Team holds short and effective meetings with clearly stated:

- Items for action
- Items for information

Way forward on sustainability

The sustainability of an institution is directly related to its ability to adapt to a changing environment. Maua Methodist Hospital will take the following steps to ensure sustainability:

- Human Resources for Health: The hospital will ensure it has capable and able leadership.
- Physical plant: Re-engineer plant to make it more effective and responsive to current demand
- ICT: Invest in a sustainable HMIS software

Governance

- Review and align the hospital's constitution
- The hospital Board should add value.
- Evidence based management

The hospital will gather, analyze and use data for better and informed decision-making. Among the data to be constantly reviewed are:

- Cost structure
- Service statistics
- Dash boards
- Documentation – timely reporting and compliance

Strategic planning

This will be essential to address threats and seize opportunities.

Kabarak teaching hospital ground breaking ceremony held

By Anne Njoki, Africa Christian Health Associations Platform (ACHAP) Secretariat

"My desire was to provide a quality and affordable services to Kenyans and the neighboring countries."- Daniel Moi.

A ground breaking ceremony for the Kabarak Teaching Research and Referral Mission Hospital was held at Kabarak University, in Kenya's Nakuru County, on June 14, 2017.

The 500-bed modern hospital will have modern equipment and technology to support provision of high quality specialized medical services thus serving as a referral facility for Kenya, eastern and central Africa. It will also have a 250-bed satellite hospital in Nairobi to meet the increasing need for health services in Nairobi.

In addition, the project will support the upgrade of facilities and services in 23 mission hospitals affiliated to the Christian Health Association of Kenya (CHAK).

This will greatly expand and improve the services provided by these hospitals. The mission hospitals will be linked to the Kabarak Teaching Research and Referral Mission Hospital and Kabarak University for patients' referral and research networking.

This project was mooted by His Excellency the Retired Second President of Kenya, Daniel Toroitich Arap Moi.

In a speech read on his behalf by Baringo Senator Gideon Moi, Retired President Moi who is also the Kabarak University chancellor said the vision to establish Kabarak University Medical School and the Kabarak Teaching, Research and Referral Mission Hospital had been inspired by the need to provide good quality medical education opportunities for the many gifted young Kenyans with passion to serve in the medical field. It was also inspired by the need to provide affordable and accessible quality medical services in Kenya with Christian love and compassion.

CHAK Chairman Rev. Dr. Robert Lang'at, General Secretary Dr. Samuel Mwenda and trustees plant a tree to mark the ground breaking ceremony of the Kabarak Teaching, Research and Referral Mission Hospital.

The Retired President paid tribute to mission hospitals which he noted had played a major role in providing holistic services that include physical, spiritual and emotional healing to many people in Kenya and across Africa.

Mission hospitals, he added, had remained a key partner to Government in supporting delivery of quality medical services to communities especially in the rural areas and the urban slums. Additionally, the facilities contributed majorly to training of nurses and other health care workers.

He was however concerned that despite their commitment and contribution, the potential of mission hospitals had been limited by inadequate and aged infrastructure and facilities.

Speaking at the function, CHAK General Secretary Dr. Samuel Mwenda expressed gratitude for the support on behalf of the CHAK family and assured all the stakeholders in the project of the support and prayers of the CHAK network.

He noted that Kabarak University had in 2014 entered into a partnership with Mis-

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CHAK participates in Washington partnership and advocacy meetings

A team from CHAK was among participants at the CCHIH Annual Conference which was held at the Johns Hopkins University in Baltimore USA. The conference whose theme was "Sustainable development; faith at the centre" took place on July 13-16, 2017.

CHAK General Secretary Dr Samuel Mwenda delivered a presentation on non-communicable diseases while project coordinator Jane Kishoyian did a presentation on the CHAK family planning programme. The team's participation at the conference was supported by Norvatis and Gates Foundation. CHAK is currently implementing an NCD programme funded by Norvatis and a family planning project sponsored by Gates foundation.

CHAK General Secretary Dr Mwenda presents an award during the CCIH conference.

After the conference, the team was able to participate in advocacy and partnership meetings in Washington DC. The CCIH Advocacy Day visits to Congress offices took place on July 17. A total of 12 offices were visited and engaged to en-

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Kabarak hospital project launched

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sion Hospitals affiliated to CHAK to roll out family medicine postgraduate training for doctors. Among the CHAK-affiliated hospitals that had signed an MOU with Kabarak University for the training were PCEA Chogoria, AIC Kijabe and Tenwek Mission hospitals. It is expected that Maua Methodist, PCEA Tumutumu, AIC Litein and AIC Kapsowar hospitals will join the partnership in 2017. The arrangement will later be expanded to other mission health facilities.

Additionally, the partnership will be extended to include clinical placement for doctors, nurses, clinical officers, pharmacists and other paramedical cadres.

Dr Mwenda also noted the Government's efforts towards expanded and improved health services in the country. He noted with appreciation that free maternity services had been extended to FBO health facilities through the Linda Mama Programme managed by the National Hospital Insurance Fund (NHIF). Further, the NHIF cover had been expanded towards universal health coverage while county hospitals were being modernized through the Managed Equipment Programme.

On behalf of the CHAK network, Dr Mwenda appealed for government support to church health facilities through:

- Tax exemption on donated medical equipment and supplies
- Secondment of health workers
- Funding
- Allocation of medical equipment and essential medicines

CHAK launches new HIV care and treatment programme

The CHAP Uzima project has been launched. The HIV care and treatment programme being implemented by a consortium with CHAK as the lead partner and supported by the Centres for Disease Control (CDC) was launched on June 16, 2017 in Nairobi.

The award commenced on April 1, 2017, and will run until March 31, 2022. CHAP Uzima is a follow-on project to the CHAK HIV/AIDS Project (CHAP) which ended on March 31, 2017, after a six-year implementation period.

CHAP Uzima is a five-year HIV care, treatment and support program in Kenya. The overall purpose of the project is to contribute to the national effort to halt and reverse HIV incidence and HIV-related morbidity and mortality by providing technical support to a network of 78 targeted, faith based and affiliated sites in 19 counties.

Uzima, Swahili for "life"is a reflection of CHAK's commitment to improving the quality of life for people living with HIV (PLHIV).

With CHAK serving as the lead partner, each member contributes complementary strengths and roles. The other partners are: Palladium, a global leader in health informatics, University of Nairobi, the leading academic institution in capacity building and HIV research in Kenya, and Mission for Essential Drugs and Supplies, the regional hub for pharmaceutical commodities supply-chain management and quality control best practices.

The project is designed around four broad objectives:

1. To provide comprehensive targeted high-impact interventions that reduce new HIV infections.
2. To increase access to comprehensive care and treatment services and improve health outcomes for PLHIV.
3. To improve information generation, management, and use at supported faith based affiliated health facilities (FBAHFs) and counties.
4. To strengthen the capacity of county and facility health systems to deliver sustainable and compre-

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CHAK in Washington advocacy meetings

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courage their continued support for Global Health.

The Gates Foundation Family Planning Advocacy Partners Meeting which involved CCIH, CHAK, CHAZ and EPN was also held and hosted by IMA WorldHealth. Dr Mwenda also held a meeting with IMA WorldHealth CEO and business development team.

During an engagement at the Bill & Melinda Gates Foundation offices, CHAK, CHAZ and EPN gave an overview of the progress of projects they were individually implementing with support from the foundation.

During a meeting with the Director, USAID office of faith based and community initiatives at USAID head office, representatives from several countries in sub-Saharan Africa shared the status of health systems in their countries and FBOs interaction with USG funding support.

During the conference, Nkatha Njeru, ACHAP Secretariat Coordinator, explained why it was important to engage religious leaders - Christian and Muslim - in Kenya to reach children in HIV testing and treatment.

Religious leaders reach people, especially children and young people, who might not otherwise be reached, she said.

ACHAP, which is hosted by CHAK, is currently implementing the Strengthening High Impact Interventions for an AIDS-free Generation (AIDSFree) Project which has taken a community approach to engage the faith sector as part of efforts to expand HIV care and treatment services in Kenya.

To equip religious leaders with the adequate tools and knowledge to make an impact, IMA World Health led and facilitated the development of the Khutbah and Sermon Guides on Children and HIV for Religions Leaders and trained religious leaders how to use them.

CHAP Uzima project launched

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hensive HIV care and treatment services.

CHAP Uzima will deliver four key intermediate results:

1. Reduced preventable HIV-related disease burden and mortality among targeted populations, including priority populations, pregnant and breastfeeding mothers, and tuberculosis (TB) patients (and reduced TB incidence in HIV patients).
2. Virtual eMTCT of HIV
3. Reduced HIV incidence in targeted counties.
4. Increased ownership and integration of HIV services

The CHAP Uzima program has stressed the importance of forming partnerships, alliances, and collaborative efforts that develop and enhance linkages between and among county governments, national coordinating mechanisms, other PEPFAR implementing partners, civil society, and communities.

As CHAP transitions to CHAP Uzima, the project will transmit the project's promising practices in HIV care and treatment programming and strengthen the groundwork for improving adherence and retention in care for HIV patients. This will be through implementation of standard operating procedures (SOPs), continued maintenance of health care workers' confidence in managing and monitoring patients on antiretroviral therapy (ART), and quality improvement to enhance programs that support patient ART retention and adherence and quality health services in the context of Test and Treat guidelines.

(Top) CHAK staff and EXCO members in a group photo with CHAP Uzima partners from health facilities, county health departments, CDC, among others. (Bottom) the guest of honour during the launch looks on as CHAP project director Dr Catherine Njigua hold up the project implementation guidelines after receiving them from CHAK General Secretary Dr Samuel Mwenda (centre).

CHAP Uzima Highlights

Donor: Centers for Disease Control

Start Date: 01/04/2017

End Date: 31/03/2022

Geographic Scope: 78 facilities; 4 OVC programs; 19 counties

Technical areas covered: HIV testing services; eMTCT; HIV care, treatment and support; orphans and vulnerable children (OVC); health systems strengthening; health informatics and data management systems

MOH issues clarification to health facilities on plastic bags ban

The Ministry of Health has issued a clarification on the ban of plastic bags for waste management in health facilities. In the letter, the MOH clarified that category 3 which includes flatbags used as garbage and harzadous waste liners has been exempted from the ban on plastic bags. In the letter, the Ministry further said that it had together with the World Health Organisation developed the Health Care Waste Management Guidelines and urged counties to take the lead in developing by-laws to enable controlled tracking of general and health care waste.

The letter sent out by MOH

MINISTRY OF HEALTH
OFFICE OF THE DIRECTOR PUBLIC HEALTH

Telephone Nairobi 2715677
Email: directorphke@gmail.com
When replying please quote

AFYA HOUSE
CATHEDRAL ROAD
P O Box 30016 -00100
NAIROBI

Ref. No MOH/EHS/Waste/ Vol.3/64

28th August 2017

To: All County Directors of Health Services
(Attn: All County Public Health Officers)

Thru'

The Chief Executive Officer
Council of Governors
P.O. Box 40401-00100
Delta House
NAIROBI

RE: EXEMPTION ON BAN OF PLASTIC CARRIER LINERS FOR MEDICAL & CHEMICAL WASTES

Reference is made to the Kenya Gazette notice no. 2356 of 28th February 2017 and the clarifications posted on NEMA website under "Plastics Bags Ban updates" link-Exemptions category 3. This category applies to flat bags used as Garbage and hazardous (e.g Medical Waste, Chemicals, etc) waste liners.

The Ministry of Health (MOH) duly appreciates the timely ban of general use of plastics in a move to reduce environmental, air, water and land pollution. Furthermore, the indiscriminate disposal, crude burning and or burial of these plastics by general public and both public and private healthcare facilities poses a risk to human health. In appreciating this move and in order to bring sanity in minimization, segregation, collection, storage, transportation, treatment and disposal of medical & chemical wastes, both the Ministry and World Health Organization (WHO) developed the Health Care Waste Management Guidelines which provide for appropriate colour-coded bins and plastic liner bags system.

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the Samaritan

A good samaritan stopped to help a stranger. he took on the burden of caring for someone he did not know. If you have a burden that you cannot bear on your own, share it with the Samaritan. Send your questions to:

The Samaritan, CHAK Times, P.O. Box 30690 - 00100, Nairobi. Email: communications@chak.or.ke

Dear Samaritan,

I am a parent of two teenagers. My communication with them has been very poor. I tell them not to watch TV the whole day but this seems to be falling on deaf ears. Sometimes they refuse to eat food prepared by my house help. Recently the younger one who is in form one refused to go back to school at the beginning of the term and insisted on a tranfer. What can I do to improve communication between my children and i?

Concerned parent

Dear concerned parent,

You sound frustrated because you are not able to communicate with your teenagers effectively. For you to communicate with your teenagers you need to become good friends. Talk to them as opposed to talking at them and speak their language.

You also need to spend a lot of time with them. You can do some activities together, for example cooking, playing or walking. Have as much fun with them as possible.

In addition, try as much as possible to talk to them when both of you are calm to enable communication to take place. Practice good communication skills like active listening, observe non-verbal communication and encourage them to talk as much as possible.

There is a great need to appreciate even the small things that your child does. That way, you build their self- esteem and help them become more responsible.

When you tell them not to be glued to the TV the whole day, are you proposing some alternative activities that they could do to keep themselves busy? Teenagers have a lot of energy and if not directed in the in the right way, they may end up engaging in some unhealthy behavior.

You may have to teach them some life skills to ensure they understand how to deal with the challenges of life.

When you say that sometimes your children refuse to eat food prepared by your house help, what do you really mean? Is your house help a good or poor cook? Do you like the food prepared by her/him? Most teenagers usually like junk food and you as a parent should discourage this and offer a healthy diet. You also teach them why junk food is not healthy for them.

You could discuss a meals timetable together with your house help and your teenagers, and ensure they are reasonable and realistic as they plan. Additionally, have the teenagers prepare a meal which you can all enjoy. Let them prepare what they like eating once in a while.

As for the one who is insisting on a transfer, you may have to find out what could be making him hate his current school. Is he being bullied by other students? May be he does not like the food in this school, or the school is far from home, What really make him hate this school?

Young people usually experience peer pressure. He/she could be getting influenced by his age mate. He may want to be with his friends as opposed to being around strangers. Listen to him and try to help him cope as much as possible.

As a parent, do not allow your children to dictate what they want to eat, where they want to go, who should cook for them, which school they want to go, etc. You must stand firm and take the leadership position in your house.

MOH issues clarification on plastic bags

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MOH letter clarifying ban on plastic bags

It is therefore a good opportunity for all Counties to take lead in developing County by-laws that provide for controlled tracking of healthcare and general wastes using the guidelines provided in the above notice, MOH & WHO guidelines, while providing clear mechanisms for enforcement, in order to control and minimize both human and environmental risks posed by unsafe management of wastes. Enforcement is expected to bring sanity in all sectors of healthcare delivery, in not-for-profit, private and public health facilities.

Thank you for your continued cooperation.

Kepha M. Ombacho, PhD, MBS
For PRINCIPAL SECRETARY

Encl.

Jokes... jokes... jokes...

Never satisfied

Two friends met in the street. One looked sad and almost on the verge of tears. The other man said, "Hey my friend, how come you look like the whole world has caved in?"

The sad fellow said, "Let me tell you. Three weeks ago, an uncle died and left me 50-thousand dollars."

"That's not bad at all...!"

"Hold on, I'm just getting started. Two weeks ago, a cousin I never knew kicked-the-bucket and left me 95-thousand, tax-free to boot."

"Well, that's great! I'd like that."

"Last week, my grandfather passed away. I inherited almost a million."

"So why are so glum?"

"This week - nothing!"

Good Old Fred

Ol' Fred had been a faithful Christian and was in the hospital, near death. The family called their preacher to stand with them.

As the preacher stood next to the bed, Ol' Fred's condition appeared to deteriorate and he motioned frantically for something to write on.

The pastor lovingly handed him a pen and a piece of paper, and Ol' Fred used his last bit of energy to scribble a note, then he died.

The preacher thought it best not to look at the note at that time, so he placed it in his jacket pocket.

At the funeral, as he was finishing the message, he realized that he was wearing the same jacket that he was wearing when Ol' Fred died. He said, "You know, Ol' Fred handed me a note just before he died. I haven't looked at it, but knowing Fred, I'm sure there's a word of inspiration there for us all."

He opened the note, and read:
"Hey, you're standing on my oxygen tube!"

Source: http://jokes.christiansunite.com

Better than all the waters of Israel

CHAK Chairman Rev. Dr. Robert Lang'at delivered the opening devotion during the Annual Health Conference and Annual General Meeting.

The devotion was taken from 2nd Kings 5:1-17 which talks about the healing of Naaman from leprosy.

Naaman was was commander of the army of the king of Aram, a valiant soldier, but he had leprosy.

Bands of raiders from Aram had gone out and had taken captive a young girl from Israel, and she served Naaman's wife. She said to her mistress, "If only my master would see the prophet who is in Samaria! He would cure him of his leprosy."

Naaman went to his master and told him what the girl had said. And the King of Aram alloweed him to go and see the Prophet Elisha.

When Naaman got to Elisha's house, Elisha did not even go out to greet him. Instead he told Naaman to go and wash himself in the River Jordan. This made Naaman very angry since he thought Elisha would come out and meet him and "stand and call on the name of the Lord his God, wave his hand over the spot and cure me of my leprosy".

"Are not Abana and Pharpar, the rivers of Damascus, better than all the waters of Israel? Couldn't I wash in them and be cleansed?" he asked as he turned and went off in a rage.

But his servants pleaded with him to obey the man of God. When Naaman washed in the River Jordan, he was cleansed of his leprosy. And because of this, Naaman said he would never make any sacrifices and burnt offerings to any other god but the Lord.

Lessons from the passage

We face many desperate situations in life. Many CHAK facilities were found at the beginning of the year because people were looking for physical healing during the doctors' strike. There are four lessons we can glean from this passage:

- Why do we exist as faithbased facilities? Why are we better than our competitors? Namaan was a very successful soldier, better than everyone else. But he had leprosy. He needed healing. Diseases have no respect for persons. Sick people can go to great lengths to receive their healing.
- The messager who brought Naaman the message of healing was a very unlikely one, very despised but she knew where the healing was. Many CHAK facilities are despised and have lots of struggles. What attitude do we assume? This lady was a messager of healing to a very desperate person. Namaan took her very seriously. Sometimes even the highest office in the land cannot provide solutions. We need to look to God in this situations.
- Means to Naaman's healing: He came to the door of the servant of God like a beggar. Elisha was in a place that was hard to find. When he arrived, instead of Elisha coming out, he sent his servant. Namaan felt very disrespected. And he said the rivers of his land were better than the rivers in Israel. People come to CHAK facilities for various reasons. Let us stay faithful to our calling. Naaman obeyed and dipped himself into River Jordan and he became clean. God does something and does it properly so that it is clear he is the one who has done it. He came back to Elisha and asked what can I give you? Elisha refused to take anything from him.
- From this healing, Namaan said that he would never again burn any offering to any other God. CHAK facilities are to bring the gospel of salvation so that when people come and go, they will say they will serve the living God. It is important to demonstrate the love of Jesus to those who come to us.

In closing, it is important to note that FBOs provide 40 per cent of health services in Kenya. During the doctors' strike, FBOs provided more than 65 per cent of medical services.

A key challenge for FBOs is financial sustainability. Insurance coverage is inadequate for the population while revenue collection challenges abound in FBOs. Over reliance on donor funding, rising cost of living, increasing wages in the public sector, labour union demands are all huge challenges facing faith based health facilities. Politics has seen some church health facilities face sustainability and ownership challenges. The CHAK network needs to use forums such as the AGM/AHC to identify solutions to these challenges.