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CASE STUDIES

A modern mission

Hospital staff in rural Kenya are delivering critical infrastructure despite insufficient finance and a limited project management skill set.

PROJECT CLIENT:	AIC Kijabe Hospital
SCOPE:	Build capacity within a Kenyan mission hospital to deliver a significant infrastructure program
COMPLETION:	2012 and continuing

KEY PLAYERS

MARY MUCHENDU
Executive Director
Kijabe Hospital

COLLINS MUIRURI
Engineering and Facilities Manager
Kijabe Hospital

SAMUEL MWAURA
Finance Director
Kijabe Hospital

ANDREW STEERE
Management Consultant
Serving In Mission

BACKGROUND BRIEFING

Kijabe Hospital is a not-for-profit facility located in a rural area of Kenya about 65km northwest of Nairobi. Founded in 1915 by Christian missionaries, the hospital boasts more than 700 staff from Kenya and other African countries. A number of foreign humanitarian volunteers also work at the hospital.

The high quality of healthcare provided at the hospital, coupled with its compassionate mission to treat any patient regardless of social status or ability to pay, has meant the facility has grown quickly and become a centre of excellence for low-resource healthcare provision.

As the patient population has increased, buildings have been added, but core infrastructure has remained primitive and is now in poor condition. The hospital regularly experiences power and water outages, which hinder the hospital from providing care to the vulnerable communities it serves.

KEY CHALLENGE

The hospital staff's lack of project delivery experience and limited financing were the two main obstacles to achieving the infrastructure upgrades required at the hospital. The hospital conducted its first master planning process in 2010 with Engineering Ministries International, which identified critical infrastructure that needed upgrading by 2015. This included major electricity, water and sanitation upgrades along with several new buildings: a large new paediatric wing, a palliative care facility, and a maternal and child health building.

The number and scale of projects were daunting, admits Collins Muiruri, Engineering and Facilities Manager at AIC Kijabe Hospital.

"More infrastructure had to be built in five years than (had been) built in the last 50."

Process

Mary Muchendu, Executive Director at Kijabe Hospital, realised in 2010 that her team didn't have the human or financial resources required to deliver all infrastructure identified in the master plan. But the most critical upgrades could not be delayed any longer. The electrical system, for example, was so unreliable that surgeons would routinely operate with headlamps in case the power went out.

Without full financing, the team commenced the most critical projects. Then, in 2011, volunteer management consultant Andrew Steere came on board to assist the managers and Engineering and Facilities team to improve their project and program management capacity. Steere, a Certified Practicing Project Director (CPPD) from Adelaide, had both infrastructure project management experience and the communication skills necessary to work successfully in a multicultural setting.

"The hospital already had the right people in place," he says. "They just didn't have the opportunity to manage multiple projects."

The first step was to create a new Capital Projects department and build project management processes within

Clockwise from top left: Construction of the sanitation project is underway; the hospital provides care for all; part of the Kenyan sanitation project; Andrew Steere on the field.

it, he continues. This included a four-fold focus on time, cost, quality and stakeholders. But, at the executive level, he added a fifth element: resource mobilisation.

Embarking on a major capital program that was initiated internally required innovation in the area of resource mobilisation, explains Samuel Mwaura, Finance Director at Kijabe Hospital. The program also required a multi-pronged approach to capital fundraising.

"The hospital barely survives financially on low patient fees charged to those who can afford them and on donated resources, both human and financial," he points out.

Outcome

When Steere arrived in early 2011, the electrical upgrade was around 50 per cent complete and the Engineering and Facilities team was working at full capacity, with team members devoting most of their time and energy to the project, while also managing their day-to-day maintenance responsibilities. Change was needed to ensure they had the capacity to deliver planned water and sanitation projects, Steere explains.

"We streamlined communication processes by creating a weekly Projects Coordination Group meeting for all key players," he says. "For half of the meeting, the team would discuss project management processes: project teams, governance structures, reporting, and risk identification and management. The other half was dedicated to management training," he says.

By early 2012, the electrical upgrade project was successfully completed, on time and within the budget of $380,000. The new maternal and child health building was finished in September within its budget of $100,000, and a new environmentally compliant incinerator was installed and commissioned.

The development phase of the water and sanitation projects has also been completed, with construction for the sanitation project, palliative care facility and paediatric wing already underway.

"If you asked me in 2010 how many projects we would have underway in 2012, I would have said one or maybe two," says Muchendu.

"To have four major projects underway and two successfully completed is far beyond my expectations and a testament to our team coming together, trying out new methodologies and discovering to our delight that we can do what needs to be done when we are willing to work in different ways." •••