NAMIBIA UNIVERSITY OF SCIENCE AND TECHNOLOGY

FACULTY OF MANAGEMENT SCIENCES

DEPARTMENT OF MANAGEMENT

QUALIFICATION: BACHELOR OF BUSINESS MANAGEMENT HONOURS	
QUALIFICATION CODE: 08BBMH	LEVEL: 8
COURSE CODE: SMM811S	COURSE NAME: STRATEGIC MANAGEMENT
SESSION: JUNE 2019	PAPER: THEORY
DURATION: 3 HOURS	MARKS: 100

FIRST OPPORTUNITY EXAMINATION QUESTION PAPER	
EXAMINER(S)	DR. CHRIS VAN ZYL
MODERATOR:	MR. RAINER RITTER

INSTRUCTIONS
1. Answer ALL the questions. 2. Write clearly and neatly. 3. Number the answers clearly.

PERMISSIBLE MATERIALS

1. Solid Africa case description
2. Business Calculator

THIS QUESTION PAPER CONSISTS OF 10 PAGES (Including this front page)

QUESTION 1

Analyse the attached case study "**SOLID AFRICA**" and present a detailed case analysis report containing reference to all the relevant strengths, weaknesses, opportunities and threats. The recommendations should include suggestions of how the current strategy could be adapted in order to provide **SOLID AFRICA** with an alternative successful strategy. The suggested changes to the current strategies need to be well justified and motivated. The recommendations should furthermore be very specific about how the strengths and opportunities that were identified to be utilized in order to improve or eliminate the identified weaknesses and to minimize the effect of the identified threats on the enterprise performance.

The following aspects need to be included in your final answer:

(a) Synopsis or Executive summary;	[5 marks]
(b) Comprehensive SWOT analysis;	[30 marks]
(c) Business model description;	[10 marks]
(d) Current organizational strategic position;	[10 marks]
(e) Discussion of the findings;	[10 marks]
(f) Conclusion;	[5 marks]
(g) Recommendations.	[30 marks]

TOTAL MARKS: 100

Solid Africa's industrial kitchen: the dilemma

Lionel Muziramakenga, Masato Abe and James Landi

Downloaded by Namibia University of Science and Technology At 01:11 05 February 2019 (PT)

Lionel Muziramakenga is based at the Department of Business Management, Webster University, Vienna, Austria. Masato Abe is Research Fellow at Thammasat University, Bangkok, Thailand. James Landi is Adjunct Lecturer in Finance at Webster University, Bangkok, Thailand.

Disclaimer: This case is written solely for educational purposes and is not intended to represent successful or unsuccessful manageria decision-making. The author/s may have disguised names; financial and other recognizable information to protect confidentiality.

Introduction

If you have ever visited public hospitals on Sundays in Kigali, Rwanda, you would have probably seen young people standing on a terrace in front of a long table filled with different dishes representing a sort of buffet, wearing the same t-shirts with the brand "Solid Africa" written on them. These young men and women, mostly Rwandese, are young professionals joining hands together to make monthly contributions and raise funds to change the lives of the most vulnerable people in their society by providing them with a warm meal at the public hospitals. Solid Africa is looking for innovative ways to become self-reliant. Should the team save the contributions until the required investment is reached to be financially sustainable or should they seek external financing?

The aftermath of the 1994 genocide against the Tutsis left the health and education systems in ruins, something which has caused continuous deficiencies in the health system. A large part of the population in Rwanda lacks the means to pay for medical care unless they are covered by medical insurance. However, even when they are, the insurance does not cover medication (only the basic ones), food and sanitary products while being admitted. The implementation of health initiatives in the country is furthermore limited.

After two years of complete dedication providing three meals a day to the most vulnerable patients who are unable to afford medical care services, concerns about sustainability arose among the founding members of Solid Africa. Relying on charity and their 148 members' contributions ($20 to 30 per month) to ensure the patients were fed was not a viable plan, and it would certainly limit the social impact. Therefore, the group decided to build Rwanda's first industrial kitchen that would cater to vulnerable patients in public hospitals. The plan was to build a kitchen and acquire the necessary equipment to be able to feed at least 1,000 patients living under the poverty line with three meals a day, throughout the main public hospitals in Rwanda. As the city of Kigali, the capital of Rwanda, lacks industrials kitchens that cater lunches for the working class, the kitchen would serve as a sustainable mechanism for Solid Africa by selling lunch boxes. The revenues from the lunch boxes would then be reinvested to afford free meals for the vulnerable patients. The group designed a financial plan, detailing what would be required for the project to be a success. But a few questions remained unanswered:

Q1. What would it take to finance the project?

Q2. How long would it take to clear the debt?

Q3. Would the project be a good investment?

Q4. What would be the capital structure?

DOI 10.1108/EEMCS-03-2016-0028 VOL. 6 NO. 4 2016, pp. 1-23, © Emerald Group Publishing Limited, ISSN 2045-0621

Solid Africa: an overview

In September 2010, feeling the urge to contribute to the development of her country by helping those affected the most by poverty, Ms Kamariza, a young Rwandan coming from a family in Kigali, soon after graduating with a bachelor's degree in social sciences from Belgium, decided to make a change. On seeing that patients were unable to pay their dues at hospitals and were therefore not discharged or were starving because the insurance did not cover food packages, she decided, together with her sister and some friends, to create an organization, Solid Africa. It is a Rwandan not-for-profit organization aiming to support the most socioeconomically vulnerable individuals' needs for medical, hygiene, emotional and dietary assistance. In Kigali, although about 100 international non-governmental organization (INGOs) and non-governmental organization (NGOs) are registered, none of these organizations, except Solid Africa, provides free food to vulnerable patients in public hospitals.

Ms Kamariza became the President of the organization and her sister the Chief Financial Officer (CFO) with other additional volunteer staff. The entire team is very passionate about the organization's social mission. Table I summarizes Solid Africa executives and managers and their backgrounds.

About 90 per cent of the Rwandan population is covered by medical insurance. The insurance only covers medical care and basic drugs, not food, which is a common and serious problem, faced by patients who are living under the poverty line throughout the country in the public hospitals, and is often overlooked by the Government. Recognizing that many patients in public hospitals are unable to cover the extra cost of admission, especially with the living cost not covered by the insurance, Solid Africa is committed to ensuring that the basic needs of these individuals, such as food, are covered. Over the past five years, the organization has done an excellent job, feeding an average of 1,000 patients every day by relying on donations from organized fundraising activities. Through a variety of youth initiatives, like waiting on patients by serving the meals at public hospitals, Solid Africa provides an opportunity for these patients to access food from its Sunday lunch program and its weekday breakfasts, covering a modest number of 1,000 patients. Solid Sundays' breakfast and dinner and weekday lunch and dinner are handled by the hospitals staff in collaboration with Solid Africa. In 2012, Solid Africa held its first Rwandan Culinary Month for Solidarity in Kigali. The concept of the event was to promote home-grown Rwandan ingredients in the preparation and presentation of fine cuisine. In collaboration with renowned restaurants, it served dishes from home-grown ingredients for a premium price. Moreover, Solid Africa, through various events, created awareness and solidarity among the Rwandan population. For instance, Solid Fridays were a monthly event organized every last Friday of the month, through which guests and attendees were able to learn about the organization and its projects and join the cause by making contributions. People were also encouraged to participate in the Solid Sundays breakfast for them to witness firsthand how their contributions were being used.

However, a problem remained: the amount raised was only adequate to pay the cost of the event and buy food for the patients until additional funds were raised once more. Although,

Table I Executives and managers of Solid Africa

Job title	*Name*	*Educational background*	*Relationship to president*
President	Ms Kamariza	B.Soc.Sci.	–
Vice President	Ms Inkesha	MA in International Relations	President's best friend
CFO	Ms Kanyange	Bachelor in Business Administration/ with two years' experience in banking	President's sister
Program Manager	Mr Nizeyimana	Bachelor in Business Administration	President's husband

Downloaded by Namibia University of Science and Technology At 01:11 05 February 2019 (PT)

including the Rwandan Culinary Month for Solidarity, Solid Africa members and volunteers have locally raised funds by continuously hosting creative fundraising activities and events, also selling Solid Africa T-shirts, these events serve as short-term solutions and only replenish the same capacity and not beyond.

Members meet every Thursday to discuss future opportunities and go through what has occurred during the week. The president starts by reading the agenda of the meeting, and the project manager begins with a brief detailed summary of the contributions' expenditure to the audience. This is done because not all members participate in weekly activities at the hospital, as most of them have a full-time job. The benchmark for contributions is set at $30 for members, on the last Thursday of the month; all the contributions are collected, the benchmark being $30. Solid Africa's members have a salary ranging from $1,000-3,000, depending on the willingness and generosity of an individual on collection day, the contribution can be 20 to 30 per cent of the salary or just $30. It is unpredictable.

Health system

Rwanda, with an area of 26,338 km^2 and population estimated at 11,262,564 (2015), borders four countries: Burundi (area 27,834 km^2, population 11,178,921), Democratic Republic of Congo (area 2,345,409 km^2, population 81,680,000), Tanzania (area 947,303 km^2, population 50,76,000) and Uganda (area 241, 038 km^2, population 37, 873,253), and it is part of the East Africa Community (EAC). Despite the fact that the country is landlocked, it has, according to the World Bank (2015), a stable economy and was ranked second in Africa in the ease of doing business and 46th worldwide. Rwanda is one of few sub-Saharan African countries that were able to achieve most of the Millennium Development Goals (United Nations, 2014); however, it is still one of the poorest countries in the world with large challenges and needs in the health-care sector. Though, the country is ranked 58 out of 140 in Global competitiveness for the year 2015-2016, it ranks 88 out of 140 on the pillar of health and primary education (World Economic Forum, 2016).

The health system in Rwanda is a decentralized, multi-tiered system which has a pyramidal structure: central, intermediary and peripheral. The scheme follows the geographical structure of the country (four provinces and 30 districts plus Kigali City. Each district is divided into sectors, which are divided into cells and finally villages). Medical services are provided at: referral hospitals (central level), district hospitals (intermediary level), health centers and health posts (peripheral level). The most advanced services are provided at the referral hospitals, where patients will be treated by general physicians and specialized doctors and nurses. At the district hospitals, there are doctors and nurses offering services such as minor surgery, etc. The health centers only have nurses, who can run simple tests, etc. Health posts in the villages are run by Community Health Workers (CHWs) (National Community Health Strategic Plan 2013-2018). The system can be described as a triangle where you have fewer hospitals on the highest tertiary level and very many health posts at the village level (Figure 1).

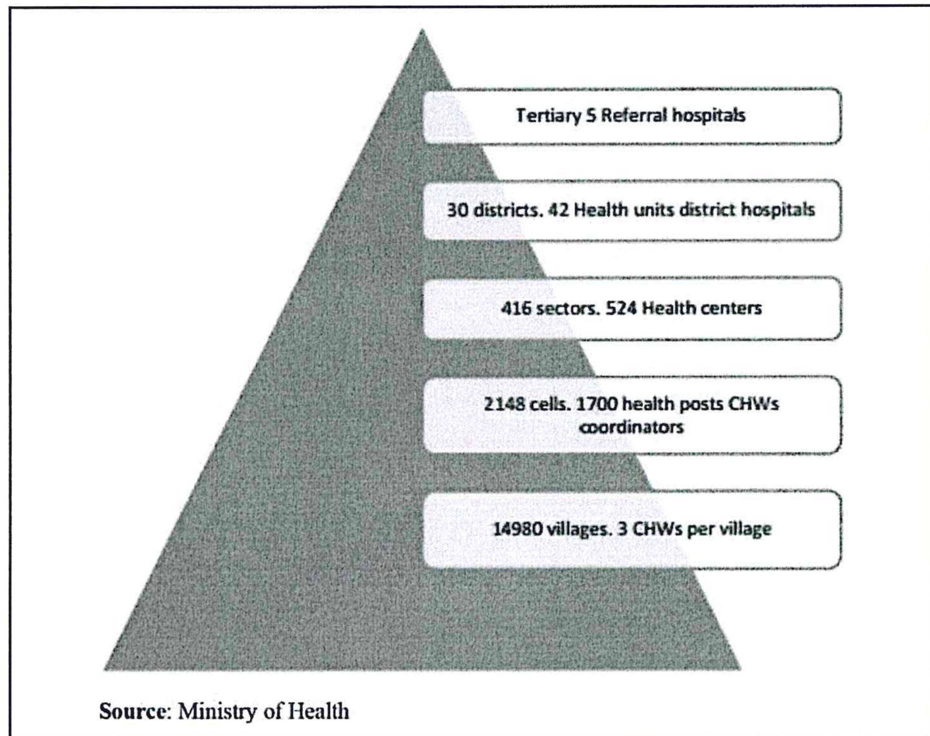
At the end of 2012, there were a total of 571 health facilities nationwide, excluding health posts. About 77 per cent of them are public: 55 per cent are completely funded by the Government of Rwanda and 22 per cent are run by faith-based organization in partnership with the Government of Rwanda. Further, 20 per cent are run by private organizations, 2 per cent by communities and 1 per cent by parastatal organizations (Ministry of Health). In 2011, a total of 7,940,927 patients was treated at health facilities. Out of these, 88 per cent visited health centers, 6 per cent district hospitals, 2 per cent referral hospitals and 4 per cent visited CHWs (National Export Strategy, revised 2014, page 60).

There are several challenges that exist in the health-care sector in Rwanda. One of the most critical is the severe shortage of qualified medical staff (doctors, nurses, technicians and laboratory staff). Other big issues include the lack of medical equipment and the knowledge of how to maintain them, and a very high import dependency in combination

Downloaded by Namibia University of Science and Technology At 01:11 05 February 2019 (PT)

5

Figure 1 Constitution of health-care service providers in Rwanda



Source: Ministry of Health

with a general heavy dependence on foreign donor support, making it difficult for the country to establish a sustainable health-care system for public hospitals. Another important issue which has an impact on the financing of medical services is the fact that a large part of the population lacks the means to pay for medical care unless they are covered by medical insurance, in this case, the community-based scheme insurance (Mutuelle de santé, 2003), and can only afford treatment in public hospitals, as private hospitals are costly. The medical services include food packages for admitted patients in public hospitals.

For instance, Partners In Health (in collaboration with the Clinton HIV/AIDS Initiative) is working with the Ministry of Health to support the cost of insurance and consultation fees for the indigent including financial support for public health insurance, medical consultation fees for the indigent and food packages for HIV or tuberculosis patients (Cancer care and control in Rwanda, 2010).

About 90 per cent of the population is covered by Mutuelle de santé, which provides them with subsidized prices for medical care and basic drugs. Anyone holding the Rwandan citizenship is eligible to subscribe for Mutuelle de santé. Mutuelle de santé subscribers will be assigned to one of three categories: the well-to-do who pay $10 per year, the less-well-off for whom the fee is $4.3 and the very poor who are covered by the Government at $2.3. These different fees, however, do not reflect different coverage: all three categories are entitled to the same services. The fees were increased in July 2011, as the previously even lower prices made it impossible for the Government to bring in enough money to cover the expenses. The incomes from the insurance scheme are still not enough, and the system therefore needs more investments to develop further and becoming sustainable (Investing in Rwanda, 2014).

The insurance only covers medical care and basic drugs, not food, which is a common and serious problem, faced by patients who are living under the poverty line throughout the

Downloaded by Namibia University of Science and Technology At 01:11 05 February 2019 (PT)

country in the public hospitals, and is often overlooked by the Government. Nutritional and health-care professionals all over the world recognize that a well-balanced meal is key to health and the healing process (NHS, 2014). Therefore, a sustainable and replicable solution is required to solve this issue. Feeding patients in public hospitals, as well as providing needed support services, is essential to improving the national health-care system, for the well-being of patients and its reputation.

Industrial kitchen project

Solid Africa strove to get on top of the issues faced in public hospitals, through fundraising and members' contribution. But in the process, the group of young men and women realized that the pace at which those in need was increasing was not proportional to the expansion of Solid Africa members' contribution; moreover, it was very difficult for them to measure the success of a fundraising event. Hence, to have an optimal impact, Solid Africa decided to become self-reliant and planned to build an industrial kitchen that would continuously generate revenue, of which a portion would be reinvested and the rest redistributed to serve its social mission, that being to support the most socioeconomically vulnerable individuals in need of nutritional assistance. An industrial kitchen provides professional catering services to several organizations that show interest in meal delivery, primarily for lunchtime. The objective of Solid Africa is to provide one free meal for vulnerable patients for every two meals sold.

But legitimate food business must cook and/or bake in a commercial kitchen that is licensed by the local health agency first. The cost to set up the business varies from $15,000 to 100,000 (Chron.com, 2015). Besides restaurants and cooking schools, industrial kitchen that serves public good are inexistent in Rwanda.

To achieve the objective of serving 1,000 vulnerable patients in different public hospitals with three meals per day, an industrial kitchen is indeed needed. Industrial kitchens generally aimed at serving the working class and are not available in Rwanda. Delivery of ready-to-serve meals is a new concept for the Kigali market. The staff in many organizations will usually go to restaurant lunch buffets where meals cost between (US$2.1-3.6). These places lack hygiene and sufficient supply of healthy food ingredients.

Furthermore, besides being scarce in the city, these restaurants have limited capacity; hence, the inefficiency to provide to a large number of customers at once. The workers usually have lunch in affordable restaurants located miles from the office, which leads to productivity issues, generated by extended lunch breaks. But most importantly, by operating the industrial kitchen, low-income workers would be able to afford healthy meals during lunch.

The planned meals produced by the industrial kitchen are grouped in two different categories: 3,000 meals for people in public hospitals free of charge and 6,000 meals cooked for commercial sale on a daily basis. Breakfast, lunch and dinner will be served to patients in public hospitals, and all meals will be delivered on schedule without disturbing the daily routine of the hospital. The appealing part is that people would support the NGO with the idea that every meal bought would feed a starving patient.

Provided the project is a success, hospitals would receive support for optimum care for patients. On the other hand, commercial meal sales would be to organizations with whom Solid Africa would work on a long-term contractual basis, as the ready-to-serve meals will be sold to quantity buyers only. Meals will be also provided to business organizations looking for catering services for their employees (e.g. on a construction site). Sales would be the fuel for financial sustainability of Solid Africa.

Financial sustainability will transform Solid Africa into a social enterprise (SE), enabling it to achieve its social mission while making a profit. Instead of relying on the donors' generosity and fundraising activities, which limit the social impact, this project would increase Solid Africa's institutional capacity.

Downloaded by Namibia University of Science and Technology At 01:11 05 February 2019 (PT)

Table II Financial plan

Product	Menu Qty per day	Measures	Unit price (RWF)	Total per day (RWF)	Period Monthly budget (30 days) (RWF)	Year Budget (365 days) (RWF)	January-December US$ per year 700.00
Meals 1 and 2 to be served between 6 a.m. and 12 p.m. (Breakfast and lunch)						*Soft food and drinks*	
Maize	30	Kg	450	13,500	405,000	4,927,500	7,039
Sorgo	30	Kg	500	15,000	450,000	5,475,000	7,821
Sugar	15	Kg	700	10,500	315,000	3,832,500	5,475
Bread	200	Pack of 10	400	80,000	2,400,000	29,200,000	41,714
Fish/meat 4 Soup	8	Kg	2,300	18,400	552,000	6,716,000	9,594
Vegetable 4 Soup	10	Kg	800	8,000	240,000	2,920,000	4,171
Potatoes 4 Soup	6	Kg	200	1,200	36,000	438,000	626
Milk	100	liters	400	40,000	1,200,000	14,600,000	20,857
Special diet prevision	4	Kg	800	3,200	96,000	1,168,000	1,669
Sub-total ($)				186,600.00	5,598,000.00	68,109,000.00	97,299
						Main course	
Rice	100	Kg	900	90,000	2,700,000	32,850,000	46,929
Beans	50	Kg	500	25,000	750,000	9,125,000	13,036
Maize	50	Kg	450	22,500	675,000	8,212,500	11,732
Fish/meat	50	Kg	900	45,000	1,350,000	16,425,000	23,464
Vegetable	80	Kg	800	64,000	1,920,000	23,360,000	33,371
Potatoes	40	Kg	120	4,800	144,000	1,752,000	2,503
Onion	5	Kg	400	2,000	60,000	730,000	1,043
Salt	2	Kg	200	400	12,000	146,000	209
Oil	5	liters	250	1,250	37,500	456,250	652
Special need	10	Kg	800	8,000	240,000	2,920,000	4,171
Fruit (alternate eggs)	30	Kg	1,000	30,000	900,000	10,950,000	15,643
Sub-total				292,950	8,788,500	106,926,750	152,753
							–
Total Meals 1 and 2				479,550	14,386,500	175,035,750	250,051
Meal 3 to be served between 5 p.m. and 7 p.m.						*Soft food and drinks*	
Maize	15	Kg	450	6,750	202,500	2,463,750	3,677
Sorgo	15	Kg	500	7,500	225,000	2,737,500	4,086
Sugar	7	Kg	700	4,900	147,000	1,788,500	2,669
Sugar 2 (tea)	5	Kg	700	3,500	105,000	1,277,500	1,907
Milk	40	liters	400	16,000	480,000	5,840,000	8,716
Special diet prevision	5	Kg	800	4,000	120,000	1,460,000	2,179
Sub-total				42,650	1,279,500	15,567,250	23,235
						Dinner aspect of the meal	
Rice	100	Kg	800	80,000	2,400,000	29,200,000	41,714
Beans	50	Kg	500	25,000	750,000	9,125,000	13,036
Maize	50	Kg	500	25,000	750,000	9,125,000	13,036
Fish/meat	50	Kg	2,300	115,000	3,450,000	41,975,000	59,964
Vegetable	80	Kg	800	64,000	1,920,000	23,360,000	33,371
Potatoes	40	Kg	120	4,800	144,000	1,752,000	2,503
Onion	5	Kg	400	2,000	60,000	730,000	1,043
Salt	2	Kg	200	400	12,000	146,000	209
Oil	5	liters	250	1,250	37,500	456,250	652
Special need	10	Kg	800	8,000	240,000	2,920,000	4,171
Fruit	30	Kg	1,000	30,000	900,000	10,950,000	15,643
Sub-total				355,450	10,663,500	129,739,250	185,342
Total				398,100	11,943,000	145,306,500	207,581
Shared and fixed cost: energy + water + electricity+ work force transport and delivery + maintenance and others							
Cooking wood (energy)	40	Load	720	28,800	864,000	10,512,000	15,017
Electricity	60	Units	132	7,920	237,600	2,890,800	4,130
Water	30	m^3	400	12,000	360,000	4,380,000	6,257
Cook/Staff/Help	10	Main hour	3,000	30,000	900,000	10,950,000	15,643
Delivery/Collection	80	Km	1,030	82,400	2,472,000	30,076,000	42,966
Management: Chef + 2 Sup.	3	Main hour	10,000	30,000	900,000	10,950,000	15,643
Waste collection	1		3,500	3,500	105,000	1,277,500	1,825
Cleaning and maintenance	1		10,000	10,000	300,000	3,650,000	5,214
Total shared cooking cost				204,620	6,138,600	74,686,300	106,695
Total all cost inclusive				1,082,270	32,468,100	395,028,550	564,327
Miscellaneous, Market price change and others of 5%				54,114	1,623,405	19,751,428	28,216
Grand total				1,136,384	34,091,505	414,779,978	592,543

(*continued*)

Downloaded by Namibia University of Science and Technology At 01:11 05 February 2019 (PT)

Downloaded by Namibia University of Science and Technology At 01:11 05 February 2019 (PT)

Table II

Overall Gemura food for all financial need				
*1 MS Gemura kitchen construction cost	RWF 237,534,112	$339,334		
Raised	RWF 3,500,000	$5,000		
Needed	RWF 234,034,112	$334,334		
*2 Kitchen equipment	RWF 60,200,000	$86,000		
Total kitchen construction need (*1 + *2)	RWF 294,234,112	$420,334	Capital expenditures	
Total cost to feed patients in Year 1	RWF 414,779,978	$592,543		
Gemura Project total financial need	RWF 709,014,090	$1,012,877		
		Assumptions		
	Selling price per meal	RWF 1,000	$1.43	
	Selling days	365		
	Minus weekends	104		
	Minus public holidays	14		
	Total	247		
	Capacity of kitchen	9,000		
	For patients	3,000		
	For selling	6,000		
		Income via selling per year/ Capacity		
	100	RWF 1,482,000,000	$2,117,142.86	
	80	RWF 1,185,600,000	$1,693,714.29	
	60	RWF 889,200,000	$1,270,285.71	
	40	RWF 592,800,000	$846,857.14	
	20	RWF 296,400,000	$423,428.57	
		Fixed costs per year		
	Fix costs (food)/Cost per meal (food)	RWF 106,781	$152.54	
	Fixed costs for 9,000	RWF 753,901,350	$1,077,001.93	
	Minus 10 per cent for quantity buying	RWF 678,511,215	$969,301.74	
	Variable costs	per day (for 3,000)	per year (for 3,000)	per year (9,000)
Increased	Cooking wood (energy)	RWF 28,800	RWF 10,512,000	RWF 21,024,000
Increased	Electricity	RWF 7,920	RWF 2,890,800	RWF 5,781,600
Increased	Water	RWF 12,000	RWF 4,380,000	RWF 13,140,000
Increased	Cook/Staff/Help	RWF 30,000	RWF 10,950,000	RWF 32,850,000
Strongly increased	Delivery/Collection	RWF 82,400	RWF 30,076,000	RWF 90,228,000
Equal	Management: Chef + 2 Sup.	RWF 30,000	RWF 10,950,000	RWF 10,950,000
Increased	Waste collection	RWF 3,500	RWF 1,277,500	RWF 2,555,000
Increased	Cleaning and maintenance	RWF 10,000	RWF 3,650,000	RWF 7,300,000
Maintenance increased over the years				
			Variable costs for 9,000 meals	*RWF 183,828,600* *$262,612*
		Total costs (9,000 meals per year)		RWF 862,339,815 $1,231,914

Source: Case authors' own

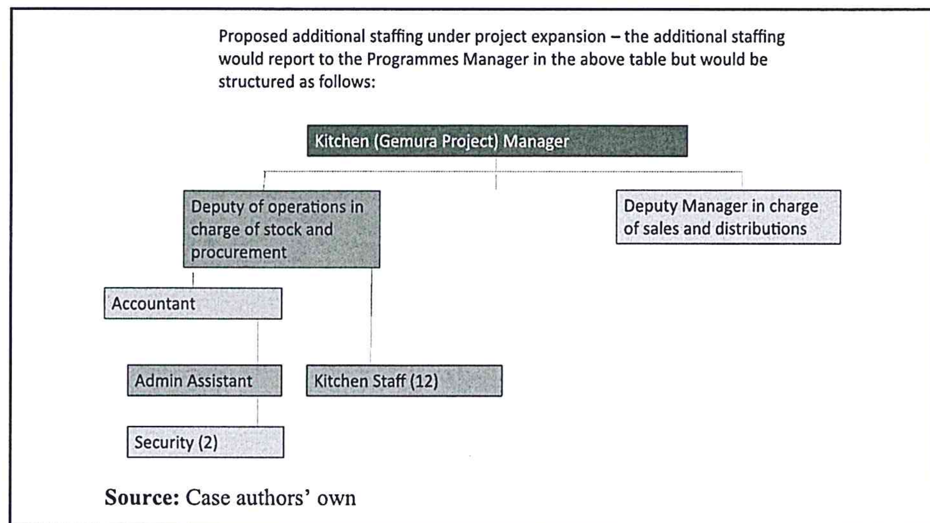
Solid Africa plans to build the industrial kitchen on land donated by the city of Kigali to Solid Africa. It will be located next to fields where a wide range of crops is cultivated, enabling the daily meals to contain fresh and organic ingredients.

Financial plan

The CFO, Ms Kamariza's sister, has prepared a financial plan shown in Table II. She subdivided the costs in three different parts:

1. Meals 1 and 2, which should be served at 6.00 a.m. and 12.00 p.m. They include breakfast and lunch. The cost of the ingredients is highlighted in the table.

Figure 2 Organizational chart of the industrial kitchen project



Source: Case authors' own

2. Meal 3, served between 5.00 p.m. and 7.00 p.m. includes dinner and the table highlights the cost of the ingredients.
3. And the third section accounts for utilities and operational costs. This section includes: water, electricity, wages and delivery costs.

Figure 2 presents an overview of additional staffing needed for Solid Africa to implement the industrial kitchen project. The additional workforce, i.e. 1 procurement manager; 1 accountant, sales and distribution manager; 1 administrative assistant; 12 kitchen staff; and 2 security guards, would report directly to the program manager.

The project would require a total of over US$1.2m as a start-up cost. The CFO's role is now to develop a concrete financial plan to realize the project. The contributions fund the everyday operations of the NGO, including feeding the patients, making promotional items for the NGO and organizing fundraising events. But the number of patients is growing fast. The member contributions are not mandatory.

The CFO has the option to save the contributions until the required investment is reached to build the industrial kitchen for the NGO to be financially sustainable (this would mean that it would curtail or temporarily halt its social mission of feeding patients, hence sacrificing the patients' well-being) or use external financing.

Keywords:
Social enterprise,
Financing/borrowing,
Management accounting/
corporate finance

About the authors

Lionel Muziramakenga is Research Assistant at the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP), and an MBA Student at Webster Private University, Vienna, Austria. Lionel Muziramakenga is the corresponding author and can be contacted at: lionel.muzira@gmail.com

Dr Masato Abe is Research Fellow at Thammasat Business School, Bangkok, Thailand.

Prof James Landi, PhD and CFA, is MBA Lecturer at Webster University, Thailand.

Downloaded by Namibia University of Science and Technology At 01:11 05 February 2019 (PT)