Review of the new coordination set-up in Haiti

Chatuley Hospital, Leogane

EVALUATION REPORT

NOVEMBER 2014

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Evaluator:

Annie Desilets

MANAGED BY THE VIENNA EVALUATION UNIT

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Acknowledgements

A very warm note of appreciation to the entire team in Haiti, but especially the persons in Leogane who welcomed me and shared their thoughts and experiences candidly during a very difficult phase of the project. A special thank you to the great team in Port-au-Prince for their support and flexibility in making this evaluation happen. Finally, the flexibility of those individuals in OCG headquarters who made time for long-distance interviews and who showed engagement and commitment to the evaluation is always essential and much appreciated. This report would not have been possible without the openness and dedication of all those involved; thank you.

1 Introduction

1.1 Background

Following the earthquake in 2010 and the emergency response that ensued, MSF-OCG took the decision to invest in a hospital in the Leogane area that was for several years the biggest hospital managed by MSF-OCG. Given that for the last three years this was the only MSF-OCG project in the country, that the capital is located only two hours from the hospital and that there is a strategic ambition within MSF-OCG to review mission set-ups, OCG and the field teams determined that 2013 was an opportune time to review the Haiti mission.

After approximately six months of discussions and negotiations, a steering committee located in Geneva designed, in collaboration with the field teams, an organisational structure for the Leogane hospital based on the Haitian hospital structures and derived from standard European or North-American models of hospital management. Consequently, the new set-up saw the reduction of size and configuration of the coordination team in the capital. In addition to the new management set-up, the operational Cell responsible for Haiti decided to phase out the hospital by the end of 2015.

On a more practical level, the changes to the set-up comprised all aspects of coordination and governance; communication flow, decision making lines, reporting system and job descriptions to give a few examples.

This is the first of a two-phased approach to the evaluation of the effectiveness and efficiency of the new set-up. The overall objective of the review is to reassure stakeholders of the feasibility of such a model, and to extrapolate lessons learnt for use in other missions that attempt a new set-up. The main objective of this portion of the review is to assess the functioning of the new set-up and propose corrective measures and/or recommendations for improvement. The second phase is proposed for April 2015.

1.2 Process and methodology

The assessment included:

- Interviews with current MSF key players such as directors, responsible for departments, managers and hospital/administrative/logistic staff
- Field visit to the project site from 25 October 2014 to 1 November 2014
- Attendance of the hospital management committee meeting and team meeting
- Review of governance documents, organisation charts, job profiles and other key project documents

Various forms of interviews were conducted such as one-on-one interviews, focus groups and group interviews depending on the circumstances and availability.

1.3 Limitations

There are some important factors to consider when reading this assessment, which may have had a significant impact on explaining some of the threats and weaknesses of the current implementation.

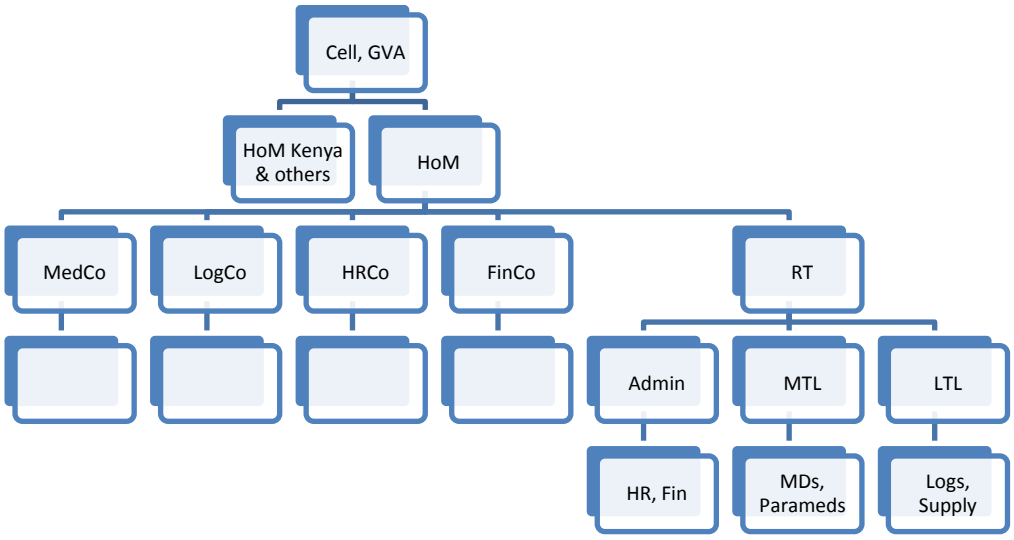
- The role of the Director General was impaired due to health issues of the incumbent.
- The Chatuley Hospital was hit by a wave of Chikungunya in May, which incapacitated 80% of the hospital staff (including expats).
- The administrative team saw many gaps in the initial phase of the set-up; especially the HR Responsible position, which was filled sporadically with three individuals in four months, and large gaps between incumbents.
- The team of directors was not at full capacity until June.
- There were many changes of staff at the Cell/Desk level.

2 Findings

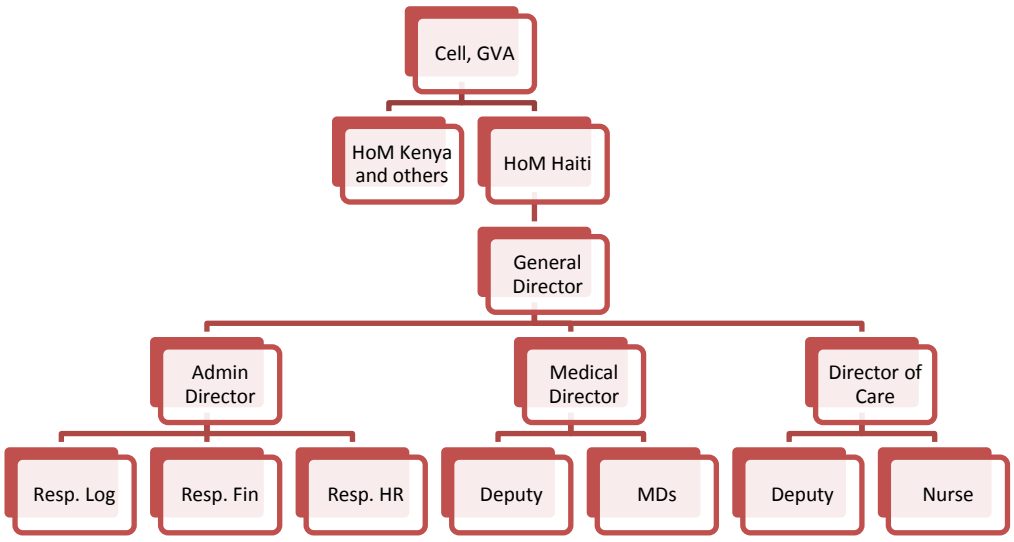
This report summarises observations during the field visit and findings from interviews. It describes current strengths, threats, opportunities and weaknesses.

2.1 The change in organisational design

Before



After



The changes in the organisational structure (practically):

- Removal Reduction of coordination positions in the capital, HoM and the national staff support team remain
- Creation of hospital management and hospital direction committees
- Medical and paramedical departments represented at the same hierarchical level
- Support services (Log/Fin/HR) grouped under one director

2.2 The benefits of the new structure[1]

- The project has a more direct line of communication with the Cell (bypass the "traditional coordination")
  - For example, the LogResp can communicate directly with the RLO at desk level technical questions while keeping the DirAdmin informed (i.e.: by copying them on the email).
  - In a standard structure, the Field log must communicate with the RLO through the Logco, sometimes causing delays in the provision of information.
- Decisions are made through committees, not individuals (CDH/CGH)
  - Decreases the likelihood of one person hijacking/derailing the objectives
  - Role of HoM as sober second thought, with an "external" view should keep the project in line with PoA objectives
- Implementation strategy developed and managed by the project
  - Faster response to concerns/issues of the project
- Streamlined decision-making process
- Equal representation of services
  - Provides a better overall view that informs decision-making
  - Feeling of inclusion, concerns are heard
- Can be used as a training (stepping stone) for those field HR/Fin/Log to become coordinators

2.3 The (currently experienced) threats to the new structure

- Lack of appropriate competencies of human resources
  - The capacity of many individuals to "manage" effectively and efficiently is insufficient; this resulted in the hospital directing team not fully internalising their decision-making power, pushing this responsibility back up to the Cell.
  - Competencies needed for Directors are different than current recruitment provides.
  - There is little capacity building strategy within MSF-OCG to assist managers with this insufficiency.
- Lack of appropriation of the structure by the directors and supporting staff

[1] The benefits were derived from the governance document and observations.

  - Individuals are more comfortable with the "known" structure and fall back to that way of functioning.
- Gaps in human resources do not allow individuals to fulfil their responsibilities.
  - In a traditional set up, coordination team members can fill gaps temporarily; with the reduction of the coordination, this is no longer the case, leaving the project more vulnerable when there are gaps.

2.4 Opportunities of the current implementation

- Buy-in of the directors is very high and can be capitalised to work towards an efficient structure.
- Change-over of key staff (General Director and Log) gives the opportunity to put a strong leader in place, preferably until the end of the project.
- Newly arriving expats have been appropriately briefed on the new set-up.
- Many expats arrived after the set-up was in place, giving the opportunity to capitalise on the buy-in.
- Timely recruitment of key positions (directors and support responsibles – Log/HR/Fin) to give directors opportunity to focus on their roles

2.5 The (currently experienced) weaknesses of the implementation

Support (Cell and project level)

- The risks that were identified at the onset were not mitigated. (Resistance by existing expat team, coaching needs of the Medical Director, complexity of making three changes concurrently – new set-up, reduction of coordination team, disengagement – and no one identified for the position of Admin Director)
- Lack of *accompagnement* through this change process towards a new set-up and disengagement (coaching, mentoring, project & change management).
- The key to successful project and change management is the capacity of the executive team to provide leadership and management of these projects and changes. Lack of knowledge of, capacity and leadership of change management at all levels left the implementation of the new set-up and other changes vulnerable and more susceptible to errors and breakdown.
- Lack of communication at all staff levels about the project and roles has left staff unsure of the reasons for changes.

Recommendation

⇒ The Hospital Direction Committee should create and implement a communication strategy to reiterate the reasons for the change in structure and its benefits, to explain the roles and responsibilities of the new positions and to review the chronology of the disengagement – at all levels, including Port-au-Prince.

⇒ The General Director, in collaboration with the Medical Director, should design a coaching proposal for the Medical Director to strengthen his competencies and abilities as a manager and give him legitimacy in the eyes of expats and national staff.

⇒ The Cell should assign an individual responsible at HQ level to provide guidance and to monitor the implementation of the accepted recommendations and of the disengagement process to avoid derailing.

⇒ At an organisational level, OCG as a whole should develop and implement a strategy to strengthen leadership capacities of the management teams at all levels.

Clarity of roles

- Lack of clarity of roles in practice (especially General Director and HoM, but also between Admin Director and support services)
- Leaving existing staff in place with different positons – it was difficult for experienced MSF staff to accept a different line of authority (for example, Log Resp. communicating with General Director or HoM directly).
- The roles and responsibilities for the staff in Port-au-Prince were not developed, thought through enough or reviewed, which produced a feeling of uncertainty and abandonment.

Recommendation

⇒ Implement, as a team project at field level, a review of the job profiles of the top eight positions (HoM, General Director, Medical Director, Director of Care, Admin Director, RespLog, RespRH, RespFin) to clarify the roles and responsibilities of each position. Communicate any changes to staff at all levels. This would preferably be done before the departure of the Admin Director and RespFin)

⇒ The HoM, General Director and Admin Director, in collaboration with the national staff in Port-au-Prince, should review the PaP roles and responsibilities.

Meetings / reporting

- A meeting schedule was developed, but poorly actualised, which left the team feeling uninformed about decisions and not consulted on their issues.
- Some team members (at the "responsible" level and below) voiced a concern that they had lost much of their influencing power because there was no forum for them to be heard.
- Reports (for example, minutes of CDH) were not provided to HoM, which did not allow for appropriate support.
- Reporting mechanisms (dashboard, quarterly reports) to inform project decisions and feedback to Geneva were never developed or maintained.

Recommendation

⇒ The directors should lead the review and ensure the adherence to the meeting schedule (*tableau de reunions*) in order to create a space for everyone to share ideas and to explain decisions and operational strategy.

⇒ The project team should design, implement and monitor a reporting structure. These reports are not to feed the information to the HQ, but rather to maintain project knowledge and inform decisions.

3 Conclusion

The concept of this new set-up is well elaborated and appears appropriate for the hospital and mission in Haiti. It clearly provides an opportunity for a hospital to gain greater autonomy and become more efficient in responding to the needs of the implementation of the strategy, which in turn can only benefit the patients.

The decision to enact three major changes concurrently (reduction of coordination team, change in set-up and withdrawal from Chatuley) was a conscious decision by the Cell, the steering committee and field team. However, it is evident that the appropriate measures to mitigate the impact of this risk were not put in place at all levels.

- Lack of a formalised project plan for the implementation of the new set-up
  - Timelines, milestones, responsibilities, monitoring, auditing etc.
- Lack of *accompagnement*
  - assigning a project manager
  - developing training plans for the “new” director positions
  - field visits by the Cell or the steering committee members
- Lack of a formal communication strategy

The consequences of this insufficiency in planning are the main reasons for the challenges faced by the new set-up. The tangible outcomes include confusion about the roles and responsibilities of the new positions, the incompletion of some key tasks (such as developing a reporting framework) and that some positions struggle to gain legitimacy.

Though sincere efforts were made to put this new set-up in place, the process was hampered by HR gaps, the difficulty the team had in appropriating the new autonomy, the uncertainty of roles and the lack of *accompagnement* by HQ.

As the project still has at least eight to nine months before the closure, now is the opportune time to make the above changes. Appreciating that some changes can be made quickly and easily (e.g. review of job profiles, re-establishing meeting schedules), it is also understood that some changes will require effort and guidance (e.g. risk mitigation strategy, communication strategy). For this reason, the role of project manager is an essential one to ensure the success of the new set-up.

4 Annex

4.1 Terms of reference

Terms of reference for the review of the new coordination set-up in Haiti

Commissioned by	Cell 2, Kenneth Lavelle & Monica Rull
Duration of evaluation	4 – 6 weeks (20 days)
Time period that is evaluated	from April to October 2014.
ToR elaborated by	Kenneth Lavelle, Isabelle Voiret, Sabine Kampmüller, Monica Rull

1. CONTEXT

Following the earthquake in 2010 and the emergency response that ensued, MSF OCG took the decision to invest in a Hospital in the Leogane area that was for several years the biggest hospital managed by MSF OCG. Given that for the last 3 years this was the only MSF OCG project in the country, that the capital is located only 2 hours from the hospital and that there is a strategic ambition within MSF OCG to review mission setups, it was decided in 2013 to have a complete review of the Haiti mission.

The three main elements of change were as follows: the implementation of a new Hospital Management System, a reduction in the volume of activities in advance of the closure scheduled for the end of 2015 and a consequential reduction in the size and configuration of the coordination team in the capital. On a more practical level these changes comprised all aspects of coordination and governance; Communication flow, decision making lines, reporting system and job descriptions to give a few examples.

2. OVERALL OBJECTIVE and PURPOSE

The main objective of the review is to assess the new functioning and propose corrective measures and/or recommendations for future improvement.

The purpose is to reassure stakeholders, extrapolate lessons learnt for use in other missions that attempt a new set-up and if necessary to modify the current setup to facilitate the smooth closure of the hospital and mission in 2015.

3. KEY EVALUATION QUESTIONS

1) Describe main changes to and advantages / disadvantages of the mission set up since April 2014, especially in terms of:
   a) Implications of the changes on key positions (HoM, newly established hospital directors, persons responsible for technical departments, cell members in Geneva). It will also be important to have the opinions of members of the FOROP who followed the implementation.
   b) Implications for matching of international staff, to also understand the perceived increased in susceptibility of this new setup to gaps.
2) How effective is the new set up in terms of
   a) Communication flow
   b) Decision making lines
   c) Reporting system

3) How efficient is the new set up as compared to the previous in terms of HR requirements, staff related costs and office expenses; taking into account parallel changes in the mission (i.e. reduction of activities).
4) What were the identified risks and how were the managed?
5) What are the lessons learnt from the change process?

4. EXPECTED RESULTS and INTENTED USE OF THE EVALUATION

Concise report of 20 pages max, including recommendations for imminent adaptions before handover and lessons learnt for similar change processes.

5. PRACTICAL IMPLEMENTATION OF THE EVALUATION

Field visit asap (in Oct) with interviews of staff in key positions, hospital staff representatives, etc. Due to the need to go ASAP before some key staff leave, a second visit can be considered.

Review of all relevant documents (to be provided where possible in advance).

Interviews with HQ staff (Cell, FOROP, DirMed).

Duration: 4 weeks.

6. DOCUMENTATION FOR READING

A dossier to be prepared by the Cell in advance.

7. JOB PROFILE/S of EVALUATOR/S

One evaluator with a background in management and sound knowledge of MSF.

Fluent French speaker, evaluation skills.

4.2 List of interviewees

Head Quarters

Kenneth Lavelle	Deputy Programme Manager
Isabelle Voiret	Medical leader of health services

Port-au-Prince

Yves SONNAY	HOM
Kelwens ALCENAT	Logisticien
William LAMOTHE	Chargé Finance
Ruth Shamma PIERRE LOUIS	Chargée RH

Leogane

Dr Adélaide OUABO	Directeur Général
Théodore WANTEU	Directeur Administratif
Dr. Erneau MONDESIR	Directeur Médical
Ankhasanamen SOW	Directeur des Soins
Roselène LOUIS-CHARLES	Adjoint Directeur des Soins
Makan DIARRA	Responsable Finance
Jules André DUCE	Finance Manager
Florence STERVINOU	Responsable RH
Chavane Edner CADET	RH Manager
Adrien GARRIT	Responsable Logistique
Juste MERCILIEN	Log Manager
Chika MURAKAMI	Midwife Supervisor
Marie Carmel DUCLERVIL	Warehouse Manager
Rapahel Ulerich	Médecin Pediatrie