Hospital Management Review

Publication date: March 2017
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Acknowledgements

We would like to extend our warmest thanks to the coordination and field teams who, sometimes under short notice, graciously welcomed us and made this evaluation possible. Thanks also go out to the all those individuals in Geneva who made time and engaged in this evaluation. A very special thank-you to Nadja Degro, Barbara Hessel and Thibaud Eudes for their advice, guidance and expertise.

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# Table of contents

Executive summary .................................................................................................................................................. 1
Acronyms ............................................................................................................................................................... 6

1. Introduction .......................................................................................................................................................... 8
   1.1 Background ................................................................................................................................................... 8
   1.2 Methodology ............................................................................................................................................... 9
   1.3 Limitations ............................................................................................................................................... 10

2. Findings ............................................................................................................................................................... 12
   2.1 Emergency, mid- and long-term management ......................................................................................... 12
   2.2 Hospital management experienced in MSF......................................................................................... 14
   2.3 Hospital management in emergencies ................................................................................................. 15
   2.4 Hospital management and quality of care ......................................................................................... 16
   2.5 Human resources ................................................................................................................................... 19
      2.5.1 The organizational design ............................................................................................................. 19
      2.5.2 The right competencies ............................................................................................................... 21
      2.5.3 Continuity of international staff ................................................................................................. 22
      2.5.4 Capacity building (learning and development) ........................................................................... 23
   2.6 Assessment / Planning / Vision ............................................................................................................... 25
   2.7 Construction / Rehabilitation ................................................................................................................. 26
   2.8 Working with the MoH ............................................................................................................................ 27
   2.9 MSF and the national health system ...................................................................................................... 29
   2.10 Support to the projects ......................................................................................................................... 31

3. Conclusion and discussion .................................................................................................................................. 33
   3.1 Hospital Management Platform in OCG ............................................................................................ 33

4. Recommendations ................................................................................................................................................ 38

5. Annexes ............................................................................................................................................................. 41
   5.1 Terms of Reference ................................................................................................................................. 41
   5.2 List of interviewees .................................................................................................................................... 45
   5.3 Reports / case studies .............................................................................................................................. 47
   5.4 References ................................................................................................................................................ 48
Executive summary

In the last few years, MSF OCG has developed an Operational Policy with the ambition to increase and improve the quantity and quality of secondary health care structures (or inpatient care). This recognition has prompted the organization to take a closer look at the challenges, lessons and accomplishments in terms of hospital management to develop strategies that will enable the organization to successfully set up, govern, implement and exit inpatient projects in all types of contexts.

The Hospital Management Review was extremely well received throughout the various layers of interviews; from the directors at the headquarters to the hospital managers of the MoH working with MSF in projects. OCG, while providing a higher standard of care for patients, must also contribute at a higher level to the management of the hospitals in which they intervene. There are some exemplary projects where the organization has attempted to introduce new ways of working and approaches that, in the long term, can yield some very positive results. The trial of a new hospital set-up in Haiti and the “integrative” approach at the Bol hospital in Chad are cases in point.

More detailed findings can be found throughout the report, but the terms of reference of this review wanted to uncover broad trends that can inform how to facilitate the institutional support of OCG to the biggest challenges of the management of hospital structures. There are five overarching themes that were uncovered during the review.

The first theme includes the ways in which MSF engages in hospital management. This includes how OCG perceives its role, how others perceive OCG’s role in hospital management; the different phases of projects (emergency, regular and exit), the size and complexity and how hospital management affects the quality of care. The conclusion is at this point in time, hospital management is a side effect of in-patient or secondary care interventions. Hospital management does not drive the process, it happens as a consequence of the intervention. The issue is that hospital management becomes a reactive process instead of a pro-active one, leaving the project teams continuously working in an “emergency” mode, putting out fires.

The second theme is human resources. MSF-OCG has a pool of very motivated and dedicated international and national staff, who are excited about the work and the contribution they make. There are some constraints, however, that are more acute in secondary health care setting and especially post-emergency. These include the difficulty associated with high turnover of international staff; the lack of knowledge and competencies required, at all levels, in hospital management; and the difficulties in managing a hospital without the appropriate team set-up.

The third emerging theme comprises how the planning cycle affects the ways hospital management is viewed, which includes developing a vision for the project and conducting assessments. In the last few years, OCG has made a terrific effort to design projects with a three-year outlook (many of the projects visited). This has allowed much more flexibility in developing the strategies and needed resources. One of the findings from the projects is that the three-year cycle stays stuck at the initial three years. There does not seem to be a re-evaluation of the finality of the project. For example, Bol has a three-year plan that “expires” end of 2018, but realistically, the project will continue for an additional two years. Furthermore, the project and country often continue to revolve around the yearly plan of action and are often too rushed to conduct the appropriate assessment.

This leads to the fourth theme of construction and rehabilitation of secondary health structures. These are often projects of considerable size and resources. OCG has made considerable progress with the logistics team in Geneva, which now includes an architect and a plan to hire a project manager. Additionally, in the project many times an experienced construction logistician is deployed
to see through the undertaking. These are very helpful initiatives, but there are some bottlenecks in the process. Some report considerable delays in the starting and completion of the process (up to one year in Bol, for example) due to the lack of “ownership” of the construction project and because of the continuous input from diverse experts with different needs and wants. Also, the tools for conducting needs assessment are not standardized and many construction logisticians rely on tools that they have used in other missions, often with other operational centres, which may not always give a comprehensive assessment of the needs.

The final theme relates to the difficulties in working with the Ministry of Health within an existing health system. There are some very constructive initiatives, like training and development of the MoH and national staff; knowledge that will hopefully remain after the departure of MSF. But, in projects where OCG intervenes in only a few services or departments of the hospital, what exactly it means to do hospital management becomes very unclear. One of the observations is that in these situations OCG tends to manage departments (the ones where they intervene), but do not engage in the hospital management, even though they have a huge impact on it; this aspect is left to the MoH to manage. However, in most of the interventions with the MoH, one of the objectives is for OCG to try to ensure continuity of care after they leave. The best way to ensure this objective is reached is to engage with the MoH in a genuine partnership, as difficult and time-consuming as it can be.

There are many positive lessons and constructive initiatives, but there is also work to be done to ensure competent and adequate human resources, improve processes, develop appropriate and pertinent systems and tools, and build solid genuine relationships for the teams to provide the best possible care and patient safety. It will be an interesting challenge for OCG to provide the required and relevant support to field teams. There are recommendations throughout the report, but the objective was to develop a proposal for a Hospital Management Platform. After reviewing the schemes and programmes that other operational centres had implemented, it is strongly recommended to have a Hospital Management Platform taskforce; a transversal, multi-disciplinary team, led by a programme manager.

This team would link the project teams, the country management teams, the cells and operations. They would be a group of subject matter experts who would assist, lead, guide, direct, negotiate, mediate and ensure the implementation of any aspect of hospital management. This can be developing an initial assessment strategy to build a new hospital, help a project develop a comprehensive exit strategy, coordinate and build the tools required to ensure monitoring and evaluation of quality of care, coordinate the development of standards for hospitals, and so on. This team would orchestrate and coordinate whatever is required for OCG to contribute to hospital management meaningfully.
Table 1: Answering the ToR questions and recommendations

<table>
<thead>
<tr>
<th>Successes</th>
<th>Constraints / Bottlenecks</th>
<th>Phases</th>
<th>Size / Complexity / Peaks</th>
<th>Standards</th>
<th>HR</th>
<th>Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>This initiative is seen by everyone as being a very positive step towards better outcomes for patients</td>
<td>The lack of guidance, support from HQ (accompaniment, change management)</td>
<td>Lack of thorough needs assessment prior to opening a project and throughout the project life cycle.</td>
<td>The size has little impact on the management structure</td>
<td>Implementing MSF standards makes it difficult to handover activities (free care, drugs, protocols)</td>
<td>The competencies of individuals are not maximized</td>
<td>Very few tools are currently used</td>
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<td>The willingness, at all levels, to try new approaches and new organizational designs</td>
<td>HR constraints such as high turn-over, inadequate matching, gaps in international positions</td>
<td>PoA cycle limits the long-term vision for projects</td>
<td>The complexity, number of services supported has a direct impact on how the org. design of the hospital mgmt. team should be laid out</td>
<td>Perception that MSF is disrupting the existing system</td>
<td>High turn-over and gaps</td>
<td>No comprehensive standards for hospitals</td>
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<tr>
<td>Three-year planning cycles</td>
<td>Lack of professional hospital management knowledge</td>
<td>Exit strategies are almost never developed at the beginning of a project</td>
<td>Peaks normally would not influence the org. design (Niger may be an exception)</td>
<td>Definition of standards is not comprehensive</td>
<td>Lack of professional hospital management knowledge</td>
<td>No systematic assessment tools to determine needs to inform the project</td>
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<td>Construction logs</td>
<td>Lack of tools</td>
<td>Lack of planning in the hand over from “emergency” to “regular” phase</td>
<td>Seasonal recurring peaks such as malaria or hunger are not always planned for</td>
<td>Training plans not always comprehensive</td>
<td>Existing tools are not easily accessible or not known</td>
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<td>Technical training and development of staff (national and MoH)</td>
<td>Difficulty developing partnerships with the MoH</td>
<td>Lack of clarity around different phases / stages</td>
<td>Impact of training not measured</td>
<td>No guidance on how and when to use tools and which tools should be standard</td>
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<td>Medical care is given to all patients</td>
<td>Lack of clarity on meaning of integration in an existing health system = creating a system in the system</td>
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<td>Mentoring and coaching seen as a positive initiative</td>
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<td>Hospital management trainings needed</td>
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<td>Main recommendations to enhance hospital management in OCG</td>
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<td>➢ MSF should acknowledge the various types of projects (emergency, post-emergency, early recovery) or phases (short-, long-term, exit) of projects and define them to create clarity around which management tools / methods / resources to use.</td>
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<td>➢ When engaging in secondary health care, MSF should conduct a thorough risk analysis for the entire hospital.</td>
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<td>➢ MSF should scale up the level of hospital managerial know-how and practices of the organization.</td>
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<td>➢ When making a shift in the management structure of their hospital projects, it is strongly recommended to make this shift happen gradually with a change management plan that would include ensuring the new positions are filled with persons who have the appropriate competencies.</td>
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<td>➢ OCG should consider restructuring the existing positions, reviewing the current profiles and adapt roles for organizational designs more compatible with hospital management in different contexts.</td>
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<td>➢ OCG should put targeted effort in the recruitment of individuals who already have hospital management competencies.</td>
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<td>➢ Effort should be done to develop the tools to evaluate the impact of trainings. It is equally important to measure the impact as the training itself.</td>
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<td>➢ Context specific needs assessment should be more comprehensive to answer the requirements of the population and to ensure that the construction plans are fit for purpose.</td>
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<td>➢ MSF should have a dialogue and formal agreement with the partner organization about their common objectives. This includes developing a robust framework around the definition of clear objectives and measurable outcomes with the partner – not for the partner.</td>
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<td>➢ MSF should consider developing strategies to overcome the difficulties placed by implementing higher standards (including free care) while compromising MSF’s principle as little as possible.</td>
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Acronyms

Admin  Administrator
DN     Directeur de Nursing (paramedical director)
DRC    Democratic Republic of Congo
E-Cell Emergency Cell
EoM    End of Mission
Explo  Exploratory Mission
FC/ FieldCo Field Coordinator
Fin    Finance
FinCo  Financial Coordinator
ForGHo Formation Gestion Hospitalière
HC     Health Centre
HGR    Hôpital générale de référence
HIS    Health Information System
HMTT   Hospital Management Team Training
HoM    Head of Mission
HP     Health Promotion
HQ     Head Quarters
HR     Human Resources
HrCo   Human Resources Coordinator
ICU    Intensive Care Unit
IEC    Information, Education, Communication
INGO  International Non-Governmental Organization
IPD   Inpatient Department
ITFC   Inpatient Therapeutic Feeding Centre
Lab    Laboratory
L&D    Learning and Development
Log    Logician
LogCo  Logistic Coordinator
Logframe Logical Framework
LRRD   Linking Relief, Rehabilitation and Development
MAM   Medical Activity Manager
MD    Medical Doctor
MDH   Médecin Directeur d’Hôpital
MedCo  Medical Coordinator
MoH   Ministry of Health
MOSU  Medical-Operational Support Unit
MoU   Memorandum of Understanding
MSF   Médecins Sans Frontières
MTL   Medical Team Leader
NAM   Nurse Activity Manager
NS    National Staff
ObGyn Obstetrician Gynecologist
OC    Operational Centre
OCA   Operational Centre Amsterdam
OCB   Operational Centre Belgium
OCBA  Operational Centre Barcelona
OCG   Operational Centre Geneva
OCP   Operational Centre Paris
OPD  Outpatient Department
OT   Operating Theatre
Paeds Paediatric
Pharma Pharmacy
PHC  Primary Health Care
PoA  Plan of Action
QoC  Quality of Care
ROI  Return on Investment
SHC  Secondary Health Care
SMART Specific, Measurable, Appropriate, Relevant, Time-bound
SUSI Soins Urgents et Soins Intensifs
SWOT Strength Weakness Opportunities Threats
TechLog Technical Logician
TMT  Team Management Training (TMT)
ToR  Terms of Reference
ToT  Training of Trainers
UNHCR United Nations High Commission of refugees
UNOCHA United Nations Office for the Coordination of Humanitarian Affairs
WatSan Water and Sanitation
WHO  World Health Organisation
X-ray Energetic Frequency Electromagnetic Radiation
1. Introduction

1.1 Background

In the last few years, MSF-OCG has developed an Operational Policy with the ambition to increase and improve the quantity and quality of secondary health care structures (or inpatient care) either as support to the Ministry of Health or fully ran by MSF. In fact, over the last four years, there was an average of 70,000 admissions per year in secondary health care (SHC) facilities. This recognition has prompted the organization to take a closer look at the challenges, lessons and accomplishments in terms of hospital management in order to develop strategies that will enable the organization to successfully set up, govern, implement and exit inpatient projects in all types of contexts.

The willingness to increase the number of SHC facilities also challenged OCG to question the adequacy of the institutional support provided to the field teams managing these structures. During this reflection, it became clear that the needs of the field were not fully understood, which made it difficult to develop the necessary tools. This review was commissioned in September 2016 to better understand the successes experienced and challenges faced by the field teams in managing hospitals with the objective of informing the development and implementation of a Hospital Management Platform.

From the Vision 2016-2019 document, the focus is on mission autonomy. This vision is soundly grounded in a competent and capable workforce that understands its role and responsibilities, has clear objectives and the tools necessary to achieve them. Many of the recommendations in this report are aligned with this vision.

To ensure that everyone has the same understanding, a definition based on the ideas and principles gathered during the review is proposed below.

**Hospital management is a multi-disciplinary, integrated approach, which provides the governance on how to lead and administer a medical facility offering secondary services (or inpatient care) with the primary objective of ethically ensuring the best possible quality of care and patient safety.**

This approach operates within a set time frame, allocated resources (human and financial) and established objectives. Planning, analyzing, organizing, guiding, supervising, controlling, monitoring and evaluating these activities are crucial functions of hospital management.

Hospital management, then, should include five components to ensure efficiency:

1. Medical and logistics (non-medical) activities as determined in the project definition (services offered, patient flow, infection control);
2. Financial resources: appropriate budget, control, stewardship, structural investment;
3. Human resources: personnel, labour relations (ROI, contracts, labour laws), supervision and evaluation of all personnel;
4. Information: an exchange of internal and external information to make relevant assessments and decisions; includes accurate data management, ensuring that the community understands the services offered and the hospital provides services based on the understanding of the needs of the population; an accurate understanding of the environment (other actors, national policies, and so on);
5. Time: appropriate scheduling of services (i.e.: 24/7); admission and discharge criteria to maximize bed occupancy rates; appropriate expectations of time required for cure / improve health (ensure patient-centric way of managing health, for example knowing and adapting to
The evaluation and analysis of all data gathered revolves around this definition and tries to look at ways to enact it in the most efficient and effective manner always with the goal to improve patient welfare in mind.

1.2 Methodology

Four hospitals were proposed for the field visits/case-studies: Bol in Chad (integrated); Gety in DRC (substitution); Kousseri in Cameroun (substitution); Nduta refugee camp in Tanzania (100% MSF). These hospitals were chosen because of the diversity in size, length of time in place and management structures.

Each project visited is briefly described below:

**Gety, Democratic Republic of Congo (DRC)**

MSF-OCG began its intervention in Gety Oriental Province, DRC, in 2008 in response to the conflict and displacement. This intervention has changed over the years and to this day includes primary and secondary health care. MSF-OCG is currently working in collaboration with the Ministry of Health (MoH) within the general referral hospital (Hôpital générale de référence - HGR). At the time of the visit, OCG was supporting the emergency and intensive care unit (ICU) and Pediatrics, which includes an inpatient therapeutic feeding centre (ITFC), and neonatology (total of ~62 beds). The end of 2017 will see the planned withdrawal of MSF support from all hospital services and a continued presence in the zone with outreach activities until the end of 2018.

**Nduta, Tanzania**

The increase in arrival of Burundian refugees in Tanzania prompted MSF to start a project in the UNHCR refugee camp in Nduta, Tanzania. The camp opened in September 2015 and the MSF hospital became fully functional in October 2015. MSF is the main medical actor in the camp and is providing primary health care (PHC) and secondary health care (SHC) in four health centres and one hospital. In the hospital, MSF runs a general ward separated in female and male, a paediatric department with a few beds for inpatient therapeutic feeding (ITFC), maternity and isolation ward (totalling approximately 110 beds). The laboratory and pharmacy are supportive departments within the hospital structure and all water and sanitation (WatSan) activities in the hospital are conducted by MSF. The hospital includes an outpatient department (OPD) with an emergency room. Surgical cases or patients in need of more comprehensive care are referred to the Ministry of Health structure outside of the camp in Kibondo hospital.

**Kousseri, Cameroon**

The instability caused by repetitive epidemics, seasonal malaria and peaks of malnutrition due to recurring lean seasons and the insecurity due to the proximity of so-called Boko Haram led MSF to intervene. The current intervention is within Ministry of Health facilities in Kousseri with a project visibility of three years. MSF is supporting primary and secondary health care. The primary health care focuses on children under five years including nutritional care in health centres. Within the hospital, MSF is supporting the paediatric ward and emergency cases for patients up to 15 years old. In addition, MSF is supporting the operating theatre (OT) within the surgical department, focusing on trauma related surgery and emergency interventions.
Bol, Chad

As an answer to a very complicated disengagement in the Massakory Hospital in Chad, and because of the obvious, but neglected needs of the population, MSF-OCG decided for a different way to provide support to a hospital. In Bol, in the Lake Chad Region, MSF engages with the Ministry of Health in an “integrated” approach. The approach is based on a strong component of knowledge transfer and capacity building provided mostly by international staff; it also means that all local staff are hired by the hospital, not MSF, with the objective of advocating for these individuals to be integrated into the public service. MSF does provide more hands-on support in the logistics areas of the hospital by hiring MSF guards, hygienists and water / sanitation staff. There is also a large construction / rehabilitation project underway to increase the space for consultations, improve patient flow and hygiene.

In addition to the field visits, the evaluators considered other reviews conducted, such as the Meta-review of MSF hospital evaluations 2008 – 2012 and the evaluation of the organizational structure in Léogâne, Haiti.

A standard evaluation methodology was designed to answer the evaluation questions elaborated in the Terms of Reference (ToR) (see Annex 4). It included:

- **Document review** of project documents, reports, meta-evaluation of 14 hospitals, and relevant evaluations.
- **Quantitative comparative** analysis of medical data, review of analysis of field visits.
- **Direct observation** of the conduct of hospital management in four projects visited.
- **Key informant interviews** with a total of 111 MSF and MoH key staff, partners and experts.

<table>
<thead>
<tr>
<th>Table 2: Key informants</th>
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<tbody>
<tr>
<td>LOCATION/TYPe</td>
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<tr>
<td>HQ – Advisors, Service heads / directors</td>
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<tr>
<td>Geneva Cells 1, 2, 3, E-cell</td>
</tr>
<tr>
<td>Coordination of 4 projects</td>
</tr>
<tr>
<td>Field – International Staff</td>
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<tr>
<td>Field – National Staff</td>
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<tr>
<td>MoH</td>
</tr>
<tr>
<td>Experts / Specialists</td>
</tr>
<tr>
<td>Total :</td>
</tr>
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Please see a complete overview of interviewees in Annex 5.2.

1.3 Limitations

Understanding that the objective of this review is to provide an overview of the trends in hospital management within MSF-OCG, many individuals, including the evaluators, felt that the amount of time allocated was very short in general, but especially true for the field visits. This restricted the number of interviews as some key informants were not present, specifically local staff / MoH staff. It may also have limited the ability for the evaluators to fully grasp (experience) the challenges of each type of project.

Furthermore, the timing of the field visits that coincided with the yearly Plan of Action (PoA) and the short delay in trying to organize the field visits contributed to the limited amount of information gathered and some findings are based more on perceptions than on hard facts.
Most of the interviewees were not prepared for the interview; some did not know that the evaluators were coming, nor the purpose of the visit. A relevant number of them did not read the ToR and others had not received it. Although this sometimes allowed for very spontaneous and candid responses, it was more often the case that individuals felt they needed more time to reflect on the questions and were not able to formulate comprehensive answers in the moment.

The OCG project with the largest hospital entirely run by MSF was not considered in this evaluation, namely because another evaluation was being conducted simultaneously to review the strategy of the project. Therefore, the commissioners felt it might be excessive for the field team to manage.
2. Findings

2.1 Emergency, mid- and long-term management

Because this review specifically looked at one project that had recently been transferred from the emergency cell to a “regular” cell, many individuals discussed the interpretation of these two classifications of projects during the interviews. There are many nomenclatures for the various stages, phases and types of projects in MSF, for example, emergency, post-emergency, regular project, exit / disengagement and so on. For the sake of clarity and perhaps to better inform how to manage projects that include hospitals during different phases, below descriptions are listed of how scholars and practitioners define different phases on the foreign intervention spectrum.

MSF-OCG does not have a recognized definition of what exactly constitutes an emergency phase and a regular phase. The process is intuitive and emergency is often an acute response that would perhaps overwhelm an existing country team or is in a location where no OCG mission exists. The project is eventually handed over from the emergency cell to a regular cell once the project is established and stabilized. However, not all MSF projects start due to an emergency. Bol, in Chad, for example was started because of alarming indicators, but these were of a chronic nature that did not necessarily meet an emergency threshold. In addition, the type of intervention in Bol could be considered as early recovery or perhaps even development.

Emergency response is most accurately explained by using definitions of humanitarian assistance provided by some organizations. For example, the Humanitarian Coalition describes humanitarian aid as “intended to save lives, alleviate suffering and maintain human dignity during and after man-made crises and disasters caused by natural hazards, as well as to prevent and strengthen preparedness for when such situations occur.”¹ In contrast to development aid, which “responds to ongoing structural issues, particularly systemic poverty, that may hinder economic, institutional and social development in any given society, and assists in building capacity to ensure resilient communities and sustainable livelihoods.”²

In brief, these two types of interventions can be described as follows:

<table>
<thead>
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<th>Table 3: Emergency vs. development</th>
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<tbody>
<tr>
<td><strong>Humanitarian aid</strong></td>
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<tr>
<td>Short-term</td>
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<tr>
<td>Delivered in disaster zones</td>
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<tr>
<td>Responds to an incident or event</td>
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<tr>
<td>Preparedness</td>
</tr>
<tr>
<td>Focused on saving lives</td>
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Humanitarian aid in emergencies and development are two extremes on the same continuum. In between, however, there are needs that often go unanswered. Few organizations try to fill the gap between aid and development, and there has been much effort towards this end in the last decade. Terms such as “early recovery” and concepts like “Linking Relief, Rehabilitation and Development (LRRD)” have become more common, bringing attention to these needs.

² [http://humanitariancoalition.ca/media-resources/factsheets/from-humanitarian-to-development-aid](http://humanitariancoalition.ca/media-resources/factsheets/from-humanitarian-to-development-aid)
According to UNOCHA, early recovery “is an approach that addresses recovery needs that arise during the humanitarian phase of an emergency; using humanitarian mechanisms that align with development principles. It enables people to use the benefits of humanitarian action to seize development opportunities, build resilience, and establish a sustainable process of recovery from crisis.” Early recovery purports that emergency and development can co-exist in certain contexts, are related and are sometimes difficult to separate. Similarly, LRRD “looks to bridge the crucial gaps between humanitarian and development aid”. The difference is LRRD accepts that relief and development each have strengths to contribute and there should exist autonomy between the two. LRRD also acknowledges that the aid→development process is not linear, but cyclical where populations go from requiring relief assistance to development or from development to relief.

These different views may be important for MSF in reconsidering the different types of projects in which they engage. For legitimate reasons, MSF often decides to stay beyond the emergency phase; in Léogâne, Haiti, for example, where two months after the earthquake, very few related cases were treated, yet the project continued for five years. Another scenario is when MSF decides to open projects to respond to chronic situations, neglected diseases or dysfunctional health systems outside of an emergency response. For example, the Bol intervention or the Likoni project in Kenya.

Although there has been some shift towards trying new and different approaches, MSF mostly remains within its standard frame. Furthermore, some believe there are missed opportunities and inefficiencies because of the adamant view that “MSF does not do development”. This is, in most instances true. However, if MSF defined its projects with a broader view and definition, it may improve effectiveness, efficiencies and relevance of the intervention. These different views would inform the type of human resources needed, the length of the project cycle, and the financial investment needed.

In those projects with a new approach, such as Bol, it became obvious that at the start of the project, MSF did not have a clear idea of what it wanted to accomplish and how. Furthermore, once it became clearer, another challenge was to secure the necessary resources (human / financial) to achieve this goal. During the interviews for this review, it became clear that the wealth of knowledge that exists within OCG is not maximized. There are many individuals with vast experience in development projects who could bring new ideas and creative solutions to the challenges that MSF faces in this changing world.

Although the Bol project cannot be classified as a pure development project, it does have some concrete aspects of development; it is long-term (in MSF jargon), it is responding to a systemic lack of health care and MSF is trying to improve that system by building the national capacity and advocating for the integration of staff into the public service. Although these are the objectives, there is a reluctance to fully engage, especially in terms of hospital management. As in many projects (including the three projects visited where MSF worked within the MoH structure) one objective for MSF is to ease their disengagement and try to ensure that some services remain after they leave, but MSF fails to support an important pillar necessary for continuity: the management of the hospital.

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3 https://www.humanitarianresponse.info/en/clusters/early-recovery
4 http://humanitariancoalition.ca/media-resources/factsheets/from-humanitarian-to-development-aid
5 The Likoni, Kenya project is designed to improve sexual reproductive health (SRH) in the immediate area, while a second, longer-term objective is to grow the Likoni intervention into a centre of excellence and offer capacity building support for MoH staff serving in areas of the country with constraints to access to SRH services that consequently negatively impact outcomes and maternal mortality rates (MMR).
Recommendation: MSF should acknowledge the various types of projects or phases of projects and define them to create clarity concerning management tools, methods and resources to use. For example, short- and long-term planning and budgeting, recruitment and placement strategies, policies as to engaging with the MoH, developing exit strategy guidelines, project management cycles, knowledge management, monitoring and evaluation tools. In addition, MSF should use the vast pool of internal knowledge about how to most efficiently implement new approaches.

2.2 Hospital management experienced in MSF

Considering the above-mentioned definition, the evaluators observed that at least in the OCG project visited missions are not fully engaging in hospital management. While the projects can often manage the different departments they are working in, they do not create hospital management teams to ensure that all the different aspects of the hospital are managed inclusively. The approaches reviewed were very department-centric, often operating in silos. In the logistics department, additionally to a department-centric there is also a thematic-centric approach, for example an architect will only be involved in architecture. Of course, the course of action is not necessarily to discontinue the management of departments or activities, but to bring these into the broader hospital management. As observed in the projects visited, it can be said that running the hospital, and therefore hospital management, is a side effect of managing the different departments and themes.

In 2014, OCG tried a pilot project in Haiti to change the approach and create a hospital management team with the objective of allowing more decision-making autonomy to the hospital. The team included a hospital director, a medical director, a paramedical director and an administrative director, mirroring the structure of national hospitals in many countries. Although some external factors made the success of this pilot difficult to assess, two separate evaluations were conducted to determine lessons learned. These reports concluded that, with proper guidance, the “right” staff (experienced, competent, long-term) and adequate resources, this approach has the potential to increase the autonomy of the field teams and improve hospital management in MSF projects.6

The challenges and opportunities related to human resources are discussed in detail in section 2.5, nevertheless, one challenge specifically relates to hospital management experienced in MSF. When reviewing most organisational designs in projects with a hospital, the role of the Medical Team Leader (MTL) stands out. In projects with outreach, PHC and SHC components, the MTL is required to manage all medical international staff (often including many first mission staff), supervise all activities (including pharmacy, laboratory, health promotion, outreach, and others), ensure quality of care (QoC), analyse data and produce reports, and make programming decisions. For many MTLs, and from a human resource management perspective, it seems to be impossible for them to fulfil all the requested tasks; it is not a job that is designed to be feasible. Being the direct manager of all international medical, paramedical staff and the medical support for departments leaves little time to manage a hospital.

Managing a hospital while working in collaboration with the MoH is certainly more difficult than managing purely a MSF structure. Collaborating with the MoH often means that MSF has less flexibility in the implementation of activities. This is especially true in the DRC where the church is often the “owner” of the hospital and must be involved in any negotiation. The church usually

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contributes to the construction and continues to provide funds and administrative support to the hospital. For MSF, this means negotiating an agreement (a memorandum of understanding - MoU) with three other parties (the church, the Médecin Chef de Zone and the Medical Director of the hospital). While these three stakeholders jockey for position, MSF tries to reconcile the needs, requests and demands of each with MSF’s objectives. As MSF arrives and sometimes destabilizes this relationship, if often creates power struggles within the MoH and was described as a “three-headed snake” by some, providing a vivid image of the challenge.

Another challenge is demonstrated in the Kousseri project, where the MoH directly limits the capacity of MSF to fully engage by placing some restrictions; the MoH accepts INGOs to support their structures but does not allow any involvement in hospital management. All activity-related or programme decisions must be negotiated with and agreed by the MoH. This can be challenging when the hospital decisionmakers are disengaged or absent. In section 2.8, we look more closely at MSF working in partnerships, where some recommendations are made that can help with these restrictions.

On another note, MSF often takes the decision to limit their engagement in the administration of hospital management perhaps for fear of completely substituting for the MoH or because, as some purport, it is “not what we do”. This was encountered in the three non-fully MSF projects visited, which created a somewhat parallel management system. See section 2.2 for a more extensive review of findings.

A third example, this one in Nduta, which is a full MSF structure, and nonetheless also shows some difficulties in working with the MoH. In this case, the MoH wants INGOs to decrease (limit) the number of international staff to allow Tanzanian nationals the work opportunities. A very legitimate request, but one that MSF can find restrictive.

Another challenge, when working within the MoH structure, is that MSF must accept, in some settings, a disparity between the quality of care offered in the MSF supported services and those offered in the MoH services; this may push MSF to intervene in other services, perhaps especially in the disengagement phase. This, however, should open MSF to question how to better align the services and accept a reduction of quality of care, for example, by adopting national protocols.

Recently, several projects have started to consider the possibility or implementing pairing (binômes) of MoH/MSF positions to create better communication channels and improve the efficiency of hospital management while building capacity among the MoH staff.

**Recommendation:** To allow this strategy to be successful OCG should invest in ensuring that staff have the competencies required to be able to transfer this knowledge to MoH staff, through appropriate matching, training and tools. During interviews, very few field staff said that they would feel comfortable to take on the role of hospital director or leading a hospital management team, many of them already are in a de facto hospital management role. However, they do think that with the right team, the right tools and adequate support it could be possible to grow into such a position. It would also allow the development of a true transversal hospital management team.

### 2.3 Hospital management in emergencies

Hospital management is especially challenging during the emergency response phase. The time pressure to respond, the quick recruitment and deployment of sometimes inexperienced staff often does not allow for the appropriate amount of planning and reflection needed to establish the required systems for an efficient and effective hospital management governance. This leads the
implementers to rely on the traditional “tried and true” MSF set-up, which may not always be the most appropriate.

In addition, the need for quick response and the pool of international staff with little experience often results in decisions being made by headquarters (HQ), which may not be completely aligned with the needs of the field because HQ are far away. The other option is for decisions to be made at the field level by inexperienced international staff, which may also not answer the needs. This can create challenges in the moment or make the transition to a regular cell more difficult.

This challenge has been recognized by the emergency cell (E-cell) and to ensure that the international team is better supported and matched, the individual responsible for human resources (HR) for the E-Cell is currently working on an assessment of individuals, reviewing their experience and specific competencies to better support emergency interventions and to personalize career planning within the emergency pool via trainings.

There is also a new initiative to create a support unit for all emergencies, regardless of who is implementing the intervention, which will develop and adapt tools used in emergencies.

### 2.4 Hospital management and quality of care

Quality of care or ensuring the best possible care for patients is the wanted outcome of good governance and hospital management. For this reason, a special focus was given to this area from a management perspective.

Section 2.6 below takes a closer look at initial needs assessments for projects, especially ones entering a regular phase, but it is worth mentioning here how the lack of comprehensive needs assessment can have an impact on the quality of care. For example, in the maternity ward of the Nduta Hospital in Tanzania, patient beds were ~35cm apart. This is much less than the WHO recommended 1 to 2 metres separation between beds.¹ (ICU, Emergency, OT).

In the case of Nduta, this overcrowding can be explained by an increase in the original number of refugees estimated for the camp by UNHCR and the high, unexpected, attendance of hospital-based deliveries. Considering the population figures and the Burundian birth rate of 4.2%, nearly 100% of pregnant women use the service provided in the hospital.⁸ The maternity data from June to November 2016 show that the maternity department oversees an average of 280 deliveries per month. Taking the different and constantly increasing population figures of Nduta Camp and the annual birth rate of Burundi (4.2%) into account, the conclusion can be reached that MSF has supported more than 100% of pregnant female camp inhabitants for their deliveries at hospital level. It is unknown which factors can explain these numbers, but assumptions include the possibility that the birth rate is greater than 4.2% in the camp or perhaps Tanzanian women from neighbouring villages are using the free services in the camp, but considering the strict enter and exit procedure applied at the entrance of the camp, it does not seem likely. It would be important to better understand patients’ origins or carte sanitaire of the camp and the hospital.

Furthermore, this overcrowding has been the case for several months and was discussed with the Health Structure Manager Advisor during her field visit. At the time of the visit, the MTL and Medical Coordinator (MedCo) were aware of this problematic and were looking at solutions, but it may be

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⁸ [http://www.indexmundi.com/burundi/demographics_profile.html](http://www.indexmundi.com/burundi/demographics_profile.html)
relevant to question if the overcrowding could have been resolved more quickly or even avoided if a hospital management team had been in place from the onset of the project (see section 2.5.1 for more details on organizational designs).

**Recommendation:** When engaging in secondary health care, MSF should conduct a thorough risk analysis, not only for the change in patient numbers but also for the entire hospital. The risk analysis should include potential solutions, like building new structures, or having a contingent workforce. See the example below:

**Table 4: Hospital risk analysis for Nduta project**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Cause</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in patient #s</td>
<td>UNHCR increases # refugees</td>
<td>Very likely</td>
<td>High</td>
<td>Decentralize some services to HCs such as simple deliveries, stabilization beds, define clear admission and discharge criteria</td>
</tr>
<tr>
<td></td>
<td>Outbreak</td>
<td>Unlikely</td>
<td>Medium</td>
<td>...</td>
</tr>
<tr>
<td></td>
<td>Natural disaster</td>
<td>Very unlikely</td>
<td>Low</td>
<td>...</td>
</tr>
<tr>
<td></td>
<td>Situation in home country deteriorates</td>
<td>Very likely</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td></td>
<td>Inaccurate catchment estimate</td>
<td>Unlikely</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>Inability to provide service</td>
<td>Government changes the approach to HR: International staff vs. Tanzanian staff</td>
<td>Very likely</td>
<td>High</td>
<td>Conduct an analysis to determine the essential International staff positions; review competencies of current NS to determine who can be promoted quickly; ensure transfer of competencies immediately</td>
</tr>
<tr>
<td></td>
<td>High number of staff leaves</td>
<td>Moderately likely</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td></td>
<td>Strike by employees</td>
<td>Very likely</td>
<td>High</td>
<td>Train a contingency workforce</td>
</tr>
<tr>
<td></td>
<td>Hospital burns down</td>
<td>Very unlikely</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>Logistics</td>
<td>Water shortage</td>
<td>Moderately likely</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td></td>
<td>Electrical breakdown</td>
<td>Unlikely</td>
<td>...</td>
<td>...</td>
</tr>
</tbody>
</table>

Not surprisingly, many recent studies corroborate the hypothesis that good or poor management practices have a direct impact on the quality of care. Some reported managerial practices that have yielded positive outcomes include establishing objectives and a clear strategy on how to achieve
these; for managers to engage in the QoC and for the organization to promote a quality culture.\textsuperscript{9} Another study, this one conducted in Iran, states that “Healthcare quality can be improved by supportive visionary leadership, proper planning, education and training, availability of resources, effective management of resources, employees and processes, and collaboration and cooperation among providers.”\textsuperscript{10} According to the WHO, “Effective leadership and management are essential to scaling up the quantity and quality of health services and to improving population health.” Good leadership and management are about: providing direction to, and gaining commitment from, partners and staff; facilitating change; achieving better health services through efficient, creative and responsible deployment of people and other resources.\textsuperscript{11}

**Recommendation:** MSF should scale up the level of managerial know-how and practices of the organization. A topic that has been discussed extensively over the years within MSF, however, is especially relevant and critical to the success of hospital management. This effort requires hiring and retaining individuals with managerial capacities and up-scaling internal resources with this potential.

There are two major difficulties in monitoring the quality of care for patients that are directly related to management. The first is the absence of agreed upon standards. Most MTLs interviewed reported they have little guidance from OCG on what acceptable standards are. While for specific disease such as Cholera or Ebola the standards are set, for regular hospital settings a comprehensive package of standards is not yet developed, for example, the nurse-to-patient ratio, or the number of beds per department for a defined population. This makes it very difficult to manage a hospital and achieve the overall objective of QoC.

The second difficulty is the lack of knowledge, at field level of the available tools for setting a baseline and the absence of guidance on specific, measurable, appropriate, relevant and time-bound (SMART) indicators of success for quality of care. This management tool can be very effective in monitoring the progress and ensuring that the field teams reach their goal of improving quality of care. There are many indicators in the logical framework of most projects that are monitored on a monthly or quarterly basis. However, when it comes to the continuous monitoring of the quality, there are few indicators or tools available to the medical or non-medical teams.

For example, OCG initiated a pilot project in Agok, South Sudan in 2011/2012 to measure QoC and established a process of self-evaluation within the project.\textsuperscript{12} The training unit worked on a simplified tool that would allow to continue this effort and established one, but this is not known by all medical staff or only used punctually when an advisor is conducts a project visit. Additionally, another QoC tool was created in 2012 and although it is slowly being implemented, it is only used as a punctual evaluation and not to continuously monitor the QoC as it was not designed for this and does not allow for comparison over time.

MSF-OCP faced many of the same challenges as OCG and in 2013 they conducted an external evaluation to develop a series of standards specific for hospitals.\textsuperscript{13} It may be very useful for OCG


review and examine further the outcomes of this evaluation and perhaps appropriate some of the findings and recommendations. This evaluation report is included in annex 5.3.

On a positive note, the Operational Policy of 2012-2015 put a great deal of emphasis on the QoC for patients in MSF projects. This has resulted in many initiatives including the above-mentioned QoC evaluation tools. In addition, many OCs, including OCG created QoC Advisor positions, whose main role is to support the field to improve the quality offered to patients. Additionally, a unique, intersectional (OCA/OCG) Medical Quality Advisor position based in Berlin, was created with the objective to focus on further development and adaptation of QoC tools and their implementation, considering the capacity building processes within the projects for self-evaluation and assessments.

2.5 Human resources

Like most organizations, and especially humanitarian ones, the core of MSF is the individuals, at all levels, that make it possible for MSF to accomplish its social mission. As the world changes and the contexts in which MSF is working evolves, so too should the management of the human resources. This section looks at some of the successes and challenges of human resources facing hospital management.

2.5.1 The organizational design

Over the years, we can see a clear evolution in the organizational structure of projects in MSF. There was a time when a project, no matter the size or activities, would function with a Field Coordinator, a medical doctor (or two), a nurse (or two), and an “all-round” logistician. As the projects increase in complexity, duration and size, over the years an informal shift has occurred.

For example, quite a few years ago, the role of Team Leaders was introduced (both in medical and logistic departments). More recently, the roles of Nurse Activity Manager (NAM) and Medical Activity Manager (MAM) were created. These roles have a few advantages, streamlining the management activities of the projects and providing a training ground for individuals to accede to positions of greater responsibility such as Field Coordinator, Medical Coordinator, and Logistics Coordinator.

During this review, it became clear that there is also a shift towards mirroring the positions of the national health system. The difficulties experienced by some when trying to handover and disengage from interventions are making this change more frequent. In addition to helping with the disengagement process, there is also the added benefit of a smoother transition into the MoH system for the MSF national staff after the departure of MSF.

OCG has also demonstrated a willingness to look at organizational designs differently. The pilot set-up in Haiti is a good example of this. MSF-OCG rethought the entire upper management of the hospital, creating a governance structure and hospital management team very similar to how many hospitals are managed around the world.14

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One aspect that was missing from most of the projects visited is the transversality in the management of the hospital; the inclusion of the non-medical departments in the decision-making process. This refers to representation from human resources (identified as a critical factor in efficient management of hospitals), logistics and human resources. Note that the organizational design in Haiti includes non-medical departments in the management of the hospital and in setting the direction for the hospital.

Recognizing that the specific Haiti set-up may not be adequate for every OCG hospital intervention, it may still be worthwhile to standardize an organizational design for hospitals and move away from the conventional set-up. Even in a “traditional” MSF intervention, such as the one in Nduta - a fully MSF-run hospital of about 110 beds in a refugee camp– inefficiencies were identified by the team and a shift in the organizational design towards (but not entirely) the Haiti set-up is being implemented.

One suggestion would be to consider the hospital as a “project within a project”, designed to function with greater autonomy. Below is an example of what a new organizational design could look like. Many of the “practicalities” around the functioning of such a set-up would require some thought and this design would need to be tailored to answer the project needs based on the context, the services offered, the size and complexity of the intervention.

This type of design needs to be adapted to specific contexts and to answer to the needs of MSF-OCG, but it could be implemented as a means to increase autonomy, efficiency and effectiveness of hospital management. It will not resolve all the issues and should not be implemented in isolation.
Consideration must be given to the competencies required in the various positions and appropriate matching. In addition, there is a caution not to impulsively add layers of management to resolve issues. A thorough assessment of the root causes of the problem should be conducted and appropriate measures taken to address the issue.

The increase in complexity in projects has often resulted in increasing the number of International Staff. For example, the Tanzanian mission, at the time of the visit, had decided to add deputy positions to most coordinator positions. This happens in a mission with only two projects, security that is quite stable and without the view of expanding the mission at this time. Additionally, this strategy is not implemented as a way of increasing coordinator capacity or to mentor the deputies, but because there are difficulties in providing adequate support to the field.

**Recommendation:** If MSF wants to create a shift in the management structure of their hospital projects, the first step must be to appropriate this shift by HQ, including operations and to make this shift gradually with a change management plan that would include ensuring the new positions being filled with persons having the appropriate competencies. Such changes should be accompanied by a change manager to overview and support the change, leading to success.

**Size and complexity of hospitals**

Most people interviewed agreed that the size of the hospital would have an impact on the number of staff needed to complete the various activities, however the complexity is where there is a requirement to re-think how the hospital management is structured. In a pure MSF hospital, it is almost unanimous that some form of hospital management team should be established. Where there is disagreement, is on the composition of the team. As suggested above, probably the most efficient way to structure the hospital is to have a director and with department directors reporting to them, however, some believe that the more traditional MSF set-up is fine. The increase in complexity of hospitals, however, makes this design less and less functional.

Where it becomes less clear is when OCG is supporting MoH hospitals with interventions in only a few services. In this case, a hospital director may not be required, as there may not be enough work for them. However, the roles of the traditional set-up may need to be reviewed in this context. A FieldCo, even if non-medical, may need to be more involved with knowledge sharing and exchange with the Hospital Director of the MoH structure; they may need to play a greater role in hospital management. There may also be a need for a hospital supervisor, or a type of head nurse position, which would oversee the services managed by MSF and the MTL could be the focal point for any medical MSF / MoH inter-departmental issues.

**Recommendation:** OCG should consider restructuring the existing positions, reviewing the current profiles and adapting roles for different contexts. This should be done in close collaboration with the HR department (field and cell) to ensure adequate use of resources.

**2.5.2 The right competencies**

Many of those interviewed admitted that the current organizational structure does not necessarily meet the needs of MSF projects in terms of hospital management, as was discussed earlier. Closely related to a change in structure is ensuring that those in the leadership positions have the relevant competencies.

A very common theme discussed during the interviews is that most people in MSF lack the full range of skills, knowledge and aptitudes to efficiently manage a hospital. The focus here was especially at the higher level of management in an organizational design such as the one described in the previous section or even in a more traditional setting with a MTL who is overseeing all activities of the hospital or MSF supported services.
Recommendation: One solution could be to recruit individuals who already have hospital management competencies. Many universities offer Masters in Business Administration degrees with a focus on hospital management. Just as many OCs and partner sections are changing their recruitment strategies to fill gaps in specific HR needs (surgeons, epidemiologists, and so on), individuals specializing in hospital management could also be targeted by the recruitment departments. The individuals could be recruited for longer-term contracts (two years) and coached for the first few months.

2.5.3 Continuity of international staff

Many projects are now being thought over a multi-year timeframe. Under some circumstances, this longer-term planning provides greater stability, increases efficiency, and the opportunity for MSF to offer more comprehensive care.

Numerous evaluations have raised concern over the detrimental effect of international staff who stay for short missions. In this review, many field-based (not coordination) international staff had signed six-month contracts for their mission, and although some individuals stay for longer, many do not even stay for six months. For example, in Bol, which has a three-year project cycle, the average length of contract is 4.8 months (data from July 2015 to June 2017); furthermore, only 14 of the 43 contracts were more than 6 months. In Nduta, the average length of contract is 4.6 months, since the project entered the regular phase, and 12 of 35 contracts were longer than 6 months. This represents that about one third of the international staff stay in projects for six months or more.\(^\text{15}\) It seems from this very crude analysis that it is even difficult to gain six-month commitments from individuals.

The issues that arise from these short missions include the difficulty for the National Staff (NS) to continuously deal with a new supervisor / manager who implements different processes, methods and tools. A related observation is that it is difficult for NS to assimilate information when the teaching methods and styles are continually changing. This is especially true in a project like Bol, where one of the primary objectives is capacity building. Furthermore, with frequent changes of individuals also come changes of ideas, interests, and expectations. This can sometimes cause the project to drastically change direction or lose its vision, which is not necessarily detrimental, but can be disruptive.

In projects that are unconventional, or when MSF is trying new approaches in non-emergency / early recovery / LRRD settings (like the “integrated approach” of the Bol project), the continuity of staff is key to providing the best chances of success. During the field visits, a few aspects were mentioned that could improve the length of stay of international staff, such as satisfactory living conditions (healthy and tasty food, the possibility of exercising, entertainment and so on), allows International Staff to have a healthier physical and mental health.

One main difference and why MSF projects cannot be categorized as development is that they tend to be in unstable / insecure settings. These settings often make it more stressful and more difficult for International staff to make a long commitment. For example, a country mission in Dar es Salaam will have a greater possibility of engaging coordinators for one, even two years because the context is very stable, Zanzibar is 45 minutes away, and it is a family mission.

Again, in a quick analysis of contracts, the trend in Kousser, Cameroon, is for International staff to agree to longer contracts initially and often to extend their stay. Looking at contracts from July 2015 to May 2017, approximately half the staff agreed to or stayed for nine months or more. Team spirit,

\(^\text{15}\) These figures are extracted from very basic reports provided by OCG Human Resources.
interest in the project and good living conditions are some of the reasons. Another factor may be that, due to security restrictions, only black International staff can be deployed to this project; there could be a correlation between length of stay in missions and country of origin.

**Recommendation:** To possibly ensure more continuity of international staff in projects, OCG should conduct further research to determine if there is a correlation between the length of stay of international staff and their country of origin.

The length of stay in projects is not a new concern for OCG and there is not a lot of additional insight to be gained from this review from what is already known to the Human Resources department. There has been a lot of effort made in recent years to develop creative solutions. For example, OCG’s current offering for contracts signed of more than 12 months includes more vacation, one flight to the home country of the incumbent paid after six months plus benefits if they have dependents.

Other initiatives that are valued by employees include recognition, training and development opportunities, career pathing, benefits, retirement plans, relevant feedback, setting achievable targets and so on.\(^\text{16}\)

There are also creative solutions being used by other OCs to entice International staff to sign longer contracts. For example, for difficult to fill positions (namely HoMs), OCBA gives the opportunity for two International staff to pair together for one position and leap frog; four month on/four months off, which allows one position to be continuously filled for 16 months, where the strategy can be agreed upon between the two individuals, minimizing the risk of drastic changes to the project or mission.

### 2.5.4 Capacity building (learning and development)

Capacity building is identified as key within OCG, therefore in 2017, a new position has been created and more resources are allocated to the Training / Learning and Development (L&D) of MSF staff; International and National. To demonstrate this, in the last year some assessments of learning needs in hospital projects were conducted on request from the project, the result being the development of a comprehensive learning strategy for that project. This is a service that is not yet fully utilized, a missed opportunity for some projects. The reason is the lack of knowledge about the learning assessments at field level.

One example is the inclusion in every PoA of ongoing training and knowledge transfer to (especially) medical national staff. The necessity to build the capacity of the staff is agreed, but one difficulty is measuring the effectiveness of these trainings; it is unclear how much the individuals learn and retain. Furthermore, even though capacity building is often part of the logframe, most projects are not able to say at the end of the year how many trainings were conducted and to which staff group. Trainings are done in all departments, at all levels, very frequently and require a lot of time and effort though the follow up and monitoring of the effectiveness is very limited.

A recurring request during the field visits was to broaden the training package to extend to mid-level and higher management positions. While the technical trainings are well developed (paediatrics training, log / WatSan) there is a clear need expressed by individuals holding management positions that training for them is not comprehensive enough. Programmes, such as Training of Trainers (ToT) and the Team Management Training (TMT) are designed for first-line managers and supervisors, and especially good for national staff, however, for higher level management positions outside coordination and relating specifically to hospital management, the only option open to OCG is the

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training offered by OCB, the Hospital Management Team Training (HMTT). But, even using this resource seems to be contentious; where some individuals state there are eight spaces available for OCG, others purport that it is a struggle to get these positions in the training and even need to involve operational directors to secure these spaces. OCP has also developed a comprehensive training, the Formation en Gestion Hospitalière (ForGHo), and may allow OCG to reserve a few spaces, but generally, do not open positions to other OCs as they already fill all available spaces internally.

The above-mentioned problematic for the international staff counts in the same way for the MoH staff in the structures MSF is engaging in. While MSF puts a lot of effort in the technical training (medical and non-medical) of national and MoH staff and invests in trainings for lower management level in the departments. At the hospital management level, OCG is often unwilling to provide training and qualified support to the MoH management level by the international staff. Often limitations of the MoH teams are identified and discussed, but the possibility of trainings is very limited. One specific need is often identified in the administrative and financial sectors of hospital management. With the decision of not engaging in the hospital management level of the MoH structures, and most often, also declines responsibility to engage in the training of the hospital management staff. One reason may be the limitation in capacity of the MSF International staff in coaching and training of managerial skills. However, this may be changing; in Gety and Boga projects of DRC, the project has made a proposal to hire an administrator to train the MoH hospital direction of each hospital for 6 six months. This is very encouraging.

In the recent past, OCG has implemented a programme to assist individuals new in their positions or in need of support. This initiative involves flying training positions who spend two to four weeks with the individual in the field shadowing the individual while discussing ways to solve any issues encountered during that time. This service can be requested by the individual staff or the field / coordination team in discussion with the individual. The mentoring / coaching is meant to support the individual to better understand the requirements of the position, to develop key competencies to be more effective and manage the requested tasks. The main objective of the mentor / coach is helping the individual to help themselves. The flying positions cover many positions including MedCo, FieldCo, pediatrics, but according to the training and development unit they have more capacity and would like to receive more requests for mentoring as the needs are higher. The department is hoping - as this is a field-driven initiative - that it will be taken up by an increasing number of missions and individuals.

**Recommendation**: From the requests of the field, especially MTLs, and as OCG is wanting to increase their role in intervening in secondary health care systems, it seems that developing a hospital management training specific to the needs of OCG would be a good investment. The training may only need to be a modified version of the OCB and OCP versions and may not require a complete redesign and could be completed rapidly by the L&D department.

**Recommendation**: The support given by the flying positions (coaches) to the international staff could be extended to MoH staff in the field. This should always be decided in discussion with the staff and a plan and objectives should be developed together before engaging the flying position.

**Recommendation**: The same amount of effort put into the development of trainings should be done for the evaluation of the impact to adapt strategies and trainings. It is equally important to measure the impact as the training itself.
2.6 Assessment / Planning / Vision

In the 2013 “Meta Review of Hospital Evaluations” report, one of the lessons learned is the difficulty for MSF to make a coherent / needs-based shift or adaptation of the projects when going from the emergency phase to the “regular” phase. These same observations made during the field visits. For example, in Nduta, the handover from the E-Cell to Cell 2 was done a few months before the beginning of the Plan of Action (PoA) period. This did not give a lot of time for the new coordination team to formulate a vision for the project and the PoA reportedly became a reactive document instead of a project plan. A push from the Tanzanian government to “nationalize” positions and requests from the Cell to reduce expenses resulted in the hasty reduction in the number of International staff, which didn’t allow enough time to have a proper transition and handover period between International staff and senior NS. Consequently, this put a lot of pressure on the team remaining, which had consequences on the hospital management.

In the same meta review, and again observed in this evaluation, is the difficulty in establishing long-term plans for projects, mostly because of the annual financial timeframe for projects imposed by the PoA. Most projects follow a yearly project management cycle instead of following the needs of the project. MSF reviews their objectives once a year and often make changes to projects based on the financial review, perhaps not necessarily on the requirements / needs of the project. Or perhaps it is the financial priorities that sometimes push the operational strategies.

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The operational direction of OCG have recognised this constraint and briefly address it in the Vision document for 2016-2019 and for some projects, there is a lengthening of the strategy up to three years. A difficulty that became obvious is to continue the longer-term project planning cycle. For example, the Bol “integration project” was planned for an initial three years, from 2015 until 2018.

At the end of 2016, at the time of this review, the rhetoric at field level continued to be that the project would end in 2018, although many expressed that there was still no concrete exit strategy and realistically, the project would most likely last for an additional two years. The context and the approach of this project make it ideal to try a long-term project planning from 2017 until 2020, which could include the exit strategy.

An integral part of planning is also planning for the end of the project, which is rarely done in MSF. In the many evaluations conducted in recent years, it is rare that projects either have a concrete exit strategy, sometimes even after the decision is made to close the project and none of the examples indicate that MSF determines and indicators that would inform if and when a project should consider engaging in an exit strategy.

**Recommendation:** In terms of hospital management, long-term planning, including developing an exit strategy, is a crucial aspect to give the best chances of achieving set objectives. MSF should consider integrating this in projects offering secondary or in-patient care and especially those where MSF is working with the MoH (as many pure MSF hospitals do not always consider continuity of care after their departure).

### 2.7 Construction / Rehabilitation

A feature of providing hospital services that is of great benefit to both the health system of the county and the population is the investment that MSF makes in the infrastructure. This is true of the construction of new buildings, the rehabilitation of existing structures, the investment in water and sanitation services and provision of electricity. Whether MSF is working within the existing health structures or as in Nduta, in a refugee camp, these structures will all remain after the departure of MSF and hopefully continue to be functional. There are a few points, however, that were raised during the field visits.

The first is the length of time that it can sometimes take to go from making the decision to build new infrastructure to the project being completed. In Bol, at the time of the visit, there was a large construction / rehabilitation project underway to increase the space for consultations, improve patient flow and hygiene. It is reported that many persons were involved in this construction project and all had a somewhat different opinion of how the site should be laid out. The discussion continued for an extended amount of time, in fact, it took over one year from the initiation of the project until a plan was agreed. Some suggest that if there had been an “owner” of the project, a project manager, perhaps the decisions would have been made more quickly and more efficiently. Furthermore, there was little information in the field as to how and why these decisions were made.

**Recommendation:** At HQ and field level many support the idea to engage a Project Manager to guide the process from its inception, help to develop the specifications, ensure decisions are made in a timely manner, keep the project on track, and ensure any changes made are valid. This position would be the “owner” of the project with some level of decision-making authority.

Second, many conveyed that the needs of the population often exceed the space allotted in the infrastructure. After speaking with a few LogCos and Construction Logs, it seems that reasons could be the lack of: comprehensive needs assessments, accurate specifications or “cahier de charges”, understanding of the “carte sanitaire” and inaccurate data, either from National databases or MSF.
data that is not representative of the target population. During these visits, the Construction Logs interviewed did not use an OCG specific assessment tool. One Log used a tool that he had brought with him from a previous project with OCP and other report using ad hoc tools and methods developed by themselves. Other OCs have developed comprehensive assessment tools, such as OCB’s Pre-Feasibility Health Facility Assessment (PASS), which is currently being piloted in Agok project of OCG. Hopefully this tool can be adapted to the specific needs of OCG without too much difficulty.

**Recommendation:** Context specific needs assessment should be more comprehensive to answer the requirements of the population and to ensure that the construction plans are fit for purpose. A tool, such as the PASS should be designed, agreed and implemented for OCG with any decision to carry out substantial construction projects (defined by scope, time, and investment).

In addition to answering the needs of the population and MSFs own objectives, an important aspect to consider is ensuring that these constructions also meet the requirement of the national building codes and standard health care setting building designs. Contextually, for OCG, this means the planning should be discussed, negotiated and agreed with the partner working in the structure, the owner of the structure and the entity responsible for health, the MoH, before construction begins and with a genuine interest in meeting their needs. For example, in Bol, the Hospital Director expressed that the plans for the new construction and rehabilitation were presented to him as a “fait accompli” and did not feel these were open for comment or discussion. The issue, often encountered, is that the local actor is often so grateful for the investment, they are reticent to make comments or complaints for fear that the project will be stopped. This may mean that MSF does not always get the full picture.

In 2008, the WHO released a guiding document to help organizations, hospital managers, architects and so on to provide adequate health-care and minimize the risk of health care-associated diseases for patients and staff.18 This document may be of some interest to OCG, perhaps in developing guidelines of their own.

### 2.8 Working with the MoH

In 2011, OCG commissioned an evaluation19 to look at three different aspects of partnerships: the first, to determine the appropriateness and effectiveness of current partnerships between MSF and local organisations; second was to draw lessons from current experiences of partnerships; and finally, to obtain and analyse possibilities and risks of partnerships. Although MSF would often prefer to work independently because of its commitment to independence and neutrality, there are occasions when it just is not feasible. An example is, when the security situation permits, it is more effective to work with the MoH and within their health structures. At that time, the evaluation concluded that, even with the recognition that some situations require to work with partners, MSF has not fully assumed the role of a genuine partner. This observation was also made during this review in the three projects where MSF is working within the MoH structures: Bol, Kousseri and Gety.

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Many persons interviewed described the relationship between MSF and the MoH as collaborative. However, when digging deeper, especially with the MoH representatives, it became obvious that the relationship can be strained and that the MoH often feels that MSF imposes decisions or presents solutions and leave very little room for negotiation. Some persons interviewed perceive a lack of initiative on the part of the MoH, there is an impression that the MoH is always waiting on MSF to discuss issues, propose solutions and so on. A different perspective, however is that MSF takes up too much space, which doesn’t allow the MoH to take any initiative. In Gety, for example, there is a sense that in previous times, MSF “told” the MoH what to do / how to do it and did not always listen, perhaps creating a culture of resignation.

The way in which MSF intervenes in hospital management was often described during the interviews as two parallel systems, stipulating that it is not MSF’s responsibility to get involved in the hospital management. However, the fact is that as soon as MSF enters the structure, it inevitably has an impact on the hospital management. There are very positive effects, such as increasing the knowledge and capacity of MoH technical staff, the betterment of water, sanitation, and hygiene, the rehabilitation and construction of new structures that improve patient flow and, of course, opening the access to health care for the population. However, many individuals, including MSF International staff, NS and MoH staff, report that there are some challenges as well. Not fully engaging with the MoH means that MSF rarely discusses their objectives with the MoH until these are already agreed upon internally. The consequence is that MSF plans often do not align with the MoH plans. For example, in Bol, the hospital where MoH/MSF work recently was upgraded to a regional hospital and was given 300 square metres of land, where a new hospital will eventually be built (a commitment from an international corporation that still has not materialized). Within this context, the main road in town is planned to be enlarged, going through part of the hospital ground (see below). The risk is that if this road construction goes through, the investment made by MSF in the construction and rehabilitation of the hospital will have been an expensive project for minimal return.

![Chart 4: Plan of Bol, Chad Regional Hospital](chart4.png)
This is also an example of the lack of engagement by MSF in the “carte sanitaire”. Many persons interviewed maintain that this is due to the lack of experience of MTLs and Medcos, and the number of first mission international staff with little MSF experience. Some claim that this is due to a lack of long-term vision perhaps because of the high turnover of international staff and the lack of time at HQ level to make the appropriate commitment.

This lack of engagement in the “carte sanitaire” also means that MSF often does not base its decisions on accurate and reliable information, whether it is the number of anticipated patients, which informs the size of the hospital or services offered by other organizations or agencies.

Many also claim that the “arrogance” necessary during the emergency phase of an intervention must be transformed into genuine partnerships in the post-emergency. Some persons interviewed perceive a lack of initiative on the part of the MoH, there is an impression that the MoH is always waiting on MSF to discuss issues, propose solutions and so on. A different perspective, however is that MSF takes up too much space, which doesn’t allow the MoH to take any initiative. There is also a sense that in previous times, MSF “told” the MoH what to do / how to do it and did not always listen, perhaps creating a culture of resignation. Moreover, in terms of planning for a handover which would maximize the chances of continuity, MSF fails to discuss and agree with the MoH on what they believe is sustainable for them.

Although not fully accepted, the definition of partnership proposed in the report is repeated here in an effort to prompt MSF to reflect on how to engage in genuine partnerships, especially, but not exclusively (the UNHCR, for example), with the MoH:

MSF partnerships are mutually beneficial, planned and formalized alliances made with diverse organizations that espouse the same humanitarian values to achieve commonly defined objectives.\(^{20}\)

Furthermore, the evaluators suggest that the Partnership Report be reviewed and reiterate some of the recommendations made at that time, which are still relevant today:

- **Recommendation:** MSF should have a dialogue and formal agreement with the partner organization about their common objectives. This includes developing a robust framework around the definition of clear objectives and measurable outcomes with the partner – not for the partner – to provide better chances of achieving these goals. MSF should establish and implement mechanisms and controls to hold all parties accountable and systematically monitor progress and re-address any deviances.

- **Recommendation:** MSF should also show curiosity in local partners’ processes. Budget cycles, annual planning, how they receive financing, and so on will help in anticipating potential blockages to the partnership.

## 2.9 MSF and the national health system

One of the most frequently addressed problematic within the projects is the interaction and the impact of MSF on the existing national system. The majority of the interviewed staff (international, national and MoH staff) mentioned that MSF is breaking the existing system with some of their

principles and standards. The most impacted is the MSF principle that the services provided by MSF must be free of charge. All national systems are working with a cost recovery system, which enables them to support the hospital financially.

In theory, some of countries offer certain medical care for free; such as cholera treatment in DRC, under five child care, particularly nutritional care and surgical trauma care for victims of attacks in Cameroon and listed emergency cases and under five child care in Chad, but the perception of some interviewed tells another story. Some members of the hospital direction have complained that by providing these mentioned services free of charge, MSF is restricting the flow of money to the hospital. This could be because, although free for patients, the MoH should reimburse the hospitals; another reason could be that the hospital was not giving this care for free before despite the national guideline, which is an assumption and not verified.

Another example, in Kousseri, MSF works within the national free care offer and would not, therefore “break” the system. However, due to the absence of national surgeons, MSF has started to perform elective surgery free of charge. Before the presence of MSF, elective surgery was lucrative for the hospital, by offering it free of care, it is perceived by the MSF national staff, MoH staff and some international staff as an interruption of the national system.

While the impact of MSF’s free of charge policy is not always felt immediately on the financial management side, it has an impact on the longer term, for example when MSF works in certain services of an existing health structure, they estimate needs in their annual planning, they manage the budget for their services, the pharmacy and ordering cycles. This essentially takes away responsibility from the MoH and substitutes these important administrative tasks, which is seen by most as harming the system in the long-term, as it weakens an already poorly functioning system further.

To address the issue and try new ways the DRC mission is trying a new approach in their project in Boga where the services will not be 100% free of charge, MSF will implement an all-inclusive rate, or “prix forfaitaire” for patients and supplement the difference to the MoH. The team hopes with this approach will allow a better integration in the existing system and give the national program later an easier way to take over the services when MSF decides to disengage.

Another point of concern per the interviewees is that there is sometimes a discrepancy between the MSF and MoH protocols (for example, nutrition protocols in some countries). While everybody agrees the MSF protocols are more advanced and align with international standards, with the newest generation of medication, MSF should consider that when they decide to leave and hand over the services back to the MoH, the teams that were trained on the MSF protocols will have to switch back to using the national protocols. This may create confusion and can have a very negative impact on the quality of care, especially if the staff is left on their own to figure out the “new” protocols. In a few projects, where the national protocols align with MSF or WHO, MSF agrees to use the MoH protocols and supplement with the MSF protocols with prior discussions with the MoH, only when there is no national protocol. Other missions automatically apply MSF protocols and then discuss changes of national protocols with the MoH at state level to advocate for improved quality for patients. This strategy, as was the case in Southern African States with Anti-Retroviral Therapy (ART) to treat HIV/AIDS should be considered as a long-term engagement.

There are often significant differences between the standards of acceptable to MSF and those at the MoH level. Because QoC is such an important objective for MSF, they invest a large amount of money and resources (in materials and training of staff) in the implementation and expect a high level of standards, particularly in the services that they support. These standards are not only limited to quality of care, but also to the organization of departments, staffing (a much higher of nurses per
patient), medications and materials (European imported), as well as support for investigations, like laboratory investigations, testing of water, x-ray, in medical or non-medical departments.

In any given project where MSF works within a MoH structure, it is most often the case that MSF will eventually hand over the services to the MoH (or perhaps another actor); this higher level of standards makes the process of disengagement difficult. This problematic is not new to MSF and some projects are looking at ways to minimize the discrepancy. In Bol, it was decided to assist the hospital to hire staff (although still more than the ratio for Chad) and advocate to get this staff integrated into the public service, with the hope that once integrated, they will remain in Bol after the departure of MSF. MSF is also engaging with the state to increase the patient to staff ratio for referral hospitals such as Bol.

**Recommendation:** If MSF decides to support an existing health-care system (such as the case in Bol), the team should consider working within the system with all the advantages and disadvantages. There should always be willingness to improve standards and protocols, but this should be done within the system and with the MoH to ensure that it is adapted to the capacity of the system, which will provide greater possibility that it will be upheld after the departure of MSF.

**Recommendation:** MSF should consider developing strategies to overcome the difficulties placed by providing free care while compromising MSF’s principle as little as possible.

A solution could be that in a set up where the population cannot afford medical services, MSF could create a “fund”, suggesting that MSF pays a sum per patient service to be given to the MoH in the disengagement phase to allow them to have a financial base on which to resume the services. Another solution could be for MSF to support the MoH in the use of the national supply system for medication and medical materials, while providing a safety net in case of rupture. The medical supply chain would be fully managed (from beginning to end) by the MoH with the support of MSF to share knowledge about ordering cycles, stock management, distribution and so on. In this way, MSF transfers this knowledge, which can safeguard continuity after their departure. It also forces MSF to engage in the MoH’s system and not the other way around. Understanding that there are often different levels of quality of the supplies provided by national companies, part of the engagement from MSF could be to lobby for better testing and quality assurance.

### 2.10 Support to the projects

The given support to the field can be divided in three different levels: HQ support, coordination support and tools.

Most the interviewed international staff stated that the support of HQ on specific identified problems is result-orientated with good in timing and outcome. This is especially the case of the support given by the cell. Nonetheless, there was mention that field visits are too frequent and take a lot of effort and energy from the teams. In an interesting review, Cell 2 tabulated the number of visits in 2016 from HQ to the countries managed by them. In Chad, there were 37 visitors between January and September of 2016; this is four visitors per month or one per week. An average of only 49% of visitors had shared their Terms of Reference (ToR) with the cell. It is difficult for the field team to prepare and ensure a useful visit without knowing the objective of said visit. Finally, it took an average of 25 days for visit reports to be shared with the cell. This delay may mean that the project has changed and the recommendations may no longer be relevant. This is not to say that

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these visits are not needed or useful, but it is often difficult for field teams to take a step back and to analyse the recommendations and act on these when the frequency of visitors is so high.

All interviewed staff are very positive about the technical knowledge of the advisors and feel that their expertise is an added value, especially when problems occur, which cannot be solved at mission level. The role of the advisors has changed in the last few years with the creation of the Medical Operational Support Unit (MOSU). The advisors are now seen as a back-office for technical support, guidelines and protocols. Conversely, the MOSU is the practical implementing partner on the ground. The field visits and the ensuing recommendations of the advisors are sometimes not perceived as adapted to the needs and strategy of the projects. This is reported to be especially true of some medical advisors who tend to overlook (or are unaware of) the limitations of the project strategy or the approach. Another concern in this regards is, that recommendations are given directly to the field before the report and lack the insight of having a discussion at a higher level to ensure that they are in line with the strategy. Ideally, the recommendations are given to cell and/or coordination first and then filtered to ensure they are relevant and applicable. Giving recommendation to the field during the field visit also has the potential to be implemented without the coordination/HQ knowing which could derail the mission strategy.

The flying positions from the learning and development unit are perceived as very supportive and very practical. As mentioned already above in section 2.4.4 capacity building, they function as mentor on request of the mission and provide expertise for the staff to help themselves and find solutions.

Field visits from the coordination and the daily support was mentioned to help the relation between field and coordination, if the coordination is experienced.

While field visits, when not too frequent, are mentioned to be helpful, the majority of the interviewees do not know where to get the appropriate tools from to support their daily work. Despite the standard tools of Gecko, HOMERE SAGA, and EsyStock there were only few staff who know about additional tools and have installed them in their mission. It is often not known which tools are approved by HQ and should be installed / used. There have been some initiatives and the logistic department is a bit more advanced than the medical side. They have created a web-based repertory, which can be downloaded to use offline, where the user can search for tools, download forms and guidelines.

To compensate for the lack of official tools, field workers creating their own tools or use tools from previous missions (even from other sections). One tool that is most obviously missing tool is a standard roster spreadsheet that would allow the teams to quickly and easily enter the needs (24/7, 2 nurses at night, 10 nurses during the day, and so on) and press a button to create a roster for the staff.

**Recommendation:** One focus of the hospital management platform should be to create a toolbox to answer the needs of the field in a transversal way. Many ideas have been expressed during the field visits and are enumerated in the individual case studies in annex 5.3.

**Recommendation:** Field visits are necessary and helpful but should not overload the projects. An annual planning of visits could help to get a better overview and the projects can plan according, despite the unexpected needs arising. The timing of delivering the report of the field visit should be as short as possible.
3. Conclusion and discussion

The current conclusion about hospital management is that it is a side effect of OCG’s work instead of a conscious decision to engage in hospital management inclusive of all departments. This evaluation and the implementation of a Hospital Management Platform is a great first step in addressing this issue.

One challenge of implementing the platform will be to look at and find solution to some of the HR constraints that were identified during the review. These include having enough HR to meet the needs of hospital projects, either through new recruitment strategies or looking internally at the individual experience and career paths of individuals already in MSF. Once the right people are in place, it is imperative that MSF provides enough support and motivation to keep, including living conditions, contractual benefits, and so on. Another solution could be to develop an intersectional pool of Hospital Managers to ensure that they are involved with interesting and challenging projects, for example a very experienced hospital manager may not find managing a 50-bed hospital with three services very challenging and may get demotivated.

MSF should give serious thought to how to work in a genuine partnership with the Ministry of Health. Increasingly, MSF is working with the local health authorities where the objective is not only to provide care in the moment, but to also try to ensure continuity of care after the departure of MSF, so these collaborations must evolve into genuine partnerships. This requires time and effort to establish trust, respect and understanding and can only be accomplished through dialogue and rigorous agreements.

Just like the Haiti experiment was quite innovative for OCG, the necessary effort and support to the team was lacking to ensure the success. Innovative or creative solutions often need to be “accompanied” (followed, mentored, helped) either by an expert or a team; these types of projects would be a perfect opportunity for the Hospital Management Platform.

3.1 Hospital Management Platform in OCG

The objective of this evaluation is to help OCG develop and implement a viable Hospital Management Platform that answers the needs of the field and helps the operations department to deliver on the vision document.

During all interviews, the evaluators asked what would be the most useful components to include in a Hospital Management Platform. Their answers were considered in the three proposals below.

**Recommendation:** To implement such a platform, MSF should first define clear objectives for the platform and a timeframe to achieve them. Once the platform is established and working for a mission project, the field mission should establish a steering committee lead by one individual (a chairperson) who would communicate with the Hospital Management Platform Programme Manager.

Hospital management is not only a medical discipline. As already mentioned in the definition given in the introduction, hospital management is a multidisciplinary transversal approach, therefore it is recommended to have a matrix organizational design for the platform and to place it in the operational department under the direct supervision of the director or deputy director, most logically, as an arm of MOSU.
The evaluators would like to propose three different options. There are some commonalities, pre-requisites and conditions to ensure the success of any of the three possibilities.

There is an urgent need to define minimum standards, which are at the base of each of the proposal.

All scenarios involve a manager of the platform. This position would be the owner of the platform, would coordinate the activities and has some level of decision-making authority. The effort required for each of the different scenarios is very different and therefore the time investment of the manager will be different.

One possibility for the first two scenarios could be to relocate the position of Health Structure Manager Advisor in the Ops department and redesign the scope of activities. That position would take on a more concentrated Hospital Management role as the manager of the platform and continue to advise the field punctually on hospital management issues. This would mean changing the reporting structure for those positions that currently report to the Head of Care Services, which is also the Health Structure Manager Advisor position. Another solution would be that the Health Structure Manager Advisor is increasing her team to take on the platform.

All scenarios should include a toolbox with a complete set of tools, guidelines, standards, presentations, assessments and so on to support a hospital. Ideally, a team can access the toolbox and search for the appropriate tool, much like the logistics web-based platform. The toolbox should include description of the different project possibilities (for example, support to the MoH in ICU service or 100% MSF structure 100-200 beds with four different services) and the minimum associated standard with the tools needed for the entire implementation, from the first assessment to disengagement tools. The hospital management platform may not necessarily maintain the toolbox, but would be the owner and responsible for ensuring the process of any changes and updates. As it is rather an IT based concept, the IT department can address the maintenance of such a toolbox better. The creation of the toolbox should involve all different departments. A lot of tools are already available and could be used or adapted.

Option 1:

The first option is a web-based platform. The manager of the platform must work in close cooperation with the IT-department for the maintenance of the platform. The idea would be similar to tele-medicine, where, ideally one designated individual from the field (FieldCo/MTL, NS FieldCo assistant) can make a request, after discussing the problematic within the mission and the decision was taken to ask for support. This person would describe their needs in detail and would receive a solution within a defined time frame. The progress would be discussed via progress reports. The manager of the platform would act as the coordinator for the requests and ensure the timely resolution of the issue by referring the question to the appropriate specialist(s) / advisor(s). Solutions would be proposed and discussed between the advisor and platform manager first, and communicated by the manager to the project, coordination and cell.

The website could include as well a forum, where good practises can be placed and field teams can discuss together their problems.

Some of the limitations of this option are that it is reactive and not pro-active. Another limitation to consider would be that solutions provided could be not fully tailored to the context, but solution-orientated. The possibility that solutions are not discussed enough especially when the different specialists have very different ideas, because of the time pressure a solution wants to be presented. Time delay is very possible, as workload of the HQ staff is already high and web-based work can be assumed as “not priority”.
Another limitation would be the capacity of the Internet set-up in rural areas of MSF projects. While MSF has invested in the recent past on providing better Internet connection, sometimes it is still limited.

**Option 2:**

This option offers a flexible task force, composed of a transversal group of specialists, which reacts on request of the field channelled through the cell; the task force dissolves when the problem is solved. Essentially, the mission discusses whatever problematic they want resolved with the cell and when no solution can be found, the cell calls upon the task force. The manager of the task force will decide per the request, which specialists need to be involved. This team of specialists would meet and discuss the problematic with the mission to find a solution. The task force should propose different solutions and give the field the possibility to choose one they find most appropriate.

Some limitations resemble those in the first scenario, where the taskforce is reactive and that the solutions may not be coherent, but result-oriented. Not being involved in the vision of the mission, the impact of the proposed solutions can be limited and only short term, because it is focused on the defined problem when sometimes the problem identified has an underlying cause. Involving many different specialists and discussions can result in delays if there is not appropriate leadership.

**Option 3:**

The last scenario involves four different components in addition to the toolbox. The first component is a copy of the second scenario. The second component is the involvement of the task force in each project opening a hospital to ensure that the strategy of the project and the implementation is inclusive of all the aspects of hospital management starting with the definition of the vision and the activities to be implemented (including exit strategy), implementation of standards and evaluation of activities, project plan, milestones, evaluations and so on. The third component would address the information sharing of good practice and lesson learned. This could be web-based in a discussion forum where all OCG staff can discuss their experience in addition to providing updates on the different projects with hospitals and their history, changes in regards to hospital management, good practice and lesson learnt. To complement, the fourth component is based on evolving hospital management and gaining more expertise; the platform should keep abreast of any research specific to hospital management, international discussions and awareness raising. This component can include the exploration of trainings and studies regarding hospital management in cooperation with the training and development unit and other OCs.

The composition of the Hospital Management Taskforce could be as follows (in a matrix organization) where the members of the task force are constant (in blue) and experts/advisors are pulled to answer needs in certain projects (in green). The projects can be anything from the implementation of a hospital in an actual project to developing indicators.
Hospital management in other OCs

Other sections have already worked in a similar direction to find solutions to support projects on hospital management. In the beginning of 2012 OCB, as part of the “plateforme d’appui technique aux initiatives opérationnelles” (PATIO) created a hospital support committee (HSC) available.
specifically to resolve issues with regards to hospital management. This initiative included a permanent team of experts (HR medical, logistics and finance) lead by a Hospital Management Coordinator and non-permanent members could be chosen according to needs. The objectives were two-fold; “to provide effective support to existing or gestating hospital structures and enhancing accountability, monitoring and reporting for OCB hospital activities.”

One of the objectives included the creation of “master plans” for four pilot projects chosen by the operations. During the process the committee was mirrored at field level to balance the accountability. This included all components of the hospital and defined the activities with all required mechanisms. Once all parties agreed to the master plan, it became the fixed strategy and was not allowed to be changed unless a drastic change in context occurred, to ensure stability in the project despite the turnover of international staff. The results of the master plan were mixed, one was very successful and the other was not adhered to. Reports look mainly at the lack of buy-in at field level as the cause for the lack of success. As for the requests for assistance, according to the former Hospital Management Coordinator, nearly all request concerned HR issues. OCB does plan to continue this initiative but unfortunately the Coordinator position became vacant in 2014 and was only recently filled. The team was working within the operations department directly reporting to the director.

Another example is OCP who established hospital management standards after an external evaluation in 2014 and created the ForGHo to ensure that their international staff is trained when implementing a hospital management structure in large, MSF-lead hospitals. In many OCP hospitals, the shift to a hospital management team including hospital directors, medical-, paramedical directors, and so on.

OCBA, in 2012, finalized the process of writing a hospital management guidance for low and middle income countries. A copy of this guideline can be found in annex 5.3.

OCA very recently formalized a Health Care Management team very similar to Option 3 proposed above. Please find a presentation of how the structure and objectives in annex 5.3

It does seem that all sections are asking very similar questions as OCG and developing various solutions to these questions.

**Recommendation:** In a broader vision and recognizing that most sections are faced with similar dilemmas, it could be beneficial for all sections to convene an intersectional meeting to discuss solutions and review lessons learned around hospital management. Longer-term, consideration could be given to creating an intersectional approach to hospital management with a common platform/programme to improve hospital management and support the projects.

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22 Review of the Hospital Support Committee: Based on experiences from the Sierra Leone and Afghanistan. See annex 5.3 for full report
4. Recommendations

From the Vision 2016-2019 document, the focus is on mission autonomy. This vision is soundly grounded in a competent and capable workforce that understands its role and responsibilities, has clear objectives and the tools necessary to achieve them. Many of the recommendations in this report are aligned with this vision. The recommendations below are in support to the Hospital Management Platform.

The first item is to agree on a definition of hospital management. The evaluators propose the following:

**Hospital management is a multi-disciplinary, integrated approach, which provides the governance on how to lead and administer a medical facility offering secondary services (or inpatient care) with the primary objective of ethically ensuring the best possible quality of care and patient safety.**

An overall recommendation is that if OCG engages in a secondary health care structure that fits the definition above, it should implement a hospital management team. This means, as soon as possible, to apply a structure as proposed in section 2.5.1 and at the very least, the team should consist of a Hospital Director, Medical and Paramedical Directors, and a Resource Director.

**Emergency, mid- and long-term management (see section 2.1):**

**Recommendation:** MSF should acknowledge the various types of projects or phases of projects and define them to create clarity around which management tools / methods / resources to use. For example, short- and long-term planning and budgeting, recruitment and placement strategies, policies around engaging with the MoH, developing exit strategy guidelines, project management cycles, monitoring and evaluation tools. In addition, MSF should use the vast pool of internal knowledge about how to most efficiently implement new approaches.

**Recommendation:** When engaging in secondary health care, MSF should conduct a thorough risk analysis, not only for the change in patient numbers, but for the entire hospital. The risk analysis should include potential solutions, like building new structures, or having a contingent workforce.

**Human resources (see section 2.5)**

**Recommendation:** To allow the implementation of pairing (binômes) of MoH/MSF positions to create better communication channels and improve the efficiency of hospital management while building capacity among the MoH staff to be successful, OCG should invest in ensuring that the MSF staff have the competencies required to be able to transferred this knowledge to the MoH staff.

**Recommendation:** MSF should scale up the level of managerial know-how and practices of the organization. A topic that has been discussed extensively over the years within MSF, however, is especially relevant and critical to the success of hospital management. This effort requires hiring and retaining individuals with managerial capacities and up-scaling internal resources with this potential.

**Recommendation:** When making a shift in the management structure of their hospital projects, it is strongly recommended to make this shift gradually with a change management plan that would include ensuring the new positions are filled with persons who have the appropriate competencies.
Such changes should be accompanied by a change manager to overview and support the change, making it to a success.

**Recommendation:** OCG should consider restructuring the existing positions, reviewing the current profiles and adapt roles for organizational designs more compatible with hospital management in different contexts. This should be done in close collaboration with the HR department (field and cell) to ensure adequate and use of resources.

**Recommendation:** OCG should put targeted effort in the recruitment of individuals who already have hospital management competencies. Many universities offer Masters in Business Administration degrees with a concentration in hospital management. Just as many OCs and partner sections are changing their recruitment strategies to fill gaps in specific HR needs (surgeons, epidemiologists, and so on), individuals specializing in hospital management could also be targeted by the recruitment departments.

**Recommendation:** There are also creative solutions being used by other OCs to entice international staff to sign longer contracts. For example, for difficult to fill positions (namely HoMs), OCBA gives the opportunity for two international staff to pair together for one position and leap frog; four month on/four months off, which allows one position to be continuously filled for 16 months, where the strategy can be agreed upon between the two individuals, minimizing the risk of drastic changes to the project or mission.

**Recommendation:** From the requests of the field, especially MTLs, and as OCG is wanting to increase their role in intervening in secondary health care systems, it seems that developing a hospital management training specific to the needs of OCG would be a good investment. The training may only need to be a modified version of the OCB and OCP versions and may not require a complete redesign and could be completed rapidly by the L&D department.

**Recommendation:** One suggestion for current international staff to gain experience in hospital management could be to have interested persons shadow a Hospital Manager for a few months prior to taking on that role themselves.

**Recommendation:** To possibly ensure more continuity of projects, OCG should conduct further research to determine if there is a correlation between the length of stay of international staff and their country of origin.

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**Support to projects (see section 2.10)**

**Recommendation:** The support given by the flying positions to the international staff could be extended to MoH staff in the field. This should be always decided in discussion with the staff and develop a plan and objectives together before engaging the flying position.

**Recommendation:** Field visits are necessary and helpful but should not overload the projects. An annual planning of visits could help to get a better overview and the projects can plan according, despite the unexpected needs arising. The timing of delivering the report of the field visit should be as short as possible.

**Recommendation:** The same amount of effort put into the development of trainings should be done for the evaluation of the impact to adapt strategies and trainings. It is equally important to measure the impact than the training itself.
**Hospital Management Platform (see section 3.1)**

**Recommendation:** At HQ and field level many support the idea to engage a Project Manager to guide the process from its inception, help to develop the specifications, ensure decisions are made in a timely manner, keep the project on track, and ensure any changes made are valid. This position would be the “owner” of the project with some level of decision-making authority.

**Recommendation:** One focus of the hospital management platform should be to create a toolbox to answer the needs of the field in a transversal way. Many ideas have been expressed during the field visits and are enumerated in the individual case studies in annex 5.3.

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**Assessment / Planning / Vision (see section 2.6)**

**Recommendation:** Context specific needs assessment should be more comprehensive to answer the requirements of the population and to ensure that the construction plans are fit for purpose. A tool, such as the PASS should be designed, agreed and implemented for OCG with any decision to carry out substantial construction projects (defined by scope, time, and investment).

**Recommendation:** In terms of Hospital Management, long-term planning, including developing an exit strategy, is a crucial aspect to give the best chances of achieving set objectives. MSF should consider integrating this in projects offering secondary or in-patient care and especially those where MSF is working with the MoH (as many pure MSF hospitals do not always consider continuity of care after their departure).

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**Working with the MoH (see section 2.8)**

**Recommendation:** MSF should have a dialogue and formal agreement with the partner organization about their common objectives. This includes developing a robust framework around the definition of clear objectives and measurable outcomes with the partner – not for the partner – to provide better chances of achieving these goals. MSF should establish and implement mechanisms and controls to hold all parties accountable and systematically monitor progress and re-address any deviances.

**Recommendation:** MSF should also show curiosity in local partner’s processes. Budget cycles, annual planning, how they receive financing, and so on will help in anticipating potential blockages to the partnership.

**Recommendation:** If MSF decides to support an existing system (such as the case in Bol), the team should consider working within the system with all the advantages and disadvantages. There should always be willingness to improve standards and protocols, but this should be done within the system and with the MoH to ensure that it is adapted to the capacity of the system, which will provide greater possibility that it will be upheld after the departure of MSF.

**Recommendation:** MSF should consider developing strategies to overcome the difficulties placed by providing free care while compromising MSF’s principle as little as possible. A solution could be that in a set up where the population cannot afford medical services, MSF could create a “fund”, suggesting that MSF pays a sum per patient service to be given to the MoH in the disengagement phase to allow them to take have a financial base on which to resume the services.
5. Annexes

5.1 Terms of Reference

Review of Hospital Management in OCG

<table>
<thead>
<tr>
<th>Commissioned by</th>
<th>Operations Department in OCG: Jean-Clement CABROL and Mariano LUGLI</th>
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<td>Duration of the review</td>
<td>About 3,5 months from the start of the evaluator’s work</td>
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<td>Time period that is reviewed</td>
<td>2014-2015 years</td>
</tr>
<tr>
<td>ToR elaborated by</td>
<td>Mariano LUGLI, Isabelle VOIRET, Mzia TURASHVILI, Jean-Clément Cabrol</td>
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CONTEXT

Hospitals and other clinics that offer inpatient care form a significant part in the overall portfolio of the services provided by MSF-OCG worldwide. The number of projects offering IPD was stable between 23 and 27 in the period from 2012 year to 2014 year. Overall there were 284,008 admissions in the inpatient department (IPD) services with about 70,000 admissions annually. Emergency projects accounted for 28% and regular projects for 78% of the admissions in the inpatient projects.

Figure 1: Number of IPD admissions and number of projects offering IPD, 2011-2014

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23 Operational strategy review, OCG. 2012-2015.
Despite the targeted efforts in supporting this priority operational direction and testing some innovative management set-ups (e.g. in Haiti project), there are continuous challenges that OCG faces in managing hospitals and inpatient clinics. Often they are related to the issues, like availability and standardization of assessment tools, decision making on the size and profile of the hospital, management and governance structure and of course the human resources. Since the re-organization of the OCG in 2014, a decision was made to create some support platforms at the headquarter’s level, including the Hospital Management platform. This review should look closer at the challenges and opportunities that are out there in the OCG and outline recommendations which will put the organization in a better position to successfully set-up, govern/implement and close inpatient projects in the diverse field-situations.

**OVERALL OBJECTIVE and PURPOSE**

**OVERALL OBJECTIVE** is to outline how to facilitate the institutional support of OCG to the biggest challenges of the Management of Hospital structures.

**THE PURPOSE** is to be primarily used internally in MSF-OCG (by the medico-operations departments, hospital management transversal platform, field operations etc) to anticipate and adjust to the challenges posed by hospital management.

**KEY EVALUATION QUESTIONS**

- Looking at the management aspects (not on quality of care) – what are the main bottle-necks in terms of adequacy of processes in our hospitals?
- What is the difference between emergency, middle-term and long-term management approaches in the hospital projects and especially in their set-up phase? How to set-up hospitals for long-term, e.g. what HR recruitment and development strategies should apply?
- How do MSF-OCG standards (size, HR quantity and positions, catchment area etc.) compare with the National norms developed by the countries for their health structures (at different levels)? How well do MSF hospitals fit to the overall national health care maps?
- Analyse the assessment and monitoring tools currently used – what are the standards that MSF-OCG wants to fulfil? How can OCG (Med and Op) help the fields improve the identification and standardization of the assessment and monitoring tools?
- Analyse the impact of the size of the hospitals (<50 beds, 51-100 beds, >100 beds) on the management needs
- Analyse the influence of pics of patient-load (e.g. epidemic seasons) on the management aspects and understand how to adapt to them
- Analyse more about HR implications of running hospital projects for OCG and its institutional structures – what can be done better and how? How to plan an adequate HR and management structure (e.g. medical vs non-medical director) based on the size of the hospital?
- How optimally are internal resources used to support hospital management in OCG – e.g. recommendations from the previous evaluations, tools available (assessment tool-kit developed) etc. What can we learn for future?
- How does MSF follow the quality of care in the management of a health structures? What are the mechanisms for this follow up and how do they work? How does the SAE (Severe Adverse Event investigation) function?
- What kind of adaptations and support mechanisms are needed to overcome the identified challenges? What should be the role and priorities of the Hospital Management Platform?
EXPECTED RESULTS and INTENDED USE OF THE EVALUATION

- A report of maximum 30 pages, produced in English.
- Case studies should be produced based on the field visits (4-5 pages each).
- Presentation to the Operations Department /Ops Meeting
- Operations department is responsible for considering recommendations and ensuring, making decision on their implementation (or not) and following their implementation
- Report to be made available to MSF people through Tukul (TBC by the commissioners)
- Consider having a report open for public view

PRACTICAL IMPLEMENTATION OF THE EVALUATION – estimated times –

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<th>Evaluator 2</th>
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<td>2</td>
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<tr>
<td>Document review</td>
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<tr>
<td>Interviews</td>
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<td>For field visits (4 field visits)</td>
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<tr>
<td>For writing up report</td>
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<tr>
<td>For finalization, presentation and other final steps</td>
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<tr>
<td>Total working days</td>
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TOOLS AND METHODOLOGY PROPOSED (if any)

- Review and analysis of reference documents
- Interviews with key-team members at HQ
- Three or four field visits in the selected hospital projects - interviews with MSF staff and key-authorities
- Observation and review of the hospital processes and monitoring systems

Determinants of a sample of hospitals to be visited in the field:
- Different size
- hospitals with mixed management (MoH and MSF) or only MSF hospitals
- With different types set-up (emergency vs middle term vs long term)

Proposed hospitals for the case-studies:
1. Bol in Chad (Cell 2, contact person: Susanna Cristofani)
2. Gety in DRC (Cell 3, contact person: Coralie Lechelle)
3. Kusseri in Cameroun (Cell 1; contact persons: Barbara Rush and Christine Jamet)
4. Nduta refugee camp in Tanzania (Ecell: Hugues Robert)

Contact persons: Coralie, Susanna, Hugues Robert (E-cell), Barbara and Christine

DOCUMENTATION FOR READING

- To be identified (will be provided at the beginning of the evaluation process).
STAKEHOLDERS AND INTERVIEWEES

- Mariano LUGLI,
- Jean-Clément CABROL
- Isabelle VOIRET
- Coralie LECHELLE
- Susanna CRISTOFANI
- Florencia ROMERO
- Michel QUERE
- Barbara RUSCH
- Dorian JOB
- Philip JANSSENS
- Mathieu SOUPART
- More to be identified ....

JOB PROFILE/S of EVALUATOR

A team of two evaluators will be selected: One of them with **medical profile** and the other with the **non-medical background**. They both are required to have the following competencies.

- Strong theoretical or practical background in project management and coordination; understanding of the full project cycle from its inception to its closure.
- Hospital/clinic management experience at high level
- Proven ability in strategy development and implementation
- Knowledge and experience of humanitarian interventions
- Strong analytical capacity
- Expertise in conducting evaluations or research
- Proven ability of report writing and presentations
- Capacity to work with quantitative and qualitative research methods
- Excellent communicator
- Ability to work and produce results under (time) pressure
## 5.2 List of interviewees

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Location 1</th>
<th>Location 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alex ROUX</td>
<td>Responsable RH Terrain</td>
<td>HQ</td>
<td>OCG</td>
</tr>
<tr>
<td>Arielle GATEAU</td>
<td>Responsable, Service de Recrutement</td>
<td>HQ</td>
<td>OCG</td>
</tr>
<tr>
<td>Aude THOREL</td>
<td>Directrice, Ressources Humaines</td>
<td>HQ</td>
<td>OCG</td>
</tr>
<tr>
<td>Coralie LECHELLE</td>
<td>Programme Manager / Adjoint Responsable Programme (ARP)</td>
<td>HQ</td>
<td>OCG</td>
</tr>
<tr>
<td>Fabrice RESSICAUD</td>
<td>Resp. Service Finance Opérationelle</td>
<td>HQ</td>
<td>OCG</td>
</tr>
<tr>
<td>Isabelle LESSARD</td>
<td>Référent Soins et Qualité</td>
<td>HQ</td>
<td>OCG</td>
</tr>
<tr>
<td>Isabelle VOIRET</td>
<td>Medical Leader of Health Services</td>
<td>HQ</td>
<td>OCG</td>
</tr>
<tr>
<td>Jean Clement CABROL</td>
<td>Directeur des Opérations</td>
<td>HQ</td>
<td>OCG</td>
</tr>
<tr>
<td>Marc BLUMET</td>
<td>Resp. Service Log Opérationelle</td>
<td>HQ</td>
<td>OCG</td>
</tr>
<tr>
<td>Marianne RAMPON BOYER</td>
<td>MSO Nursing Health Structure Management</td>
<td>HQ</td>
<td>OCG</td>
</tr>
<tr>
<td>Mariano LUGLI</td>
<td>Chef du Service, MOSU</td>
<td>HQ</td>
<td>OCG</td>
</tr>
<tr>
<td>Micaela SERAFINI</td>
<td>Directeur, Département Médical</td>
<td>HQ</td>
<td>OCG</td>
</tr>
<tr>
<td>Monica RULL</td>
<td>Operational Health Coordinator</td>
<td>HQ</td>
<td>OCG</td>
</tr>
<tr>
<td>Philip JANSENNS</td>
<td>Resp. Service Technique Log</td>
<td>HQ</td>
<td>OCG</td>
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<tr>
<td>Philippe RUSCASSIER</td>
<td>Resp Learning and Development</td>
<td>HQ</td>
<td>OCG</td>
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<tr>
<td>Pierre MAURY</td>
<td>Référent Technique Log (construction)</td>
<td>HQ</td>
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<tr>
<td>Robert De La TOUR</td>
<td>Référent Laboratoire</td>
<td>HQ</td>
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<tr>
<td>Tammam ALOUDAT</td>
<td>Dir. Adjoint, Départment Médical</td>
<td>HQ</td>
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<tr>
<td>Vincent RICO</td>
<td>Coordinateur, Unité RH Opérationelle</td>
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<tr>
<td>Barbara HESSEL</td>
<td>HR Coordinator / Hospital Manager</td>
<td>Amsterdam</td>
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<tr>
<td>Debbie DUNCAN</td>
<td>Health Care Management Advisor</td>
<td>Amsterdam</td>
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<tr>
<td>Elvina MOTARD</td>
<td>Technical Referent for Hospital Logistics Management (HLM)</td>
<td>Brussels</td>
<td>OCB</td>
</tr>
<tr>
<td>Maya FEHLING</td>
<td>Medical Quality Advisor</td>
<td>Berlin office</td>
<td>OCA/OCG</td>
</tr>
<tr>
<td>Nadja DEGRO</td>
<td>Independent specialist (ex-OCB)</td>
<td></td>
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<tr>
<td>Peter WHISKERD</td>
<td>Programme Manager</td>
<td>Amsterdam</td>
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</tr>
<tr>
<td>Dana Krause</td>
<td>Former Emergency coordinator</td>
<td>E-Cell</td>
<td>TNZ</td>
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<td>Dorian JOB</td>
<td>Adjoint Responsible Programme</td>
<td>E-Cell</td>
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<td>Hugues ROBERT-NICOUD</td>
<td>Responsible Programme</td>
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<tr>
<td>Roberto Milioti</td>
<td>Responsible Logistique Operations (RLO)</td>
<td>E-Cell</td>
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<tr>
<td>Yoann Calla</td>
<td>Responsible RH Operations (RHOp)</td>
<td>E-Cell</td>
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<tr>
<td>Geneviève CHABRé</td>
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<td>Kenneth LAVELLE</td>
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<tr>
<td>Susanna CHRISTOFANI</td>
<td>Responsible Médical Programme (RMP)</td>
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<tr>
<td>Dr. Serge KAZADI KYANZA</td>
<td>MedCo</td>
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<td>TCH</td>
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<td>Federica ALBERTI</td>
<td>HoM</td>
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<tr>
<td>Jérôme BASSET</td>
<td>LogCo</td>
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<tr>
<td>Marie Spéciose M. NSABIMANA</td>
<td>HRCo</td>
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<tr>
<td>Danielle (Dany) ROUCHON</td>
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<td>Diouf BALE</td>
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<td>Ali MAHAMAT</td>
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<td>Ahmat DAWAH RAMADAN</td>
<td>Gestionnaire</td>
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<td>Akoun Fatime BADOU</td>
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<td>Emmanuel BOCQUET</td>
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<td>Ivan AQUALINA</td>
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<td>Resp. Terrain (08/15 – 06/16)</td>
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<td>Jérôme FREYCON</td>
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<td>Maria L CHACÓN ROLDÁN</td>
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<td>Bibiana NJAO</td>
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<td>David NASH</td>
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<td>Paula LOPEZ</td>
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<td>Marcus SHELLEY</td>
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<td>Sally PARKER</td>
<td>Midwife</td>
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<td>Sammy NYUMU</td>
<td>Head Nurse</td>
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<td>Tania HACHEM</td>
<td>Medical Team Leader</td>
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<td>Valerie TOMASSI</td>
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<td>Wail AHMED</td>
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Barbara Rusch | Responsable Medical Programme | Cell | CAM
Christine JAMET | Dir Op / Responsible Programme | Cell | CAM
Gregory Boisset | Responsible RH Operations (RHOp) | Cell | CAM
Najet Makhloufa | FinOp | Cell | CAM
Ann MUNINA | Medical Coordinator | Coordo | CAM
Hassan MAIYAKI | Head of Mission | Coordo | CAM
Jean BOURGES | Financial Coordinator | Coordo | CAM
Jean-Claude KAMUHANGIRE | Human Resources Coordinator | Coordo | CAM
Patrick NKEMENANG | Deputy Medical Coordinator | Coordo | CAM
Freddy VONDI NZITA | Medical Team Leader | Field | CAM
Joachim BIAKANGA | Field Coordinator | Field | CAM
Joseph NADJITAN | Nurse Activity Manager | Field | CAM
Raissa KOLLOGO | Field Admin | Field | CAM
Richard AN'ENHY | Logistician | Field | CAM
Christiane Gladice NZENCHI TESSA | MSF Paramedical Supervisor | Field-NS | CAM
Isidore FANTHE THEUUMASS | MSF Supervisor OT | Field-NS | CAM
Jacky Dominique GVEMNE DJUIJE | MSF Medical Supervisor | Field-NS | CAM
Abubakar BOUKAR ABALI | Paramedical Director | MoH | CAM
Angaye DAVID | Hospital Director | MoH | CAM
Bale ROGER | MoH Supervisor OT | MoH | CAM
Falmata GUSMAN | MoH Supervisor paediatric ward | MoH | CAM
Joseph TCHOMPO | Comptable Matiere / Coor.Unité d'Hygiène | MoH | CAM
Lade FILACH | Chef de Bureau Sante | MoH | CAM
Ngamji DAKAOUSSOU | MoH Supervisor surgical ward | MoH | CAM

5.3 Reports / case studies

**Hospital management guidance documents:**

Critical review of the use of generalist hospital-based indicators at MSF OCP

OCB Review of the Hospital Support Committee: Based on experiences from the Sierra Leone and Afghanistan

Healthcare Management Programme

OCBA Hospital Management Guidance document for setting field hospitals in Low and Middle Income Countries

**Case studies:**

Gety (DRC)
Nduta (Tanzania)
Kousseri (Cameroun)
Bol (Chad)
5.4 References


