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The Factors of Adhesion of the Personnel of the Hospital of Beni Mellal to the Hospital Establishment Project (Morocco)

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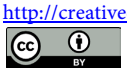

Abstract

The Hospital Establishment Project (PEH) is subject to many criticisms and most of the objectives are not achieved. The objective of this study is to analyze the factors of adhesion of the personnel to the elaboration and implementation of the Beni Mellal EPH. **Methodology**: The study is transversal, descriptive, quantitative and qualitative. It was conducted from 21-04-2010 to 30-04-2010. The data was collected using a questionnaire and semi-directive interview guides. The targets were hospital staff, the director, delegates, central level officials and Canadian consultants. Quantitative data were entered and analyzed using Epi Info 2000, and qualitative data were transcribed, synthesized and analyzed on the basis of the content of the speeches. **Results**: 56% did not understand what the HDP was and few perceived its usefulness. 85% were not prepared for the EPI; only the managers ($p < 0.05$) were prepared. Only the managers ($p < 0.05$) were involved in the development and implementation. Information/communication was insufficient. There was a constant mobility of managers from their position of responsibility. The development of the HDP was subject to several constraints (technical, time, financial, and planning). **Conclusion**: In order to create the conditions for staff to adhere to the next generation of HDPs, there is an urgent need to reduce the instability of those in charge of the structures, to simplify the planning method, to prepare and involve the staff in the HDP, to set up a communication plan, and to train the chief doctors and department heads in strategic planning.

Subject Areas

Public Health, Health Policy

Keywords

Hospital Establishment Project, Membership Factors, Change, Strategic Plan, Beni Mellal Hospital, Morocco

1. Introduction

In Africa, hospital reforms have been introduced to cope with financial burdens, poor patient reception, absenteeism and declining quality of care [1] [2] [3]. In Morocco, this reform was essentially aimed at modernizing hospitals (buildings, technology, etc.) and improving management to achieve better performance [4]. The Hospital Establishment Project (PEH) was one of the main tools advocated as part of this reform. A tool for change, the PEH requires internal reflection and mobilization of hospital players and partners before it can be implemented [5]. Yet "change, an organizational reality that leaves no one indifferent, entails continual questioning of practices and modes of interaction between players [6]. It calls into question the very nature of the orders legitimized by the pre-existing organization and its forms of control" [6]. This implies clashes of powers, beliefs and goals that belong to the organization and are external to it [2]. A better understanding of these phenomena would enable us to facilitate change induced by the PEH [6]. Béni Mellal Hospital, a pilot site for the Health Services Financing and Management Project (PFGSS), was a forerunner of the PEH in Morocco. As recommended in the context of the reform, it has developed, thanks to significant technical and financial support, its PEH to improve its performance. Normally defined as a genuine participative management tool for driving change [6], this EPH should have led, through the mobilization of the hospital's resources in a direction shared by all and adapted to the characteristics of its environment, to the implementation of coherent, programmed actions. However, difficulties have been encountered in its implementation. It has been subjected to criticism at various levels by those who are supposed to have participated in its development and who are called upon to implement it. Certainly, already during its development and as stipulated in a mission report, several doctors refrained from taking part in meetings for lack of time or other reasons [7]. It has also been noted that there is little or no commitment on the part of some staff [7]. What's more, HDP documents are not to be found in the departments, and some employees are not even aware of their existence. The consequences of these findings are the limitation of the effects established for the facility project, in this case, the improvement of the hospital's performance and quality of care through a process of innovation and proactivity. As a result, most of the objectives set for 2007 as part of the 2003-2007 EPH were not achieved. For example, the targets set for Medicine and Maternity had not been met [8]. Finally, since the end of the project period, there has been no elaboration or reflection on the second-generation HDP. This leads us to ask the following questions: Has the staff at Béni Mellal Hospit-

al, on whom the change depends, been adequately prepared for the HDP or not? What factors may or may not have influenced their adherence to this HDP? The HDP, one of Morocco's reform tools, is a participative tool for change, and its success depends on the involvement of all staff in all phases of its development and implementation. If properly managed, it can improve the performance and quality of care at the hospital level. It is also necessary for all managers to understand the factors that promote or inhibit change in an organization, so as to be able to identify the facts and better manage it to achieve the objectives defined by all concerned [9]. Individual factors, collective factors, the quality of change implementation and the organizational system can all influence staff adherence to the Hospital Project.

2. Methodology

The study was cross-sectional, descriptive, quantitative and qualitative. It was based on a single case and carried out from 21-04-2010 to 30-04-2010. The target population was Beni Mellal hospital staff (medical, paramedical and administrative). The other actors targeted in the study were the former hospital director, former delegates to the province of Béni Mellal, officials at the central level and Canadian consultants from the Consortium-University of Montréal, Biomedical Engineering, Management Consultant (C-UGC). For quantitative data collection, a stratification was carried out on the basis of the sampling frame constituted by the list of medical, paramedical and administrative personnel. Two strata were defined. One was composed of staff with responsibilities and the other of staff without responsibilities. As there was no previous data available to determine the sample size, we chose the age variable from which the sample was defined. Thus, we calculated the average age (μ) of the staff and its standard deviation (s). The average age of the target population is 48 and the standard deviation is 9.8, $n = [C\mu 1 - \alpha/2)/I]$ 2, we assumed $\alpha = 5\%$ and $I = 4\%$. Thus, applying the formula, the sample size is equal to 103. With regard to qualitative data, the interview sample was not defined in advance. We conducted interviews with the hospital's medical, paramedical and administrative staff until the information to be gathered was repeated. The people included in the sample were selected on the basis of their participation in the development of the facility project, and by simple random selection by stratum. The choice of participation criterion was based on the need for more information on the HDP development process. Data were collected by means of a questionnaire and semi-structured interviews. The questionnaire was administered to all staff (medical, paramedical and administrative) included in the sample. Semi-structured interviews were conducted with staff who had participated in the development of the PEH, and with managers (director, delegates, Ministry of Health, and C-UGC consultants) who had accompanied the development of the project. Prior to data collection, a pretest was carried out to check the quality of the tools and the data collection itself. Quantitative data were entered and processed using Epi Info version 2000 software.

To this end, we described the survey population by determining frequencies and averages for each type of variable. Statistical tests (Chi-square and Fisher) were used to define relationships between certain variables. Qualitative data were transcribed and synthesized. Information was then grouped according to themes defined on the basis of the analysis framework (theoretical model). Discourse content was analyzed by examining the concordance or discordance of information within and between themes. Finally, following the strategy of information triangulation, we cross-checked the information in the quantitative and qualitative data to describe the factors driving staff buy-in to the hospital project.

3. Results

3.1. Description of the Survey Population

Men represented 67% and women 33%. The M/F sex ratio was 2. The mean age of the survey population was 49 years, with 95% CI [48 - 50]. The mode (50 years) was identical to the median. Professionally, nurses represented 79%, medical staff 18% and administrative staff 3% (Figure 1).

39 individuals (43%) held a position of responsibility. These included 24 nurses (61%), 12 doctors (31%) and 03 administrative staff (8%). 75% of the population surveyed had been with the hospital for ten (10) years. The average length of service was 19 years 95% CI [17 - 21].

3.2. Preparing the Survey Population

15% of agents surveyed said they were prepared for the HDP. Of these (14), 79% said they were prepared through information and awareness-raising meetings, while 21% were prepared through information meetings and memos. This preparation was carried out mainly at the central and local levels. At the central level, meetings and training sessions on the HDP were held for managers from certain central departments and those from the provinces (delegations and hospital team staff) of the pilot sites. According to a local manager: "This began with several information and awareness-raising meetings for all the departments involved in the project, as well as for all the local players and managers in the above-mentioned provinces, in the presence of Canadian technical assistants, to explain from the outset the relevance of the project, and then the process to be followed in the field for its development and implementation". At the local level, information

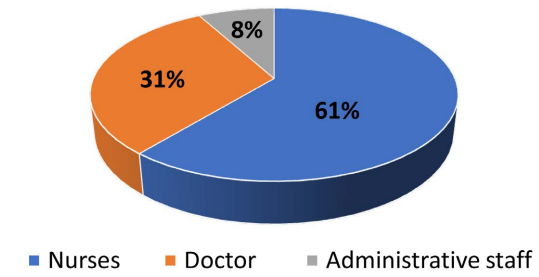

Figure 1. Breakdown by staff category.

and awareness-raising meetings were held for some of the hospital's medical and paramedical staff. According to one of the hospital's managers: "Locally, we held several information and awareness-raising meetings, with the aim of involving all the hospital's medical and nursing staff and raising their awareness of the importance of strategic planning (PEH)". This has greatly reduced the resistance of professionals and unions to the hospital project. On the other hand, most of those interviewed were unprepared. Their main concerns were inadequate communication with hospital management and the fact that they did not hold a position of responsibility within the hospital. There was a statistically significant relationship between the number of hospital staff in positions of responsibility and preparation for the hospital project ($p < 0.05$).

3.3. Factors Influencing Staff Buy-In

3.3.1. Individual Factors

Of the 91 employees surveyed, 44% said they knew what a hospital project meant. For 16%, it's a new management method, for 7% it's a planning and communication tool, and for 77%, it's a new management method, a planning and communication tool. There is a statistically significant link between preparation and the survey population's understanding of what a hospital facility project is (Table 1).

1) Comprehension

Most of the interviewees did not understand the PEH. For some, this was due to the novelty of the tool, while for others it was due to their position in the structure (level of responsibility) and the availability of documents. According to central-level players and consultants, some hospital staff did not understand the logic of strategic planning. Managers at the central level declared: "This is a first experience. From one day to the next, we're asking them (hospital staff) to implement it (PEH), understand it, assimilate it and carry out the activities. Despite explanations (awareness-raising and meetings), they (hospital staff) were unable to understand and use the logic of future planning (they were asked to be 'experts' and carry on with their activities)". In interviews at Béni Mellal Hospital, one doctor said: "I didn't talk to the nurses because I hadn't mastered the 'thing' (PEH); no documents either!" Certainly, some doctors consider the PEH to be fundamental for a hospital. One of them even declared that "a hospital without an HDP means nothing".

Table 1. Relationship between preparation and understanding of HDP.

	Includes	Doesn't include	Total
Prepared	13 (93%)	1 (7%)	14 (100%)
Unprepared	31 (40%)	46 (60%)	77 (100%)
Total	44 (48%)	47 (52%)	91 (100%)

X2 = 12.98 and p = 0.0003161 (with $p < 0.05$).

2) Skills

The lack of local skills to implement the tools led to renegotiated contracts, extended the duration of technical assistance and influenced the appropriation of management tools. A central-level manager commented: "Various tools were developed, and it was recommended that local teams should use them to implement their facility project. However, the local teams had no local skills: contracts had to be renegotiated (financial and accounting management, hospital reorganization, quality improvement process) and the duration of technical assistance had to be extended in order to start implementing the various tools (for the tools there was a 'lost year')". According to one of the delegates from the province: "There was a shortage of qualified personnel to help with the appropriation of management tools".

3) Usefulness

At the hospital level, some people saw the benefits of the HDP. According to one of them: "With the FHP, everyone had the feeling of experiencing change: training, equipment, reduced workload, additional staff and improved working conditions". Some interviewees said that the HDP had enabled the hospital to acquire equipment and benefit from the creation or redevelopment of several departments, including intensive care, emergency, laboratory and radiology. A central-level official declared: "What they have received in terms of equipment, they had never dreamed of seeing". According to him, some said: "This only exists in the United States". Others, however, didn't see the point. Their expectations of the HDP were not fulfilled, resulting in dissatisfaction, lack of confidence, lack of cooperation and a feeling of indifference. Several interviewees stated that they had expected to achieve a great deal within the framework of the facility project. Other interviewees, however, added that many things had been planned but not carried out. According to some doctors: "A lot of activities that had been planned were not carried out. This has led to discontent among local teams, loss of confidence and refusal to cooperate (broken promises)". According to one nurse: "We're working in the field, but we can't see any improvement".

3.3.2. Collective Factors

The people involved in the development and implementation of the HDP were chosen on the basis of criteria based on their function as managers, their managerial skills probably based on their relational skills both locally and centrally, their closer collaboration with hospital management and the central level, and their availability. These choices would have different effects on the development and implementation of the HDP. Activities were concentrated at the level of one category of staff. Some doctors, especially specialists, were demotivated, and divergences and tug-of-war were noted during meetings between practitioners. According to one of the hospital's managers: "The teams were chosen on the basis of their managerial skills, their collaboration with management and their availability". According to one of the delegates: "In the management hubs, there was

one category of staff who occupied several roles at the same time, to the detriment of others". "A proportion of doctors, especially unit head specialists, were demotivated in working groups". According to some interviewees, meetings were marked by tug-of-war: "During meetings, there were a lot of divergent opinions, especially among practitioners". However, some doctors were aware of the need to participate in hospital management. Among them, one doctor declared: "There's a 'void'; 'doctors need to have knowledge of hospital management'".

3.3.3. Implementation Quality Factors

1) Information/Communication

Several means of communication (meetings, open days, memos, communication plans and "focal point" appointments) were used by the central and local levels to prepare and support staff for the HDP, and to make the activities developed visible. Of all the staff surveyed, 54% were aware of the existence of an EPH within the hospital. Of these, 25% said they had learned of its existence during an information and awareness-raising meeting on the hospital's project. Among the factors thought to be responsible for this situation are meetings not scheduled in advance, meetings held during working hours, staff summoned one or two hours before the meeting, lack of follow-up to meetings previously organized at the hospital level, etc. As a result, few people attended the meetings, and most were not informed about the facility project. According to some doctors, "it was like an interrogation to get the opinions of doctors and nurses". This even led some doctors to say: "As soon as the administration invites us, there must be something behind it". For them, sometimes the meetings were not planned in advance. In addition, some doctors stated that "the meetings organized had no follow-up: that's why most doctors, heads of department, no longer took part". Also, some of those interviewed said they had learned of the existence of the facility project through memos, while others had learned of it outside the hospital (through promotion or discussions with colleagues).

2) Training

A number of training courses were held at the central level (prior to start-up, at launch and during the HDP development phase) to prepare staff for the facility project. Prior to start-up, training was provided for all regional managers in the Kingdom. At the launch, only the delegates, hospital directors and bursar administrators of the pilot sites were involved. During the development phase, the resource persons to be trained were selected according to their profile and degree of commitment. In Beni Mellal, not everyone was involved in the training sessions. Some said the training concerned department heads, while for others there was no training but meetings to gather their opinions. According to one central-level manager, delegates organized regional training sessions, and hospital managers within the hospital. However, he said: "We received reports, but as for the quality and nature of the training, we couldn't say whether it was well done or not". Chief physicians, department majors and administrative managers

were trained at the PEH. According to one of the hospital's administrative managers, "the preparation was done through training, and the targets were the chief physicians, department majors and administrative managers. They in turn had to train the staff under their responsibility".

3) Participation in development and implementation

Of those surveyed, 12% stated that they had participated in the development and implementation of the facility project. There is a statistically significant link between holding a position of responsibility at the hospital level and participation in the development and implementation of the hospital project (Table 2).

a) Participation in development

In Beni Mellal, not everyone was involved in the development of the HDP. Not everyone who was prepared for the HDP took part in its development. Those who did were mainly chief physicians, majors and administrative managers. According to one central-level manager: "We involved as many staff as possible. However, not everyone could be available full time all the time to carry out the exercise. The absence of said staff to work constantly during the meetings (need to demobilize from technical activities) meant that few people (three to four) worked on a permanent basis…" The difficulties encountered during the validation sessions were the lack of habit of working as a team, the feeling of mistrust (doctors difficult to convince), the loss of confidence in the system (PEH like the old projects) and multidisciplinarity. According to officials at the central level: "When it came to validating the final stage of the project, for them it was an experience just like the old projects. They had lost confidence in the system and in the field. As a result, they withdrew".

b) Participation in implementation

With regard to participation in the implementation of the HDP, most of the agents who had been involved in its development were not involved in its implementation. According to some doctors: "There is a discontinuity between development and implementation: in other words, those who participated in its development were not involved in its implementation". For most nurses, there were no follow-up activities at the time of implementation. For some hospital managers, implementation was carried out by the delegation, the hospital administration and the central level. According to one of them: "We weren't involved in the implementation. Doctors' demands were not met: complaints, union actions, lack of trust between doctors and administration".

Table 2. Relationship between responsibility and preparation.

	Prepared	Unprepared	Total
Responsibility	12 (31%)	27 (69%)	39 (100%)
No responsibility	2 (4%)	50 (96%)	52 (100%)
Total	14 (15%)	77 (85%)	91 (100%)

X2 = 12.27 and p = 0.00046079 (with $p < 0.05$).

A number of difficulties were encountered in implementing the HDP. According to officials at the central level, these included the low level of credit consumption and the multitude of tools to be implemented. With regard to the medical project, the problems mentioned by those interviewed included the lack of training in planning and management for doctors, the absence of computerization, and doctors' lack of interest in planning activities. According to one provincial manager: "In the medical project, there was insufficient ownership by the medical profession (due to lack of training in planning and management)…" Also noted was the effect of coordination between the central and local levels, and adherence to work schedules. According to a hospital official: "There were some coordination problems between the central and local departments. For example, we sometimes received equipment before the premises in which it was to be housed were ready". There were delays and difficulties in carrying out the activities set out in the HDP. Most of the objectives set were not achieved. It was a plan we could work on for ten to fifteen years, said a central-level official. He added that the failure to meet targets was to be expected: "It was a first experience with an untested team. What's more, people had a lot of problems: they tried to fit everything into this project…"

3.3.4. Factors Associated with the Organizational System

1) Background

The PEH, a component of the PFGSS, was financed by the World Bank through a loan of thirty-eight million dollars. Five pilot hospitals (Agadir, Béni Mellal, Meknès, Settat and Safi) were identified for the introduction of the facility project. According to one of the focal points: "This was the first time that the facility project was introduced in hospitals in Morocco…" A timetable was defined for each stage in the development of the EPH. For each stage, there was a timetable and the teams had to respect it. A manager from the central level declared that "the measures that were taken (timing of stages, tripartite control...) represented constraints for the hospital teams". Since this was the first experience, and there was a lack of expertise in this field in Morocco, the Ministry of Health recruited a consultancy firm (CUGC) for the FHP. According to an official at the central level, "Technical assistance was not permanently present at the site level or in Morocco". This latency allowed the teams to carry out the work required of them. On the other hand, "it would have been better if the team had been more experienced, or if it had been a second or third-generation project".

After 4 years of project implementation, the disbursement rate was low (5%). The project was reoriented by a return to the Plan of Procurement (PPM). In Béni Mellal, the buildings were dilapidated, with a layout that did not allow for ideal phasing. Caves were found on the hospital grounds. It took a year and a half for the Ministry of Culture to give the go-ahead to start construction. What's more, between the preparation phase and the end of the project's implementation, there were numerous changes at the head of the delegation and the Hospit-

al. At the delegation level, there were two movements. One of the delegates, after coordinating the preparation and development of the HDP, was transferred. The other began implementation, then was transferred before the project was completed. At the hospital level, there were two directors between the preparation phase and the end of the project. One began the preparatory phase (and is still at the hospital as a practitioner) within the framework of the FHP, then was replaced by another who followed the development through to the end of the project's implementation. When he left (less than a year later), the hospital had two directors. According to one central-level manager: "There is no stability in the staff we had invested in."

2) Leadership

Stakeholders' assessments of the discourse vary. According to some, the discourse must correspond to the facts and help build trust between the players. For others, the discrepancies between rhetoric and facts led to difficulties in coordinating HDP activities. There was insufficient coordination, a mismatch between rhetoric and reality, and a failure to listen to stakeholders. According to some: "Difficulties in coordinating and managing the various strategic axes of the HDP"; "Discourse must be translated into facts: *i.e.*, avoid demagoguery"; "We need to listen to the practitioners at the work level who feel the need more". While for others, the discourse is positive and their opinions are solicited: "The discourse they had with us was positive, if they asked for our opinions this would give us more confidence" and "Access to the director's office was easy, it didn't require an appointment".

4. Discussion

4.1. EPH Preparation

With regard to hospital staff preparation for the development and implementation of the facility project, the results of both quantitative and qualitative data analysis concur. For example, we found that preparation for the HDP was not at all optimal, with 85% of those surveyed declaring that they had not been prepared. When preparation did take place, it was fairly selective, affecting in particular professionals occupying positions of responsibility within the hospital. According to the data, it was mainly department heads who were prepared (statistically significant link between preparation and holding a position of responsibility with $p < 0.05$). The most frequently used methods of preparing for the HDP (79% of respondents) were information meetings and awareness-raising meetings. The failure to adequately prepare hospital staff for the HDP is a real handicap, with repercussions for both its development and implementation. In the absence of preparation, monitoring and evaluation, progressive accountability cannot be achieved [10]. What's more, without awareness-raising and preparation, staff cannot change the way they see the future of their institution overnight [11]. To ensure that staff adhere to the HDP, it is essential to prepare them for change.

4.2. Individual Factors

4.2.1. Understanding

Understanding of the HDP and its importance as a hospital management tool is poor at Béni Mellal Hospital. Over half (56%) of the population surveyed said they did not understand what the HDP was. This situation may well be linked to the lack of preparation for HDP. (85% of the population surveyed were not prepared). Indeed, there is a statistically significant link between preparation and understanding (with $p < 0.05$). This lack of understanding is also linked to the fact that the PEH is a new, complex tool which, what's more, is a "command from the central level to which the periphery must respond". For an individual to adhere to change, he or she must appropriate it and integrate its values, norms and goals, and to do this, he or she must understand its content [10]. Simplifying the development method to make it easier to understand can help staff to better understand the HDP, and thus contribute to their buy-in.

4.2.2. Skills

The renegotiation of contracts and the duration of technical assistance to accompany the implementation of tools, in order to compensate for the shortage of qualified personnel, has not led to the tools being adopted by all staff. Department heads are better informed and more familiar with the tools than other staff. Lack of time contributed to this situation. "We had deliverable commitments, so the compromise to meet commitments didn't allow us to give the hospitals the time to make sure there was ownership". "However, there was ownership by hospital directors and staffs. The more we reach out to the care teams, the less we find the information available and the knowledge we need". The lack of mastery of these different tools has been a barrier for some managers to passing on the skills they have received to the staff in their departments. "I didn't talk to the nurses because I hadn't mastered it, and I didn't have any documents". When individuals lack the necessary skills to perform the tasks required of them, they will not adhere, for fear (lack of confidence) of not being up to the job [9]. This leads to a blockage in the dissemination of information (lack of communication) to the recipients. Most of those who do not occupy a position of responsibility have not been prepared and do not understand what PEH is. These managers and agents without positions of responsibility find themselves in a context that may encourage their non-adherence to the HDP. So, if employees at all levels are to adhere to the program, managers and their colleagues need to be informed and trained, so that the information reaches the right people.

4.2.3. Benefits

The HDP has brought many benefits to the hospital in a number of areas. There has been a transfer of skills, the implementation of several tools, and an improvement in working conditions through the equipping, creation or reorganization of certain departments. However, few individuals perceived these contributions. Focusing on their expectations led them to consider that the project had achieved

less than it should have. Some even said that "if the FHP had been fully implemented, the hospital should have looked different". The failure to meet their expectations is a source of frustration. It also breaks the trust between staff and management. In the words of some interviewees: "You see, my office, my heart isn't in it, hence the development of a feeling of indifference". "We work in the field and we don't feel any improvement". This gap between the achievements of the HDP and the expectations of staff may be linked to inadequate communication. If communication had been carried out regularly and closely throughout the project, it would have demonstrated its usefulness, the objectives achieved and the difficulties encountered in implementation. Its effect is to ensure staff buy-in to the HDP. So, to ensure that staff adhere to the HDP, communication must focus on the benefits and difficulties encountered in implementation, and must target everyone.

4.3. Collective Factors

The way in which team members are selected, and the concentration of power in the hands of one group, can be the source of tug-of-war and misunderstandings at meetings, reflecting the existence of power games between practitioners. "Departmentalization" is an issue. Its implementation may mean the loss of a position of responsibility for several agents. The stability gained or lost (power) for some can lead to resistance. Some may be demotivated by the inability to protect their interests. All this can lead to staff not joining the PEH. However, despite this situation, a fringe group of doctors has become aware of the need to get involved in hospital management. For, in their view, it's not just the hospital director's prerogative. There's a gap, they say, and doctors need to have some knowledge of hospital management. And since the ability to embrace change depends on the modalities and construction of the games that enable players to cooperate [12], it is necessary in this case to put in place a communication plan, and to train doctors and chief majors in management to enable shared leadership.

4.4. Implementation Quality Factors

Quantitative and qualitative data show that communication was inadequate. This can be explained by the following facts: many people (46%) were not informed about the HDP, the communication plan was very insufficient to mobilize all staff, meetings were not scheduled in advance, many agents learned about it informally (57% learned about it through their preparation for promotion and discussion among colleagues). What's more, those informed were mainly department heads (statistically significant link between knowledge of the existence of the PEH and preparation $p < 0.05$). This is contrary to what is intended in the HDP, which is a communication tool. According to Demers 1983 and Giroux and Chreim 1997 [13]: the function of communication is to prepare stakeholders for change. To this end, it must take place at different levels. It must be direct, interpersonal (between superiors and subordinates) to maintain a "sense of commu-

nity" in times of disruption. It must be repeated, and in this context middle managers play a central role in the hospital's performance.

4.4.1. Training

Training was of particular concern to the hospital director and his direct staff. "We have never been trained to develop an HDP". "Nor have we ever been trained to train nurses". The lack of training at the expense of middle managers can act as a brake on the dissemination of the vision advocated by the HDP. It can also be a source of frustration. All of this can contribute to staff not adhering to the facility project.

4.4.2. Involvement

1) Participation in the development process

There is a gap between what is recommended in the HDP development methodology and the reality on the ground. A very large proportion of staff (88%) did not take part in drawing it up. Department heads (chief physicians, department majors and administrative managers) were more involved than other hospital staff. This can be explained by the existence of a statistically significant link between holding a position of responsibility and taking part in drawing up the HDP (Fisher test with $p < 0.05$). It can also be explained by statements made by some of the staff interviewed: "I took part, but my department didn't". "It was a symbolic participation: difficult application, between the Canadian context and the Moroccan context". The consequence of such a situation is staff non-adherence to the HDP. Change is a complex, unpredictable phenomenon, which would benefit from being introduced through participative, decentralized strategies involving a wide range of agents and pilots [14] [15].

2) Participation in implementation

Implementation did not involve all those who participated in its development. "Involve at the start, but not at the end: when they place orders to meet the needs of the departments, they don't involve the staff concerned directly, even though they participated in the planning". This situation can lead to frustration and non-adherence to the HDP. Especially as there is a significant proportion of staff who have not been prepared. What's more, communication was inadequate during its development. This may contribute to the failure to achieve the objectives set for the HDP. According to research conducted in the field of change management, non-adherence to change by stakeholders is a factor in the failure to achieve expected performance [16].

4.5. Organizational System Factors

4.5.1. The Context

The development of the Béni Mellal HDP has been greatly influenced by its context. In this context, there is the non-permanent presence of certain technical assistants, the chronogram, the timing of the different stages and the tripartite control (Ministry of Health, World Bank and C-UGC). All these factors influenced the development and implementation of the project. They led to delays,

the impact of which was the low disbursement rate (5%). The result was a reorientation of the project. In Béni Mellal, in addition to the factors mentioned above, the dilapidated state of the buildings, the layout (inadequate phasing) and the discovery of caves (technical constraints) caused delays in the execution of the work. As a result, the hospital's budget was exceeded, and the project was not completed on time. The effect on the development of the PEH can also be seen in the mobility of the delegation and hospital managers. "There was no stability in the staff we invested in". This means that planning for change is not enough. There is a need to make improvements during implementation through learning. This must be based on shared experience involving all staff, hence the importance of communication [13] and the involvement of everyone in all phases of HDP development [14].

4.5.2. Leadership

The interviewees' statements are ambivalent. Leadership is not recognized by all interviewees. "There is insufficient leadership". The non-participation of several people in the development and implementation of the HDP, and the context of instability of those in charge, may be the cause. Non-participation in development and implementation may have resulted in a negative perception that stimulates a propensity to oppose change [17]. As far as the leader is concerned, he or she must be a strategist, encourage participation, be a skilful negotiator and capable of building winning coalitions [14]. To this end, the communication essential to the successful implementation of change must be based on participation and the decentralization of decision-making processes [14]. In fact, several empirical studies on organizations have shown the importance of collective leadership in mobilizing the full range of expertise [16]. The instability of leaders from the preparation phase to the end of implementation can influence the behavior of the leader. Leaders are subject to two situations at hospital level. The first is a change at his or her level to assert leadership. The second is to lead the change advocated by the hospital project. This situation may have an impact on the way he manages the hospital's human resources. As indicated in the literature, a leader must be a strategist if he is to encourage the participation of stakeholders, and hence their adherence to the HRP [14] [18]. Thus, it is necessary to make positions of responsibility stable to enable those concerned to better position themselves in order to encourage the participation of all staff in the development of the HDP.

5. Conclusion

The implementation of the HDP in Béni Mellal, one of the FHP's pilot sites, has led to a number of achievements, including the upgrading of the hospital. Despite the results observed, we have noted that the development of the HDP has encountered problems, particularly in relation to staff buy-in. The study carried out on staff buy-in showed that most staff had not been prepared for the HDP. Its usefulness was perceived by a few individuals. Communication was inade-

quate, training involved only a few managers, and the planning method adopted was complex. Its development has been marked by instability among the delegates to the province and the directors appointed to Béni Mellal Hospital. The director's leadership is not recognized by all staff. The timing of stages and tripartite control, insufficient funding and technical constraints have contributed to the non-realization of several investments, as a result of which most staff have not seen the realization of their expectations. All these factors can have a negative impact on staff buy-in to the HDP. To this end, in order to create favorable conditions for achieving the objectives of the next generation of HDPs, the following measures need to be put in place to encourage Beni Mellal Hospital staff to embrace the HDP: prepare all staff for the project, establish appropriate communication at all stages of its development, simplify the planning method, ensure the stability of provincial and hospital managers, train all managers (chief physicians and majors) in strategic planning, and accompany leaders throughout the process from preparation to implementation. Certainly, these proposals can contribute to staff buy-in to the HDP. However, it would also be important to carry out an in-depth analysis of leadership and the interplay of players, in order to refine decisions further and identify ways of strengthening staff buy-in.

Conflicts of Interest

The authors declare no conflicts of interest.

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