

The ROMAC program: Managing Complex “Family” Crisis Projects in Developing Countries in the Asia-Pacific

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Abstract

This paper describes, discusses and comments on the Rotary Medical Aid for Children (ROMAC) program and its constituent projects supported by the Rotary Organisations in Australia and New Zealand from a crisis management and recover. The crisis faced by the children cared for by ROMAC cannot be compared to disasters as we know them (natural disasters such as earthquakes or manmade disasters such as nuclear accidents or humanitarian disasters such as an epidemic). The authors would like to classify ROMAC projects as ‘family disasters’ for children and their families from developing countries who need lifesaving or dignity restoring surgery and treatment. These families cannot find facilities to for such treatment nor afford to be treated abroad. There is much that the project management field can learn from the ROMAC programs and projects in dealing with crises and disasters.

Keywords: Crisis Management; Complex Projects; Rotary

ROMAC

ROMAC or Rotary Medical Aid for Children (<http://www.romac.org.au/>) is an organisations established in collaboration with the Rotary clubs in Australia and New Zealand to provide medical aid to children from developing countries and in particular children from countries in the Asia-Pacific region.

The mission statement of ROMAC is:

“To provide medical treatment for children from developing countries in the form of life-saving and/or dignity restoring surgery not accessible to them in their home country.”

The objectives of ROMAC are:

1. To provide hope where there is no hope
2. To restore dignity to human life
3. To save or transform the lives of children from developing countries.
4. To provide the best possible medical and surgical expertise

The idea of ROMAC germinated when Barrie Cooper (Cooper et al. 2003), A Rotarian from Bendigo in Australia who was a member of a team of surgeons who went to Fiji to treat local children with cleft lips and found the local facilities to be totally inadequate. The idea of bringing children over to Australia was considered and a Victorian Rotary club started sponsoring children to be brought over to Australia to be treated by Australian surgeons. This idea was then endorsed by several other Australian Rotary clubs which gave rise to the formation of ROMAC twenty years ago. Soon Rotary clubs from New Zealand also joined in. Today ROMAC’s aim is to treat 50 children each year in major cities in Australia and New Zealand. So far more than 300 children from over 20 countries have benefitted from the ROMAC program. Thirty-five children have been treated in 2011 -2. The annual budget of ROMAC is around 1 Million A\$.

ROMAC project as a crisis to be managed

A ROMAC project is not a typical crisis as we know them. However it is a crisis in its own right for the child and the family who are supported by ROMAC. If the child is born with some deformity it is shunned by the society (Changing Faces 2012) in most of the countries where these children come to Australia/NZ from. Sometimes there is local belief that the defect is due to a curse on the child or family and this makes it extremely difficult for the child as well as the family to lead a normal life. In some cases the child's misfortune is taken advantage of by some family member using the child as a means of income through begging with the child. The families where these children are born are very poor and have no recourse to any funds to treat the child. This is one type of 'family crisis' that is managed with the help of ROMAC.

There is another form of crisis that ROMAC supports as well which is closer to the way we know them. In some projects that the ROMAC program undertakes it could be an emergency situation such as a burn victim which requires speedy action. Thus the ROMAC program is managed to be flexible enough to deal with both 'fast' and 'slow' projects while maintaining the integrity of the processes lay down by the governing board of ROMAC.

Data Collection:

Four people, responsible for different aspects of ROMAC projects, were interviewed to develop and understanding of how these projects are managed with actual examples. These were the operational director, a regional director, a medical doctor and a volunteer from a Rotary club who provided different perspectives. Extracts from each of the interviewees has been used to come up with an account of the life cycle of the crisis that is managed by the ROMAC program and its constituent projects.

Figure 1 shows the different layers of the ROMAC program.

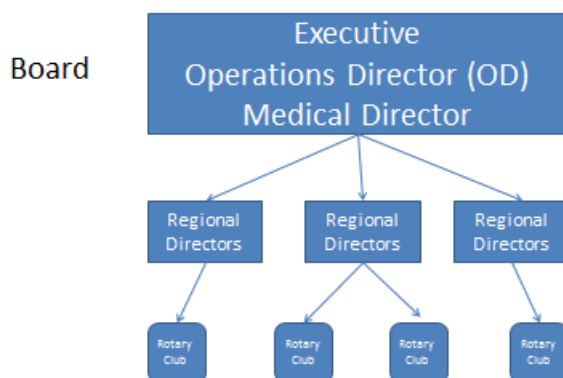


Figure 1 – ROMAC Basic Structure

While no patient or the family of the patient was interviewed for this paper the author had an opportunity to look after one of the ROMAC patients in transition from Townsville to Ho Chi Minh City when the patient and his mother stopped over in Sydney. Some observations of the author about this experience are also included in the paper.

Processes used by ROMAC

The processes used by ROMAC are described in this section. While there is an operational procedure manual for the overall program and projects the account presented in this chapter has been based on the four interviews to capture the richness of the projects and the variations. This will help to appreciate the complexity of the ROMAC program and its projects.

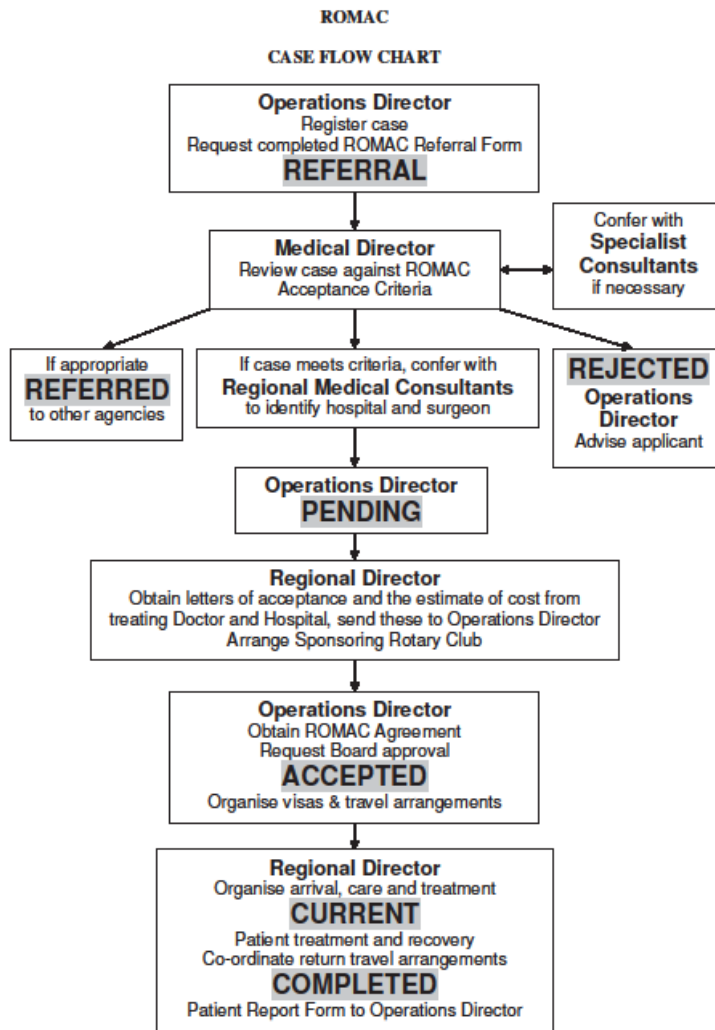
The Operations Director

The Operations Director (OD) brought an operations manual to the interview. This manual is used includes procedures, forms, a work flow chart and a database of records used for oversight. Although the operations manual has been in existence for ten years OD has been updating and improving it over the past five years since he took over this role. He has had many years of experience managing projects and is aware of the importance of keeping the procedures updated in the operations manual as people change both at the ROMAC operations and at the Rotary clubs that support ROMAC.

The ROMAC projects adopt a case management approach to manage. It became evident through the interview that while they include several standard practices that you will find in any project such as scope, cost and risk management the cases handled by ROMAC are often unique and have a large medical element in them. Therefore some aspects of case management from medical practice have been incorporated in the procedures.

The procedures showed evidence of a clear work flow as shown in Figure 2, budget and cost management, financial management, delineation of roles and responsibilities and risk management. OD also emphasised the importance of human resource management through a team effort as both ROMAC and the Rotary Clubs were made up of volunteers.

PROCEDURE



Adopted 20 Feb 2010

Page 1 of 1

Figure 2 – ROMAC Process

(<http://www.romac.org.au/downloads/Case%20flow%20chart%2010Feb2010.pdf>)

The first step in a ROMAC project is a referral to ROMAC that is sent to the OD using a ROMAC referral form. While this is expected to be filled out by a local doctor where the patient is located it is not always the case. Normally it is easier if there is a Rotarian located at the place where the patient lived to guide the completion of the referral. It was also dependant on whether there was someone locally available with skills and expertise to fill out the referral.

Often the referrals came from medical personnel, such as surgeons from Australia or NZ, who had gone to the location to do some other volunteer work, and came across a patient who could not be treated locally. They then referred the case to ROMAC. Almost 70% of the cases originated through this channel. Sometimes they also performed the necessary operations when they returned home.

Once the referral has been received OD passes it on to the Medical Director who may then consult with his network of consultants and specialists to determine whether the case should be undertaken by ROMAC from a medical point of view. Sometimes this will be done via an expert's conference. Other considerations that are used to accept a patient are:

1. Ideally the case needs one surgical intervention that is not available locally. This may not always turn out to be the case as complications could arise after the first operation is carried out as will be pointed out later.
2. The case had to be lifesaving or dignity restoring. In general patients who need cosmetic surgery will not be entertained unless this is necessary to restore their dignity.
3. The cost is affordable. Once the medical risk has been assessed and the Medical Director clears the case cost may determine taking on the case. The decision is normally easier when the estimate for the treatment is < \$ 40K. Projects that are estimated to cost between \$ 40 K and \$ 60 K will be taken a closer look at while projects that are likely to cost \$ 60K are rejected. But there may be overwhelming humanitarian reasons to take on a patient whose treatment may cost more than the limits set by ROMAC for acceptance. In fact, in some cases the actual cost did exceed the limits but ROMAC continued to support the patient once it took on the case.
4. Cases that may need a great deal on-going maintenance and care of the patient were normally not undertaken. An example pointed out by OD where a cochlear implant would have helped a patient. But this required on-going maintenance and there was a concern that the implant may not last the wear and tear of a tropical environment where most patients came from. However in some cases like a burn victim it was necessary to bring them back and this was anticipated and accepted. Sometimes other agencies visiting the location where the patient is located, such as Interplast, may undertake to do what is needed locally instead of bringing the patient back to Australia or New Zealand. In other instance it was possible to train or work with local doctors who could take over the on-going work.
5. Once the patient has been accepted arrangements such as locating the hospital where the surgery has to be done, availability of beds, visas and transport were organised in conjunction with a Regional Director in whose region the patient was likely to be sent.
6. A cost estimate was also performed out to manage the budget.

Once the patient or case is handed over to the regional director the operations director took on a monitoring and supporting role. In project management terminology this was the demarcation between the ROMAC program and a project.

The Regional Director

The activities of a ROMAC project are now explained as seen by the eyes of the regional director RD who was interviewed about a recent case he had handled.

RD was a district chairman when he encountered the case of AK in which he became very personally involved. Often volunteers at the ROMAC or the Rotary Club develop attachments to a particular case and his eyes lit up as he started to talk about AK.

AK came to the attention of ROMAC by happenstance, as it often happens with ROMAC patients. A visiting Rotarian from Rotary Australia World Community Service Limited (RAWCS) project visiting Papua New Guinea (PNG) came across AK. RAWCS is another Rotary project that also helps needy people from developing countries which provided assistance at the location where there is a need whereas ROMAC takes on patients who cannot be treated locally and have to be brought to Australia or New Zealand for treatment.

AK was one year old when he fell accidentally into an open kitchen fire and nothing was really done to treat him as there were no local facilities. When people from RAWCS travelling in PNG found him they suggested that the family contact ROMAC. A local doctor filled out a medical report in the format required by ROMAC and this was sent to OD, with pictures of his injuries, to take a decision. The ROMAC Board decided positively after receiving a report from the medical panel.

Once the decision was made, preparations to bring AK over to Sydney started. He was to be treated at the Westmead Children's Hospital which specialised in burn injuries. Visas had to be prepared for AK and his father to come to Sydney, travel had to be booked and arrangements had to be made to receive AK to be cared for a few days until the hospital had a bed. This required careful planning as beds are not available easily to foreign children if local children had to be operated upon. So timing had to be carefully managed so that the patient and his carer arrive just before the bed will be available to settle down to the new environment before being admitted into a hospital. The cost of maintaining the patient in Australia waiting to go to the hospital was also a consideration.

The culture shock for the child and care starts at this point. AK was from Mt. Hagen in PNG whose population was about 33,000 and for the first time in his life AK was transported to a modern metropolis with nearly four million people. It was the first time someone like AK had even ridden an escalator.

A Rotary volunteer offered to accommodate AK and his father in their modern house in Sydney. A house is preferred by ROMAC as it saves valuable funds and also helps the patient and the carer to acclimatise in a homely environment. Normally a family from the same country who could speak the language of the patient is preferred but this may always not be possible as it was in the case of KA. This did complicate matters further but it was manageable. However the hospital bed was not free for KA and KA had to wait longer than expected.

AK was finally admitted into the Westmead Children's Hospital and had to have a series of surgeries to release the contractions, treatment around his eyes which were burnt, treating infections that had happened due to putting off the treatment. It is normally not easy to predict how many operations had to be done based on the first evaluation. So several operations had to be scheduled for AK.

Once the operations were completed AK had to stay back to be checked over a few times as an outpatient. At this time there were no families were found to look after KA and his father. RD's Rotary Club finally found a College belonging to Macquarie University to provide KA and his father accommodation at a subsidised rate. This also saved some money for ROMAC.

While KA and his father were staying back in Sydney several Rotarians offered to visit them and take them out to visit sights in Sydney to keep them engaged and comfortable. The club put together a roster and this helped KA and his father to meet more Rotary volunteers. A farewell dinner was organised as the time for KA to leave to thank all the people who supported KA's treatment one way or the other. The last step was to take KA and his father to the airport.

When asked if AK would come back he felt that he would. In all probability AK would probably not adhere to all the precautions explained by the doctor in Australia, including wearing a mask to keep the treatment intact, and this may cause infections and AK may have to be brought back to Australia.

RD also explained that while AK's treatment could have been deemed a success not all cases end happily. In another case a one week old baby who had to be flown urgently out of Dili in East Timor with intestines protruding out of her body. While she was successfully operated in Canberra she died after returning home due to an unrelated ailment – pneumonia. There were other issues ROMAC faced with this patient. When she was brought to Darwin from Dili to be boarded on a flight to Canberra it was not possible to use a commercial airline as the boarding turnaround time was insufficient to cater to the patient. A private plane had to be arranged and the flight itself cost \$ 50,000 which was more than the budget for the entire treatment of most patients. In addition the Rotarian who was taking care of the child in Canberra got very attached to the child and was distraught when the patient died after returning to Dili. On her own she flew to Dili to be with the mother for the funeral of the child.

The two cases clearly show that each patient is a unique project with its own complexities.

The Rotarian

A more detailed account of what happens to a ROMAC patient in Australia was gathered through an account of a case involving a member of the Rotary club (LC) who provides direct support for the patient and carer.

LC recounted a recent case of a child from Fiji, a burn victim, as the patient she looked after. The patient was involved in a domestic fire accident when a kerosene stove exploded burning the child affecting most of her front side from the leg to the neck. Fortunately the head was intact. It was determined that she could not be treated in Fiji and was brought to Australia on the recommendation of a surgeon from Sydney. Once the decision was made and the patient and her mother were transported to Sydney LC's role started for this project. LC said that it was always surprise to see the patient for the first time even though some information was received about the condition.

When she met BV she found that she could hardly walk due to the intensity of the burns. BV arrived with her mother as her care. One of the important tasks of the Rotary volunteer like LC was to make the mother and patient comfortable when they visit the hospital for the first time and give them the confidence that there is someone to look after them. It was important to build a relationship with BV and her mother to make them feel that they will be looked

after well. It was also important for them to have one person whom they can lean on for little issues while medical treatment is progressing.

With BV, one of the first things they had to do was to strengthen her leg so that she could walk and then open up the area around the groin so that she can also lift her legs. Soon BV started walking but with some difficulty and had to use a wheel chair. The wheel chair gave her freedom to roam around and talk to people and she was excited.

One day the hospital could not find either the mother or child and called LC. The mother had forgotten to pick up the child from the school in the hospital and had gone shopping with a cousin whom she had found to be living in Sydney. That became a mini crisis in itself. The mother was so trusting of the hospital that she was not worried but the hospital became very concerned

However other complications arose as BV needed multiple visits to the hospital. A home had to be found for her and it was not easy as she was in a wheel chair. Finally ROMAC was able to find accommodation at the Ronald McDonald House located next to the Westmead Children's Hospital so that she can be transported back and forth. While BV has returned to Fiji she is expected to return soon for further treatment.

The Doctor

A surgeon (JH) who had performed several ROMAC operations, especially on burn victims, also spared some time to talk about ROMAC from his viewpoint. He felt that the ROMAC projects could definitely be considered as a crisis as several of the patients are either have grotesque congenital malformations or had been burnt resulting in scars and this may lead to a sense of shame attached to the child and the family and they may be socially isolated by their society. If someone like ROMAC can help the child to be integrated back into its own society to be accepted by the society with some pastoral care it is a worthwhile achievement. The follow up process after the patient returns back to where they come from is very important and local Rotarians can play a big part in this effort.

JH became involved with ROMAC projects ten years ago when a volunteer in the Collo Valley requested him to attend to a burn victim in Indonesia. The child had fallen accidentally into a cooking pot and had burns to the extent of 40% and had not been treated for more than four months. This became a ROMAC project and JH has since then been involved in attending to several ROMAC patients.

JH also helped clarify how medical decisions were taken for a ROMAC project. When a referral is made to ROMAC it is passed on to the Board which consists of a Medical Director and several lay people. The Medical Director has an extensive network which he can consult to assess the case and make a recommendation to the Board. He may also be involved in recommending where (the hospital) where the patient could be treated based on the knowledge of surgeons around Australia and New Zealand. Usually the Regional Director can also help to suggest a hospital due to local knowledge.

While most of the ROMAC patients brought for treatment to Australia JH recalled two instances where ROMAC/Rotary did something unusual which he really appreciated. The first was when funds were raised by Rotary Club in the Northern Beaches of Sydney to bring one surgeon and two nurses from East Timor to learn about performing surgery on burn victims. Although the visit was cut short by the insurrection in East Timor they learnt a lot from their experience and are now doing well. In another instance, where a child was badly

burnt in Fiji, and was not fit to travel and urgent action was necessary. ROMAC managed to send JH nine times to Suva in Fiji along with nurses to perform operations.

JH felt that the two unusual projects would be very beneficial to the local medical staff to be able to look after children when they went home and needed further care.

Evaluation of Complexities in ROMAC projects

The ROMAC program has incorporated several excellent features of program and project management (Sankaran 2010). The Operations Director acts like a Program Management Office taking care of receiving proposal (or cases) and has laid down some clear selection criteria based on achievability (medically), cost and availability of resources (hospital beds, carers etc.). The author was shown a very detailed spread sheet that he maintained and reviewed regularly (once a week for taking any action and a more extensive review every month). There were 138 patients on the list who needed some action or other with 50 of them being actively monitored. He had a clear budget projection and costing (although invoices were not received on time). ROMAC had a budget close to a 1 Million A\$ for a year (ROMAC 2011/2). Risk was managed both medically as well as legally (based on immigration issues). The Operations Director maintained strict financial control which is often tough when dealing with humanitarian projects. Although the budget was limited to 40 to 60 K A\$ for an individual project there were instances when a single flight to bring the child for treatment cost more than A\$ 50,000 as special arrangements had to be made. While there was an extensively documented process to be followed ROMAC was able to fast track the process for emergency cases without losing the integrity of the process.

ROMAC projects were managed with the Regional Director distributing the work to Rotary Clubs who were involved. They acted more like self-organising teams due to the involvement of the volunteers.

ROMAC projects exhibited a high level of complexity due to several issues: (Remington and Pollack 2007)

Structural: While the ROMAC organisation itself is not very complex, due to its voluntary nature, relationships that were required to successfully carry out its projects created structural complexity. Close relationship had to be maintained with hospitals and surgeons who are the key to treatment, logistics (especially when a patient had to be transported urgently) and dealing with immigration and visa. The Operations Director stated that he would meet with immigration authorities once a month and spoke to them frequently to keep abreast of necessary procedures to bring a patient and a carer over for treatment. To ensure that the budget is well used it had to rely on several contacts. JH compared ROMAC and Rotary to be like an octopus with several tentacles reaching out to reach difficult places. ROMAC also has to use political influence on the government to ensure that hospital charges are affordable.

Culture was an issue that added to structural (organisational complexities). Often the patients came from remote towns in developing countries and adjusting to the city in Australia and New Zealand had to be managed well by the Rotarian like LC who became the trusted friend. There were also instances where even the parent who came along needed parental training.

Technical: The technical complexity of ROMAC projects was mostly related to medical issue. Often the initial report does not tell the full story. Often complications are discovered when the child has its first operation. LC pointed out to a case where a patient arrived with jaundice and found to have tumour that needed to be looked at. Another patient whose tongue

was affected had to come two or three times before the surgeons could determine what type of surgery was the best. It costs more than A\$ 100 K ultimately to do the surgery.

Temporal: The status of the patient changed over time and the treatment had to be varied to accommodate the changed conditions of the patient. Although ROMAC aimed to treat patients who needed very few interventions this was not sufficient in many cases putting pressure on the budget as well. One of the problems being faced by ROMAC is the attitude of the government towards overseas patients. The cost of beds has recently more than doubled in New South Wales and this had led to patients having to be taken to other cities where the state governments are more tolerant.

One of the major aspects of ROMAC projects is its reliance on the goodwill of key personnel involved. The medical doctors and surgeons who often do not charge for their services (even though the beds and intensive care units have to be paid for), the volunteers who manage ROMAC at the central and local level and the Rotary club who support the program (not all clubs do) and the members of the Rotary club who often devote their time to provide pastoral care.

When asked why they got involved with ROMAC the regional director said

“It is very easy to get involved. It is a project that offers many rewards. When you think you are doing something for a child that you can see and enabling them to lead a normal life it is terrific. You get a lot of good feeling helping these kids”/

The Rotarian who looked after the patient and carer said

“I feel reasonable privileged with my life. Some people need help. To help people directly and see the outcome what you do feels better. Money given to charities often does not reach the people affected. If I can help human beings (directly) I prefer do it this way”.

While ROMAC has achieved a great deal over the years some issues are still difficult to resolve. Often when patients come to Australia they are given gifts by many people. They come empty handed but return with several bags and this does not augur well with the society they return to. The Operations Director said that the society may feel ‘You went to get treatment and that itself is a gift’. This may create social issues back home. Sometimes volunteers who are involved in other Rotary programs, like looking after exchange students, try to treat the patients the same way which is not very good for the patient to be assimilated back into their society. Volunteers need to draw the line and let go once the patient has reached the ‘new normal’ and ready to go home. But often Rotarians get emotionally attached to some case as it became evident during the interviews. LC said ‘I would have liked that child to be my granddaughter’.

Although ROMAC and Rotary have extensive networks it is often difficult to ensure that the patient is given the care that is required for ongoing maintenance when they return home. If they do not do this they may have to come back for treatment again draining the budget that can be used to treat another worthy patient.

Conclusions:

ROMAC is a unique program that caters to a variety of patients. There are organisations around the world that do similar work but they look after certain types of situations like a cleft lip or plastic surgery. ROMAC also provided holistic care by combining medical treatment and pastoral care done entirely through the efforts of volunteers. ROMAC has

learnt a lot over a period of twenty years and has captures lessons learnt effectively by continuously improving its processes and procedures. There could be lessons that volunteer organisations could learn to manage personal or family crisis.

References

Changing Faces 2012, Living with disfigurement: Managing the Challenge.

[http://www.changingfaces.org.uk/downloads/Living%20with%20a%20Disfigurement%20Managing%20the%20challenge%20\(web\).pdf](http://www.changingfaces.org.uk/downloads/Living%20with%20a%20Disfigurement%20Managing%20the%20challenge%20(web).pdf)

Cooper, B., Lester, M. & Walker, M. 2003, Strangers in paradise, Australia: ROMAC.

Remington, K. & Pollack, J. 2007. Tools for Complex Projects, Aldershot: Gower.

ROMAC, 2011/2, Annual report, Willetton, WA: ROMAC.

Sankaran, S. 2010, 'The project as a socio-cultural system: Investigating humanitarian projects managed by volunteers in not-for-profit organizations, *Asia Pacific Research Conference on Project Management*, Melbourne, February 25-16, 9 pages.