

# Development of Health Professional Associations' Organizational Capacities in Low-income Countries: Myth or Reality in Haiti?

André B. Lalonde, MD, FRCSC,<sup>1</sup> Vladimir Larsen, MD,<sup>2</sup> Lauré Adrien, MD,<sup>2</sup> Liette Perron<sup>1</sup>

<sup>1</sup>Society of Obstetricians and Gynaecologists of Canada, Ottawa ON

<sup>2</sup>Société haïtienne d'obstétrique et de gynécologie, Port-au-Prince, Haïti

## Abstract

Over the last decade, the Société haïtienne d'obstétrique et de gynécologie (SHOG) has positioned itself as a key player in the maternal and neonatal health agenda in the country. This transformation arose from the association's commitment to strengthening its organizational capacities in order to enhance its operations and consolidate its contribution to the national efforts to reduce maternal and infant mortality. The SHOG benefited from the SOGC's technical assistance to reinforce its organizational capacities, support that it received as part of the SOGC Partnership Program from professional associations working in low-income countries. We describe the results of the SHOG's organizational assessments in 2008 (in the middle of the five-year cycle) and in 2006, according to the organizational capacity development approach promoted by the SOGC. A comparison of the 2008 and the 2006 assessment results shows that the SHOG progressed substantially during that period, shifting from "basic-moderate" to "moderate" regarding its organizational capacity, its operational capacities and its relationships with other organizations, including the way it is perceived by interested parties involved in the maternal and neonatal health agenda. The SHOG's experience shows that the SOGC's approach to capacity development can assist professional associations committed to reinforcing their organizational capacities in a tangible way. This will enhance their contribution to the national efforts pertaining to maternal and newborn health in their country.

## Résumé

Depuis les dix dernières années, la Société haïtienne d'obstétrique et de gynécologie (SHOG) s'est positionnée en tant qu'intervenant clé dans le dossier de la santé maternelle et néonatale au pays. Cette transformation a été possible grâce à l'engagement de l'association de renforcer sa capacité organisationnelle en vue d'améliorer son fonctionnement et de consolider sa contribution aux efforts nationaux visant la réduction de la mortalité maternelle et infantile. La SHOG a tiré profit de l'appui technique en matière de renforcement de la capacité organisationnelle qu'elle a reçu dans le cadre du Programme de partenariat de la Société des obstétriciens et gynécologues du

Canada (SOGC) avec les associations professionnelles œuvrant dans les pays à faible revenu. Cet article fait état des résultats d'une évaluation organisationnelle de la SHOG menée en 2008 et à mi-cycle (c'est-à-dire au milieu du cycle de 5 ans) selon l'approche promue par la SOGC pour le développement de la capacité organisationnelle. Une comparaison des résultats de l'évaluation de 2008 avec ceux de l'évaluation de juin 2006 démontre que la SHOG a fait d'importants progrès pendant cette période, passant du niveau de « base-moderé » à « modéré » en matière de capacité organisationnelle et ce, dans les dimensions liées à sa culture, sa capacité opérationnelle et ses relations avec l'extérieur, y compris la façon dont elle est perçue par les parties intéressées prenant part au dossier de la santé maternelle et néonatale. L'expérience de la SHOG démontre que l'approche retenue par la SOGC quant au développement des capacités des associations professionnelles peut apporter un appui tangible aux associations engagées à renforcer leur capacité organisationnelle en vue d'améliorer leur contribution aux efforts de leur pays en matière de santé maternelle et néonatale.

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## INTRODUCTION

The SHOG was created in 1950 by a group of obstetrician-gynaecologists from Port-au-Prince working in the national university institutions.<sup>1</sup> The association was developed with the objective of promoting the specialty and ensuring an exchange platform to discuss problems, challenges and new practices in the field of obstetrics and gynaecology for specialists.<sup>2</sup> Since then, the SHOG has transformed itself to become an association playing a leadership role pertaining to sexual and reproductive health issues in Haiti. This transformation was supported by several factors that, acting in synergy, guided and motivated the association throughout its development: the desire and the commitment of a small group of members to see the association taking part in concrete community initiatives for the benefit of the most vulnerable women of the country; the support and technical expertise contributed by the SOGC as part of its Partnership Program; and international recognition of the vital contribution of health professional associations to achieve MDG 4 (reduce child mortality), MDG 5

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(improve maternal health), and MDG 6 (combat HIV/AIDS, malaria, and other diseases).

### Professional Association Role

The contribution of civil societies to the sustainable development of low-income countries is an accepted and promoted concept in the field of international cooperation. The WHO recognizes the vital contribution of active civil organizations in the health sector and their noteworthy capacities regarding technical expertise. The WHO also recognizes their skills with the implementation of programs and strategies aiming at community awareness, education, and participation; the promotion of public policies in order to improve the health of underserved, poor, and marginalized population; and the development of innovative initiatives designed to respond to particular situations and/or particular population needs.<sup>3</sup>

Health professional associations, including those representing obstetrician-gynaecologists, are strategically positioned and equipped to contribute to the efforts put forth to achieve the MDGs, especially those linked to maternal and neonatal health. Thanks to their knowledge and their expertise in the field of reproductive health, and specifically of obstetrics, the associations can promote health care access and quality for mothers and their newborns by collaborating (1) to establish clinical and practice standards, (2) to develop and disseminate evidence-based clinical protocols, (3) to implement a follow-up and program assessment aimed at improving maternal and neonatal health, (4) to train and upgrade stakeholders practising in the field, and (5) to promote new approaches and strategies aimed at reducing maternal and infant mortality. Examples of the last would be the promotion of active management of the third stage of labour to prevent postpartum hemorrhage and the concerted approach and task delegation intended to strengthening the health system capacity to provide quality maternal and neonatal care.<sup>4-6</sup> The associations also have a distinctive status and credibility to lobby for policies aiming at promoting the status of women, teenagers, and girls, as well as to attract greater funding for the sexual and reproductive health sector.

#### ABBREVIATIONS

MDG	Millennium Development Goals
OCIF	Organization Capacity Improvement Framework
PAHO	Pan American Health Organization
SHOG	Société haïtienne d'obstétrique et de gynécologie
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

### SOGC Approach

As is the case with other civil society stakeholders, the contribution of professional associations to improving maternal and neonatal health depends on their organizational capacity to undertake and carry out their activities successfully in order to reach their mission and their strategic objectives and priorities. This statement holds true especially for associations working in low-income countries, where the majority of maternal and infant deaths occur.<sup>5</sup> Surviving thanks to the goodwill of a small group of interested parties, and often operating out of the designated president's briefcase, these associations have limited capacity to contribute in a sustainable way to concerted efforts in their country to improve maternal and neonatal health.

Since 1998, the SOGC has implemented a Partnership Program to help four professional associations of obstetrics and gynaecology in low-income countries to develop their organizational capacities. Thanks to funding from the Canadian International Development Agency, the SOGC actually supports professional associations of obstetrics and gynaecology in Burkina Faso, Guatemala, Haiti, and Uganda in their efforts to develop their organizational capacities.

The SOGC defines capacity as the ability of an individual, an organization, or a system to perform planned functions effectively, efficiently, and sustainably in support of their mission and long-term goals.<sup>7</sup> This definition is congruent with those accepted by other international agencies in terms of attributes related to ownership, capacities, and relationships contributing to the performance of the organization as whole, not only its individual members.<sup>8-10</sup>

The SOGC's OCIF prioritizes four core processes performed consecutively and in a cyclical way: organizational capacity assessment, data analysis resulting from this assessment, organization capacity improvement planning, and implementation and performance measurement. Each cycle runs over a three- to five-year period, in order to give the association the time required to fully integrate the prioritized measures into its development, implementation, and activities. According to the OCIF, each cycle end announces the beginning of another, guiding the association in promoting the progressive development and strengthening of its organizational capacities.

The association assesses its initial organizational capacity through a questionnaire that enables it to consider its capacity according to four specific perspectives: its culture, its operational capacity, its performance, and its external relations, including the way it is perceived by others. Each perspective includes a series of specific questions linked to aspects considered to be essential for the development of health professional associations (Table 1).

**Table 1. Capacity perspectives and aspects considered essential for the development of health professional associations**

Capacity perspectives	Aspects considered as essential
Culture	Vision and mission
	Values
	Rewards/incentives
Operational capacity	Leadership and strategy
	Structure (governance) and management (exploitation) structure
	Financial management (planning, accountability, follow-up and resources)
	Human resources
	Systems and procedures (planning, implementation, and follow-up)
	Communication
Performance	Infrastructure
	Effectiveness
	Efficiency
	Relevance
	Financial health
External and perception factors	Rules and norms
	Legal and political framework
	Linkages and networks
	Ownership and participation

To assess its organizational capacity, the association must first complete the questionnaire by ensuring it considers and allocates a rating (on a scale from 1 to 5) to each question. Once the questionnaire is completed, the ratings are compiled to determine the capacity development level for each aspect considered essential, and then the global capacity level for each perspective. The data summary will help to identify the association's organizational strengths and weaknesses.

The weaknesses identified, once prioritized according to the association's mission, objectives, and strategic priorities, will help determine the association's capacity improvement plan.

### SHOG's Capacity Development: 2006–2008

Since it has been participating in the SOGC Partnership Program for 10 years, the SHOG undertook an assessment of its organizational capacity for the second time in its history in 2008. The objective was to assess mid-cycle the organizational capacities developed within the framework of the existing SOGC Partnership Program (2007–2011) by comparing the results obtained in 2008 with those obtained in 2006. As required by the OCIF, the exercise results helped to readjust the SHOG's capacity improvement plan, to guide its work within the Partnership Program over the next three years.

### METHODS

The same questionnaire was used to assess the SHOG's organizational capacity in June 2006 and in 2008. The SOGC coordinated the 2008 assessment, which comprised three separate steps: (1) the assessment questionnaire was first completed by two SHOG leaders commissioned by the Executive Committee; (2) the assessment results were compiled and compared with the 2006 results by the Partnership Program's manager; and (3) the final document, including the two assessment results, was revised by SHOG and SOGC representatives to validate the whole process. As with the 2006 assessment, and following the OCIF guidelines, the objective of the 2008 exercise was to enable the association to define its current capacity level and to compare the results with those of a previous assessment. This experimental approach enables the association's members not only to discuss organizational experience and challenges openly and in a systematic way but also to enhance their knowledge in the area of organizational change.

### RESULTS

Comparison of the two assessments (2006 and 2008) shows that the SHOG progressed substantially regarding its organizational capacity in three out of four OCIF capacity perspectives (Table 2). The data analysis shows that the association's capacity level increased from "basic-moderate" to

**Table 2. Result comparison from the 2006 and 2008 assessments: progress**

	Capacity rating	
	June 2006	December 2008
Organization culture	Basic–moderate	Moderate
1.2 Values	10/25 (40%)	19/25 (76%)
1.3 Rewards/incentives	5/10 (50%)	7/10 (70%)
Organization operational capacity	Basic–moderate	Moderate
2.3 Financial management (planning, accountability, follow-up and resources)	31/90 (34%)	53/90 (59%)
2.4 Human resources	25/60 (42%)	38/60 (63%)
2.6 Communication	9/20 (45%)	13/20 (65%)
2.7 Infrastructure	12/35 (34%)	23/35 (66%)
Organization performance	Moderate	Moderate
3.4 Financial viability	4/20 (20%)	9/20 (45%)
External and perception factors	Basic–moderate	Moderate
4.4 Ownership and participation	22/40 (55%)	28/40 (70%)

“moderate” in terms of perspectives related to its culture, operational capacity, and external relations, including the way the association is perceived. The greatest progress occurred in the following aspects, which are considered essential: the association’s values (which showed an improvement from 40% to 76%); the rewards and incentives offered to its members, volunteers, and staff (from 50% to 70%); its capacity in terms of financial management of its workforce (from 34% to 59%), and of recruiting and maintaining employees, compensated or not (from 42% to 63%); the internal communication with its members and the external communication with other active stakeholders (from 45% to 65%); its infrastructure (from 34% to 66%); its financial health (from 20% to 45%); and, finally, the support received from its members for the association’s participation or involvement in the health sector of the country (from 55% to 70%) (Table 2).

Those aspects considered essential in which the least progress was observed were the following: systems and internal procedures for the management of the association’s files (which showed an improvement from 48% to 57%); its effectiveness (from 63% to 68%); its efficiency (no improvement); its relevance (from 63% to 68%); and the rules and norms that can influence its operations and performance (from 36% to 40%) (Table 3).

## DISCUSSION

### Leadership Within the Organization

Data analysis and other information compiled within this assessment confirm that the SHOG achieved substantial

progress with respect to organizational perspectives linked to its culture and operational capacities between 2006 and 2008. This success, resulting in part from the organizational changes that occurred between 1998 and 2006, was boosted by the SHOG’s capacity to accomplish two essential functions in the last two years: the review of its statutes and bylaws and the renewal of its Executive Committee.

Between 2001 and 2006, a period during which the country was plagued by a sociopolitical crisis, the SHOG also experienced its own crisis. The association was affected by its inability to renew its Executive Committee, the departure of several of its members, and a substantial decrease in its activities. It was also affected by the questioning of its *raison d’être*, especially its “social mission” as part of the SOGC Partnership Program and its growing involvement in the activities aimed at reducing maternal and neonatal mortality in the country. The SHOG managed to survive this crisis as a professional association thanks to the leadership assumed during that period by a small group of members (some elected and some not), motivated in part by their involvement in the SOGC Partnership Program.

In 2006, the SHOG undertook a review of its statutes and bylaws. This exercise gave way to the redefinition of the association’s goals, the inclusion of other health professionals in the membership, including residents, general practitioners, nurses, and midwives working in the women’s health area and, finally, the clarification of its members’ rights and obligations. The SHOG “social potential” confirmed itself and became more precise in the new goals defined in its statutes and bylaws, making the association a

**Table 3. Result comparison from the 2006 and 2008 assessments: challenges**

	Capacity rating	
	June 2006	December 2008
Organization culture	Basic–moderate	Moderate
Organization operational capacity	Basic–moderate	Moderate
2.5 Systems and procedures (planning, implementation and follow-up)	31/65 (48%)	37/65 (57%)
Organization performance	Moderate	Moderate
3.1 Effectiveness	25/40 (63%)	27/40 (68%)
3.2 Efficiency	7/10 (70%)	7/10 (70%)
3.3 Organization relevance	25/40 (63%)	27/40 (68%)
External and perception factors	Basic–moderate	Moderate
4.1 Rules and norms	18/50 (36%)	20/50 (40%)

key promoter and collaborator in the sexual and reproductive women's health sector in Haiti.<sup>1</sup>

In October 2006, the SHOG had also duly appointed an Executive Committee committed to fully assuming its roles and responsibilities as a decisional executive body during general assemblies. The Committee also gave itself the mission to consolidate the SHOG's operations and to complete the exercise related to the development of its strategic plan.

The review of its statutes and bylaws and the appointment of the Executive Committee enabled the SHOG to re-establish a balance within the association. In the last year, the SHOG, with its procedures being revised and reconfirmed and its leadership formalized has reoriented its efforts towards the consolidation of its operations. In a short period of time, these efforts led to an increase of its members from 78 members (all obstetrician-gynaecologists) in 2006 to 116 members (103 obstetrician-gynaecologists and 13 contributing members) in 2008. Furthermore, more contributing members paid their dues, from about 4% in 2006 to 100% in 2008.

### Association's Role in Maternal Health in Haiti

The SHOG's organizational capacity assessment has also showed that it maintained and consolidated its role as a key player in maternal and neonatal health in the country in the time between assessments. The SHOG continues to be solicited for the development of protocols and guidelines linked to maternal and neonatal health, the training and upgrading of health professionals in emergency obstetrical care, the training initiative and follow-up assessment, and the assessment of health centres delivering emergency obstetrical care. Its partners include the Ministry of Health,

WHO/PAHO, UNFPA, UNICEF and, recently, Doctors of the World.

This expertise enabled the SHOG not only to increase its credibility with its members and other stakeholders in this area but also to contribute to its members' technical capacity development in procedures towards the reduction of maternal and neonatal mortality.

Finally, for the first time in its history, the SHOG was chosen as an executive body for a community initiative in an effort to strengthen the capacity of a public health care centre to offer maternal and neonatal care, including emergency obstetrical care. Supported by the International Federation of Gynecology and Obstetrics, this four-year initiative enables the SHOG to collaborate with many partners in the field to ensure service availability 24 hours a day, seven days a week. This initiative allowed several members of the SHOG to become more familiar with the challenges and complexity of development projects in which the partnership with the government bodies and other stakeholders is favoured, and the sustainability of the initiative comes to depend on it.

### Long-term Perspective

Despite achieving progress in its capacity development, the SHOG is facing many internal and external challenges that may influence its sustainability and especially its capacity to maintain its position as a consultant, trainer, and reviewer in maternal and infant health.

### Financial Health

Although the 2008 assessment confirmed an improvement of its financial capacity, this progress is related to the increase in the number of donors in the last two years and

not, as we would expect, to a better capacity to ensure its financial well-being independent of the donors' support. Analysis of the conditions of acquired funding (which actually represents more than 80% of the association's entire revenues for 2008) shows that the funding the SHOG receives is almost all intended for the implementation of specific activities and projects. Furthermore, other than the minimal amount allocated within the SOGC Partnership Program, the funding and resources to ensure the association's basic operations (i.e., employees' salaries, the costs of the facility and communications, and other daily fees) are limited and are insufficient to support its organizational development. Therefore, to ensure its sustainability, the SHOG must develop and implement a strategy that will allow it to improve its financial condition over the years; this will be a huge challenge for an association in its early stage of capacity development and surviving mostly with the support of a few donors and with the voluntary technical contribution of its members.

### Human Resources

Over the last two years, the SHOG has managed to bolster its workforce in the area of human resources substantially as a result of the subsidy it received. The association's national office now has an executive director, an administrative assistant skilled in financial management, and two administrative support persons. The technical support offered by the SHOG as consultant, trainer, and reviewer is provided by its members. Although these members receive compensation for their one-time services, their private or public medical practice is nonetheless their primary responsibility. Given this reality, it is reasonable to question the ability of the SHOG to maintain or increase its involvement in the maternal health agenda. The continued involvement of its members must be assured in the light of the economic situation in which the SHOG offers its expertise. As a national organization, its consultants are compensated for their work according to the country scale, but this is considered inadequate by many.

### Country Economic Conditions

The unrest in Haiti between 2001 and 2006 was particularly difficult for the country and its population. Although Haiti now is in a relatively stable and safe period, the sociopolitical situation is still fragile, as evidenced by the UNO continued stabilization mission in the country. Each time the social and political situation degrades in the country, the SHOG faces pressures and the demobilization or exodus of its members from the country, resulting in a complete or partial interruption of activities, including those supported by international partners.

The continual sociopolitical crisis also has consequences for the country's capacity to meet the general population's health needs, especially the needs of those who must count on the public system. The health system itself is inefficient and often inadequate, both on the level of human, material, and financial resources and on the level of information systems. Furthermore, the state faces important challenges in assuming its roles and responsibilities as the leader of public health policies, which complicates the implementation of coordinated interventions intended to strengthen the health system, including the maternal and neonatal health services.

Given its role in the maternal and neonatal health agenda, and more specifically its expertise to participate in the interventions aimed at reducing maternal and infant mortality, the SHOG's contribution to national efforts is influenced by the challenges to the state to assume its leadership role in the health area fully. The files progress slowly, often with huge difficulties and long delays. Consequently, the SHOG members involved in specific activities may eventually lose motivation because of the cancellation of these activities or delays resulting from the inactivity of public servants. Despite the expectation that the SHOG will deal with this possibility in a positive way, how it will maintain the resources necessary for advancing and managing these initiatives and keep its members involved in the long run remains to be seen.

### CONCLUSION

Developing the organizational capacity of professional associations in low-income countries is not an impossible dream. The SHOG's experience shows that a professional association can progressively reinforce its capacity in a relatively short period of time. Over a 10-year period, the SHOG transformed itself from a self-centred association interested only in professional promotion into an association that has assumed a leadership role in the sexual and reproductive health sector, working for the benefit of the poorest and most vulnerable women and their newborns.

The SHOG's experience also shows that capacity reinforcement is a dynamic process that can be facilitated by knowledge of organizational development and a strategy to guide the association. The SOGC approach, adopted to develop professional associations' organizational capacities as part of the Partnership Program, can facilitate this process for the associations involved, focusing on increasing their capacity to contribute to their country's efforts to improve maternal and infant health.

**REFERENCES**

1. Statuts, règlements, code d'éthique. Port-au-Prince: Société haïtienne d'obstétrique et de gynécologie; 2007.
2. Propos d'ouverture du Président de la SHOG lors des XIVe journées de la SHOG. Bull SHOG 2002;7:1–4. Available at: <http://haitimedical.com/shog/bulletin/802/index.asp>. Accessed March 16, 2009.
3. World Health Organization. Civil society initiative (CSI). Geneva: World Health Organization; 2007. Available at: <http://www.who.int/civilsociety/en>. Accessed August 27, 2008.
4. International Confederation of Midwives (ICM), International Federation of Gynaecologists and Obstetricians (FIGO). Prevention and Treatment of Post-Partum Haemorrhage: New Advances for Low Resource Settings. Joint Statement. London: the Federation; 2006. Available at: [http://www.pphprevention.org/files/FIGO-ICM\\_Statement\\_November2006\\_Final.pdf](http://www.pphprevention.org/files/FIGO-ICM_Statement_November2006_Final.pdf). Accessed April 14, 2009.
5. Health professional groups key to reaching MDGs 4 & 5 [joint statement]. Geneva: The Partnership for Maternal, Newborn and Child Health; 2007 Jan. Available at: <http://www.who.int/pmnch/events/2006/HCPjointstaterév0102207.pdf>. Accessed February 11, 2009.
6. Human resources for health in the low-resource world: collaborative practice and task shifting in maternal and neonatal care. *Int J Gynaecol Obstet* 2009;105(1):74–6.
7. Lalonde AB, Senikas V, Bateson DS, Perron L. SOGC Partnership Program 1998–2006: building organization capacity to support improved maternal and neonatal health. *J Obstet Gynaecol Can* 2008;30(11):1014–24. Available at: [http://www.sogc.org/jogc/abstracts/full/200811\\_WomensHealth\\_1.pdf](http://www.sogc.org/jogc/abstracts/full/200811_WomensHealth_1.pdf). Accessed March 2009.
8. Capacity development [Technical advisory paper 2]. New York: Management Development and Governance Division, United Nations Development Programme; 1997. Available at: <http://mirror.undp.org/magnet/docs/cap/Capdeven.pdf>. Accessed October 2006.
9. ECDPM. 2007. Study on capacity, change and performance. Maastricht: European Centre for Development Policy Management; 2007. Available at: [http://www.ecdpm.org/Web\\_ECDPM/Web/Content/Navigation.nsf/index2?readform&http://www.ecdpm.org/Web\\_ECDPM/Web/Content](http://www.ecdpm.org/Web_ECDPM/Web/Content/Navigation.nsf/index2?readform&http://www.ecdpm.org/Web_ECDPM/Web/Content). Accessed August 27, 2008.
10. van Geene J. Renforcement participatif des capacités: une boîte à outil du facilitateur pour l'évaluation et la planification stratégique des capacités des ONG. Zimbabwe: Jouwert van Geene; 2004.