

PROCEDURES OF NONGOVERNMENTAL ORGANIZATIONS AND SOCIAL
ENTREPRENEURSHIP IN INTERNATIONAL DEVELOPMENT: TWO CASE STUDIES

by

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Honors Thesis

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Abstract

In a world where nongovernmental organizations (NGOs) and social entrepreneurs are becoming increasingly significant in the development of disadvantaged communities around the globe, specific methodological research in the field is more important than ever before. With heightened demand, however, also comes greater responsibility for such organizations to successfully and efficiently ignite positive change in the communities they serve. This paper broadly explores the structures and intentions of NGOs and social enterprises in international community development, particularly discussing steps taken by two comparable case study organizations attempting to establish trusting relationships with community members and respond appropriately to their needs. This paper examines in detail one nongovernmental organization and one social enterprise working to improve public health conditions in rural Guatemala. Curamericas Global, Inc. is an NGO dedicated to improving overall health standards of families through creating self-sustaining, community-run maternal and neonatal health clinics in remote, impoverished communities; Tiendas de Salud is a social enterprise which builds micro-pharmacies in isolated communities, engaging in microlending to employ locals in order to bolster household economic autonomy and improve the access and affordability of medicines for these populations. In this most-similar focused comparison analysis, evaluations of each organization's projects are closely studied to understand their procedures when intervening in communities.

Literature Review

Previous research surrounding the definitions of nongovernmental organizations (NGOs) and social entrepreneurship has achieved varying degrees of scholarly consensus, though there are clear distinctions in some cases depending on the scholar's background knowledge and experiences (Lewis, Martens, Lewis & Kanji, Peredo & McLean). There is definite consensus noting the incredible diversity within the industries, however, in terms of nearly everything from core values to program intentions to evaluative procedures (Lewis & Kanji, Defourny & Nyssens). Additionally, some experts believe in distinguishing between non-profit organizations (NPOs) holistically and NGOs, citing differences in core values and intentions (Vakil). Even less clarity exists when attempting to distinguish between NGOs and some social enterprise models, as scholars disagree about the appropriate place to draw a line between a for-profit commercial enterprise that incorporates social benefit- some refer to this model as corporate philanthropy- and a non-profit organization that utilizes an entrepreneurial model to create social value (Weerawardena & Mort, Peredo & McLean, Defourny & Nyssens). However, there appears to be consensus within the literature that social entrepreneurship emerged in the 1990s a possible development "solution" in response to growing criticism of the economic sustainability of NGOs which remain dependent on charitable public and private funding (Rugendyke, Lewis, Kerlin).

Previous research in the field of small-scale community development projects conducted by scholars of both NGOs and social entrepreneurs appears inconclusive regarding the universal utilization of organizational procedures (Martens). Despite the ever-expanding plethora of research being released *about* the third sector, only a sliver of the pie seems to have been dedicated to the improvement of the third sector itself. Instead of elevating

exemplary development procedures to the forefront of the discussion or investigating ways to improve organizational effectiveness across the board, much of the research has remained focused on individual case studies or comparisons of a few similar- or distinctly different- organizations (Lewis & Kanji, 3). Additionally, the international community's inability to codify or even discuss the impacts of establishing a broad, overarching set of standards for the third sector to utilize has contributed to overall perpetual ineffectiveness (Martens, Lewis). Development NGOs and social entrepreneurs face significant challenges to date such as donor conflicts of interest, inefficient project management, and shrinking available resources (Fowler, Lewis). These challenges are not insurmountable but will require a universal collaborative effort to better serve the disadvantaged populations with whom they work.

Some literature on the subject suggests that NGOs and social entrepreneurs could potentially collaborate with the potential to instigate even more successful social change (2005). This can be found in the social enterprise Tiendas de Salud (discussed in Part III), where a humanitarian NGO and social innovation investment non-profit established a symbiotic partnership with indigenous communities, ultimately giving the organization to a local corporation in order to sustain the project (Lehr, Jones Christensen & Lehr, Morgan). The coexistence of an NGO, non-profit investor, and private corporation have significantly impacted over 100,000 rural Guatemalans, empowering communities both economically and socially. Development scholars and analysts believe in the power of partnerships and local ownership and believe similar models could be beneficial in other communities as well (De La Cruz & Beyeler, Lehr).

This paper intends to offer more data and analysis of the organizational procedures of NGOs and social enterprises. Utilizing two case studies, one being a standard international NGO and the other a social enterprise, the paper feels somewhat like a most-similar comparison but, more importantly, hopes to simply elevate the exemplary project procedural models of two highly successful organizations. The Northern-based non-profit organizations both focus on improving public health standards in rural Guatemalan indigenous communities, and both rely heavily on a committed and involved local population. Understanding the potentially debilitating limitations of the study given the author's lack of expertise, time, and resources, the paper aims to serve as supporting research in the increasingly relevant discussion surrounding the project procedures employed by third sector organizations.

Introduction

In an ever-evolving, globalizing world, states and welfare programs are becoming increasingly less willing and able to support and respond appropriately to the needs of their citizens. Public funding for everything from infrastructure to education has diminished globally, which has spurred an emergence of private, autonomous organizations around the globe aiming to provide the resources their governments either do not or cannot provide. The increasing presence of nongovernmental organizations and social entrepreneurs in international development has deeply influenced how individual communities are progressing in multiple areas. As a result, over the past several decades extensive research has been conducted in the overarching field of global development and humanitarian aid projects taking place in less developed, also referred to as “underdeveloped” or Third World regions around the globe.

Despite a plethora of new research in the field, specific organizational procedures utilized in these development projects are often ignored, meaning very little information exists about how organizations specifically engage with their beneficiary communities. Social entrepreneurs and NGOs display both similarities and differences in terms of their structure and purpose, but there is incredible diversity particularly in regards to their organizational procedures and methodologies. Additionally, due to an overarching lack of accountability within the third sector because no centralized administrative body or international treaty exists to set universal standards, NGOs and social entrepreneurs are not necessarily required to communicate their procedures or project results with their benefactors, beneficiaries, the general public, or other third sector organizations. This absence of conversation allows for the perpetuation of potentially devastating community

development projects while simultaneously preventing successful projects from being shared. It is imperative to discuss both the failures and successes of these organizations- particularly in regards to how their chosen procedures and methodologies might positively or negatively affect the development of disadvantaged communities around the globe.

This paper discusses the organizational procedures and methodologies employed by both NGOs and social entrepreneurs, specifically in small-scale, community development public health-related projects located in rural Guatemala. It specifically dissects two international organizations- an American-based NGO, Curamericas Global, Inc., followed by a “hybrid” non-profit social enterprise, Tiendas de Salud. Both focus on improving the health standards within some of the most impoverished and isolated indigenous communities in Latin America. The central questions which this work attempts to address include, *what are the procedural methodologies utilized by different international development organizations in Latin American development? Are there significant differences between NGOs and social entrepreneurs in terms of their goals and project techniques? If so, do these differences significant impact the effects organizations have on beneficiary communities?* The intention of this paper is to offer additional research discussing the organizational procedures of NGOs and social entrepreneurs in small-scale, internationally-based community development projects.

The evidence discussed within the following paper suggests that despite the recent challenges faced by NGOs in regards to financial stability, accountability, and evaluation, some “good” development organizations based in the Global North do exist and coexist with communities in the Global South, creating sustainable social value in the lives of the beneficiaries with whom they work. Curamericas Global, Inc. is an example of such an

organization. From its inception in the early 1980s to today, it has gained international recognition and greatly expanded its reach across the globe while remaining true to its mission and core values- to “partner with underserved communities to make measurable and sustainable improvements in their health and well-being” through their vision of “hope through health: creating a world free of suffering from treatable and preventable causes” (www.curamericas.org). Between engaging in nearly constant self-evaluation as well as external evaluations, advertising both its successes and failures, never straying from its highly personalized and inclusive project methodology, and very intentionally choosing to work with the most impoverished and geographically challenging communities, Curamericas has proven its value as a gold standard in the world of NGOs.

Social entrepreneurship has gained significant popularity since the 1990s as some scholars believe it is a more economically sustainable method to create social value. Tiendas de Salud is an example of a self-sustaining, “hybrid” non-profit social enterprise which aims to economically empower impoverished indigenous community members through microfranchising techniques. Established in 2009 through a partnership between humanitarian-focused NGO Mercy Corps and social innovation investment organization Linked Foundation, Tiendas de Salud gave start-up loans to help locals own and operate their own micro-pharmacy which sells medicines and other health-related products. Intending to increase access and affordability to the geographically isolated, indigenous populations, “*Tienda* franchise owners are able to build a social enterprise that not only generates income for their families and provides jobs in their communities, but also helps their neighbors to become healthier” (Lehr, 57). The pharmacies have been credited with saving lives because of the store locations and the basic health knowledge each franchisee is required to attain in

order to effectively serve their community. Tiendas de Salud partners also shows their commitment to local ownership through allowing Guatemala's largest pharmaceutical company, Farmacias de la Comunidad- also the direct supplier to franchisees- to eventually absorb Tiendas de Salud in 2012; the sustainability of an originally Northern-dependent organization ultimately lies in the hands of the beneficiaries, which was their intention from inception. Tiendas de Salud was clearly built for economic sustainability, and their model is highly regarded among social innovation scholars.

Both Curamericas Global, Inc and Tiendas de Salud have executed exemplary internationally-based community development projects, mainly due to their commitment to empowering their beneficiaries. Each organization carefully planned, piloted, and implemented their well-researched procedures in order to maximize efficiency and community benefit. Because of their success, over 200,000 indigenous Guatemalans living in poverty and wholly isolated from the formal economic and health care systems have found hope and a healthier, more autonomous future. I firmly believe in the positive impacts of responsible third sector organizations- with Curamericas Global and Tiendas de Salud standing as two of the very best.

Part I: Overview and History of Community Development in Non-governmental Organizations and Social Entrepreneurship

Overview and History of Development

It is widely understood that billions of people around the globe are living in situations of extreme poverty and destitution. The ability for the general public to “see” the circumstances of these people through news outlets and the media has helped fuel the era of global development involving both the public and private sectors. Since conversations about development and its many forms and consequences formally began in the 1940s, nearly every aspect of the concept has been perpetually debated and contested. Everything from the core definition of the word “development” to its historical timeline to which theories and practices are likely to produce the most successful results cannot be agreed upon among scholars in the field, even today. Additionally, an accumulation of development theories exists today as previously proposed models are not typically abandoned by academics or active organizations, even if there are considered outdated by some due to examples of failed development attempts (Potter, 83). This growing collection of ideologies, strategies, and practices combined with a lack of conceptual consensus in the field showcases the truly multifaceted nature of development.

For the purposes of this paper, remaining relatively broad in defining development seemed most appropriate. In *The Companion to Development Studies- Third Edition*, Potter writes that “development involves the intention to change society in some defined manner” (85). This definition encompasses the very core of what development at least attempts to accomplish, whether it be greater economic stability, expanded religious freedoms, or the improvement of sustainable agricultural techniques. So, despite there being countless ways to

more specifically define the term development, scholars can generally agree on this broader definition.

A second highly significant point to discuss before continuing to dissect the concept is the difference between development as a theory and as a practice or strategy. According to Potter, development theories are propositions which aim to explain how development has occurred in the past, and, therefore how it should occur in the future (82). There are normative and positive types of development theory, which includes generalizing about what should happen in an ideal world and dissecting what has been done in the past, respectively (Potter, 83). To further categorize approaches to development thinking one can consider different theories as either partial or holistic, where one theory might focus on only economic development while another might focus on addressing all basic needs of a community. Conversely, development strategies are “the practical paths to development which may be pursued by international agencies, NGOs and community-based organizations, or indeed individuals, to stimulate change within particular areas, regions, nations, or continents” (Potter, 84). These terms help categorize the wide variety of development guiding models and resulting projects which have taken place around the globe.

A discussion of Potter’s four overarching development theories with accompanying examples is below:

1. *Classical-traditional theory*: utilizes top-down development, neoliberalism, and modernization theory (normative and partial) (Potter, 86)
 - a. Theory example: *mainstream economic development*. This theory focuses on a straightforward path to an improved quality of life which can be applied universally around the globe. Measuring progress using a short list of factors

including Gross National Product and per capita Gross Domestic Product, this model classifies development as an increased consumption of goods and services on a national scale. A unique quality of mainstream development theory is the idea that development is a process with no foreseeable end because it is always possible for people to consume more products; McMichael claims that “development is an endless process, not an end” (16). Development, in this model, is attained when the nation is consuming in mass amounts any and all available goods and services. Wealthy states see their systems as “a set of idealized outcomes to be emulated by other states” (McMichael, 2); this stems from the post-WWII Western ideologies about the suffering Third World and is discussed in more detail later in this section. Because much of the Third World lacks either the proper capital or labor forces to develop on their own, however, “development require[s] a kind of jump-start” (McMichael, 49) through creating an export-based economy and accepting loans from Bretton-Woods systems and private investment firms who will establish infrastructure and institutions within struggling states. This sort of global interdependence advances the global economy as well, benefitting a broader range of states. However, this top-down approach to development almost exclusively carries a Western bias, which can prove incredibly dangerous if beneficiary communities are not given a voice or a stake in the project.

- b. Practice example: Developed by economist Jeffrey Sachs and his team at the United Nations Development Programme, the Millennium Villages Project were sure to restore hope to thousands of the rural poor in Malawi, Ghana, and several

other Sub-Saharan African villages. In these perpetually impoverished regions, “the goal was to show that ‘the poorest regions of rural Africa can lift themselves out of extreme poverty in five years’” (cgdev.org). This was to be accomplished by way of increasing the communities’ incomes through a variety of avenues focused on “the premise that, with modest support, rural economies can transition from subsistence farming to self-sustaining commercial activity” (millenniumvillages.org). Through providing resources such as fertilizers and high-yield seeds alongside training led by appointed local “Team Leaders”, it was clear that communities were seeing more successful crop yields than ever before. Since the project’s inception in 2005, however, it has also been widely criticized as a failure- particularly by those who note that all project evaluations are based on internal, confidential information with no empirical data to support its success. This prompted Kenyan economist Bernadette Wanjala to conduct her own unauthorized analysis where she interviewed 236 randomly-selected households at the site in Sauri, Kenya and compared them to a similar, untreated community; her findings exposed that “the project had no significant impact on recipient’s incomes” (cgdev.org). Because the Western developers focused solely on agriculture as a means to increase income, households’ diversity in sources of income was consequently lowered which, in turn, lowered their overall income levels to match those of untreated sites. Interestingly, a 2013 article in *The Economist* confirmed the project’s future expansion with a robust multi-million dollar budget increase. Examples like the Millennium Villages Project showcase that utilizing a partial approach to development (in this case,

focusing on economic impact) can very easily become more harmful than helpful to beneficiary communities.

2. *Radical-dependency theory*: employs neo-Marxist ideals and the articulation of the modes of production (normative and partial) (Potter, 86)

a. Theory example: *dependency theory*. This theory emerged to counteract mainstream, classical-traditional ideologies because many believed that the effects of colonialism and the “colonial division of labor” (McMichael, 32) were not only detrimental to future opportunities for progress in underdeveloped states, but that the same process perpetuates today under the alias of capitalism and economic interdependence. Through the exploitation of labor and resources, the underdeveloped communities continue to help modernize the industrialized world by working on their terms. The concept that the underdeveloped and developed worlds progressed together but in opposing directions, creating a parasitic relationship that benefited one while destroying the other, has evolved into modern Third World dependency theory. This theory utilizes a historical perspective to explain today’s circumstances- hence Potter’s *positive* theoretical classification. According to this theory, after falsely “assisting” undeveloped regions the West is now attempting to repair the damage in a different light through offering private and multilateral loans for development projects where the benefactors explain exactly how and where funding will be used. With this model, development can be achieved only by severing ties with the First World and focusing on engaging in local commerce with “sister states” of sorts, or those in similar

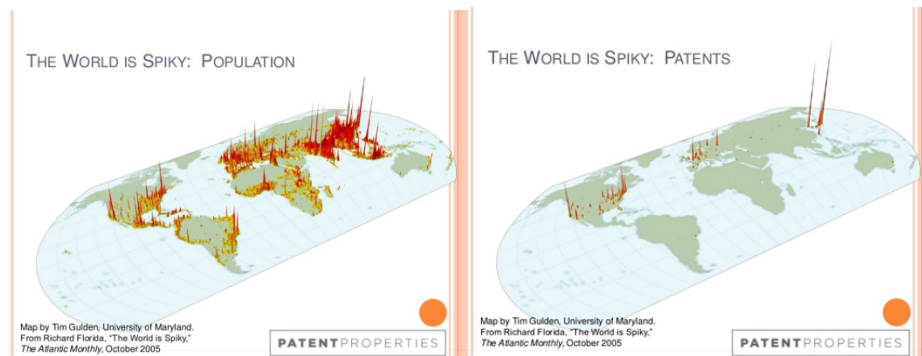
economic situations. Wealthy countries do not, in fact, help poorer states develop because there is always a conditional statement involved in the relationship.

- b. Practice example: The Democratic Republic of the Congo (DRC) is one of the most politically and economically volatile states in the entire world. Having gained independence from its colonizing state Belgium in 1960, its vast natural resources and labor had been exploited for hundreds of years prior (bbc.com). The DRC has never fully recovered from the Congolese Civil Wars in the 1990s and 2000s and has since failed to build infrastructure while also dealing with incredible political corruption. Incredible poverty runs rampant throughout the country and the wealth gap between the rich and poor means that over ninety percent of the population lives without electricity (internationalrivers.org). The Grand Inga Dam, more commonly referred to as “Inga 3” because once completed it will include three individual dams, offers a potentially viable solution to the intrastate energy gap while simultaneously promoting regional peace in Central Africa and raising the bar for creating cleaner energy sources. Theoretically, the project would benefit the DRC and its neighbors; it would offer debt relief for the struggling DRC through energy sales (it was once estimated that the DRC would make \$40 million annually from selling hydroelectric power produced by Inga 3) while also supplying thousands of temporary jobs to local Congolese and electricity to hundreds of communities. Taking a closer look, however, with a price tag of approximately \$80 billion USD, the Western-based banks and IGOs such as

the European Investment Bank and the World Bank which have pledged their financial support would gain much more from the dam construction than their “beneficiary”. To pay back the nearly insurmountable loans most of the hydroelectric power would actually be pumped back to lending states who are also strapped for energy sources such as South Africa, for example, meaning that many of the impoverished locals currently off the drawn power grids would continue to be ignored. One internationalrivers.org contributing writer says, “lost in all these considerations are the Congolese themselves... Would they share in the spoils? Will their lives change? Even if they are given access to the grid, will Congo’s poor be able to afford power from Inga 3?” (internationalrivers.org). Despite these serious consequences, the dam has been approved for construction to begin in 2016. Countless similar examples boasting deceptively positive impacts for underdeveloped regions could be referenced from every corner of the globe.

3. *Core-periphery theory*: uses the mercantile model and historical references (positive and partial) (Potter, 86)
 - a. Theory example: *world-systems theory*. Scholar and author Richard Florida wrote in his article “The World is Spiky: Globalization has changed the economic playing field, but hasn’t leveled it”, a rebuttal to Thomas Friedman’s famous book *The World is Flat: A Brief History of the Twenty-First Century* about the “peaks, hills, and valleys” which contribute to global inequality. As seen in Figure 1.1, for example, population density is one indicator which “suggests that at least some of the tectonic forces of

economies are concentrating people and resources, and pushing up some places more than others” (Florida, 590). What is astonishing is to compare the more evenly spread population density graph with the incredible “spikiness” of the issuing of patents around the globe as seen in Figure 1.2; nearly all of the world’s innovation is concentrated in Western Europe, Southeast Asia, and the United States.



Although creative minds most certainly come from all corners of the world, their innovations will likely go unnoticed unless they are living and working surrounded by like-minded people in a similarly stimulating environment, such as the Silicon Valley in California, for example. These figures indicate staggering global inequality and world-systems theory scholars believe that “the growing divide between rich and poor countries is the fundamental feature of the world economy” (Florida, 591). As scholar Thomas Klak argues, many refer to this inequality in relation to the international division of labor, naming industrialized, Western states “core” states, middle income countries as “semi-periphery” states, and the underdeveloped world as “periphery” states (121). Core states, who also tend to be the most advanced societies politically and militarily, enjoy economic power, particularly in

industry, through all avenues including multinational corporations (MNCs), geopolitics, and international institutions such as the World Bank (122). Semi-periphery states are the most turbulent category, as these countries likely combine industrial prosperity and stability with poverty and a reliance on primary product exports- depending on the health of the global market, these states could either gain or lose power quickly (123). Periphery states are perpetually disadvantaged due to their lack of economic and political influence; this means that core and semi-periphery countries can, and do, exploit those in the periphery (124) through utilizing cheap labor, more relaxed environmental and labor standards, and cheap resources, among other techniques. This geopolitical imbalance allows for the conation of widespread poverty and concentrated wealth, significantly disadvantaging the vast majority of the world's population.

- b. Practice example: In 2012, more than one hundred people died in a massive garment factory fire outside Dhaka, Bangladesh. The nine story building collapsed while approximately 1500 workers were working inside, despite the fire alarm having gone off earlier that evening and factory managers informing nervous workers it was simply a "test" (nytimes.com). Upon later inspection of the building it became clear that simple safety codes had been blatantly ignored such as there being too few fire escapes and improper storage of flammable materials. As the second largest clothing exporter after China, Bangladesh employs more than three million workers in the industry, the vast majority of them women (nytimes.com). Also commonly referred to

as “sweatshops” by activists, these factories are strategically placed in Third World countries around the globe as a highly exploitative “development” technique to benefit MNCs. MNCs can significantly lower production costs by outsourcing jobs to unskilled laborers in places where pay, working conditions, and safety and environmental standards are much lower than in their home country- all while simultaneously heralding capitalism as the driving force for improving the lives of the poor. “Activists say that global clothing brands like Tommy Hilfiger and the Gap and those sold by Wal-Mart need to take responsibility for the working conditions in Bangladeshi factories” (nytimes.com), but many are able to cry ignorance when problems arise due to the company’s extensive organizational structure. While these types of failures have shed light on the negative impacts of the international division of labor and consequently improved some standards, the global textile industry remains a compelling demonstration of the power struggle between historically powerful, industrialized states and the rest of the world.

4. *Bottom-up and alternative approaches*: applies sustainable and eco-development ideals which focus on addressing basic needs (positive and holistic) (Potter, 86)
 - a. Theory example: *human development*. Human development allows for the “promotion of overall freedoms of people to lead the kind of lives they have reason to value” (Sen, 10). With a propensity for the word *freedom*, this model focuses on returning to and celebrating the distinct values and traditions of a community in order to improve their overall quality of life. The belief that development thrives only when there is substantial

commitment to the community or individual's goals, such as cultural preservation, is paramount to this ideology. Three umbrella categories of freedoms characterize the human development model: "political freedoms, social opportunities, and economic facilities" (Sen, 11). These are manifested in many interconnected forms which gradually improve the lives of citizens through avenues such as improved education, health, economic involvement, and political participation. Development, then, is not only measured by economic health but also personal happiness, equality, and countless other factors which might contribute to a thriving community- factors which the community members define themselves. Sen also denotes a concept called "capabilities" which essentially means that all individuals should have the capacity to choose to do, or not to do, something; it combines the idea of a *state of doing* such as reading or eating, with the idea of *being* such as being well-nourished, literate, or part of a community (Northover, 35). Despite the complexity of human development theory, some of the most successful examples of development projects have taken place

- b. Practice example: South Africa's Joubert Park sits in the middle of one of the most troubled and dangerous neighborhoods in the world. Between apartheid, AIDS, poverty, and horrific crime, the park and community have truly seen it all. Today, however, the park is a haven for young people to escape the negativity of their everyday life and instead celebrate life through learning and playing. The passionate and desperate surrounding community organized itself, using what resources were already available, to create a safe space for

children and, eventually, their parents as well. The Photographers Association, the GreenHouse Project, the Youth Empowerment Network, and the Joubert Public Art Project all “formed in response to rising crime in the park, recognizing that people won’t come to have their picture taken if it doesn’t feel safe” (Wheatley, 85). From their initial success in improving the security of the park, the Lapeng Family and Childhood Center was established and they “began to invite unemployed parents to participate more actively in caring for the children, adding classes in literacy, math and science, art and Montessori training” (86). The Center celebrates the distinct culture and rich history of South Africa while teaching children more positive practices as opposed to what they would learn if they spent all day on the streets. Mothers and community members have gathered together and used pre-existing skills and materials to dramatically improve the lives of future generations as well as their own, and although the transformation of Joubert Park did not directly improve the health or financial circumstances of its visitors, it did empower children and families to live lives they have reason to value outside the boundaries of the park as well. Joubert Park stands as an example of what can be accomplished when different pieces of communities come together in partnerships, listen to each other, and remember to celebrate the community’s individuality.

Each of the above four ideologies and strategies are inextricably interconnected, as it is impossible to ignore economic factors when looking to engage in a sustainable development project, for example. No development scholar or NGO project manager would

choose to continue pursuing a community development project that is doomed to fail- it just happens that sometimes, pieces of the puzzle are overlooked. Over time, newer models have been developed simply in response to both successful and failed project attempts from all over the globe. It is also important to note that at one point in time, each of the above approaches experienced an era of prominence where its theories and strategies were more commonly employed by individuals and organizations (Potter, 19).

Development studies as an academic field initially emerged in Great Britain in the 1960s and 1970s (Schuurman, 21). The field was dominated by European economists and social scientists whom undeniably carried the industrialized, Western bias with them as there were very few academics studying development from the Global South; according to Potter and others, this Western bias and command over the field perpetuates today. The field began largely as a theoretical study in response to heightened interest in travel and geography from a military perspective following World War II, as well as a response to an increasing presence of development projects already taking place in the era of rebuilding and development of poorer states by Western countries. In the 1980s, the United States experienced the rise of neoconservatism, or “the strong view that liberal free trade and unregulated free markets should be left to make economic decisions and that they will do so rationally and effectively (Potter 19). Not unexpectedly, this perspective gained popularity in congruence with United Kingdom prime minister Margaret Thatcher's “popular capitalism” and US president Reagan’s “Reaganomics”, which were highly regarded by the general public in these and other developed states. Consequently, the 1970s and 1980s also marked the beginning of a longstanding United States presence in Latin America, following a period of populist politics and communist dictatorships in the 1960s and 1970s; states such as

Argentina and Chile which had closed off their markets to the West suddenly felt Cold War-era pressure to implement neoliberal economic and democratic political policies in order to emulate the self-declared “beacon of hope” that was the First World.

Some scholars also label the 1980s as an “impasse” of sorts in the field of development studies, when “old certainties were fading away” for three key reasons: 1) “a growing diversity of (under)development experiences” (Schuurman, 21) where the Global South did not benefit from an external guiding presence; “2) the postmodernist critique on the social sciences in general and on the normative characteristics of development studies in particular and, finally; 3) the rise of globalization” (Schuurman, 21). The emergence of such critiques combined with the unprecedented rate and frequency of cross-cultural exchanges due to globalization opened lines of communication across the globe for unsuccessful (and some successful) development projects to be discussed. As a result, the 1990s brought an era of questioning and further critiquing from scholars, creating opportunities for new and improved development theories, more commonly named “postmodernist” or “post-development” ideologies, to unfold. Postmodernists “suggested that emphasis should be placed on a wide range of possible discordants and even contradictory views, voices, and discourses” (Potter, 20) and some scholars even began to reject the concept of development entirely. Citing the irrefutable Western bias and wondering how such postcolonial models could have ever truly benefitted the underdeveloped world, the 2000s onward have focused on a post-development model which looks at the most critical issues development faces today, such as growing inequality and ecological interdependence (Potter, 20).

Some scholars claim that development as a practice or strategy also began during the same time period, often referencing former United States president Harry Truman’s infamous

1949 inaugural address where he confirmed that the world was divided into the developed democratic states, or the First World, the less developed and demonic communist states, dubbed the Second World, and the marginalized, underdeveloped Third World; he claimed that “more than half the people of the world are living in conditions approaching misery... their poverty is a handicap and a threat both to them and to more prosperous areas... only by helping the least fortunate to help themselves can the human family achieve the decent, satisfying life that is the right of all people” (trumanlibrary.org). His grand plan included the idea that the less developed Second and Third Worlds would emulate the First World’s economic and political regimes- in other words, democracy and unrestrained capitalism. Perhaps an unintended consequence of his speech, he thrust the impoverished Third World into the international spotlight and ignited a race of sorts for MNCs, IGOs, NGOs, and Western governments to begin development projects in the Global South.

Other intellectuals, however, see strategies of development as having begun hundreds of years earlier (Craggs, 5). Craggs writes in *The Companion to Development Studies- Third Edition* about the emergence of development during the colonial era and its legacy on development theory and practice today:

Many of the ideas, policies, and priorities of postcolonial development can trace their genealogies to the colonial era... colonialism therefore not only contributed to the material economic and social conditions in which development takes place today, but also fundamentally shaped the project of development itself, through continuities between the ideologies of people, and practices of colonial and postcolonial development. (15)

Despite a lack of consensus regarding the historical timeline of development, scholars do agree that as development has evolved over time its focus has shifted from using more rudimentary, exploitative methods with a broader, national scope (mainstream economic development) to employing more project-driven techniques with small-scale, individual community-based goals (alternative approaches) (Potter, 83). Today, development studies is considered cross-disciplinary because it employs many academic fields including international relations, politics, economics, urban planning, geography, history, anthropology, and sociology (Potter, 17). This broad range of development backgrounds certainly contributes to the incredible diversity of ideas, and likely also to the lack of academic consensus, in regards to which theories and strategies are the most successful models.

Defining Nongovernmental Organizations

Nongovernmental organizations (NGOs) are an incredibly diverse body within the recently named “third sector”, “so called because they form an important area of social, cultural, economic, and political activity alongside the state and the market” (Lewis, 7). Within this sector, everything from the core mission of the organization to the methods in achieving the mission can vary greatly depending on several factors, most notably how one chooses to categorize NGOs. “Not surprisingly, some scholars have already stated with resignation that there is simply no such thing as the ‘typical NGO’” (Martens, 277). As long as profit is not gained from the organization’s activity, any private organization can theoretically be categorized as an NGO (Lewis & Kanji, 11); Egg Farmers of Canada, for example, exists to promote and represent the interests of Canada’s egg farmers and consumers nationwide

(www.eggs.ca), while on the other end of the spectrum, the American Red Cross focuses on natural disaster relief efforts both in the United States and around the globe (www.redcross.org). However, some might classify organizations like Egg Farmers of Canada in the broader category of non-profit organizations (NPOs), meaning that NGOs “actually represent a subset of NPOs engaged in economic and social development” (Vakil, 2059). This distinction is significant in understanding that while all NGOs are non-profit organizations, not all non-profit organizations’ intentions necessarily align with those of NGOs. In fact, even some social enterprises are classified as NPOs, which is discussed in the following section.

NGOs have undeniably experienced exponential growth in their numbers, size, and scope over the past several decades. According to some scholars, NGOs have emerged largely in response to the changing role of the sovereign state, where sovereignty is defined as a state’s monopoly of force over a given territory (Love, 13). Many claim that state sovereignty is under siege or transformation because countries’ roles are either diminishing or being transformed by shrinking resources and expanding populations, meaning that in today’s increasingly competitive global climate states are either unwilling or unable to provide their citizens with necessary public services (14). Therefore, one could reasonably assume that NGOs exist largely in hopes of narrowing the ever-growing gap between people’s needs and available services.

In the following paragraphs, several definitions will be utilized to help clarify the organization and intentions of NGOs:

Scholar Anna Vakil writes that “NGOs are self-governing, private, not-for-profit organizations that are geared toward improving the quality of life for disadvantaged people” (2060). This simplistic definition denotes the structural *organization* of NGOs and further clarifies characteristics which would differentiate an NGO from another non-profit organization

not specifically intending to benefit underserved populations, such as the Egg Farmers of Canada example mentioned above. Though broad, it provides the basic information needed in order to understand the basic composition and purpose of all NGOs. Now let's delve into a couple more thorough definitions which highlight the incredible diversity within the field.

The following definition helps clarify the core *intentions* of NGOs:

NGOs tend to be best known for undertaking one or other of these two main forms of activity: the delivery of basic services to people in need, and organizing policy advocacy and public campaigns for change. At the same time, NGOs have also become active in a wide range of other more specialized roles such as emergency response, democracy building, conflict resolution, human rights work, cultural preservation, environmental activism, policy analysis, research and information provision. (Lewis & Kanji, 1)

Lewis and Kanji describe NGOs also from a purer perspective, focusing on explaining what these organizations attempt to accomplish. They also make an important note that as NGOs have gained legitimacy and power on the global stage, their role in society has expanded to attending to people's needs in more categories than simply advocacy and providing basic services. Many organizations exist not only to serve people who are lacking some basic necessity, but are also organizers for social change- and an increasing number of organizations are also taking on unconventional roles in hopes of assisting populations previously thought to be impenetrable by organizations working outside a state's sovereign borders. The International Justice Mission (IJM), for example, works to bring impoverished people out of situations of modern-day slavery and violence while simultaneously fighting for policy changes to bring

swifter and more consistent justice to perpetrators. Their robust advocacy campaign based in Washington, DC serves as a way to raise awareness about the unseen realities of many in the developing world and, consequently, raise funds in the developed world in order to execute rescue missions and operate aftercare clinics (www.ijm.org). The increasingly invasive roles of organizations similar to IJM have become particularly important in holding governments responsible for their incapacity or unwillingness to attend to their populations' basic needs (Love, 82). Additionally, as organizations are faced with greater competition for resources and funding than ever before, some NGO missions and procedures have also become more multifaceted in recent years to help them remain relevant in an ever-globalizing world (Rugendyke, 574).

The final definition serves to further describe the intentions of NGOs through their *relationships* with other individuals or groups:

NGOs raise consciousness regarding issues with elites, masses, or both. NGOs often practice resurrection politics, taking issues previously thought dead on arrival (such as landmines and debt relief), and raising them up onto the public and political agenda... NGOs frame or reframe issues. NGOs change language, beliefs, and symbols surrounding issues (which may later translate into behavioral changes)... NGOs move issues to a forum more amenable to a favorable response... NGOs change government, IGO, or MNC policy, or individual behavior. They adapt or create institutional structures or advocacy networks to further particular issues. NGOs practice transparency politics and sunshine politics, shining a light on problems and shaming and naming perpetrators. (Love, 81)

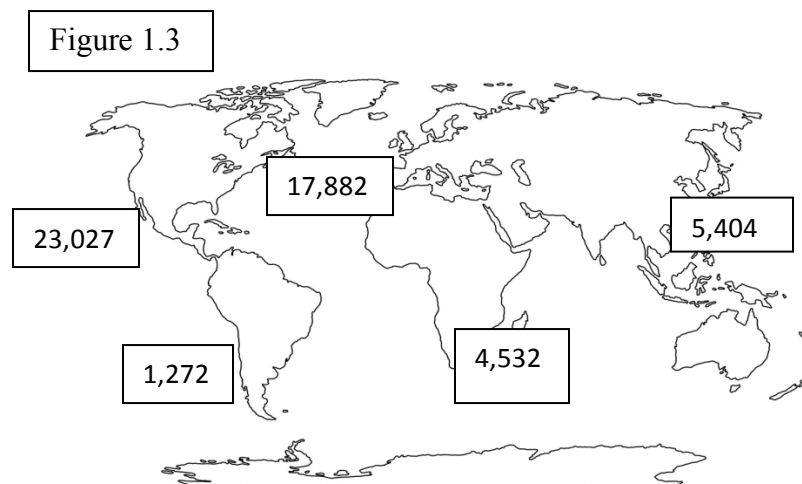
Both of the above definitions help clarify what NGOs actually *do*, as opposed to Vakil's definition which denotes how they are organized. Scholar Maryann Love's comprehensive yet complex definition breaks down nearly all avenues in which NGOs are currently working. She begins by discussing the audiences for whom NGOs work, which are typically either the general public through advocacy and awareness efforts- such as the Alzheimer's Association, an organization dedicated to raising awareness about Alzheimer's disease and, consequently, funds for research through events around the United States- or governments, inter-governmental organizations (IGOs) such as the World Bank, and/or MNCs through political lobbying- such as the American Council on Education, which lobbies for issues surrounding postsecondary education institutions across the country. Focusing on the relationships between NGOs and whichever individuals and/or groups have the power to affect the desired change is one way to begin understanding NGOs. Additionally, it is imperative to note that many NGOs will also rely heavily on making the public aware of whatever issues they are attempting to address in hopes that with the people's support, NGOs can hold the appropriate individuals or groups responsible for their actions. On the other hand, NGOs typically exist in hopes of either affecting policy- such as HealthBridge which works with local NGOs in Africa, Asia, and Latin America to reduce tobacco use in low-income areas through legislation (healthbridge.ca)- or benefitting underserved communities, such as ZOE which is dedicated to bringing orphaned children out of poverty through entrepreneurial empowerment (www.zoehelps.org). As Love described, each type of NGO utilizes different techniques to accomplish similar goals of instigate positive change in a wide variety of communities around the globe.

While each of these quotes highlights specific aspects of different NGOs around the world, each one also shares significant pieces in common. There appears to be an overarching agreement amongst all three scholars regarding the common purpose of NGOs, as each of them mention an intention to improve the social, political, and/or economic quality of life of those living without some range of basic services. Though each scholar implies the incredible diversity in how these services are delivered, be that through advocacy, fundraising, or direct relationship-building with communities, it is universally understood that NGOs intend to assist disadvantaged people. Along a similar vein, these definitions clearly support what was discussed earlier in this section that some scholars believe there should be a clear distinction between NGOs and NPOs, a concept I have also come to support through my research. Overall, despite the incredible complexity of NGOs and their relationships with different groups of people around the globe, the basic form and function of each organization within the industry remains the same.

Another highly significant aspect of NGOs which differentiates them from others in the third sector is their non-profit financial model. What constitutes NGOs as NPOs, or non-profit organizations, is that “the money they make with publications, fund raising, and selling is used to pay for staff and activities to support their aims and goals more effectively” (Martens, 279). Additionally, “if a financial surplus is generated it does not accrue to owners or directors” (Lewis & Kanji, 11). Many organizations do depend on government and public funding in order to run their operations, particularly when the purpose of such NGOs is to provide resources and/or services previously supplied by the government (Martens, 279). As the state has become less committed to its social welfare programs due to mounting national debts and pressures from the global market, however, NGOs have become increasingly dependent on private

funding as well. This dependence on individual donor pools and even MNCs and other large corporations through fundraising events and campaigns indicates the increasing competition NGOs are facing across the board (Lewis, 12). The non-profit financial model which all NGOs follow has begun to receive more criticism in recent years, as some do not believe it is sustainable in today's constantly changing economic climate. Hence, the swift rise of social entrepreneurship beginning in the 1990s- which is discussed in the section below.

Referring back to the earlier mention of Western dominance in the field of development which has existed since the concept's inception, there remains a clear imbalance in influence between the Global North and the Global South in terms of who develops, modifies, and experiments with development theories and practices. A harrowing example can be found in Figure 1.3 below, which is a map showing the distribution of registered NGOs in the Global North and the Global South:



This map confirms that a significantly larger number of registered NGOs are based in the Global North, supporting the concept that the Global North has dominated not only the theoretical but also the strategic arenas of development since the emergence of development as a concept in the 1960s. As Valik points out, “can NGOs based in the industrialized

countries learn something from community-based NGOs in the Third World (and vice versa)? Are the regional or national differences among NGOs significant enough to impede cross-learning among organizations located in different parts of the world?” (2057). These questions denote an important but largely ignored aspect of development NGOs. Despite many local organizations in the Global South sharing similar goals with those based in the North, a lack of communication between organizations combined with the longstanding Western dominance of the field significantly impacts the success of NGOs across the board. Perhaps a less dominant, more malleable and responsive Global North would positively influence the genuine advancement of underserved populations.

Defining Social Entrepreneurship

As discussed in each of the previous sections, it is clear that “the very basic needs of millions of people in non-industrialized countries remain unmet, mainly because these potential customers are willing but unable to pay for products and services that would satisfy their needs” (Seelos & Mair, 241). It has also become widely accepted that “in recent years, there has been an upsurge of interest in social entrepreneurship driven by several changes occurring in the competitive environment faced by not-for-profit organizations” (Weerawardena & Mort, 21). Scholars agree that social entrepreneurship, also commonly referred to as social enterprise, has emerged beginning in the 1990s and gained significant popularity in response to the financial challenges some NGOs have come to face due to shrinking donor pools and budgets (Kerlin, xi). While some NGOs have been forced to search for alternative methods of obtaining funding, such as large corporations, or have experienced financial struggles, some scholars have begun to view social entrepreneurship as a sustainable solution to the issue of funding socially-driven,

private organizations. Additionally, one must consider the idea that world hunger, disease, and poverty have yet to be solved, despite the diligent work NGOs have been doing for over half a century. Social entrepreneurs are, as is expected, entrepreneurial, and are looking for unconventional ways to solve some of humanity's most complex problems with a fresh lens.

This should no longer come as a surprise- one of the most profound challenges within the field of social entrepreneurship is the lack of an agreed-upon definition of the term. The research is largely inconclusive in regards to clarifying a definition of social entrepreneurship, particularly when determining what classifies entrepreneurship as *social* as opposed to simply commercial. Peredo and McLean emphasize this issue when writing that “in fact, the only consensus among the research is that there is no consensus on a clear definition” (57).

Weerawardena and Mort display a two-page “Summary of Social Entrepreneurship Literature” in their article “Investigating social entrepreneurship: A multidimensional model” which highlights over fifteen definitions of the term, each unique to the scholars' perspectives due to their own varying backgrounds and experiences. Some authors classify social enterprise as part of the public sector, some as the nonprofit sector, and some even as “individuals working in either for-profit or NFPs” (23)- which means that such an organization could be found virtually anywhere. As outlined in the previous section about NGOs, a lack of consensus in conceptualizing such diverse terms means that several definitions should be considered.

I will begin by defining an entrepreneur, followed by defining the term social in the context of development organizations. Emerging in 17th century French economics, an entrepreneur embodies several key characteristics, including that “they create value... they are the change agents in the economy... they are people who organise, own, manage, and assume the risk... they have the ability to adapt their style to the needs of the people” (Mort et al., 78). I

believe the most compelling and relevant aspect of this definition in regards to entrepreneurship that is also social discusses their ability to adapt to the needs of the people whom they are serving; in an organization dedicated, in whole or in part, to improving the conditions of disadvantaged populations, this seems a particularly important characteristic to embody. Therefore, an entrepreneur who is a *social* entrepreneur does not assume risk and adapt to the people's needs for his own benefit, but in an altruistic manner; “[they] attempt to make profits *for* society or a segment of it by innovation in the face of risk, in a way that involves that society or a segment of it” (Tan et al., 13). Using this definition, it can be stated that a social entrepreneur employs innovative techniques, taking on some varying degree of risk and gaining some varying degree of profit- depending on how philanthropic said entrepreneur is- to have a positive impact on society.

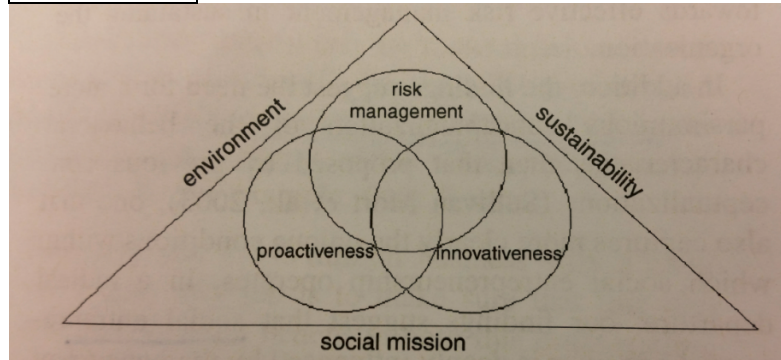
Despite the relative ease in defining the characteristics of a social entrepreneur, there remains little consensus in the conceptualization of social entrepreneurship due to the incredible diversity of purposes, organizational structures, and business models of existing social enterprises. Similar to Love's discussion of NGOs, Peredo and McLean offer a specific yet encompassing definition of both the *structure* and *intentions* of a social enterprise:

Social entrepreneurship is exercised where some person or persons (1) aim either exclusively or in some prominent way to create social value of some kind, and pursue that goal through some combination of (2) recognizing and exploiting opportunities to create this value, (3) employing innovation, (4) tolerating risk and (5) declining to accept limitations in available resources (Peredo & McLean, 1).

This holistic definition discusses not only the innovative, entrepreneurial aspect of a social enterprise, but also touches on the significance of its mission being socially driven. Most scholars agree that the creation of social value must be a focal point of the organization, considering this the distinguishing factor between social entrepreneurship and commercial entrepreneurship. Innovation is, of course, what makes social entrepreneurship entrepreneurial, implying that founders of social enterprises have pursued an unconventional route to solving a social problem; these organizations also tend to cater to specific communities as opposed to utilizing broad, universally-applicable solutions based on assumptions (Seelos & Mair, 243). The exploitation of opportunities is best described as “bringing new products or services into existence such that individuals or organizations are able to sell new outputs at prices higher than their cost of production” (Certo & Miller, 267). The toleration of risk is widely agreed-upon by most scholars as a significant aspect of social enterprise, as there is always the potential for financial loss should the product fail. Wangsa Jelita is an example of a social enterprise dedicated to the development of underserved communities in Indonesia. Rose farming is very popular but not always profitable, and poor families were not finding financial stability in the business. So Wangsa Jelita converted the rose petals into everyday products such as soaps and body butters, empowering women in the community to make the products by offering training and guidance- but the company is solely responsible for the marketing and sales of the products (www.wangsajelita.com). By tolerating risk and coming up with an innovative idea, Wangsa Jelita has also helped many Indonesian women and families find greater financial stability and have increased opportunities for their futures.

Seen below in Figure 1.4, Weerawardena and Mort offer another perspective of social entrepreneurship with their multidimensional model. It coincides with much of what Peredo and McLean describe as key characteristics, but takes it one step further by discussing how these characteristics interact with each other:

Figure 1.4



In order to produce viable social value creation in a community, social entrepreneurs must utilize risk management behavior, innovativeness, and proactiveness all while recognizing the constraints of an increasingly competitive environment (29). Because the social mission is most central to the company, it sits at the base of the triangle. In regards to sustainability, the authors write that “sustainability resulting from a balance of the entrepreneurial drivers of innovativeness, proactiveness, and risk management is not seen as an end in itself, but sustainability is focused on ensuring the continuation of the organization because of its social mission” (30). With their model, social value creation can only occur when each of the three above strategies overlap and remain intertwined “within the constraints of environment, sustainability, and social mission” (33). These authors view social entrepreneurship as chiefly social, where profits are not the main focus of the organization- this could differ from other

perspectives where profits might be placed at the triangle's base and the social mission might replace either environment or sustainability.

To further clarify the intended *results* of social entrepreneurs, note authors' Seelos and Mair's definition:

Social entrepreneurship creates new models for the provision of products and services that cater directly to basic human needs that remain unsatisfied by current economic or social institutions... social value creation appears to be the primary objective, while economic value creation is often a by-product that allows the organization to achieve sustainability and self-sufficiency (244).

One aspect of the industry that has not previously been discussed is the production of some goods and/or services being an integral part of a social enterprise. An example would be Yellow Leaf Hammocks, which is an international social enterprise committed to economically empowering mothers in Thailand by providing them with the skills to make hammocks which are then sold to consumers around the world, thus lifting them out of extreme poverty and into the middle class (www.yellowleafhammocks.com). Yellow Leaf Hammocks cater to these communities' basic needs through providing them with a sustainable income while also producing, marketing, and selling goods which can be sold to a broader audience. Similar to Lewis and Kanji's definition of NGOs, this simplified perspective describes the intentions of social entrepreneurs as bettering some disadvantaged sector of society. Again, this definition also views profits as a consequence of engaging in social entrepreneurship as opposed to the company's main goal- this distinction is discussed in greater detail in the paragraph below.

Another interesting aspect of social enterprises, which also results from a lack of consensus on a universal definition, is the incredible diversity in types of profit margins. Many scholars agree that “[it] includes a wide spectrum of organizations, from for-profit business engaged in socially-beneficial activities (corporate philanthropy) to non-profit organizations engaged in mission-supporting commercial activity” (Defourny & Nyssens, 4). Some social entrepreneurs are largely motivated by profits with societal improvement being a consequence of the company’s structure, while others are solely focused on societal improvement and reinvest all profits back into that mission. This makes classification incredibly challenging and allows for debate about the existence of a sort-of continuum where organizations fall between being considered a commercial or social enterprise. According to Peredo and McLean, the largest group who classifies themselves as social entrepreneurs “will extend the range of its use to include individuals or groups who are *chiefly* motivated by the wish to produce social benefits, but who aim to produce monetary and other benefits for themselves, and perhaps others, as well” (64). To some, organizations that are solely dedicated to benefitting disadvantaged people could even be seen as nongovernmental organizations because they are not profit-seeking. On the other end of the continuum would be an organization established with a central goal of making a profit while displaying some level of commitment to a social component in their mission (64). To some, however, this might be classified as simply a charitable business or corporate philanthropy instead of a social enterprise. This diversity in profit margins has left some wondering if there is even a difference between NGOs and social enterprise in today’s competitive market; Atul Tandon, corporate banker-gone famed nonprofit fundraising manager, does not see a difference. “In my view every non-profit is a social enterprise. The tax label of an enterprise, whether it’s for-profit or non-profit, - all it really is a

tax label” (forbes.com). All types of organizations initially depend on external funding, whether public or private, and all types of organizations incorporate societal enhancement within their mission- beyond that, what else really matters?

What each of these definitions shares in common is the concept that social entrepreneurs are dedicated to social value creation through employing innovative, profitable techniques. All three scholars agree that their intentions are to address complex development problems such as a lack of access to clean water, inadequate economic opportunity, and poor public health standards through community involvement, utilizing a business model which aims to remain sustainable despite inevitable fluctuations in the global market. They assume and tolerate some amount of risk in the marketing and selling of whatever goods and/or services are produced, understanding the possibility that the company may not succeed. Despite incredible diversity within the industry, my research also indicates that most social enterprises tend to include beneficiary communities directly in their projects, having them assume some amount of the risk as well whether through microlending, education, or production training programs. Without a doubt, social enterprise is gaining popularity in response to the difficulties faced by NGOs in recent years and many more will likely emerge in the future.

Limitations of Nongovernmental Organizations and Social Entrepreneurship

Despite a generous and ever-increasing body of research surrounding the two theories, the world has yet to unveil a one-size-fits-all solution to community development problems or even to immediate humanitarian crises in general. Examples of poor development can still be found happening today all over the globe, and unfortunately, most of the world will likely never be made aware of these misguided projects and its negative impact on beneficiary communities.

Of course, it is highly unlikely that any organization would choose to engage in a development project with the intention of harming the community with whom they are intending to serve, but in many instances good intentions are not nearly enough to create sustainable, positive change in suffering populations. This section attempts to unpack some of the limitations the third sector currently faces in light of increased criticism from scholars and activists alike.

There are several limitations to both NGOs and social entrepreneurship, mostly resulting from an overall lack of accountability shared by both NGOs and social enterprises. Third sector organizations are theoretically held accountable internally by donors and beneficiary communities, while being held accountable externally by the general public (Desai 571). However, it has proven highly challenging for this to take place on a wide scale because of overall disorganization. According to Desai, there are two types of accountability which should be employed by evaluators in order to determine the success of third sector organizations: “*functional* accountability in relation to accounting for their resources and their impacts, and *strategic* accountability, which relates to the wider implications of [their] work” (572) with regard to how they impact the global environment of the third sector. The monitoring and evaluation of third sector organizations has become increasingly complex, meaning that attempts to find viable solutions to this problem have been largely ignored or deemed impossible by the international community. This problem stems from a lack of international consensus on the nature and definition of third sector organizations, as discussed extensively in the above two sections,

As a body of law between different geographically defined nations and, states set up conventions and treaties to regulate and define important relations in the international arena. NGOs, however, have not yet been recognized by

states as having a legal international personality. Despite several attempts since the beginning of the twentieth century to define NGOs and codify their legal status, there is as yet no widely adopted international convention on the nature and law of NGOs (Martens, 275).

This lack of organization by the international community gives NGOs incredible freedom to organize themselves, and their resources, however they please; in turn, this has aided poor-quality organizations in continuing to engage in unsuccessful projects. I strongly believe that disadvantaged populations around the globe would greatly benefit from there being an agreed-upon, codified international standard for all third sector development organizations to follow. Not only would such measures help dissolve the problem of unregistered NGOs in the Global South, but required reporting would also ensure that all development projects are responsible and community-focused.

Due to this lack of accountability, an overarching skepticism of the third sector's effectiveness in addressing global development problems has gained popularity in recent decades. Development scholar David Lewis writes that "long gone are the days when [they] could simply rely on the 'moral high ground' to give them legitimacy and justify their work. This is entirely as it should be... The idea of [them] as a 'magic bullet' that can easily solve development problems is one that has now passed (Lewis, 12). As the third sector has evolved and embraced its critical role in civil society, it has also become more thoroughly scrutinized and, in turn, harshly criticized by those who claim they are "ineffective do-gooders" who will readily tout their successes while simultaneously hiding their defeats. Along this vein, perhaps the most significant but least mentioned internal problem faced by the third sector is best described by development scholar Alan Fowler; "to remain credible, [they] need to be more

modest about what they are able to achieve” (18). While this may sound counter-intuitive, particularly when dealing with increasing competition among organizations in maintaining funding, the third sector must admit its own inherent limitations in solving world hunger, eradicating global poverty, or eliminating disease.

In many development projects there exists an alarmingly large gap between what organizations claim to accomplish and what they actually accomplish. Many organizations will report, typically through self-evaluations, that their project has positively changed many lives through whatever techniques they employed, when the beneficiary community does not feel the same; in fact, some projects would be classified as failures where beneficiaries were actually harmed by the project. For example, international NGO Save the Children claims to have “led the emergency response” effort to the 1976 Guatemalan earthquake which devastated many impoverished communities by totally re-constructing hundreds of leveled homes (savethechildren.org/history). However, development scholar Earle paints a different picture, claiming that the “primary activity of the program focused on housing as a material object, without taking into consideration its local cultural logics” (Earle 58). Developers used economical materials like tin for the roofs, trapping heat and humidity within the house despite the region’s tropical climate. By simply assuming the needs of the community and virtually excluding local villagers from the project, it ended with a collection of hundreds of abandoned homes. However, the NGOs’ webpage still claims their leadership in the emergency response effort in Guatemala. Countless factors including donor interests, the introduction of unsustainable practices, ignoring cultural traditions, inadequate preparation and research, and neglecting to incorporate the community in the project planning and execution can quickly destroy the fragile ecosystem of a community. As more of these previously unknown

disappointments are uncovered by critics, it has become clear that NGOs and social entrepreneurs are damaging their own industry in terms of their legitimacy and credibility (Fowler, 19).

Sometimes a schism emerges between donor desires and the pressing needs of beneficiaries. Again, Fowler puts it best; “when there is a disparity between primary stakeholders and donors’ views, project-based assistance deflects NGO [and social enterprise] attention, behaviour, and interests away from those they are meant to serve towards satisfying donor requirements” (18). Donors and funding groups will generally want to see their charity being used in tangible ways, such as the construction of schoolhouses or hospitals or the installation of water wells. However, in many instances what communities need most cannot be seen; Kiva, for example, is a social enterprise which utilizes microfinancing, or small loans with lower interest rates, to individuals living in poverty. These loans, given in \$25 increments, “help very poor households meet basic needs and protect against risks” (kiva.org). Although these funds certainly help lift people out of poverty, it can be more difficult to trace where exactly such charitable donations are going. This can ultimately drive organizations to engage in projects that “feel good” to donors but do not positively impact communities.

I will close this section with two examples of attempted development projects that have received significant criticism due to the organizations practicing a number of the concerns discussed above:

In 2015, NPR in collaboration with ProPublica released a highly controversial piece on the American Red Cross titled, “In search of the Red Cross’ \$500 million in Haiti Relief”. The telling work exposed a highly disorganized, poorly managed, secretive development project that had fallen grossly short of delivering on its grandiose promises to a devastated Haitian people.

When an earthquake reduced an already impoverished and unstable country to rubble in 2010, the Red Cross swiftly stepped in and collected almost \$500 million from kindhearted donors all over the globe. The organization claims to split the significant budget into sectors, where \$69 million was going to emergency relief, \$170 million would be spent on shelters and housing, and \$49 million was dedicated to water and sanitation improvements. “The charity says it has done more than 100 projects in Haiti... but the charity will not provide a list of specific programs it ran, how much they cost or what their expenses were” (ww.npr.org). This ongoing secrecy indicates the organization’s internal disorganization because the Red Cross would inevitably become a public embarrassment should their accurate expenditures be revealed. One local, still living in a tent five years after the quake, said that “about three years ago [it] came with glossy booklets saying it was going to build hundreds of new homes, a water and sanitation system and a health clinic. None of that happened” (www.npr.org). Titled “Rebuilding Neighborhoods” with a \$24 million budget, this project serves as but one of countless undelivered promises made by the Red Cross to the Haitian people- and to hopeful donors. Typically serving as an emergency humanitarian aid NGO, their inability to create positive, lasting change in Haiti through development projects also speaks to the significance of conducting extensive research and relying on community involvement, two things which the Red Cross certainly overlooked.

TOMS shoes is a social enterprise developed by American Blake Mycoskie in 2006. Inspired by a trip he took to Argentina years earlier, he created a one-for-one business model where every time a consumer purchases a pair of TOMS shoes, a pair is given to a child in need somewhere in the developing world. According to their glittery webpage, TOMS has delivered over 35 million pairs of shoes to children in over seventy countries and due to its unbelievable

success, the company has since expanded their venture to include eyewear, potable water (through purchasing coffee), and most recently, bags (www.toms.com). However, recent criticism has exposed a more realistic, even negative impact the company can have on recipient communities. Skeptics point out that the model is “a new form of colonialism that fosters dependency and ignores the deeper problems of poverty... its plaster-like approach to the problems that result from walking around barefoot [still mean that] when that child outgrows a pair of shoes, the health problems from contracting hookworms or dangers of stepping on a hypodermic needle do not go away” (theguardian.com). Referring to the radical-dependency theory discussed in the “Overview and History of Development” section, suddenly supplying an entire village with free shoes undoubtedly put a financial strain on households who had previously depended on making and selling shoes at the local market as their source of income. Still others argue that without investing in the community members themselves through resources, education, and empowerment, TOMS would have little longstanding positive impact on the communities. And, of course, I cannot forget to mention that TOMS likely assumed instead of asked if the recipient communities needed and wanted shoes in the first place.

As noted above, many third sector organizations are built upon nearly angelic intentions and exist in hopes of serving disadvantaged populations around the globe. It is admittedly challenging to recognize that not all organizations are able to live up to these goals, especially because as humans, we all want them to be successful. After all, organizations like the Red Cross and TOMS shoes are not giant, for-profit MNCs employing young women in sweatshops overseas just to make a quick buck. However, it is clear that even the most popular and well-respected organizations must be scrutinized and evaluated by scholars, potential donors, and the public in order to raise the standards for third sector organizations across the board. When this

is accomplished, whether through international cooperation, the creation of individual state standards, or a collaborative effort by the third sector themselves, I believe that more legitimate, sustainable, positive change will take place in communities all over the globe- and they will thank us for it.

Preview: Health in Guatemala

Because the following two case studies both take place in incredibly rural regions within Guatemala, it is important to note several overarching themes of the global rural poor. According to a 2011 United Nations report, it is estimated that of the 1.3 billion people living on less than \$1.25 per day, approximately 1 billion, or seventy percent, of that population resides in rural areas (Heinemann, 225). Additionally, a 2008 study conducted of rural households claims that “compared to the non-poor, poor households are significantly larger and have a higher share of [non-working-age] dependents” (Heinemann, 226). Typically relying on agriculture to sustain themselves, the rural poor often also have access to the smallest plots of land or, in some cases, no land at all. With the worst health, sanitation, education, and overall access conditions, these dire circumstances frequently arose out of historically strained or negligent relations with local and national governments (Heinemann, 227) and this unequal distribution of resources and power between the haves and have-nots has proven to be a vicious cycle that perpetually disadvantages the rural poor.

Guatemala struggles with some of the worst health standards in Latin America, despite significant progress being made in recent years. More than half of Guatemala’s population lives in financial poverty, and poverty among indigenous groups, making up almost forty percent of the total population, averages seventy-three percent (Jones

Christensen & Lehr, 40). With some of the highest infant, child, and maternal mortality rates in all of the Americas and over forty percent of the population being under age fifteen (who.int), the circumstances are worse in indigenous communities where child mortality and malnutrition rates are fifty percent higher than in urban populations (Lehr, 57). Even today only fifty-one percent of births are attended by a skilled health worker and there is less than one physician and midwife per 1000 people in the nation (who.int)- and rampant, overarching inequality remains between the urban and rural populations, meaning that there is likely a much higher concentration of physicians and skilled health workers in Guatemala's cities than in the more impoverished rural regions. Much of the rural population is not involved with the state's formal health care system due to a lack of funding, geographical and cultural factors, and overall less state government involvement with the rural population (Jones Christensen & Lehr, 40). In 2014, the United Nation's Human Development Index ranked Guatemala 125 out of 187 countries, and they scored "low" on the Gender-related Human Development Index as well with the same ranking (hdr.undp.org). The World Health Organization indicates that Guatemala needs to "reduce inequalities and encourage greater participation by decision-makers, thus empowering the population to exercise its right to health and to benefit from de facto cultural inclusion" (who.int), while also calling for a government budget increase for the Ministry of Health.

Affordability is obviously a nearly impassible obstacle, especially for the rural populations, which perpetuates the country's poor overall health standards (De La Cruz & Beyeler, 4). Another factor contributing to these public health problems is access to health care, also particularly within rural communities. Guatemala's mountainous topography and wet, humid climate combined with a lack of crucial infrastructure, such as roads, makes it

incredibly difficult for impoverished rural villagers to receive the care they need. For many, traveling to a hospital or health clinic could take days and the associated transportation costs could push families well over their available budget before even being seen by a doctor (Beracochea, 4). This lack of affordability to obtain resources as well as lack of access to clinics, medications, and education is precisely what both organizations discussed below are working to address.

Part II: Case Study- Curamericas Global, Inc.

History of Curamericas

Curamericas Global, Inc. was founded in 1983 by Johns Hopkins University faculty member Henry Perry III, M.D., Ph. D, M.P.H. and his colleague Alice Welton, Ph. D. who first traveled to Bolivia as Duke undergraduate students in 1969. Seeing an overwhelming need in the rural altiplano Aymara communities, they felt inspired to instigate change. In 1981, the two created a “community health project with the Bolivian Methodist Church, Duke University, and the Bolivian Ministry of Health” (www.curamericas.org). Two years later, Dr. Perry founded Andean Rural Health Care (ARHC) which allowed for the continuation and expansion of the health project in Aymara communities. The mission of the organization states that they will “partner with underserved communities to make measurable and sustainable improvements in their health and well-being”, which will be accomplished through their vision which states that there is “hope through health: a world free of suffering from treatable and preventable causes” (www.curamericas.org). When engaging in a development project they incorporate these core values into their work:

Compassion: giving a helping hand to those who are suffering or dying from readily treatable and preventable conditions; *equity*: prioritizing those in greatest need and asserting that everyone should have access to health care, leading Curamericas Global to work in remote and forgotten places; *empowerment*: assisting individuals, communities, and local organizations to contribute to their community’s health and well-being; *sustainability*: creating lasting benefits through education and long-term partnerships with communities, local implementation organizations, and local leaders; *data*

driven: commitment to use of evidence-based practices to achieve maximum health benefits for impoverished people and to demonstrate that these benefits have been achieved (www.curamericas.org).

By the 1990s this 501(c)3 nonprofit organization had begun expanding to Mexico and Guatemala, which prompted its eventual name change to Curamericas Global, Inc.

As the organization gained recognition for its commitment to fostering community partnerships and its thorough, unique methodology, Curamericas was able to bring their programs to Liberia in 2008 and then Haiti in 2009. In collaboration with Dr. John Wyon of Harvard University, Dr. Perry created and implemented his innovative census-based, impact-oriented (CBIO) procedure for their health programs. This transformational methodology for international development is discussed more fully in the following section. Alongside expanding its global reach, the organization has also maintained its commitment to establishing community partnerships with local villages, empowering locals to ultimately create their own self-sufficient organization. For instance, Mr. Nat Robison and Dr. Dardo Chavez worked with Curamericas in Bolivia to found Consejo de Salud Rural Andino (CSRA) as its own local health institution. Physician and project director Dr. Mario Valdez created Curamericas Guatemala as a self-sustaining community NGO to serve remote Mayan villages, and the organization continues to serve people today (www.curamericas.org).

Also paramount to the success of Curamericas over the years has been its lively volunteer program. Thousands of students, laypersons, health professionals, and many other groups have traveled to Guatemala, Bolivia, Haiti, and Liberia to gain hands-on experience directly participating in the programs through a variety of opportunities such as attending home visits or helping to construct health clinics. These trips not only offer an enriching cultural

experience to its volunteers, but also provide transportation of necessary supplies to project sites, short-term program assistance, and fundraising opportunities. A personal account of my own experiences as a volunteer and later an intern with Curamericas Global, Inc. in Bolivia and Raleigh, respectively, is described in a later section.

Procedures and Results: Census-Based, Impact-Oriented Methodology

The census-based, impact-oriented (CBIO) model for community development was created by Dr. Henry Perry during his time at Curamericas Global, Inc. The program's goal is "to improve the health of geographically delineated communities" (Perry et al., 1055). This is accomplished by addressing the concerns of the community through open, frank conversation with villagers, formal community leaders, and local government officials. According to the study, the program has been successful because the field staff and project leaders provide services which the community members actually value, which can only arise from having developed an honest and deep understanding of the community itself. Though typically a lengthier process than other development programs of similar scopes, statistical support shows a consistently high success rate for the specific methodology. By identifying the health priorities through conducting censuses, location mapping of each household, and regular home visitations by staff members, trust can be established between the organization and the community and legitimate progress can be made (Perry et al., 1062).

There are two key stages within the census-based, impact-oriented methodology. The following paragraphs will describe in detail this procedure for community development:

The first stage is called the exploratory and pilot program stage. This stage includes two long-term phases, an exploratory phase and a pilot program phase, which ultimately aim to

“collect necessary epidemiological information/priorities of the community” (Perry et al., 1056). In total, the first stage typically spans over a twelve to twenty-four month period. Each of the phases include two smaller segments for a total of four segments within the first stage.

1. Exploratory Planning: This segment typically spans over a six to twelve week period. Much significant information is collected and discussed during this initial segment. For example, the long-term project goals are specified, conversations take place with community and government leaders to establish trust and help reach agreements about the project, and other outlets for resource, space, and financial support are discussed and identified. Additionally, initial research is gathered by project leaders in a two-part process referred to as “reconnaissance”. Intending to gain an initial understanding of the community health priorities, project leaders engage in both “library” and “field” reconnaissance; library reconnaissance being the collection of print resources and field reconnaissance being the initial visits to homes and around the community (Perry et al., 1056).
2. Exploratory Implementation: During this segment of the first phase, field staff are recruited, hired, and trained. The hope is that most of these staff members will be local members of the community as opposed to international workers because trusting, long-lasting relationships can be more successfully built between community members and field staff who will remain in the area even after the project is completed. Specific communities are invited by Curamericas to be included in the project, and several aspects of the program are designed and tested repeatedly. For example, the field staff will gather information about and from the community members in order to design a method to best understand the major health concerns of the village and how to

- successfully address them. Lastly, field staff will begin testing ways to distribute various necessary medical services out to the entire community. From start to end, this segment of the process can take anywhere from six to twelve months (Perry et al., 1057).
3. Pilot Program Planning: This next segment of the first stage includes the collection and synthesis of much of the demographic data of the community members. A second significant portion of this step is the creation of a pilot program to be utilized in the third segment, pilot program planning. This preliminary report describes how a pilot program would take place for a smaller, manageable initial project site which could potentially be expanded to a greater geographical area in the future. This report includes a path for identifying each community resident and the health priorities of the community as a whole; a method for collecting data on the rates of births, deaths, migrations, and diseases; agreeing upon what will likely be the most common diseases within the community, specifically preventable diseases, and how to best address them; and establish a time frame for the pilot program. Typically, this segment of the process takes between three and six months. It is imperative that from this initial segment of the entire project, trust is established between the field staff, project leaders, and community members so that the entire community feels compelled to engage in the project throughout (Perry et al., 1057).
 4. Pilot Program Implementation: The longest segment of the exploratory and pilot program stage, pilot program implementation begins to address the medical needs of the community over a one to two year period. Throughout the duration of this segment, field staff will establish a repeatable procedure for maintaining contact with each community member, or, at the least, a representative sample. Much of this aspect of the segment can

be completed by volunteers or minimally paid staff; my personal experience with home visitations is discussed in a later section. Utilizing these regular home visitations as an opportunity to continue building relationships within the community, another aspect of this segment includes the treatment of acute medical needs among village residents. By assisting with easily treatable, short-term illnesses in addition to providing long-term preventative care, community members can begin to feel more comfortable around the field staff and project leaders. Throughout this segment, data continues to be analyzed in order to more efficiently affect healthy changes within the community and establish the changing medical priorities of the residents (Perry et al., 1057).

The second and final stage of the CBIO methodology is called the definitive program stage. This stage takes place on a much broader scale than the initial exploratory and pilot program stage because the necessary demographic information has been collected by the field staff, so the needs of the community are understood. Throughout this stage, relationships between community members, field staff, and project leaders are strengthened as well. Perry writes that “like the physician’s diagnosis of an individual patient’s medical problems, a program’s ability to make an accurate community diagnosis is highly dependent upon a relationship of trust with open and frank communication between the health program staff and community members” (Perry et al., 1058). Similar to the initial stage, there are also four smaller segments within this stage.

1. Community Diagnosis: This segment is one of the most significant aspects of the entire process because the data collected must be accurate in order for the results to correctly reflect the progress made within the community. A second impactful aspect of

community diagnosis deals with “defining” the community; at this point, a census is taken of each resident within each household and their locations are mapped for the Curamericas field staff and project leaders. In congruence with everything leading up to this point, repeated household visits help to define the most pressing preventable health concerns within the community and identify any common characteristics displayed by those who are affected. Defining the community and then keeping track of each resident through household visits is what constitutes the “census-based” portion of the CBIO methodology. Typically, this segment of the development process takes between six and twelve months (Perry et al., 1059).

Home visitations are an exceptionally important aspect of the CBIO methodology and deserve a closer examination. Curamericas refers to the process as Routine Systematic Home Visitation (RSHV) and has several key advantages. Routine visits allows for the data collection to be longitudinal which helps to determine the success of the project after its completion. Additionally, virtually all barriers within a community that attribute to their public health concerns can be broken through RSHV. Geographical barriers are broken when people no longer have to find their way to a remote clinic to receive medical assistance; informational barriers are broken when community members learn about family planning, immunizations, and neonatal care; socioeconomic barriers are broken when such services are offered to them at a lower cost than they could obtain anywhere else. Acute illnesses can also be treated at this time (Perry et al., 1059). ANother significant aspect of RSHV is the identification of individuals and families who are at a higher risk of contacting whatever the main

health concerns are within the community; depending on the condition of the individual, up to daily follow-up visits will then occur in these households. For some, referrals to hospitals or other health clinics can also take place as a result of RSHV. Lastly, trust is further cultivated with RSHV because it is an opportunity for field staff, volunteers, and project leaders to showcase their commitment to the community through engaging in an open dialogue. RSHV is exceptionally important for households with newborns and infants under two years because mothers are able to not only receive neonatal care, but also education regarding immunizations, nutrition guidance, vitamins, and other necessary resources to raise their infant as healthfully as possible. Growth monitoring through RSHV is also essential in order to help the organization obtain the most accurate results at the conclusion of the project (Perry et al., 142). These home visits are implemented through a process called the Care Group Model (CGM), which “includes the training and support of a network of village health volunteers... who were each responsible for ten to fifteen surrounding households” (Beracochea et al., 3). Continued support is offered by Curamericas staff members throughout the process. These volunteers were dubbed “Health Communicators” and facilitated regular meetings of “mothers’ groups”, called “Self-Care Groups”, which acted as a space for open dialogue and support concerning the health priorities of new and expecting mothers.

1. Program Implementation: This segment is the longest portion of the entire project, lasting between three and five years. Program implementation focuses on the continuation of RSHV, the construction of local health clinics, including those called

Casa Maternas (homes for mothers) that provide neonatal and infant care, and continuing to build relationships with families spanning to all corners of the community. As part of the Group Care Model, these health clinics were manned by paid Institutional Facilitators who are typically auxiliary nurses (Beracochea et al., 4). The main concerns during this part of the process are reaching the entire community and, of course, having a notable impact on the health of those within the community (Perry et al., 1059).

2. Program Evaluation and Community Rediagnosis: This approximately three month segment begins the perpetual data collection, synthesis, and redesigning of the project which could continue indefinitely. Utilizing the information collected throughout the program implementation phase, health priorities and concerns can be re-evaluated and adjusted to best meet the needs of community in that moment. This is referred to as the community “rediagnosis”. Typically, this segment of the project takes between three and six months (Perry et al., 1059).
3. Program Planning for the Next Program Phase: The eighth and final segment of the CBIO procedure for community development technically takes over a three to six month time period and utilizes the data from the previous segment to continue instigating positive change in the community (Perry et al., 1060). Although this is the end of the initial process it is only the beginning of the perpetual cycle of inquiry and data collection, community diagnosis and strategic planning. Eventually, a goal of the project would be to establish a local sister organization that could sustain and advance the work that Curamericas began. An example of this is Consejo de Salud Rural Andino (CSRA), which was launched from Curamericas and continues to do meaningful work in Bolivia today.

The CBIO program was first utilized by Andean Rural Health Care (now Curamericas Global, Inc.) in the early 1980s in the rural altiplano region of Bolivia. Inhabited by indigenous Aymara and Quechua peoples, several key factors have contributed to longstanding poverty and a lack of development in the region including harsh mountain climate conditions, language barriers, and geographic isolation which prevents modern medicine from reaching these communities. As discussed in the earlier history section, Curamericas expanded their efforts to other countries such as Guatemala in the early 2000s. The following evidence is based upon a thorough evaluation of the program conducted by Curamericas Global and attempts to determine the health impact of the organization and its unique methodologies on two specific communities in Guatemala. The project, called the “Child Survival Project”, took place from October 1st, 2002 to September 30th, 2007. Data was synthesized and reported at the conclusion of the entire CBIO process in 2007.

In this particular study, Curamericas worked with three neighboring communities in the Department of Huehuetenango, which is an isolated region that lies in the northwestern portion of the state of Guatemala. The community names, called municipalities, were named San Miguel Acatan, San Rafael La Independencia, and San Sebastian Coatan. Each of the three municipalities consisted of approximately five to seven villages, called sectors, each with further individualized needs. As stated above, several significant barriers were considered by Curamericas when choosing where to engage in their next CBIO project; for example, each community spoke their own local dialect such as Akateko and Chuj which instigated a very challenging language barrier and the rugged, difficult terrain made the creation of infrastructure like roads nearly impossible. In addition, these communities were highly skeptical of

development organizations due to the thirty year civil war which had finally ended just years earlier. One of the communities, San Sebastian Coatan, had been exposed to several years of community development organizations before while San Rafael La Independencia had never come into contact with such an organization (Beracochea et al., 1). It was also very important to Curamericas that this project take place in communities where there are some of the most dire needs in regards to public health, which adds yet another layer of difficulty to the project. These examples help unearth some of the basic but highly important challenges that NGOs and other organizations face and must be privy to when attempting to forge a relationship with a new community.

There were several pivotal aspects of the project that Curamericas chose to focus on based upon the demographic information gathered about the community during stage one of the CBIO procedure. A breakdown of these priorities includes:

The project partnered with the Ministry of Health (MOH) and the communities to provide well-known and effective child survival interventions and assigned a level of effort according to the magnitude of the problems: Nutrition (including breastfeeding promotion) had 30% of the level of effort (LOE); Maternal and newborn care, 25%; Childhood pneumonia, 15%; Control of childhood diarrhea, 10%; Child spacing, 10%; and Immunizations had 10% (Beracochea et al., 2).

Key goals of the project included the improvement of the “scope and quality” (Beracochea et al., 2) of neonatal and infant healthcare through better community outreach efforts and the

utilization of RSHV, as well as the improvement of childhood illness prevention, recognition, and treatment within households (Beracochea et al., 3). These lofty Child Survival goals were achieved through the utilization of the CBIO methodology.

321 Health Communicators were engaged in regular neighborhood home visits as well as routine Self Care Group meetings to facilitate constructive conversation regarding their neonatal and infant health concerns. Though there was initial pushback from some families, particularly the male heads of households who were generally more skeptical of community development programs and modern medicine, eventually over 400 households were participating in these groups as well as RSHV. Additionally, Curamericas implemented 62 local paid Community Facilitators to support the work of the Health Communicators who provided preventative care as well as recorded statistical information during home visitations. There was one Health Educator stationed with each municipality for a total of three Health Educators, and 15 Institutional Facilitators were hired, typically as auxiliary nurses, to offer care at each of the health clinics (Beracochea et al., 3).

Training and supervision of the above employees and volunteers took place on an ongoing basis throughout the life of the project. Field staff members were reviewed by Curamericas Global staff members either every month or every other month, depending on the “score” received by the reviewing process in the previous month. Using a universal checklist for all staff members depending on their duties, if a staff member scored above an eighty percent during the previous reviewing period they were not reviewed for another two months; those who received a checklist score below eighty percent were reviewed and supervised monthly.

Curamericas also showed commitment to evolving their own CBIO method throughout the duration of their Child Survival project. An example of this can be seen in their creation of a new position after discovering a need to organize the influx of community participation during their midterm project evaluation. This position, named the Community Organization and Participation Manager, was charged with finding several representatives from each of the five sectors within each of the three villages to serve on local health committees. By the project's close, a fully-functioning committee had been established for each of the seven sectors. These committees worked to further address concerns with hygiene, sanitation, nutrition, and emergency (Beracochea et al., 21).

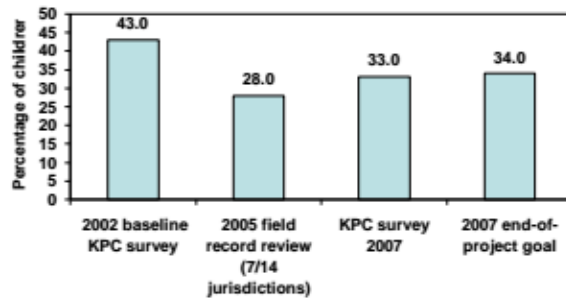
Census-Based, Impact-Oriented Project Evaluation

“The CBIO methodology was one of the most important reasons- if not the main reason- for the success of this project” (Beracochea et al., 2).

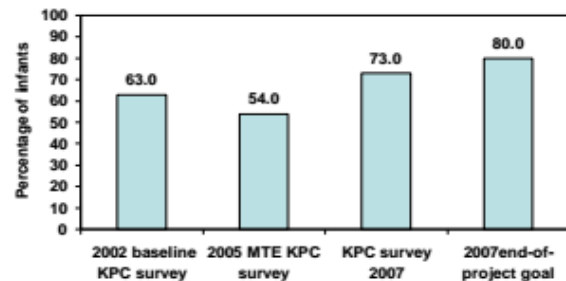
The Child Survival project which took place in rural Guatemala reportedly experienced great success. Following the project evaluation from August 27th to September 7th, 2007 conducted by Curamericas Global staff as well as USAID representatives, it was determined that the project had either achieved or surpassed twenty of the twenty four project goals. The remaining four goals were achieved in some part or community, but not holistically. As discussed later in this section, the final evaluation indicated that these incomplete goals were likely due to an insufficient amount of time devoted to the project. Below are some key results that the final evaluation highlighted as exceptional successes of the project:

1. Improving child nutritional status, including the promotion of breastfeeding and micronutrient supplementation

Percentage of Children 0-23 Months of Age with Moderate or Severe Malnutrition



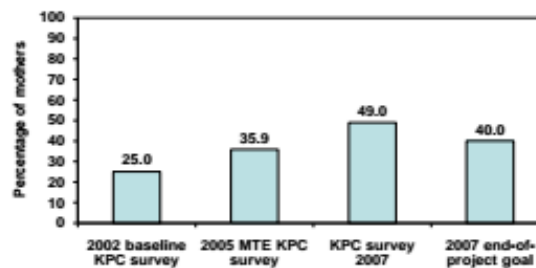
Percentage of Children 0-5 Months of Age Receiving Exclusive Breastfeeding during the Previous 24 Hours



The percentage of malnourished children decreased from 43% to 33% overall, meaning that the project surpassed its End of Project (EOP) goal of 34%. Between the midterm evaluation and the EOP, the percentage of mothers engaging in immediate and exclusive breastfeeding raised from 54% to 73%, though falling short of the project goal of 80% (Beracochea et al., 4). The Care Group monthly meetings played a large role in the improvement of this second figure, as mothers were educated about the significant health benefits to breastfeeding as well as learning proper techniques.

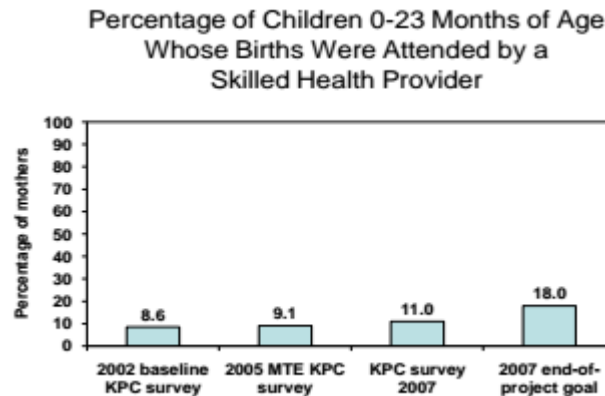
2. Improving coverage of prenatal care

Percentage of Mothers Who Had Obtained at Least Two Prenatal Care Visits Prior to Her Most Recent Delivery



By the EOP, 49% of mothers had received antenatal care which surpassed their 40% goal. The percentage of mothers receiving iron tablets during her pregnancy also improved significantly from 33% to 58% (Beracochea et al., 4).

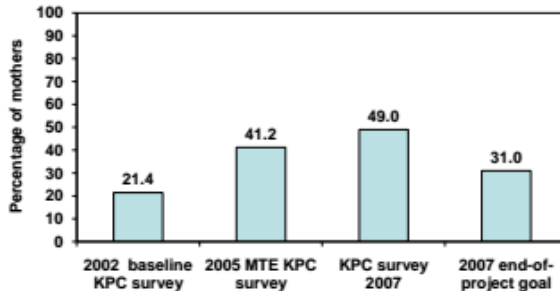
3. Eradicating dangerous baby deliveries



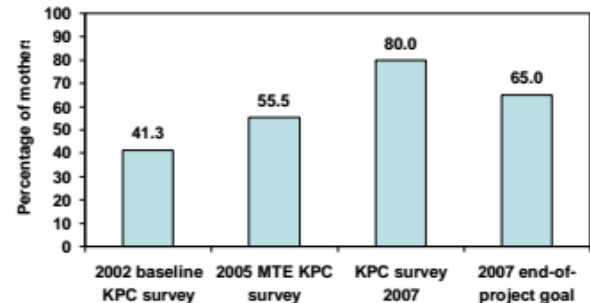
Perhaps the most difficult target to reach given the incredibly isolating geography of the region and ensuing large number of impassable roadways in the municipalities, the percentage of deliveries assisted by a skilled attendant increased from 8.6% to 18% during the project's lifespan. However, many Traditional Birth Attendants were trained through the project and were able to offer delivery assistance at maternity waiting homes, or *Casas de las Maternas*, one of which was built in the San Sebastian municipality (Beracochea et al., 4).

4. Improving upon and advocating for child spacing

Percentage of (Non-Pregnant) Mothers Who Desire No More Children in the Next Two Years (or Who Aren't Sure) Who Are Using a Modern Method of Child Spacing



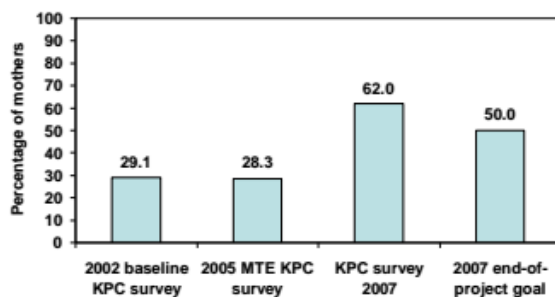
Percentage of Mothers of Infants Who Know at Least One Place Where She Can Obtain a Method of Child Spacing



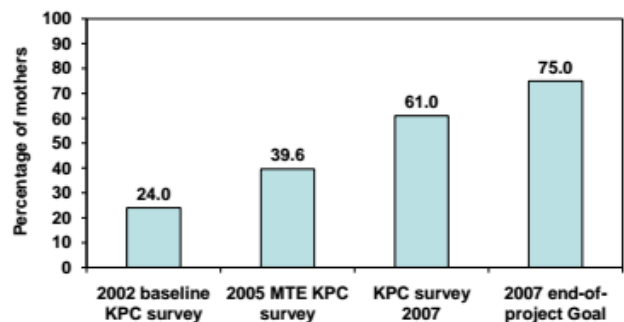
The project found great success in increasing the percentage of mothers engaging in child spacing options in each of the municipalities, reaching 47% and exceeding the EOP target of 31%. Additionally, by the end of the project 80% of mothers were educated about how to obtain child spacing methods, exceeding the EOP target of 65% (Beracochea et al., 5). Similar to the breastfeeding target, much of this success is due to the mothers' passionate involvement in Care Groups where they were able to engage in an open dialogue and address their concerns, particularly with regards to the male stigma around child spacing.

5. Assuring proper case management of common childhood illnesses, including pneumonia and diarrheal disease

Percentage of Children 0-23 Months of Age with Cough and Fast/Difficult Breathing Who Were Taken to a Health Facility or Who Received Antibiotics from an Alternative Source



Percentage of Mothers of Children 0-23 Months of Age Who Know at Least Two Signs of Childhood Illness Which Indicate the Need for Treatment



The percentage of mothers who were able to recognize at least two signs of illness in their child increased from 24% at the project's inception to 61%, though it fell short of the EOP target of 75%.

Much of the above results were collected and synthesized through a Curamericas ongoing self-evaluation process called KPC, or Knowledge, Practice, and Coverage. It is typically conducted in collaboration with the state's health department. For the case of Guatemala, workers within the Ministry of Health were trained by Curamericas field staff to administer surveys to a representative sample of households throughout the entire process; collecting a representative sample was simple due to the census-based nature of the project. These extensive questionnaires were created by Curamericas staff members and were administered annually, including a mid-term evaluation and a final evaluation. According to leaders Henry Perry (Curamericas founder) and Mario Valdez (Curamericas Guatemala project manager), the KPC evaluations were "an activity which further strengthened the staff capacity and the level of community support" (Beracochea, 76). Each of the surveys were conducted in the community's native dialects, which was significant in understanding the villages' cultural norms while maintaining consistency among communities. Different surveys were administered to different family structures, such as a specific questionnaire for mothers with infants aged zero to eleven months and mothers of twelve to twenty-three month-old children; conceptually, however, the surveys were largely similar, including questions regarding the types of acute illnesses experienced, knowledge regarding health issues as a result of education through the Care Group model, an understanding of child spacing and pre/post-natal care, and experience with breastfeeding (Beracochea, 78). Each interview lasted between twenty and forty minutes,

and the results were initially tabulated by hand before entering the data into a computer program.

Of course, much was learned by both the beneficiaries and Curamericas through engaging in this Child Survival project. The evaluation indicates that there are definitely still needs in all three of the municipalities which could not be addressed in the amount of time and resources allotted for the project. For example, throughout the project it was determined that there should be at least two healthcare providers present at each health center at a time, yet at the project's end there were some villages with only one doctor who had to serve several communities at the same time- up to twenty-two in one municipality. The evaluation stated that there was a need for at least one permanent Institutional Facilitator (typically auxiliary nurses), or *Facilitator/a Institucional*, in each municipality (Beracochea et al., 30). Additionally, there appeared to be a need for local, highly involved mothers to be trained in community-based treatment methods and given the proper tools to address these concerns, specifically with regards to pneumonia in children. Given that the third target was exceptionally difficult to achieve (see Figure 4), the evaluation also called for more maternity waiting homes, or *Casas de las Maternas*, to be built in each municipality in order to lower maternal death rates. Not surprisingly, sustained funding issues are apparent in continuing to address the above ongoing concerns. This will likely be the greatest challenge in building upon the successes of the project for years to come.

Within these studies, several strengths and limitations of the program are dissected. One exceptionally significant strength of the project is its commitment to and inclusion of the entire community every step of the way. Each project conducted by Curamericas utilizes the many voices of the villagers to construct their project guidelines and continues to depend upon the

villagers throughout the entire process. Because of the continued focus on relationship building, much of the success of the program is actually reliant upon a feeling of legitimate trust between the community members and the Curamericas field staff. Many villagers had never been exposed to modern medicine prior to the introduction of Curamericas into their neighborhoods, which meant that there were significant trust barriers to overcome as far as introducing resources such as vitamins, vaccinations, and nutrition planning is concerned. As a result, the significance of the initial formulation of relationships is repeatedly discussed within each of the articles. Without this symbiotic relationship, the villagers would likely stop engaging in open dialogue with the organization which would halt progress because field staff would no longer be able to determine and address the community's' health priorities. According to the author, relationship building is much of what makes the CBIO methodology so uniquely powerful and successful (Perry et al., 1058).

A second significant strength of utilizing CBIO procedures is the relatively low financial commitment required by both the organization and the beneficiary communities. Curamericas depends on grants from the USAID, the Health Grants Program, and private donations in order to engage in their development projects across the globe. The Guatemalan office of Curamericas managed the budget and distribution of funds throughout the duration of the project. For accountability purposes and to ensure the proper management of funds, financial reports were regularly submitted and routine audits were conducted. At the project's inception, Curamericas had budgeted \$2,003,508 and \$2,351,228.80 was spent throughout the duration. 58% of the operating budget was spent in Guatemala, and \$21.05 was spent per beneficiary per year on the 22,338 women and children involved in the project (Beracochea et al., 25). The relatively small amount of funds utilized throughout the project indicates a high level of

efficiency as well as the organization's extensive utilization of volunteer positions to help achieve project goals. Through their CBIO process and a commitment to doing more with less, Curamericas is able to instigate tangible and sustainable change in the communities in which it works.

Frequently cited as the most significant and also somewhat unexpected victory resulting from the utilization of the CBIO methodology was the dramatic increase in female participation and resulting empowerment of women in health-related decisions. Within the Conclusions and Recommendations section of the final project evaluation, it states that "women's participation has increased and has been pivotal to increasing the coverage of child survival interventions" (Beracochea 29). Women are typically viewed as the caretakers of the home and family within these communities, but their limited knowledge and understanding of how to appropriately address and prevent health concerns had previously barred them from fully exploiting the opportunities of their cultural positioning. With the introduction of Curamericas' integrative CBIO procedures, women began to much more fervently embrace this responsibility and role in society through their active involvement in Self Care Groups, employment in health-related services around their villages, and overall improved knowledge regarding these concerns. This success was repeatedly referenced throughout the Curamericas Global project evaluation, including quotes from mothers who claim to have been transformed by their participation in the Self Care Group such as the following: "the group is good. We now support each other" and "I learned it is very important to wash our hands before feeding my baby and washing my baby's hands" (Beracochea et al., 18). Additionally, the evaluation writes that "the role of women as Health Communicators (*Comunicadoras en Salud*) cannot be overstated. Some of them have even moved on to become facilitators and health educators [themselves]" (Beracochea, 8),

which confirms that some women began to pursue health-related professions as a result of their involvement in the Curamericas Child Survival project. Staff surveys conducted at the close of the project indicated their understanding of the lasting impression these groups and the RSHV process had on women in the communities. Several charts also showcase the statistical impact of the project, particularly through the Care Group Model and RSHV, within each municipality (see Figures 2, 5, 6, 7, and 8). Lastly, the impact of Curamericas Global on the empowerment of women can be seen through their support in creating the new, “local NGO created by and for women, the Wajan Nab’al Ix, or ‘Women’s United Dream’” (Beracochea et al., 23) which is mentioned below.

To complete an entire cycle, the CBIO project can take anywhere from seven to ten years. For a community to experience the full effects of the project, ten to fifteen years are required. To many, this is seen as a major limitation. The benefits of such development projects will not be seen immediately, which deters organizations from engaging in such a longitudinal endeavor. Therefore, the authors warn that this type of program is “not a suitable methodology for short-term projects” (Perry et al., 1063). An example of this limitation is cited repeatedly throughout Beracochea’s final evaluation of the Curamericas Child Survival project in Guatemala. For example, she writes that “the CBIO and Care Group methods were effective and suited for this project area. However, because of the relatively short five-year program length was not sufficient for some jurisdictions to reach targets... [particularly for municipalities] that had no previous experience with community-based services and distrusted outsiders... a ten-fifteen year commitment to child survival interventions seems to be required” (Beracochea et al., 28-29). However, it is clear that the CBIO procedure produces measurable, positive impacts on the health of those whom it touches and it has gained meaningful support

from local, regional, and international groups (see project results below). Bercochea, et al. writes that “the mid-term evaluation revealed that the project... had made strong progress toward meeting the end of project goal” (5).

To address concerns regarding the fact that such projects are very labor-intensive, it is important to mention that the CBIO methodology depends heavily on its field staff and project leaders in hopes of, over time, creating a feeling of ownership by the community members themselves. Through processes such as RSHV, however, the community will eventually become comfortable around field staff and at this stage in the process home visitations, with close supervision by experienced professionals, can be largely conducted by minimally paid staff and volunteers (Perry et al., 1064). This also helps to alleviate concerns regarding the involvement of skilled labor throughout the project, as it is undoubtedly necessary for some positions within the project but not all. Additionally, as discussed above, some who are trained by Curamericas field staff choose to pursue professional careers in health care and Curamericas actively seeks out local community members who are more likely to continue providing vital health care long after Curamericas field staff have left the project sites. This responsible methodology also showcases the sustainability of these projects.

The CBIO methodology which took place in these rural Guatemalan communities is discussed in a holistic final evaluation which focuses on both the organizational procedure and the results of the program. Additionally, the first CBIO Child Survival project implemented in rural Bolivia back in the early 1980s also indicated great success in its evaluations. Particularly with the Guatemala project in the 2000s, some best practices as well as future action areas were

discussed in their final project evaluation. Some of these conclusions discussed by Curamericas and the USAID include the following:

1. *The role of health communicators (Comunicadoras en Salud) in building lasting, trusting relationships with community members.* At the project's close, families felt enthusiastic about the positive health outcomes which had arisen out of the project.
2. *The role of the Care Group Model in educating community members about vital health information.* Organized and maintained by Community Facilitators (Facilitadora Comunitarias), these groups met monthly to discuss different topics directly related to the most pressing concerns the villages were facing, and continued to evolve their programs as the community's concerns also evolved.
3. *The magnitude of volunteers (Comunicadoras) who chose to dedicate their time to assisting mothers and children through the Care Group Model and RSHV.* Their sense of pride in helping the community was also noted, and some who began as volunteers have were enlightened by their work and chose to move into more permanent, paid positions within the local public health sphere.
4. *The empowerment of women in the community.* Because of the success of the Care Group Model and RSHV, many women felt empowered to establish smaller, more specific imitation care groups, enter the public health sphere as professionals, and even create their own organization; this small NGO called Wajan Nabal' Ix, or Women's United Dream, aims to help local families find economic independence while educating them through finding strategies to properly manage money received from family members living in the United States.

5. *The ability to showcase quantifiable results.* The dedication of the Comunicadoras in data collection and synthesis throughout the project, specifically through RSHV, has provided Curamericas with a large body of information to share the project's success. This is incredibly valuable and, as discussed in the limitations section of Part I, typically a legitimate challenge that many NGOs and social entrepreneurs face (Beracochea et al., 56- 57).

Interview: Andrew Herrera, Executive Director

I was able to conduct a phone interview with the Curamericas Global, Inc. Executive Director, Andrew Herrera, on March 26th at 11:30am. He has been serving the organization in this capacity for close to one year. The following section is his verbatim responses to my questions:

How did you become involved with Curamericas? Describe your role within the organization.

“I have a passion for all things global and specifically within the context of public health. I consider myself a “Latin Americanist” with significant experience in and ties to various developing countries in Latin América. With this in mind, my undergraduate majors were Hispanic Studies and Religious Studies and I have a strong desire to be able to communicate and understand people. I started as the volunteer coordinator at Curamericas and have since become deeply passionate about both the mission and the methodology used to achieve the mission. I have been fortunate to work in every role at the organization. Currently, I serve as the Executive Director and my role is to raise funds and awareness to support our mission and partners across the globe.”

What is your involvement specifically with the census-based, impact-oriented methodology?

“I have closely studied the methodology and supported implementation of the methodology in Guatemala for over 2 years as the program associate to backstop the USAID Child Survival Program there. I have also had the opportunity to train partner staff in the CBIO methodology while also raising awareness among non-public health professionals about what the methodology consists of.”

How might you compare your organization to one that engages in social entrepreneurship? What can your organization do that social entrepreneurs cannot? How might you respond to critiques regarding the sustainability of NGOs for the future?

“The ultimate goal of social entrepreneurship is self-sustained improvement in specific indicators, whether those be health, financial, or education. Curamericas Global implements grassroots health systems that strengthen the most remote areas of post-conflict countries. The health programs are comprehensive and context-specific and usually integrates some sort of entrepreneurial activity. For example, in Liberia, women would sell education of contraceptives for family planning while giving the commodity itself away for free. In Guatemala, communities plan for obstetric emergencies through maternal health insurance, and again in Liberia, emergency transport plans include a financial savings club.

Typically, social entrepreneurship is associated with some sort of financial transaction. In all communities around the world, there exists a health economy. Somebody is paying someone for some sort of health care. We work to educate communities on what is evidence-based, quality health care and to prioritize maternal and child health (the most vulnerable populations where we work) to prevent needless death.

Our focus is on long-term development through an integrated and evidence-based program. Many social entrepreneurs are not trained to engage in any specific interventions, such as water and sanitation or maternal health, and often do not use proven methods to generate long-term change. I also do not believe it is necessary to start new organizations but rather to support existing great organizations. Efforts can then be focused on the social change rather than on building an organization's human resources or finance departments, for example. NGOs are private organizations that are typically 501c3 (not-for-profit) and therefore do the work of both large governments and smaller faith-based or general civic organizations. NGOs are professional actors who are competing for funds to make the world better. For-profit entities can do good work but ultimately place profit above the mission. Often social entrepreneurs still depend on government subsidies and support to make real change, such as Tesla Motors.

I absolutely believe that NGOs are sustainable because I believe that mankind is inherently good and wants to help each other. Many people are looking out for their fellow man and philanthropy is a large piece of that ideology. Part of what will make NGOs sustainable is the diversification of revenue and funding. For organizations like Curamericas, this is part of the strategic plan in order to ensure that there are multiple revenue streams and prevent the organization from becoming dependent on only a few donor pools.”

Where do you see Curamericas in five years?

“Curamericas Global has been implementing community-based health care for over thirty-two years. The WHO, UNICEF, Gates Foundation, USAID, and others are also beginning to prioritize this integrated community approach, rather than siloed disease-specific health interventions for conditions like HIV or TB. Curamericas Global has proven tremendously

successful across challenging locations and is in a prime place for growth as an iNGO. In five years, I see Curamericas Global continuing to work in our current countries as we phase our communities in Guatemala into the sustainability phase of our partnership while continuing to support our partners in Liberia and Kenya. I also see opportunities to provide leadership development in conflict-stricken areas such as Haiti, the Democratic Republic of the Congo, Syria, Iraq, and Afghanistan after immediate relief is no longer needed.”

Personal Experience

My personal relationship with Curamericas began in 2011 when I participated in an annual trip to Bolivia through my local church, First United Methodist Church- Cary. In partnership with Curamericas, twelve adolescents and four adults from the church traveled to La Paz, Bolivia, in mid-July to work on constructing a playground for a primary school in the nearby slum city of El Alto. In addition to working in the schoolyard, each day we engaged in home visits with families in the area which is an integral aspect of the Curamericas CBIO program. Alongside a trained, experienced field staff member, we asked questions and recorded responses listed on the surveys that asked questions regarding various healthcare-related concerns which may have occurred since the last home visit. Data collection included recording major events within the family (such as pregnancies, births, and deaths), updated child immunizations, and family planning education. Later in the week, we had the opportunity to visit a Casa Materna, or local health clinic, under construction where local nurses would eventually provide immunizations, neonatal care, and other necessary health services. This experience greatly impacted my life because it helped guide me toward my field of study, language, study abroad experience, and ultimately my potential career path.

Several years later, I was seeking a summer internship with a nonprofit organization and remembered my experience with Curamericas. For six weeks I worked as their Communication and Development intern, where I was given the opportunity to gain a much deeper understanding of the organization internally. My main task was to organize and re-apply for annual state and federal campaigns such as the SECC and United Way, but I also launched their Instagram, redesigned their Twitter, wrote blog posts and “press releases” on their website, and responded to private donor letters. This experience was eye-opening because I was exposed to so many aspects of the organization, which gave me a much deeper appreciation for the complexity of small-scale international NGOs like Curamericas.

Having experienced the organization from both the volunteer and intern perspectives, I have gained a relatively broad understanding of the procedures and priorities of Curamericas. Personal relationships with donors, partner organizations, and local community members are of great significance to the organization, as well as a commitment to their unique procedural methodology. Reviews conducted by external organizations like USAID also speak to these aspects of the organization’s mission. My positive experience with the care and concern of staff members lends to my overall very positive experience with Curamericas Global, Inc.



Visiting with children at an orphanage in Tacachia, Bolivia (2011)

The Future of Curamericas

Based on the research and results discussed in the previous sections, it appears that Curamericas Global, Inc. has a very bright future. Its innovative programs have been evaluated and praised by well-respected, large-scale international organizations and its impressive international expansion throughout its 32 year lifespan speak to the organization's credibility. Perhaps most significant, however, is the local support Curamericas has received from the communities they serve. Throughout their Guatemalan Child Survival project, for example, the organization worked in three municipalities, one of which had never been reached by an external NGO before and all of which had "suffered from the long tradition of distrust of community development activities" (Beracochea et al., 1). By the project's end, however, there was incredible support from all three of the municipalities- particularly with the mothers who found hope and empowerment through the Care Group Model. Their success stories help paint a picture of what the organization was able to accomplish, in both tangible and intangible ways.

Curamericas has also found great success in supporting the emergence of other local organizations, some of which are now self-sustaining, locally run and owned NGOs continuing to serve their communities years after Curamericas has left. An example of this would be the Andean Rural Health Care (ARHC) organization, or the *Consejo de Salud Rural Andino*. During Curamericas' initial projects in Bolivia in the 1980s, local community members and trained health professionals decided to establish their own non-profit to continue the work of Curamericas; today it serves over 83,000 people in the El Alto and Montero slum cities outside of the capital city of La Paz. ARHC works in collaboration with the United Methodist Committee on Relief as well as the Evangelical Methodist Church in Bolivia to obtain financial support from international groups, but it also brings in an annual average of \$65,000 through local support and grants. This impressive organization aims to “reduce morbidity and mortality... [and] develop a sustainable model for the delivery of accessible, high quality, preventive and curative health services to underserved communities” (www.umcor.org), echoing the goals of Curamericas Global, Inc.

Curamericas has written various detailed guides which outline every aspect of the project from training of field staff and volunteers to proper evaluation techniques, which would inevitably prove very helpful for other organizations should they choose to implement Curamericas' procedures. The USAID and Curamericas collaborative evaluation indicates that Curamericas' organizational procedures can and should be utilized by other NGOs with similar aims:

In sum, Curamericas Global has established themselves as leaders in Child Survival through this project. They have demonstrated the CBIO approach is cost-effective, evidence-based approach to implementing well-known child

survival interventions. When combined with the Care Group Model, the CBIO approach empowers women and communities to participate actively in the process of health care delivery and achieves significant results in relatively short periods, even with remote populations. We recommend that Curamericas Global promote and disseminate this flagship approach for which, we predict, they will soon become globally recognized (Beracochea et al., 19-23).

USAID claims to have received a “very high return on this investment” (Beracochea et al., 29) for this particular project, and this positive response helps explain the organization’s potential for scaling up as well as sharing their ideologies and successes with other like-minded NGOs. I believe the intentions, values, and strategies of Curamericas Global, Inc. best align with the human development model discussed in the “Overview and History of Development” section in Part I. As the creator of this model claims, the core of human development is the “promotion of overall freedoms of people to lead the kind of lives they have reason to value” (Sen, 10).

Because it has proven so difficult for Northern NGOs to resist viewing unknown places as opportunities to create communities who emulate Western ideologies, it is especially challenging to see tangible, sustainable results when partnering with international organizations instead of employing locally-managed projects. However, Curamericas’ structure and organizational procedures indicate their commitment to establishing true partnerships with local community members and organizations, listening and responding to their desires and needs as opposed to simply assuming an understanding of them. As author Susanne Schech writes about the significance of culture in development, “culture [should be] treated as a kind of glue that holds societies together and gives them a coherent structure that can be used for development interventions” (44). If more development NGOs entered into projects with a respectful, humble,

and interested attitude, I believe more successful projects would take place more frequently.

Additionally, by addressing the basic needs of the communities through focusing on health at a deeply holistic level, Curamericas has had a much broader impact on the villages than simply lowering infant and maternal mortality rates. They have empowered women to make their own health decisions and become leaders in their families, they have equipped entire communities with vital knowledge and inspired people to pursue professions previously deemed impossible to pursue, and they have given a local organization the opportunity to continue building upon the work Curamericas began. These three communities were given the tools needed to help them live lives they have reason to value, which meant much more to them than a simple hand-out ever could.

Part III: Case Study- Tiendas de Salud

History of Tiendas de Salud

Tiendas de Salud, which directly translates to “Stores of Health” or more loosely to “health shops” in English, was founded in 2009 through the establishment of a partnership between Linked Foundation and Mercy Corps. Co-founder David Lehr, then a Mercy Corps employee, traveled to rural Guatemala in 2008 “to investigate the potential for market-based approaches to improving rural health care” (Lehr, 57). While there he took note of the many indicators perpetuating the unbelievably poor health standards in these impoverished communities, including the fact that “in many cases... the only available health options are to consult a traditional healer, to self-medicate, or to make an expensive visit to a doctor in a town that is several hours away” (Lehr, 57). Additionally, Mercy Corps staff members discovered that although in some communities there were “health facilitators” who were loosely connected to the formal health system and recorded births, deaths, and major health issues to state health care administrators and perhaps stored a few medicines for sale, most were not health professionals and had little knowledge of preventative or emergency health training (Jones Christensen & Lehr, 41). Another significant danger these rural populations faced was the sale of counterfeit or substandard medicines which could potentially cause harm to villagers or increase the development of antibiotic resistance (*Highlights*, 22). By 2009, Lehr had begun developing a core team who would be responsible for building Tiendas de Salud “from the ground up”, and as the team gained expertise specific to the organization he stepped back from a leadership to a consultant role. Today, he still acts as a strategic development and problem-solving advisor to the Linked Foundation’s involvement with

Tiendas de Salud. Lehr “has over 15 years of experience creating social and for-profit businesses. His focus is on sustainable approaches to development that create employment and economic growth” (unc.edu), so his expertise was especially pivotal to the project’s economic sustainability.

In response to the many seemingly insurmountable challenges rural communities face with regards to health care, Tiendas de Salud was formed with a purpose to improve the affordability of and access to medicines and other basic health-related necessities through the establishment of locally-owned and operated micro-pharmacies (Jones Christensen & Lehr, 39). In some cases, the existence and strategic placement of these pharmacies has been credited with saving lives through the distribution of proper medical products in a more timely and affordable manner than if the individual were required to travel, sometimes up to a full day, to the nearest hospital to receive care. The Center for Health Market Innovations describes Tiendas de Salud as a “direct purchase non-profit franchise network” (*Highlights*, 22), meaning that the store owners purchase their products directly from a Guatemalan pharmaceutical supplier, in this case the nation’s largest- Farmacias de la Comunidad, translating to “Pharmacies of the Community”- at a discounted price and then are able to sell them to local families for a slight profit. This was incredibly important to the overall mission of the organization because it empowered local families through employment opportunities, providing another outlet for earning an income while simultaneously improving the overall health of the communities.

What makes Tiendas de Salud unique is the local ownership aspect of their sustainable social enterprise model, which has been heralded as a “rare example of achieving a successful exit for such an enterprise by means of private sector acquisition” (Lehr, 57).

From its inception, Tiendas de Salud partners had aimed to build an economically sustainable enterprise at the local level that could eventually be transferred to a partner in Guatemala; this was accomplished when Farmacias de la Comunidad eventually incorporated Tiendas de Salud into their daily operations (Jones Christensen & Lehr, 42). Farmacias de la Comunidad had not previously been involved with rural, indigenous populations, but as Tiendas franchisees continued to purchase products the private corporation began to take notice of the potential within this untapped market (Lehr, 58). After careful consideration from Mercy Corps and Linked Foundation partners to ensure the continued success of the project, Tiendas de Salud became a subsidiary of Farmacias de la Comunidad in 2012 (Lehr, 58). This “healthy exit” of Northern-based, third sector involvement elevates Tiendas de Salud as a prime example of a self-sustaining, locally-owned social enterprise.

Mercy Corps and Linked Foundation chose to establish this partnership because of the close alliance in their missions and their complementary strategic advantages. Mercy Corps “believes that innovative solutions will solve some of the world’s toughest problems... we support and invest in social innovations that take responsible risks, champion new ideas, and have a high potential to reduce suffering, poverty, and oppression” (Lyon, 1) and had a deep ethnographic understanding of Guatemala’s rural populations because of their longstanding presence in the region. Their non-profit model and humanitarian focus complemented Linked Foundation’s specific mission to “promote and invest in solutions that improve the health and economic reliance of women and their families in Latin America” (linkedfoundation.org). Their role within Tiendas de Salud was to provide technical and financial assistance, particularly throughout the planning and pilot program periods. The private US-based Foundation offered \$400,000 in grants toward the project in addition to

other resources (Lehr, 58). Currently, the Foundation is also supporting the improvement of Tiendas de Salud's monitoring and evaluation procedures to procure more holistic program results (linkedfoundation.org). The partnership brought together two distinct organizations with similar aims, building a highly successful enterprise model which has the potential to be scaled-up and/or emulated by other rural communities facing health concerns.

Procedures and Results: Methodology

David Lehr writes that “in places like rural Guatemala, the quest to sustain a vital social enterprise often depends on finding the right private sector partner” (57). In the case of Tiendas de Salud, the partnership between US-based private, nongovernmental organizations Linked Foundation and Mercy Corps which eventually brought about their partnership with Guatemalan pharmaceutical corporation Farmacias de la Comunidad and national bank BanRural were pivotal to the organization's success. Mercy Corps had been working with indigenous communities since 1999. Through these partnerships, ownership was able to remain in the hands of those most affected by the project throughout the entire project's lifespan.

Tiendas de Salud includes three main elements: business support, medicine supply, and training (De La Cruz & Beyeler, 3). Each franchisee is given a microloan from Guatemala's largest national bank, BanRural; the bank also conducts monthly visits to each store for supervisory and support purposes. Typically, franchisees are able to keep a twenty percent profit from medicine sales, as they purchase the generic products from Farmacias de la Comunidad at a twenty percent discount and then sell to the community at full price. In regards to training, franchisees “receive basic book-based training in business and health practices, and an instructional manual including information on business operations, and

storing and dispensing medicines” (De La Cruz & Beyeler, 3). These three principles, particularly the training of franchisees, was initially conducted by Mercy Corps and Linked Foundation staff members before gradually being transferred to become the responsibility of Farmacias de la Comunidad.

An interesting aspect of the project was the selection of Tiendas de Salud franchisees. De La Cruz and Beyeler observed during the case study evaluation that “storeowners are generally wealthier and more education than the community members... all of the storeowners had a second source of income or employment in addition to the store” (8). This discovery is particularly interesting because it is not specified on average *how much wealthier* franchisees are in relation to their neighbors, but many local families are dependent on a single income in agriculture. As is noted in the following “Project Evaluation” section, however, the case study indicated incredible variation in the profits collected from different micropharmacies. Less challenging to distinguish was the levels of formal education franchisees had received in comparison to the general community; “five out of the six owners had completed secondary school” (8), where only thirteen percent of the overall sample population had even completed primary education. These discoveries do raise the question of how Tiendas de Salud may have been giving more opportunities to those already more advantaged than their neighbors, although limited resources, such as funding, may have prevented the partners from having the opportunity to train the poorest local families. Having the ability to read and count, for example, is incredibly important when maintaining records and dealing with money- skills that the general, less educated population likely do not possess.

The branding of the products sold to community members was significant to the level of trust felt by local villagers purchasing the medicines. Because of the historical abuse of pharmaceuticals by various a general community mistrust in pharmaceutical supplies due to their reputation of

After spending more than three years “testing various products, services, pricing options, and owner-support arrangements” (*Highlights*, 22), partners Mercy Corps and Linked Foundation offered strategic and training support to the franchisees, or Tiendas micro-pharmacy owners.

Project Evaluation

In 2013, Anna De La Cruz and Naomi Beyeler of the University of California San Francisco Global Health Group performed a case study evaluation of Tiendas de Salud. De La Cruz is an independent consultant who also works as a Senior Advisor with Linked Foundation. Naomi Beyeler is a project analyst with the UCSF Global Health Group. At this point in the lifespan of the project, there were about fifty stores in operation scattered throughout the Alta Verapaz and Baja Verapaz states in central Guatemala (De La Cruz & Beyeler, 3) and Guatemalan pharmaceutical corporation Farmacias de la Comunidad had already acquired Tiendas de Salud in 2012. Overall quality of life in the Alta Verapaz and Baja Verapaz states was very poor with forty-three percent of Alta Verapaz residents living in extreme poverty, which the World Bank defines as “the inability to consume a minimum level of calories” (worldbank.org). Additionally, only approximately one percent of the population had attended college, only thirteen percent completed primary education, and thirty-seven percent received no formal education at all (7). The data shown below in Figure

3.1 indicates that those who utilized the micropharmacies were generally even worse-off than those who were not in communities served by Tiendas de Salud:

Percentage of community participants who fall below...				
	USAID extreme poverty line	\$2.50/day line	National poverty line	Food poverty line
All participants	38%	44%	73%	18%
TISA-users	40%	47%	77%	19%

The evaluators do admit that due to the community samples being small and non-random, these figures may not be accurate (7). Future studies could attempt to examine this interesting and highly relevant question.

Before delving into the project evaluation itself, it is important to have an understanding of the community health context. Although all of the researched communities exemplified poor health standards, there was incredible variety in terms of the types and amount of health options, besides Tiendas de Salud micropharmacies, that were available to residents. Throughout the interview process (which is described in more detail below), De La Cruz and Beyeler asked a series of questions to villagers about “where they go to get medicines and healthcare, the time and cost involved to reach those places, and the time they wait to receive services once they arrive at the facility” (8). Their responses showed the surprising diversity within and among communities in regards to affordability and availability of health-related concerns. This raises the question of which communities had more, or less, health options besides Tiendas de Salud micropharmacies, and what factors contributed to these discrepancies. Other options to receive care ranged from nothing to several combinations of the following:

1. *Centro de Convergencia*: Loosely translating to “government health posts”, these small centers are most commonly staffed by a nurse or community health worker. They offer the most basic government health services including some preventative

services and basic medicines. Although all six communities with Tiendas de Salud micropharmacies also have a Centro de Convergencia, these health posts are not necessarily open daily; some, in fact, only open weekly or monthly to offer routine preventative services (De La Cruz & Beyeler, 9).

2. *Centro de Salud*: Translating to “health centers”, these clinics are also government owned and operated. They are typically staffed by doctors and nurses and offer somewhat more extensive services than the *Centros de Convergencia*, including some treatment services. Only “some” of the communities employing the Tiendas de Salud model also have a *Centro de Salud*, although it is not specified how many have this service (De La Cruz & Beyeler, 9).
3. *Hospital*: None of the Tiendas de Salud communities also have a hospital, although it was reported during the evaluation process that a number of residents from each of the six communities have traveled to the closest city to receive care at the hospital (De La Cruz & Beyeler, 9).
4. *Pharmacies*: All Tiendas de Salud community members also reported traveling to the closest city to visit a privately-run pharmacy, and “several” communities also have these pharmacies (De La Cruz & Beyeler, 9).
5. *Provisions Stores*: Selling basic over-the-counter treatments and sometimes medicines like antibiotics, a “majority” of Tiendas de Salud communities reported that these small stores are present in their villages. Of all the above possible health options available in communities, provision stores are the most similar to Tiendas de Salud micropharmacies (De La Cruz & Beyeler, 9).

Understanding the various health options which exist in some of the evaluation participant communities helps to clarify the potential ease, or challenge, in receiving health care in rural Guatemala. Although it is not specified which of the six communities have, or do not have, access to these various health options, it can be deduced that none of them have access to legitimate and fully operational clinics or trained health professionals. The varying types of health options offered besides a Tiendas de Salud micropharmacy explains the varying degree of impact each store has on the surrounding community. This is discussed in more detail later in this section.

In addition to understanding the variety of health options available to rural Guatemalan populations, it is important to discuss the progression of health-seeking behaviors generally employed by community members. Typically, families attempt to first address their illnesses on their own at home because it is the least expensive option. As is mentioned earlier, there remains a heavy reliance on self-treatment using traditional, herbal home remedies for a variety of basic illnesses such as diarrhea or the common cold. If these at-home solutions do not improve the patient's condition, families will then purchase basic over-the-counter medicines to offer symptomatic relief, such as cough syrup or ibuprofen. This is where community members will most commonly utilize a Tiendas de Salud micropharmacy or, if available, another pharmacy or provision store, but families will not typically travel to a health clinic at this stage. Should the patient's condition does not improve and/or the family believes the illness may be severe, most will travel to the closest health center (a Centro de Convergencia, Centro de Salud, or a hospital) to have an examination performed by a health professional. Should the above health facilities not offer free medicines or not have the appropriate medicines in stock, families will then attempt to

fill their prescriptions at the nearest pharmacy or health center (De La Cruz & Beyeler, 10). The variety of other health options available to communities in collaboration with the typical progression of health-seeking behavior also helps determine the varying degrees of success franchisees have experienced; communities with greater access to other affordable health options would be less likely to utilize a micropharmacy, while those with access to few other health options or more expensive health options would be more likely to depend on the presence of a store.

Of course, not all families can afford to purchase prescriptions or even travel to a health center, which is part of what perpetuates the poor health standards of rural Guatemalan populations. Several factors influence families' decisions when determining whether or not they can or should seek health care. The cost of receiving care and purchasing medicines greatly impacts this decision, and every research community indicated cost as a major barrier. Oftentimes families cannot afford the cost associated with traveling far distances to a hospital, so if a Centro de Convergencia or Centro de Salud does not provide whatever is needed for free there are few other options to pursue. Families will also take on significant financial challenges in order to purchase medicines, including borrowing money, selling animals, or requesting a credit. Widespread preference exists among all research communities to visit pharmacies, health centers, or private hospitals because they believe the staff are more qualified and experienced to treat their illnesses. Families are very generally very reluctant to self-diagnose and self-medicate with prescription drugs if the illness is perceived as severe, however, so they will go to great lengths in order to receive professional care in these cases (De La Cruz & Beyeler, 11).

Upon engaging in the project evaluation, the analysts noted three “study objectives” which they attempted to answer throughout the process. They were as follows: “1) understand when and how community members use the Tiendas de Salud stores; 2) assess the community-level effects of the Tiendas de Salud program, including what health care gaps the program fills; and 3) assess the operations and management of the Tiendas de Salud stores” (De La Cruz & Beyeler, 4). Ultimately, they hoped to understand and identify areas for improvement as well as the successes of the program which could be utilized in potential future projects similar to this model. De La Cruz and Beyeler selected six communities with operating micropharmacies from a data pool provided by Mercy Corps with information about fifteen potential communities. Staying in the Coban area of central Guatemala, they excluded three communities which would require more than a two hour drive to reach. They also eliminated two communities where a recent documentary had been filmed, choosing to split the remaining ten potential communities into four categories based on when the micropharmacies became operational and whether there were “few” or “more” health options available in the community: they selected two villages with stores opened under Mercy Corps and “few” other health options, two villages with stores opened under Farmacias de la Comunidad and “few” other health options, and two villages with stores opened under Farmacias de la Comunidad and “more” health options. There were no matching villages with stores opened under Mercy Corps and “more” health options (De La Cruz & Beyeler, 5).

Upon entering each of these six communities, De La Cruz and Beyeler conducted qualitative interviews with each franchisee as well as any other store attendants who might work shifts at the micropharmacies, asking questions about their “role in the community,

experience as a Tiendas de Salud storeowner (franchisee), common illnesses in the community, client interaction, and experiences with the Tiendas de Salud program... [as well as] sales, profits, and products sold” (De La Cruz & Beyeler, 5). Sales record data from parts of July 2013 was collected from each store as well which listed each transaction with the date sold, product name, price, quantity sold, and the total amount charged in the transaction. In order to have a full understanding of the micropharmacy usage and environment the analysts also spent several hours simply observing each micropharmacy, paying particular attention to the nature of the interactions between franchisees and customers, the product types and prices, and the overall store appearance (6).

The analysts also conducted an extensive interview process with many of the local community members in order to better understanding of the overall village experience with Tiendas de Salud. The selection of these community members for interviewing was done by “approaching houses in each community”, but it is unclear how the households were approached, how many were approached, and the percentage of households who accepted or denied the request to be interviewed. When a selected household accepted the request to be interviewed, the analysts specifically asked to speak with the female head of household who was over eighteen years old; this coincided with Linked Foundation’s mission to advance the causes of women and families as opposed to only focusing on the male head of household. According to the evaluation, “the majority of women approached agreed to participate”. The evaluation also indicates that “interviews were conducted with residents in most areas of the community, including those areas closer to and farther away from the [micropharmacy], rather than concentrating interviews in any one place” (De La Cruz & Beyeler, 6). Focus group discussions also took place in two of the six communities, though it is not specified

which two or why only two were selected. Interviewers and focus group facilitators asked a variety of prepared questions such as the villages' "most common health concerns, care-seeking behavior and progression, common health and medicine questions, and knowledge, use, and perceptions of Tiendas de Salud stores" (6). Although specific data and responses was not available, it appears the analysts engaged in responsible and thorough qualitative analysis.

De La Cruz and Beyeler attempted to determine the impact of a Tiendas de Salud micropharmacy on the surrounding community through researching three key procedural components of each store:

1. *Business operations and finances*: These statistics reported by franchisees indicates their financial success. All franchisees are required by Tiendas de Salud to keep sales records of each transaction including the date of the sale, the type and quantity of products sold, the price of each product sold, and the total sale amount. Sales record data from July 2013 was collected and analyzed by the evaluators.
 - a. Four out of six storeowners restock their products every fifteen days, while the other two reported a need to restock with even more frequency. Each time they purchased products from Farmacias de la Comunidad, franchisees indicated spending between 200- 800 Quetzals, which equates to between \$25- \$100 USD. Most storeowners reported restocking based on the demand of their customers, meaning that depending on the primary use of their store, some had large surpluses of medicines that remained from their first purchase (De La Cruz & Beyeler, 12-14).

- b. There was incredible variation in the sales and restocking difference among the six stores for each fifteen day period. For example, one storeowner reported a loss of 583 Quetzals (\$80 USD) and another reported a gain of 1200 Quetzals (\$156 USD). These differences are likely due to the number and type of other health options, particularly those who give out free medicines, in close proximity to the community. Another possible factor is the availability of necessary medicines for restock, as some storeowners reported “stock-outs” at the Farmacias de la Comunidad manufacturers (13).
- c. On average, franchisees reported approximately half of their sales as medicine sales, one fourth as hygiene sales, and one fourth as “other” products such as soaps and candles. There was also great variation among the stores regarding their primary purpose, as some predominantly relied on non-health related products to make a profit (13).
- d. An interesting discovery of the evaluation was the fact that the most profitable products were predominantly non-medicine products. The percentage of medicine sales ranged from fifteen to ninety-one percent, while the percentage of hygiene sales ranged from one to forty percent and “other” sales ranged from five to sixty-three percent. Examples of popular products included soaps, super, diapers, and detergent. The two most popular medicine-related products were oral electrolytes, which are helpful for diarrhea cases, and vitamins (13).
- e. Using the data collected from each of the micropharmacies, the most common products sold overall were sugar, candles, soap, cold medicine, over-the-counter pain medication (such as acetaminophen), and anti-inflammatories

(such as ibuprofen). Over-the-counter pain medications, cold medicines, and antibiotics (specifically in two of the six communities) were the most commonly sold health-related products. The most commonly sold hygiene and “other” products included soaps, detergent, diapers, toilet paper, sanitary napkins, bleach, shampoo, and water. To reiterate and clarify, “although the common products were similar across stores, there was much variation in whether the top-selling products were medicines or hygiene products or ‘other’ products” (14).

- f. Storeowners reported several significant challenges in their sales, prices, and profits. During the observation period, analysts determined that most stores had a small number of customers and several franchisees reported a recent decline in customers as well. Storeowners believed this was because of several factors, including the option for families to obtain free medicines at some health centers, overall difficult economic times, and their inability to restock due to sporadic Farmacias de la Comunidad product stock-outs. Due to these problems, some storeowners also indicated having difficulty paying back their loans from BanRural, who provided franchisees with start-up loans.

Additionally, overall poor financial literacy among storeowners and their attendants indicated some discrepancies in profit margins, as some were apparently not selling their products for the prices initially set by Tiendas de Salud (they receive the products at a twenty percent discount from Farmacias de la Comunidad and are supposed to sell them to the community at full price for a twenty percent profit across the board). Community members who were

interviewed during the evaluation also indicated this discrepancy, saying that the same medications were sold at different prices. The analysts determined that some franchisees were changing prices either to help their fellow villagers who could not afford their medicines by lowering the cost or offering a credit, or to help themselves generate more profit by raising the cost (De La Cruz & Beyeler, 15). Several storeowners indicated this in their interviews, saying:

“There are women that in reality they need the medicine and don’t have the money, they say ‘look ma’am, can you give it to me and another day I’ll pay you?’ Since they are people that I know will pay, I give it to them. But there are others that I know don’t pay and I feel bad but I don’t give [medicine] to them.”

The storeowners’ strategies to either raise or lower prices for products also has an impact on how their micropharmacy is perceived, and therefore used, by community members. Families tend to prefer stores in villages where prices are lowered or drugs are offered on credit, so those stores are used more often.

2. *Training and staffing:* As previously discussed, when families are faced with an illness they perceive as serious, they prefer to see a trained health professional before purchasing medicines and, consequently, also before visiting a Tiendas de Salud micropharmacy. Although all franchisees do have some training in the medical field and several are, in fact, nurses or somehow connected with the formal healthcare system, most are not health experts with diagnostic and/or treatment qualifications. Because of this, interviewed community members stated their level of trust and willingness to purchase medicines depended on the storeowner’s perceived level of

health-related training and expertise. Community members specifically mentioned having lower levels of trust in Tiendas de Salud micropharmacies where their owners are viewed as businessmen rather than health professionals (De La Cruz & Beyeler, 16). Below are two opposing perspectives from community members about their level of trust in the storeowners depending on their levels of training:

‘In other places they have more health experience, and they can give me advice about the medicine or I can ask questions about the medicines. But the difference is at Tiendas de Salud they can’t give me this advice because they have almost no health experience.’

‘She [storeowner] works in the health center, so we can go to her with confidence. We trust that she gives you the right medicine, she knows these things because she works in the health center.’

- a. All franchisees are given two types of medical training- one is provided through the Tiendas de Salud program and the other is received through external programs (not specified whether this is included in the overall program or whether it is a government-operated or private training program). Tiendas de Salud requires “a very basic level” of book-based business management and medicine sales training. It is largely self-taught. The instructional manual contains worksheets for each content module and during Mercy Corps and later Farmacias de la Comunidad monthly monitoring visits, supervisors will review the worksheets with franchisees (De La Cruz & Beyeler, 16).
- b. It is important to note that four of the six storeowners are also trained nurses or community health workers, and they reported this being significant in their

work as a Tiendas de Salud storeowner because they focused on their role as healthcare providers in addition to storeowners. Some even reported offering basic medical services such as simple diagnostic testing and preventative care (De La Cruz & Beyeler, 17). Although it is not specified, one could presume that sales and profits were higher at micropharmacies where the storeowners are also trained health professionals.

c. Many franchisees were unable to operate the micropharmacy during regular business hours because of their other employment, typically also in the health profession. Utilizing family members or other community members as attendants when storeowners are unavailable proved to be challenging, however, because of their lack of training in both medical and business procedures. This produced noticeable differences in the use and perception of the micropharmacy during the hours when franchisees could not operate the store. Storeowners and residents alike claimed that sales were lower during times when untrained attendants manned the store (De La Cruz & Beyeler, 17).

2. *Connections to the health system:* Linkages between the Tiendas de Salud project and the formal healthcare system of Guatemala proved to be integral to the success of the overall project.

a. Every community with a Tiendas de Salud micropharmacy also has a Centro de Convergencia in order to provide the connection between receiving a diagnosis and relevant prescriptions (at the Centro de Convergencia) and purchasing said prescriptions (at the micropharmacy) (De La Cruz & Beyeler, 18). It is not clear whether the Centros de Convergencias offer free medicines when they are open,

which would contribute to the low numbers of customers at Tiendas de Salud stores as indicated by community members. Either way, the limited availability and resources offered by the Centros de Convergencia still forces some families outside their community to the more reliable Centros de Salud, or even hospitals in some cases, in order to receive care. Because Tiendas de Salud stores sometimes face stock-outs and do not have certain medicines, when families must travel into town they prefer to also fill necessary prescriptions at that time where the pharmacies are larger and will certainly have what they need (De La Cruz & Beyeler, 19).

b. The professional health training which four of the six franchisees possessed had a significant positive impact on the success of their micropharmacies. By having connections with the public health sector they were able to provide more effective health information as well as pull from a broader network when answering a question or referring someone to a specific healthcare professional. While franchisees recognized their limitations, the more expertise they had in the field, the more their business benefitted (De La Cruz & Beyeler, 19).

Overall, the analysts viewed the Tiendas de Salud model as an innovative approach to filling a gap between the needs and available services of isolated Guatemalan communities. Not only does it empower women and families economically through providing them with another source of income, it also empowers women and families with knowledge about important health and business strategies while simultaneously empowering the community as a whole through providing them with local health services. The case study evaluation also revealed significant differences in the aforementioned impact depending on several factors

which were present at some or all of the micropharmacies. Both positive and negative impacts of the presence of Tiendas de Salud stores are synthesized below:

1. *Storeowners reported satisfaction with the program:* Franchisees were pleased to have an opportunity to start their own business and proud to provide this essential service to their neighbors. They took this position seriously, most perceiving themselves not only as businessmen but also as healthcare providers who wanted to integrate their knowledge into helping others while also learning new skills. Community members also began to place more trust in storeowners as they began to take on more of a leadership role within the village. One franchisee indicated her satisfaction, saying “The benefit is that I have a way to help people that need it because before there wasn’t anyone to see all medicines. The benefit is that people now come during the day or at any time of night to find medicine so they don’t have to go to [the nearby town]” (De La Cruz & Beyeler, 19).
2. *In some cases, Tiendas de Salud micropharmacies offer additional important health services:* Depending on the storeowners’ levels of professional health training, some were able to offer more extensive health services than simply selling over-the-counter and prescription drugs. According to the analysts, “several” franchisees offered additional services such as health education programs, examinations, referrals to higher level care, and administering vaccinations (De La Cruz & Beyeler, 20). These potentially life-saving procedures could be potentially life-saving if the local Centro de Convergencia is closed and/or the family cannot travel to or afford to seek care at the Centro de Salud or hospital. Although it is not specified in the case study evaluation, one could presume that stores offering these types of services also

experienced more financial success as they fostered a higher level of trust within the community.

3. *There is an overall lack of financial literacy indicated by most storeowners as well as interviewed community members:* The case study evaluation wrote that they “had trouble articulating their profit margins and overall profits, and had limited understanding of their business operations- none of the owners seemed to calculate overall profits by looking at their sales compared to what they spend restocking”, for example (De La Cruz & Beyeler, 15). Initially, Mercy Corps staff members trained franchisees in this area, and that responsibility was transferred to Farmacias de la Comunidad when they acquired the organization in 2012. Today, the original US-based partners have little involvement in or knowledge of the project’s continued success; it would be interesting to obtain information regarding any differences in financial competency between micropharmacies opened under Mercy Corps’ supervision and Farmacias de la Comunidad, if any. Perhaps a more fully developed financial literacy training program should be implemented in future Tiendas de Salud projects, although overall low levels of education is likely a hindrance to storeowners’ ability to comprehend general mathematics and finances.
4. *Tiendas de Salud stores do not stock all medicines that are prescribed:* Because the micropharmacies are restocked based on community demand in order to prevent storeowners from losing profits, not every possible medicine a family could need will necessarily be available if someone is prescribed an uncommon medicine. Additionally, sporadic stock-outs at Farmacias de la Comunidad will also prevent storeowners from offering the medicines needed by community members (De La

Cruz & Beyeler, 21). Some franchisees indicated that these circumstances hindered their overall success because families will naturally choose to visit the Centro de Convergencia in order to receive both a diagnosis and free medicine- although certainly not always the case.

5. *Even with reduced prices, some community members cannot afford medicines offered at micropharmacies:* Many community members are too poor to purchase medicines under any circumstances and reported that they cannot utilize Tiendas de Salud stores for this reason. These families are forced to rely solely on the distribution of free medicines at health centers or on their own at-home remedies in order to receive care (De La Cruz & Beyeler, 21). Some might view this as a limitation of the overarching concept of social enterprise, which in this case limits access to the very products and services which the project is attempting to make available to everyone. One community member said, “I can’t go there to buy [medicines]. I don’t have enough money for my home... I see that he sells medicines but I see that is a little expensive. I don’t have money, where am I going to find it? There is nowhere for me to find money for medicine” (21).
6. *The proximity and cost of pursuing health care services significantly impacted the role of Tiendas de Salud within communities:* Figure 3.3 displays data collected from five of the six research communities, indicating the location and wait times of Tiendas de Salud micropharmacies in comparison to other health options:

COMMUNITY	B (3)	C (17)	D (16)	F (17)	G (7)
Reported TISA as source of medicines in community	100%	53%	69%	18%	100%
Number of reported stores selling medicines	0	5	4	8	1
Number of reported pharmacies in community	0	2	0	4	0
Average time to arrive at TISA	6 min	9 min	13 min	13 min	9 min
Average time to arrive at centro de convergencia	--	9 min	10 min	--	15 min
Average time to arrive at puesto de salud	40 min	58 min	41 min	21 min	70 min
Average wait time at TISA store	0	1 min	2 min	0	4 min
Average wait time at centro de convergencia	--	1.9 hrs	15 min	--	30 min
Average wait time at puesto de salud	0	4.5 hrs	2.9 hrs	1.8 hrs	1.5 hrs
Average cost to arrive at puesto de salud	10 Q	6.25 Q	9 Q	1.5 Q	10 Q

As is shown above, the impact of Tiendas de Salud (called TISA in Figure 3.3) was significantly lower in communities with shorter travel and wait times at the Centro de Convergencia or the Centro de Salud (called Puesto de Salud in Figure 3.3). For example, only eighteen percent of residents in Community F reported using Tiendas de Salud as a source of medicine, and they reported the longest travel time to arrive at their Tiendas de Salud micropharmacy (thirteen minutes, tied with Community D) while having the shortest wait times at the Centro de Convergencia and Centro de Salud (zero minutes); perhaps even more significant, Community F also reported the lowest cost associated with arriving at their Centro de Salud (1.5 Quetzals) as well as having “more” other health options than other communities (eight places to purchase medicine and four other pharmacies). Communities B and G, however, rely on Tiendas de Salud stores as a source of medicine while having the highest cost associated with arriving at their Centro de Salud (10 Quetzals) and “few” other health options compared with other communities (zero places to purchase medicine and zero other pharmacies). These significant differences in reported cost, wait times, and access to other health options clearly had a legitimate impact on the utilization of the local Tiendas de Salud store; communities with “few” other health options and/or

more expensive options were the most dependent on the micropharmacies (De La Cruz & Beyeler, 11).

De La Cruz and Beyeler offered several recommendations for increased effectiveness and success in improving access and affordability to life-saving health-related services in isolated Guatemalan communities:

1. *Expand business and health training for franchisees:* Storeowners indicated a strong desire for expanded training, particularly in regards to healthcare. Given the communities' preferences toward being examined by a health professional prior to purchasing medicines, it would be beneficial for both the community and the franchisee if the latter had received more extensive training (De La Cruz & Beyeler, 22). In order to increase efficiency, training could be targeted so that franchisees had a more thorough understanding of the specific medicines they frequently sell.
2. *Ensure all staff receive training:* Training micropharmacy attendants in both business operations and the stocked health-related products is incredibly important because it negatively impacts both profits and the atmosphere of trust within the community (De La Cruz & Beyeler, 23)). All store attendants should also be given basic training in order to improve upon the delivery of services to families and the profitability for the franchisee.
3. *Select sites with highest impact potential:* Although no quantitative data specifically supports this claim, it can be deduced that micropharmacies located in the most remote areas of the region with “few” other health options, such as consistently open Centros de Convergencias or Centros de Salud, were more profitable and impactful

than those located in areas with “more” health options (De La Cruz & Beyeler, 23).

Location would likely play an even larger role in the store’s sustainable profitability if franchisees and attendants also had fully-developed health training, diagnosing illnesses and prescribing appropriate medicines to families who truly have nowhere else to go.

4. *Develop stronger linkages with public health system:* Improving referral chains and ensuring the medicines provided in government health facilities match what is stocked in Tiendas de Salud micropharmacies are two examples of ways the connections between the formal and informal healthcare systems can be strengthened (De La Cruz & Beyeler, 23). These improvements could significantly increase the trustworthiness of storeowners which could, consequently, increase their prominence within the community.
5. *Consider options for increasing profit margins:* Several storeowners indicated their financial difficulties in maintaining profitability due to product stock-outs and a low number of customers. The analysts proposed two possible solutions, being to re-negotiate product prices with Farmacias de la Comunidad or to increase the customer base through utilizing the above four recommendations (De La Cruz & Beyeler, 23). It would be interesting to look at the feasibility of reducing the prices of medicines and other products for sale, although it would likely be fruitless given they are already being sold at a twenty percent discount.

In my opinion, if these five recommendations were implemented in future Tiendas de Salud projects in complementary communities around the globe, the franchisees and community members would experience even more success. These encouraging

recommendations, as well as the fact that they were published openly by the Tiendas de Salud partners, showcase the partners' desire to improve and are a true learning opportunity for the organization. There appears to be great potential for the organization to be scaled up and its model to be shared with others.

A major limitation in synthesizing and analyzing the case study evaluation was an overall lack of raw data provided by the analysts. My Tiendas de Salud evaluation would be much more thorough had this information, such as specific storeowner sales data, maps denoting the location of the micropharmacies in proximity to the various other health options, information regarding the BanRural loan process and the Farmacias de la Comunidad manufacturing outlet locations, and a list of the amount and types of products offered at each store and their corresponding sales data. Additionally, in order to determine the financial sustainability of Tiendas de Salud stores over a longer period of time, it would be beneficial to obtain sales record data from the entire lifespan of each micropharmacy. Overall, having access to more data regarding Tiendas de Salud would allow me to better understand the impact of organization on the communities with whom they work. As founder David Lehr indicated during our phone conversation, however, the aim of the organization was not to spend resources on extensive evaluative data research but to determine if this particular social enterprise model worked and share the model with other organizations.

Interview: David Lehr, Founder

I was able to conduct a phone interview with Tiendas de Salud founder and strategic economic advisor David Lehr on Friday, June 26th, 2015. Today he works in an advisory capacity with Linked Foundation:

Please describe your current role within the organization.

Lehr explained how since Mercy Corps and Linked Foundation agreed that Farmacias de la Comunidad would acquire Tiendas de Salud in 2012, he has played a much smaller role with the organization. Originally an employee of Mercy Corps back in 2008 when he began working on the creation of Tiendas de Salud, he left Mercy Corps about five years ago but remained a consultant for the project through Linked Foundation. Three years after transferring project ownership from the Northern-based organizations, neither organization continues to play an integral role in the sustained success of Tiendas de Salud. Linked Foundation remains involved through some amount of impact measurement and “offers as much guidance as they (being Farmacias de la Comunidad and the franchisees) need”, but at this point there isn’t really an in-depth understanding of the project.

During the planning and pilot stages of Tiendas de Salud, Lehr played an integral role in the social innovation aspect of the project. As a Mercy Corps senior advisor with both public and private sector experience, his business expertise was highly valuable in creating an organization with sustainable economic viability. Of course better solutions exist than the Tiendas de Salud model if the only goal had been to improve public health standards, he said, but their model was the best solution given that their main concerns also included economic sustainability and maintaining local project ownership. “You need an NGO who believes in business, because if you can’t find a service or product that people need, it’s not going to last.” Mercy Corps was a much more market-based NGO than most at the time the project was being developed, as NGOs generally had not yet embraced the earned-income model.

Their willingness to engage in a business model as opposed to the typical donor-based model is what perpetuates the project today.

Please describe a little of TISA's procedural methodologies (ie, how were communities selected for intervention? How were local storeowners chosen? How were the communities involved throughout the overall process?) During the pilot program, how did the TISA model change, if at all?

I found his response to this question particularly enlightening, as it was not only the question I was most looking forward to discussing but also the question where I had the least developed prior understanding. Lehr explained how the project evolved extensively over time, calling the process a learning experience because “as we went along, we became more sophisticated.” When planning the overall project, the development team looked at what Mercy Corps was already doing in rural Guatemala and asked themselves “can we take a current program and somehow commercialize it?” The NGO had been working to address public health issues in indigenous communities since 1995, so Lehr and his team wanted to build upon what the organization was already working to accomplish. That was the “initial genesis of the work.” Ultimately, that type of innovation coincides perfectly with the definition of a social enterprise.

When selecting locations for new stores, the partners initially focused on communities where Mercy Corps already had built relationships and trust and eventually reached out to unknown villages as well. When selecting franchisees, at first the partners almost always approached the community leader or the health facilitator who was connected to the national health care system and might have a better understanding of health-related concerns. Essentially utilizing the trial and error technique, not every community accepted their proposal; sometimes the person they initially approached was not interested in taking on

the responsibility of owning and operating a store. Lehr described one particular community where this was the case, and it ended up being a young woman going through nursing school who wanted to become a franchisee- she was the first female storeowner. As they gained expertise and respect in the region, they began to expand their efforts outside of communities where Mercy Corps had already established relationships. In these instances, the partners would typically bring along a franchisee from another community to describe their experience in that role and how it had positively affected their family's life.

In 2012 when Mercy Corps and Linked Foundation project managers felt that Tiendas de Salud had been properly researched, developed, piloted, and executed and they were confident the project could sustain itself, the process of transferring project ownership and support began. Lehr described their initial goal from back in 2009, which was "to see if we could be commercially interesting enough for someone local to take it over." While searching for the appropriate company to absorb the project, staff members looked at several NGOs but ultimately selected Farmacias de la Comunidad because most NGOs were still uninterested in a earned-income development model; today, of course, the pressure to incorporate a similar structure is much greater. Additionally, Farmacias de la Comunidad was already heavily invested with Tiendas de Salud since they had been directly working with franchisees throughout the project's lifespan. Since 2012, Farmacias de la Comunidad has been responsible for the maintenance and expansion of Tiendas de Salud throughout rural Guatemala.

In regards to monitoring and evaluating Tiendas de Salud, Lehr readily admitted that although they "produced some research, of course, we didn't end up writing much because it's expensive and time-consuming." So, while they could have released hundreds of pages of

data showcasing the project's success and highlighting areas of improvement, the implementation model for future Tiendas de Salud projects in different places will likely be just as much of a learning experience as the first try. For this reason, the organization chose to engage in a less extensive evaluation process- although part of Linked Foundation's continued involvement with the project focuses on discovering more effective monitoring and evaluation techniques.

How might you compare your organization to a nongovernmental organization (NGO)? What can your organization do that NGOs cannot?

Lehr's response to this question was unexpected and incredibly comforting for someone who believes strongly in the capacity and longevity of the third sector and NGOs. Reflecting on his prior experiences with various non-profit organizations including Mercy Corps, he opened by saying "well, it really all started with an NGO in the first place." He expanded on this claim, describing how he believed the project would not have been viable without the involvement of Mercy Corps because "you're going and messing with people's livelihoods, so building trust is a huge, huge advantage. Having an established NGO really made it feasible." Because of MercyCorps' longstanding involvement in the region, the field team staff members had extensive knowledge of the communities, spoke the indigenous languages, and had built organizational credibility and relationships with the locals through conducting other projects in their villages before Tiendas de Salud. This made every aspect of the project more manageable, from selecting store locations to selecting franchisees to training the franchisees in business and health-related areas- even when entering communities where the partners were unknown, they could more easily build trust in other

villages because of the previously-established relationships with franchisees and community leaders where they already worked. Clearly, Mercy Corps' cultural knowledge was integral to the project's success, and Lehr discussed the importance of donor group, NGO, and economic expert working symbiotically in order to find the appropriate model. Without all three, including the NGO, Tiendas de Salud would never have made it off the ground.

Where do you see Tiendas de Salud in five years?

The success of Tiendas de Salud in Guatemala has certainly inspired the partners to continue their work in addressing public health concerns through social innovation. Lehr discussed how Mercy Corps and Linked Foundation have looked at opportunities to scale-up the Tiendas de Salud model in other Latin American regions. He specifically mentioned their interest in Mexico, where the process to implement a similar project began about three years ago. The partners are also conducting research in Brazil to determine if implementing a similar model would be appropriate. However, the partners are taking a different approach to developing this project including how they set up the project, how they select local partners, and several other procedures. A valuable lesson learned through the Tiendas de Salud project was the importance of having local participation and support; they will likely approach future projects with a more supportive as opposed to leading role, offering financial support and implementing a "we will work with you if you want to build it yourself" attitude. Ultimately, each micropharmacy project will be very unique because of Latin America's incredible cultural, geographic, and economic diversity. Although there are impoverished indigenous populations spread throughout the region, each community has individualized needs which make project replication difficult.

The Future of Tiendas de Salud

Based on the research above, it appears that Tiendas de Salud has a bright future. Its highly innovative social enterprise model achieved some great success. Particularly through the unique utilization of partnerships, the organization was able to accomplish its goal of maintaining and eventually transferring ownership to I Lehr indicated the success of the social innovation model and its potential for scaling-up in other regions of Latin America, discussing Mercy Corps' research in Mexico as well as Brazil. Several tangible, sustainable successes of the model can and should be implemented in other regions with a strong presence of impoverished, isolated communities exemplifying poor health standards. Utilizing some of the recommendations offered by the Guatemala project analysts in the "Project Evaluation" section above, an even more successful model could be applied elsewhere.

I strongly support the Tiendas de Salud model and believe in its vision to improve the health standards of disadvantaged, isolated populations. In my opinion, the recommendations made by De La Cruz and Beyeler in the case study evaluation are incredibly important to implement in any future projects- particularly in regards to site selection and health training of both franchisees and other store attendants (**see page**). After all, given the overall project goal was to improve community access to and affordability of health and wellness-related products and services, it is imperative for the project not to impede upon what it was attempting to accomplish in the first place. The sustainable profitability for franchisees would likely also improve if the placement of the micropharmacies was consistently directed at the most isolated communities with "few" other health options. With extensive and careful

research in community and micropharmacy location selection, this model should be implemented in other regions struggling with poverty, geographic isolation, and poor health standards.

Part IV: Conclusions

The traditional, patriarchal family remains the most common structure in much of rural Latin America. Stemming from strong roots in Catholicism instilled in indigenous populations during the colonial era when Spanish conquistadors claimed much of the region, this family structure includes a male head of household, typically the father, while the wife is responsible for the well-being of the children and home. Within the constraints of rural poverty, many wives and mothers lack even a basic understanding of healthcare which prevents them from adequately assuming their role in society. Mothers are isolated from resources including medicines, clinics, and vital health education such as vaccination information, family planning options, neonatal and infant care procedures, and both acute and chronic illness prevention and care. Adding fuel to the fire is poor economic status due to a subsistence lifestyle, typically in agriculture, which impairs the family's ability to obtain the aforementioned knowledge and resources needed to live healthy lives. The beauty of the third sector is their unique ability to work privately and independently of the state, using their small-scale, individualized projects to their advantage. Organizations like Curamericas Global and Tiendas de Salud have experienced such success because they are able to deliver much more meaningful, sustainable, positive change to families through involving and respecting each individual community's differences and needs. These organizations can utilize the strong bond of a nuclear family to the advantage of the entire community through various innovative avenues, such as the empowerment of women or the sustainable employment of men. As seen in both Curamericas Global and Tiendas de Salud, responsible engagement with communities often has secondary unintended positive effects as well, such as having the economic freedom to educate children and offer them a brighter future. Where the state is unable or unwilling to intervene appropriately or at all, as has

been proven through the motivation behind the two case studies' projects, the third sector can provide. Their unique placement in society is why I believe strongly in the power and significance of the third sector.

It is also important to remember that the third sector has not been perfected, however. As is mentioned in the "Defining Nongovernmental Organizations" section in Part I, there remains an incredible divide between Northern and Southern third sector organizations in terms of their numbers, size, scope, and influence. In my opinion, the Global North's unwillingness and inability to resist viewing the world with a Western perspective severely hinders the overall success of community development. I believe that, whether intentionally or unintentionally, many organizations continue to hold their "top-down" development ideologies and ignore the incredible diversity of cultures, needs, and expectations of beneficiary communities around the globe. A lack of an ethnographic understanding of the communities in which these organizations work can quickly spiral out of control into a devastating "development" project. Having a false, narrow understanding of the community- such as the idea that all populations in the Global South are the same and, therefore, whatever procedures utilized in one community can be utilized anywhere else in the Third World- is the best way to engage in a bad development project.

Curamericas Global and Tiendas de Salud are examples of third sector organizations which embody responsible and successful international development techniques. Their work is clearly well-planned, well-tested, and well-executed, and this can be stated with confidence because both have experienced success which has been touted by scholars working outside of their organizations. As discussed in the "Limitations of Nongovernmental Organizations and Social Entrepreneurship" section of Part I, not all organizations display these characteristics.

This is why I believe in the importance of transparency within and among third sector organizations. My overarching questions when beginning this paper were, *what are the procedures or methodologies utilized by different international development organizations in Latin American development? Are there significant differences between NGOs and social entrepreneurs in terms of their procedures or techniques?* After conducting my research, I believe that given the current lack of external evaluative reporting, these questions are difficult to answer. The procedures and methodologies employed by third sector organizations are what distinguishes between successful and damaging development projects. How an NGO or social enterprise chooses to intervene in a particular community, the intensity of background and ethnographic research conducted prior to intervention, the existence and/or length of pilot programs, the level of commitment required of the community as a whole, and the involvement of *all* community members in decision-making throughout the project's lifespan are all vital pieces which will ultimately determine the success of the project.

The concept of empowering disadvantaged women and families through providing them with both economic and educational opportunities is one of paramount importance. Approximately half of all Tiendas de Salud franchisees are women, and many more are co-owned by couples; Curamericas directly and indirectly employs women through utilizing them as field staff members and through arming them with the knowledge necessary to apply for health-related career positions outside the organization. Additionally, Curamericas inspired many mothers to find more autonomy within the home as they began to feel more confident in their role as the family caretakers. Because both organizations developed a deep understanding of the communities with whom they worked, they were aware of the difficult circumstances many women and mothers faced in their everyday lives which prepared them to more

effectively address their concerns. In the case of these two organizations, women were positively impacted by their benefactors.

Relationship-building with the local populations proved to be the key for both Curamericas Global and Tiendas de Salud's success. Without Mercy Corps' deep understanding of the indigenous community and culture prior to the introduction of Tiendas de Salud, founder David Lehr does not believe the project would have been sustainable or prosperous. Curamericas' census-based, impact-oriented project methodology was reliant upon building longstanding relationships with community members as well. Ultimately, these two organizations highlighted the significance of responsible and intentional relationship-building by continually sharing its importance both within and outside of their project evaluations; their efforts and focus on this aspect of their projects should be more frequently discussed and emulated by other NGOs and social entrepreneurs.

Upon completing this paper, I am not convinced that the distinction between NGOs and social enterprise is of paramount importance to the disadvantaged populations these organizations are attempting to serve. Some social entrepreneurs will undoubtedly choose to be more profit-seeking than others, but I believe that so long as societal benefit is integrally connected within the organization's mission, scholars need not focus on definitions and comparisons but rather on improving organizational effectiveness in creating social value. Even Ben and Jerry's, who some classify as a social enterprise and some a corporate philanthropy, proudly showcases their commitment to environmental sustainability as an integral part of their company's mission. While they certainly have proven to be a profitable business, they have also incorporated societal benefit into their business model. I do support a distinction between NGOs and the overarching category of NPOs, however, because there is a clear difference between

serving disadvantaged populations, whether locally, nationally, or internationally, and self-serving special interest groups. Not all non-profit work is focused on aiding the developing world, and I believe this is an important discussion for the public to be made aware of as NGOs and social entrepreneurs inevitably gain more prominence on the world stage.

I hope to someday edit and build upon this work through several avenues- some known and some unknown at this time. Initially, I would like to have an understanding of cooperatives in addition to NGOs and social enterprise, as several books and articles included cooperatives in their discussions of the other two third sector industries. Additionally, I would like to develop my comprehension of the concept of microlending within social enterprise, as I have seen conflicting reviews of the concept; some report that it is damaging to beneficiary communities, and I would like to understand why and what, if anything, is being done to improve this service. In regards to the two case studies, ideally I would have also had a longstanding personal and professional relationship with Tiendas de Salud in order to more holistically and fairly evaluate their projects, as I do with Curamericas Global. Ultimately, this paper was undeniably somewhat bias in favor of NGOs simply because of a lack of prior knowledge of social enterprise in general. Given these limitations, I hope to expand upon my understanding of the third sector in my future endeavors.

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