‘Teaching Them to Fish’: Towards a Practical Approach to Capacity Development for Non-Governmental Organizations

by

Jennifer Allen

B.A., University of Victoria, 2009

MA Project Submitted in Partial Fulfillment
of the Requirements for the Degree of
Master of Arts

In the
School of International Studies
Faculty of Arts and Social Sciences

SIMON FRASER UNIVERSITY

Summer 2012

Approval

Name: **Jennifer Allen**

Degree: **Master of Arts (International Studies)**

Title of Thesis: ***'Teaching Them to Fish': Towards a Practical Approach to Capacity Development for Non-Governmental Organizations***

Examining Committee:

Chair: Dr. John Harriss, Director of the School for International Studies

---

Andrew Mack
Senior Supervisor
Limited Term Professor
Director of Human Security Report Project

Morten Jerven
Supervisor
Assistant Professor

Date Defended/Approved: 13 August 2012

Partial Copyright Licence

Abstract

This paper engages in a critical examination of capacity development by service-providing international nongovernmental organizations (INGOs), arguing that capacity development is a path to improve the sustainability of development interventions. In recent history, some INGO practices have undermined local and state capacity in developing countries; these side effects are illuminated through a case study of Haiti. This paper outlines principles for INGOs to employ when pursuing capacity development goals and highlights the challenges associated with implementing a long-term process, which are amplified in fragile states. This paper presents one model for capacity development through an analysis of Partners in Health, a health care INGO operating in Haiti. Partners in Health reinforces capacity through its community health worker program and partnerships with governments. Suggestions are made for further research into suitable monitoring and evaluation tools able to assess a long-term process, such as capacity development, rather than an end result.

Keywords: capacity development; aid; non-governmental organizations; Partners in Health; Haiti; monitoring and evaluation

To Matt, for his continuous love, support, patience, encouragement and inspiration.

To those of you across this Earth who have taught me more about myself and the world than can ever be taught in a classroom.

Finally, I dedicate this to all who have suffered and continue to do so because of the White Man's Burden, may we all live and learn harmoniously.

Acknowledgements

I am pleased to be given the opportunity to thank those who made this journey possible. I would to thank Simon Fraser University and the School of International Studies for offering this unique and challenging program. I would like to acknowledge particular faculty, Dr. Susan Erickson, for her relentless challenging of her students and Dr. Onur Bakiner, for his kindness and willingness to digress. As well, a big thank you goes to my supervisor, Andrew Mack, for his suggestions and criticisms and for his guidance in turning my ideas and a yearning for optimism into an actual research project.

I would like to thank my 2011/2012 cohort for providing support, entertainment, inspiration and friendship throughout this past year. I could not imagine a better group of people to accompany me on this journey. A special thank you goes to Suzi Livingstone for sharing with me a fervent attention to detail and for always being available to offer honest criticisms, as well as encouragement.

Table of Contents

List of Acronyms

CGD	Center for Global Development
CHW	Community Health Worker
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
INGO	International Non-Governmental Organization
MSPP	Ministry of Public Health and Population (Haiti)
NGO	Non-Governmental Organization
PIH	Partners in Health
TB	Tuberculosis
UN	United Nations
UNDP	United Nations Development Program
USAID	United States Agency for International Development

Introduction

The idea of capacity development has increased in popularity in the development community in recent years. This approach to development is motivated by the belief that rather than simply providing welfare services, such as health care and education, for people in impoverished countries, provision should be complemented by investments in fostering the capacity of the people to eventually provide and carry these services themselves. This is recognized as a way to move aid away from being life support for developing countries and towards empowering people to guide their own development. As such, capacity development is one means to ensure the more effective use of the billions of dollars spent each year on development aid (Kuhl, 2009).

For the last several decades, development aid has been administered mainly by non-governmental organizations (NGOs) that provide services for the sick and the poor. This system has certainly brought improvements to the lives of the millions of people living in poverty, but is not without drawbacks. The operations of international NGOs (INGOs) pursuing development objectives have had far-reaching implications, both positive and negative, for the capacity of the people, communities and governments they serve. INGOs are positioned to reinforce the capacity of the people with whom they work to realize their visions of development; however, they may also inhibit their capacity by displacing services and creating a dependency on outside assistance.

This paper engages in a critical examination of capacity development[1] approaches by service-providing INGOs, arguing that capacity development is a path to bringing profound and lasting progress in lifting people out of poverty. The key to lasting development is providing people and governments with the tools to improve their situations and maintain their development, eventually without outside support.

The paper is organized into seven sections. The first section outlines how the current system of development aid evolved and came to be administered by INGOs. The second section defines the concept of capacity at both local and state levels, what it means to develop it and why this is important. The third section examines how, over the past several decades, some INGO practices have undermined the capacity of the individuals and communities they serve, whether intentionally or through the misguided application of good intentions. The fourth section illustrates these consequences through a case study of Haiti, an impoverished country that is host to a plethora of INGOs.

Despite their history of displacing local and state capacity, INGOs are poised to reinforce the capacity of the people they serve. The fifth section presents principles for capacity development by service-providing INGOs in developing countries. The literature discusses ways in which INGOs can and should approach capacity development; however, it also highlights that capacity development can be profoundly challenging and requires a fundamental change in the way many aid organizations view their role in

[1] 'Capacity development' is also conceptualized in the literature as INGOs engaged in improving their own organizational capacity, to increase their capability to fulfill their own mandates. However, for the purposes of this paper, capacity development is conceptualized as INGOs engaging in the process of developing the capacity of the people and the governments with whom they work. For more on organizational capacity development see Horton, D., (2002), Briefing Paper: Planning, implementing, and evaluating capacity development, *International Service for National Agricultural Research* and R. Mackay, D. Horton, L. Dupleich, and A. Andersen, (2002), Evaluating organizational capacity development, *The Canadian Journal of Program Evaluation* 17(2), 121-150.

providing development assistance. Furthermore, this paper identifies that the challenges, as well as the potential benefits, of capacity development are amplified in humanitarian situations, such as those experienced by fragile states.

The sixth section presents one model for capacity development through an analysis of Partners in Health, an organization involved in global health provision and the strengthening of health systems. This INGO illustrates an approach to capacity development that follows the principles identified in the literature. Partners in Health aims to build local and state capacity through its community health worker program and partnerships with governments in the countries in which it works.

Finally, this paper examines one major challenge that the development community faces in pursuing capacity development visions: creating suitable monitoring and evaluation models to assess the broadly defined, intangible goal of capacity development. The paper concludes with suggestions on how to conceptualize new monitoring and evaluation models that can measure the value and success of the *process* of capacity building, rather than the end result.

1. Background: The Evolution of Aid Practices

An NGO is, by definition, any organization that is not the government. These can range from grassroots community organizations to large international organizations. They include charitable, religious, research, social justice and environmental groups that provide social welfare, development, political and technological support (Fisher, 1997). However, the term has come to be representative of a certain type of organization: one which is "involved in development, broadly defined. More specifically, they are development oriented, officially established participatory organizations, constituted by middle or lower middle class professionals, serving communities and external constituencies to whom they are not directly answerable" (Ghosh, 2009, p. 475). Heins (2008) refers to NGOs as "benign parasites," meaning that they seek to infect their host and thereby change their behaviour, without intentionally harming them (p.2). For the purposes of this paper, INGOs are conceptualized as non-profit organizations based in wealthy countries that operate in the developing world providing welfare services to the people.

Beginning in the late 1970s, a shift occurred in international aid practices. Previously, donor countries had provided funding directly to developing country governments; at this time, they began to sub-contract development projects to INGOs. Up until this point, many developing country governments had relied heavily upon foreign aid to function. Hence, the redirection of these funds to INGOs had major

implications for state[2] capacity as governments were now working with significantly smaller discretionary budgets and became reliant upon relationships with INGOs for survival. This change was motivated, in part, by a desire to combat government corruption; however, it was also embedded in the neoliberal revolution of the late 1980s and 1990s (Fukuyama, 2004).

According to Fukuyama (2004), as the powerful Western nations promoted the privatization of state functions on a global scale, in many cases, the strength of the state was greatly reduced. While the International Financial Institutions (IFIs), the World Bank and the International Monetary Fund, provided conditional loans to developing countries, donor states encouraged INGOs to take over governmental functions such as health care, education and infrastructure projects. As INGOs rely mostly upon funding through bilateral arrangements with Western countries, such as the United States Agency for International Development (USAID), decisions about which projects to fund are made by, and often in the interests of, the donor countries (Fisher, 1997; Winters, 2010). The IFIs promoted this model of development as a win-win situation: wealthy countries reap the economic benefits of easy trade on a liberal global market while developing countries have their development programs subsidized (Fisher, 1997).

Models of assistance by INGOs in the 1980s and 1990s centred on 'non-governmentality': the idea that non-state actors could best serve the welfare needs of the population (Schuller, 2007). 'Technical experts' moved into developing countries for short periods of time and offered technology, expertise and financial resources with little attention paid to skills transfer or sustainability of interventions (UNDP, 2009, p.4). INGOs were viewed as the 'magic bullet' to provide essential services to people in impoverished countries (Lister, 2003). They provided social safety nets for the inequality

[2] The term 'state' refers to government institutions, in general (Fukuyama, 2004).

created—or permitted—by government policies under global capitalism and the structural adjustment programmes[3] that were promoted at this time (Pfeiffer, 2003). However, there were obvious issues with sustaining programs when technical experts moved on, and many development programs inevitably collapsed.

Fukuyama (2004) argues that, as a side effect of these aid practices, the capacity of the state was diminished in the process of reducing the scope of its functions. Governments lost legitimacy in the eyes of their citizens as their service provision capacity was reduced (Papagianni, 2008). Rather than building robust, self-sustaining states, this model led to dependence on external assistance.

In the mid-1990s, a new paradigm for aid emerged that questioned this model of development aid (Kuhl, 2009). The illusion that INGOs were the 'magic bullet' to reduce poverty began to evaporate (Obiyan, 2005). Developing countries now question the right of foreign INGOs to operate in their countries without accountability to the intended beneficiaries of their programs (Lister, 2003). There are now calls for a balance between INGO and state power in order to ensure a successful and enduring development system (Obiyan, 2005). This emerging perspective of capacity development places INGOs in supportive and consultative roles, rather than as the main suppliers of welfare services.

[3] Structural Adjustment Programmes are "designed to encourage the structural adjustment of an economy by, for example, removing "excess" government controls and promoting market competition as part of the neo-liberal agenda followed by the [World] Bank…They aim to achieve long-term or accelerated economic growth in poorer countries by restructuring the economy and reducing government intervention" (World Health Organization, 2012c).

2. What is Capacity and Why Should We Develop It?

According to the United Nations Development Program (UNDP, 2006), *capacity* is defined as “the ability of individuals, institutions, and societies to perform functions, solve problems, and set and achieve objectives in a sustainable manner” (p. 3). Simply put, it is the ability of an individual or organization to be self-sufficient and care for dependants. Capacity is the embodiment of more than just ‘hard’ or technical skills; it is also the internalization of ‘soft’ skills such as self-confidence, legitimacy, resilience and a positive organizational culture (Huyse et al., 2012).

This paper examines the development of capacity at both the local and state levels. *Local capacity* refers to the individual or community level: the ability of individuals and communities to fulfill their own needs and the needs of those who depend on them. *State capacity* refers to the government level: a public sector that provides welfare services for its citizens in return for the legitimization of its power. For a state to build and strengthen capacity it must be reinforced by its citizens, therefore, it must earn and maintain their respect and support (Papagianni, 2008). The ultimate outcome of attaining both local and state capacity would be communities and governments able to function without the presence of INGOs. However, a more realistic goal in this current climate is one where people and communities guide and actively participate in their own development, with INGOs playing a supporting role. Hence, this latter conceptualization of capacity development informs the subsequent discussion.

Capacity development is an approach to development that shows real promise in bringing people out of abject poverty and ensuring the sustainability of development programs. However, like many development initiatives, it is a complex process that cannot be reduced to a recipe (Eade, 2007). *Capacity development*[4] is "the process through which individuals, organizations and societies obtain, strengthen and maintain the capabilities to set and achieve their own development objectives over time" (UNDP, 2006, p.3). It is driven by the stakeholders and is as much about changing values and ways of thinking as it is about acquiring skills and knowledge (UNDP, 2009, p.4).

Capacity development is a multifaceted process that requires in-depth knowledge of a context and a long-term commitment to the cause. Local people already possess these qualities and this expertise should be respected. This process embodies ideas of *empowerment*, where INGOs work to give people power over their own lives, and *ownership*, where stakeholders feel a sense of responsibility and control of the projects meant to improve their situation. Huyse et al. (2012) state that "capacity develops via endogenous processes from the inside and therefore cannot be controlled from the outside. However, external actors can influence the direction and pace of change" (p.131). Capacity development is, therefore, a participatory process in which the intended beneficiaries are involved in, and ideally initiate, the planning, implementation and maintenance of development projects, with INGOs in a supporting role.

Capacity development involves the fostering of abilities (Kaplan, 2000). Brinkerhoff and Morgan (2010) describe the concept of capacity through the Five Capabilities Model, an articulation of five core abilities (p.3). First is the ability to commit

[4] Note on terminology: This paper deliberately uses the term 'capacity development', referring to a process driven from the inside beginning with already existing capacity, rather than another commonly used term, 'capacity building' which refers to, and can imply, the process of creating capacities, based on the assumption that there is little or no capacity to begin with (UNDP, 2009).

and engage. Actors are able to mobilize resources, act independently and plan and make decisions collectively. Second is the ability to carry out technical, service delivery and logistical tasks. Actors can operate at acceptable levels of performance, produce significant outcomes (such as health services) and maintain the program over time. Third is the ability to relate and attract support. Actors are able to establish relationships, make contacts, build legitimacy in the eyes of stakeholders and manage politics and power relations. Fourth is the ability to adapt and renew. This requires flexibility to adapt operations to changing contexts and anticipate potential challenges. Lastly is the ability to balance diversity and coherence. Actors can develop shared short- and long-term strategies and put plans into action in complex, multi-actor settings.

Capacity development is a goal, a process and a result (Kuhl, 2009). It is a long-term process of cultivating the potential of people and governments to build on their strengths; it is also an end goal, that local and state capacity will eventually be fully developed and outside assistance will no longer be needed. For the purpose of this paper, the Five Capabilities Model serves as the working definition of capacity development. This refers to the goal and the process of developing capacity, rather than the end result. This model is also utilized as a tool to measure the effects of capacity development, a point that is explored further in chapter seven.

Capacity Development for Sustainable Development

It is now widely recognized by scholars and development practitioners alike that a capacity development approach should be integrated into development initiatives to ensure that short-term solutions do not evolve into long-term problems (Barber and Bowie, 2008; Pfeiffer, 2003; Waisbord, 2006). This approach shows great promise in enhancing the sustainability of aid interventions (Hameiri, 2009; UNDP, 2009), which refers to the ability of a program to endure and be viable (Obiyan, 2005, p. 303). Ultimately, development programs are sustainable when they are integrated into the societies where the intervention takes place.

Slim (1997) presents two ways of conceptualizing motivations for action that inform and justify development aid practices. The first, the *deontological* perspective*,* understands actions to be good in and of themselves, regardless of consequences. This is the justification of programs such as food aid, which bring food to starving people, but do not prepare for future famines. The second perspective, the *consequentialist* perspective, measures the value of action by its consequences. This requires thinking beyond the immediate moment and considering the wider ramifications of action. It is this consequentialist perspective that informs the capacity development approach and this paper. INGOs must consider the effects of their actions as their operations have been shown to have negative consequences for individuals, communities and governments (Anderson, 1999).

Capacity development is informed by the notion that sustainable development requires a focus on reinforcing and creating enduring institutions (D. Brinkerhoff, 2010; Cliffe and Manning, 2008). Waisbord (2006) observes that the "current interest in capacity development is based on the realization that development efforts cannot deliver sustainable results without institutions and professionals adequately prepared to meet technical responsibilities" (p.231). Institutions are more than just organizations; they are deeply embedded in society. Cliffe and Manning argue that institutions cannot be imposed but must develop endogenously and be legitimated by the people. Strong institutions provide the foundation for local and state capacity.

The UNDP recognizes capacity development as a necessary means to achieving the Millennium Development Goals, which are objectives set by the international community to reduce poverty and its consequences by 2015. Additionally, capacity development is high on the agendas at international meetings on the quality of international aid such as the High Level Forums on Aid Effectiveness that have taken place in Paris in 2005, Accra in 2008 and, most recently, in Busan in 2011 (Huyse et al., 2012).

One final note on the merits of capacity development is inherently moral. As Anderson (1999) notes, an INGO's first imperative is to 'do no harm' to the societies they serve. INGOs must reflect on their place in a system of global inequality and

acknowledge that good intentions are not nearly enough, and self-interest is not appropriate. It is the old adage: ‘Give a man a fish you feed him for a day. Teach a man to fish, you feed him for life.’ Although the global system is infinitely more complex, the underlying sentiment holds true. By their nature, INGOs are close to the people and communities they work with; with this proximity comes the responsibility to empower the people to plan, guide and maintain their own development (Eade, 2007). The role of INGOs should be to support, advise and partner with people in impoverished countries as they strive to adapt to the challenges of the 21st century; however, in the past INGOs have not always acted in this way.

3. How INGO Operations Can Undermine Capacity: Views from the Literature

Schuller (2007) argues that INGOs were central to the spread of global neoliberalism in the 1970s and 1980s because they weakened state institutions, diluted state power and undermined the capacity of the state to provide for its citizens. INGOs were originally perceived as an extension of state power, working with the state to provide services to the people; however, this system evolved to work outside the state, taking over primary state functions (Pierre Louis, 2011). Papagianni (2008) contends that a state must perform significant functions, deliver services and maintain order to achieve and maintain legitimacy in the eyes of its citizens. The provision of welfare services, such as health care, through organizations parallel to the state creates a situation where the state must compete with INGOs for legitimacy (Haque, 2004; Pfeiffer, 2003).

This paper focuses on the provision of health care as an essential state function that has been assumed by INGOs. Pfeiffer (2003) notes that “in this unusual social interface between highly educated technicians from rich countries and communities in extreme poverty, relationships of power and inequality are enacted in ways that profoundly shape primary health care policies and programs” (p.726). The presence of INGOs can have consequences that diverge from the mandates of the individual organizations themselves.

One particular side effect of INGO-provided care is internal brain drain. In this context, *brain drain* refers to the luring of government workers out of the public sector into employment with INGOs. As aid funds shifted away from governments, many states saw their budgets reduced. This coincided with an influx of INGOs that offered high salaries to align with the expectations of well-educated professionals from wealthy countries. INGOs were criticized for capitalizing on development efforts in this manner,

so then opened up positions to local people to provide employment opportunities. The combination of employing local people and foreign professionals has proved to be problematic as public sector jobs continue to be measured against the local minimum wage, which results in glaring discrepancies between public sector and INGO salaries (Schuller, 2007). For example, Pfeiffer (2003) notes that in Mozambique, in the late 1990s, salaries for health care workers with INGOs ranged from US$500-$1500 per month compared to US$50 per month with the National Health Service. This creates a situation where the upper echelons of government workers are drawn into the INGO sector because it is lucrative. Subsequently, the service provision quality and capacity of the government declines and the next generation is deterred from joining the government. In this way, it becomes a cycle of diminishing quality of the public service (Barber and Bowie, 2008).

Scholars have also noted the problem of per diems[5], especially prevalent in the health field, even going so far as to claim an epidemic of 'perdiemitis' (Pfeiffer, 2003; Ridde, 2010). Originally meant to compensate for loss of time and fulfill ethical requirements, they are now manipulated by both local people and INGOs (Ridde, 2010). Health care workers, motivated by the financial incentive of the per diem, abandon their daily tasks, leading to gaps and unreliability in health care provision (Pfeiffer, 2003). Some INGOs use it as a competitive tool by offering higher rates to attract more qualified public servants (Ridde, 2010). It is such an issue that several states—such as Niger, Mail and Burkina Faso—have passed legislation restricting the usage of per diems and setting maximum amounts. In Mozambique, one week of per diems could exceed one month's salary for a health care worker (Pfeiffer, 2003; Ridde, 2010). Simple practices

[5] These are payments given by INGOs to local people for training sessions, travel expenses, research review sessions or extra contracts, such as conducting surveys.

such as employing local people and offering per diems have far-reaching effects on both local and state capacity.

A common criticism of INGO service provision is that it is excessively oriented towards producing immediate results. Short-term achievements are championed and long-term visions are rarely prioritized. Kaplan (2000) criticizes this idea of *strategic planning*: a focus on the tangible aspects of planning—goals and objectives—that result in a plan of action, but are not open to innovation and flexibility to adapt as circumstances and time progress. Results must be proven to donors in order to continue receiving funds, which constrains long-term planning (Brinkerhoff and Morgan, 2010; Kaplan, 2000; Pfeiffer, 2003). Overall, donors have shown hesitance in investing in gradual, long-term, capacity development projects (Obiyan, 2005).

As many INGOs are sensitive to election cycles, short funding cycles and donor funding trends in their home countries, their presence in developing countries is not assured. For example, Gariyo's (1995) study of INGOs in Kenya, Tanzania and Uganda showed that high levels of foreign donor dependence deprived INGOs of having a strong base in community contexts and eroded their capacity to plan for the long term.

It is true that many INGOs have not viewed their role in terms of long-term, capacity development projects (Waisbord, 2006); however, if INGOs are not involved in such projects, their development efforts will not bring sustained progress. INGOs need to recognize the inadequacy of short-term, results-based approaches; Brinkerhoff and Morgan (2010) show exasperation by declaring this as a lesson that needs to be perennially relearned.

So why do organizations behave in this manner, if it is obviously unsustainable? Barber and Bowie (2008) criticize the current mode of operations for INGOs and ask a simple question of the international community: "Most INGOs claim to want to work themselves out of a job. So why do so many fail in this endeavour, while a few organisations are consistently successful in doing so?" (p. 752). This paper strives to answer the latter part of the question while Kaplan (2000) wagers an answer to the former gleaned from his experience:

> Because we take comfort in what we can provide rather than in what may be really necessary. Because these kinds of interventions are sanctioned by donors. Because organisations have learned to ask for them. Because [results] are tangible and quantifiable. Because they can be delivered. Because their delivery and assessment can be easily managed and monitored. (p.521)

INGOs have positioned themselves as the saviours of the poor and the sick, providing essential services in many impoverished states. While their operations may often prove beneficial, the literature emphasizes that many organizations have developed bad habits that prove hard to break. This system of INGO service provision has been detrimental for local and state capacity and many societies have come to rely upon the INGOs to provide welfare services. As we will now see, this is quite evident in Haiti, an impoverished country that hosts an overabundance of INGOs.

4. Misguided Action in Context: A Case Study of Haiti

Haiti provides an exemplary case study for the examination of INGO practices and their implications for local and state capacity. Over the last century the poverty of the Haitian people has been perpetuated by natural disasters, environmental degradation, demographic pressures, government corruption and inappropriate international intervention (Mangones, 2002). Both local and state capacity has suffered as a result. The majority of the population lives in conditions of abysmal poverty; political instability and persistent inability or unwillingness of the government to provide for its people have turned Haiti into a quintessential fragile state.

For such a small country, Haiti has garnered copious amounts of international assistance. INGOs have acquired the nickname ‘other-governmental organizations’, and the country is referred to in the media and literature as a ‘Republic of NGOs’ (Zanotti, 2010). Despite the quantity, there are serious questions of quality. Life expectancy has slightly increased between 1995 and 2009 from 57 to 61; infant mortality rates (per 1,000 live births) decreased in the same time span from 90 to 59. Conversely, the percentage of the population with access to improved sanitation has steadily decreased between 1995 and 2009 from 25 percent to 17 percent and maternal mortality rates (per 100,000 live births) have increased between 2000 and 2006 from 520 to 630 (World Bank, n.d.). Evidently, aid efforts have produced mixed results in the way of improvements to the standard of living of the Haitian people.

A Troubled Past and Present

The name Haiti is often followed by the epithet, ‘the poorest country in the Western Hemisphere.’ It was not always this way. The country came into being in a burst

of optimism in 1804, as the first nation borne of a slave revolt. Since its independence, Haiti has struggled with issues of international embargoes, US occupations, countless coups, decades of oppressive dictatorships, natural disasters and a controversial 'kidnapping' of their elected President[6]. The earthquake of 2010 can be viewed as simply another incident in a long history of misfortune.

As a hotspot for hurricanes, Haiti is no stranger to natural disaster. Regardless, the 2010 earthquake wreaked unprecedented devastation. Striking on January 12, the earthquake registered a 7.0 on the Richter scale, killing an estimated 222,570 and leaving 1.3 million people homeless (Pierre Louis, 2011, p.187).[7] A year later, an outbreak of cholera began—foreign to Haiti and brought by United Nations peacekeepers—and has since killed another 7,442 people and infected over half a million (Partners in Health [PIH], 2012; Sontag, 2012 July 21). Today, nearly half a million people still live in makeshift shelters (Amnesty International, 2012).

Haiti has been a devastatingly poor country for decades and this was only exacerbated by the earthquake. Approximately 76 percent of people live on less than

[6] Jean-Bertrand Aristide was elected as president in 1990 in Haiti's first free and fair elections with 67% of the vote. He was a popular, outspoken minister who claimed to speak for the poor. He was forced from power in a coup seven months later, and then re-elected in 1996, after a UN peacekeeping intervention (which still exists to this day). In 2004, Aristide was forced to flee Haiti amidst rebellion and was escorted by US military personnel to the Central African Republic. Aristide claims he was forced against his will. The US denies using force. For more information see A. Dupuy, (2008), From Jean-Bertrand Aristide to Gerard Latortue: The unending crisis of democracy in Haiti. *Journal of Latin American Anthropology,* 10(1), 186-205.

[7] This is the death toll reported by the Haitian government in 2010, and is the number most often cited by NGOs, the media and in the literature. However, these numbers are under dispute, as the Haitian government adjusted the number in 2011 to 316,000. For more information see M. O'Connor (2012 January 12) Two years later, Haitian earthquake death toll in dispute, *Columbia Journalism Review*, Retrieved from http://www.cjr.org/behind_the_news/one_year_later_haitian_earthqu.php?page=all

US$2 per day and 56 percent on less than US$1 per day (Zanotti, 2010, p. 758). 40.6 percent of the population is unemployed and the majority of the population is engaged in subsistence agriculture (Central Intelligence Agency [CIA], 2012).

Haiti is considered a fragile state by most measures—and was so prior to the earthquake—due to political instability and high rates of poverty and unemployment (Brookings, 2008; The Fund for Peace, 2011). The earthquake added the burden of a large number of internally displaced persons as housing in and around the capital, Port-au-Prince, was destroyed. Haiti experiences some of the most extreme poverty in the Americas; as such, the overall health of the country is incredibly poor.

The Health Crisis in Haiti

The health statistics on Haiti are grim. Before the earthquake, only 17 percent of people had access to adequate sanitation (CIA, 2012) and 63 percent had access to treated drinking water, with substantially lower access to both in rural areas (WHO, 2012b). As mentioned previously, the average life expectancy is 61, and child mortality rates (per 1,000 children under five) are at 87, with an annual government expenditure per capita on health care of US$71 (WHO, 2012b).

To put these numbers into context we can compare Haiti to the Dominican Republic, a country which shares similar geography but a very different fate. The Dominican Republic has a life expectancy of 72, child mortality rates of 32 and an annual government expenditure per capita on health of US$495 (WHO, 2012a).

Haiti is also a hotspot for diseases such as malaria and rabies, which have long been under control in other parts of the Americas (Dowell et al., 2011). HIV/AIDS, tuberculosis (TB) and, most recently, cholera are the major causes of adult mortality. Haiti has the highest rates of infant and maternal mortality, malnutrition and prevalence of AIDS and TB infection in the Western hemisphere (PIH website, n.d.; WHO, 2009). On measures of health care utilization—contraceptive use, antenatal care, births attended, immunizations—Haiti scores far lower than the regional averages on almost all

measures[8]. Extreme poverty and poor infrastructure have created a health crisis in Haiti that has subsequently attracted a monumental international response.

INGOs in Haiti

Amidst poverty and instability in Haiti exists the second highest concentration of INGOs in the world, next to India. The shift to contracting out foreign aid to INGOs had a major impact on the capacity of the Haitian government. In the 1980s, 70 percent of Haiti's government budget came from foreign donors; today, that number is close to 30 percent—an extraordinary decline (Schuller, 2007).

The Haitian American Voluntary Organization estimated in 1984 that approximately 200-300 NGOs were operating in Haiti (Pierre Louis, 2011). In 2010, it was estimated that around 10,000 NGOs operate to varying degrees in Haiti, with only 500 registered with the Haitian government (Adelman, 2011, p. 93; Kidder, 2010; Pierre Louis, 2011, p. 190). One Haitian graduate student called this situation an "invasion of NGOs" (Schuller, 2007, p. 87).

Haiti's biggest donor is USAID, which, like most donors, contracts out the majority of its development programs to INGOs; however, much of the money spent in Haiti by donors goes to foreign nationals (Pierre Louis, 2011). Indeed, 84 percent of money spent by USAID in Haiti goes back to the US in the form of salaries (Zanotti, 2010).

[8] The one measure on which Haiti scored higher than the regional average was on smear-positive TB treatment success. Speculation attributes this to successful INGO treatment programs, including Partners in Health. This speculation is not backed by sufficient evidence at this time.

Adelman (2011) estimates that 80 percent of Haiti's welfare services are provided by INGOs (p. 93). Before the earthquake, 70 percent of available health care was provided by INGOs—with 72 per cent of people having no access to health care at all—and 85 percent of education was provided through private schools, mainly run by INGOs.

A study by the National Academy of Public Administration (NAPA) in 2006 concluded that excessive funneling of aid to Haiti by INGOs has exacerbated the problem of poverty by limiting local and government capacity. The study highlights that INGO programs are eroding the legitimacy of the government and are leading to a situation where the government shows little interest in the success or failure of programs (Adelman, 2011). As such, public expenditure on health has steadily decreased from 3 percent in 1995 to 1 percent in 2009 (World Bank, n.d.).

Haitian-born Michaëlle Jean, the UN Special Envoy for Haiti and Canada's former Governor General, comments on the situation in Haiti:

> The problem is a lack of coordination. This country has been transformed into a huge laboratory of all kinds of projects and experiments that has not delivered anything really sustainable. [It is] total chaos and confusion and [programs] are not connected to the government policies. There is the problem. (quoted in Schwartz, 2012 January 13).

Misguided and uncoordinated action has led to a situation where there are large numbers of programs but very little progress is actually achieved.

As cautioned in the literature, internal brain drain has a major impact on state capacity in Haiti. INGOs are the single largest employment sector. Schuller (2009) noted that in August 2004, there were 145 employment ads in the country's largest newspaper, *Le Nouvelliste*, 65 of which were for international agencies. This undermines the national health system, as local medical staff leave to acquire better-paying employment with INGOs. This problem has been exacerbated in the aftermath of the earthquake.

The humanitarian apparatus has been criticized for displacing local services through its failure to work with local NGOs and health care providers. Local medical

facilities often rely on user fees to stay afloat and free, INGO-supplied health care has resulted in the loss of patients for doctors and pharmacy closures (Batha, 2011). A physician in the city of Leogane attributes the destruction of his obstetrics practice to the influx of humanitarian workers that followed the earthquake. Before the earthquake he saw 20 patients a week, a figure that was reduced to two per week in 2010 (Adams, 2010 September 11).

Dr. Ronald LaRoche, the President of the Association of Private Hospitals in Haiti, noted that it was understandable that international health organizations came to Haiti's assistance following the earthquake. However, their continued presence was destructive:

> These people kept going and kept giving free health care to the Haitian population, which led to the collapse of the whole Haitian health care systems. No doctors, Haitians, have jobs. No nurses could work. No labs, no X-ray, because everything was given free to the Haitian people. (quoted in Beaubien, 2010 November 10, n.p.)

This is a clear violation of Anderson's (1999) 'do no harm' imperative for INGOs.

Evidently, in the case of Haiti, quantity of aid is not determining quality. Disorganized and self-interested international intervention has significantly restricted the capacity of the Haitian people and their government. Michaëlle Jean declares that "you cannot build a sustainable economy on charity. When you speak to the decision makers here in Haiti, this is one of their nightmares. They need the necessary funds to implement their policies" (quoted in Schwartz, 2012 January 13). It is the responsibility of INGOs to reinforce government capabilities rather than undermine them. There is

optimism that Haiti can emerge from “absolute misery into dignified poverty”[9] by implementing bottom-up approaches that are guided by the local communities and governments (Adelman, 2011).

In 2006, Jacques Edouard Alexis, then Prime Minister of Haiti, proposed a new paradigm for aid to Haiti. He made four requests of the international community: 1) INGOs should be accountable to government approved projects; 2) there should be a gradual transfer of project implementation to state agencies; 3) INGOs should recruit, train and nurture local and external experts to build the state’s capacity to combat corruption; and, 4) projects should be aligned with the government’s vision of development (Pierre Louis, 2011). In short, the Haitian government was requesting an investment in its capacity.

Reinforcing local and state capacity requires long-term planning, patience and faith in the future. Criticisms of INGO practices, such as those discussed above, have been widely documented in the literature. As INGOs have increasingly recognised the far-reaching implications that their actions have had for local and state capacity, there have been movements towards reinforcing and supplementing existing capacities.

[9] Well known quote by former President, Aristide, on his realistic vision for the Haitian people (Globalsecurity.org, 2012).

5. How INGO Operations Can Develop Capacity: Views from the Literature

If INGO operations have such a propensity to undermine the capacity of the people they serve, how can they address this problem? Solomon et al. (2008) assert that deep reflection is needed:

> An INGO must examine its own notions of development, community participation, and decision making, and determine how these ideas fit within a specific community context. This involves exploring the ways in which interactions occur, dialogue is encouraged, and new opportunities for decision making and participation are created. (p. 36)

INGOs must adopt an open, integrative approach that constantly re-examines their projects and is flexible to adaptation when appropriate.

Cliffe and Manning (2008) highlight the importance of strengthening existing state capacity by recognizing and reinforcing existing institutions rather than introducing novel models. Local people recognise existing institutions and know how to work with them. The authors call for three essential components of capacity development: 1) assess existing institutions and build on strengths; 2) always have a view to the long-term; and, 3) encourage a dialogue between the government and the international community. It is important that organizations commit their presence and resources for an extended time period, beyond the two-year project cycles that are common, and ensure that their practices are consistent and reliable (Barber and Bowie, 2008).

These three essential components of capacity development can be difficult to implement in situations where INGO staff rotate frequently and do not possess substantial knowledge of the context. Cliffe and Manning (2008) warn against INGO projects that simply provide for basic needs as they are very likely to undermine local capacity. Provision of services is not the means to developing sustainable institutions.

Eade (2007), a worker in the INGO sector for over 30 years, states that for INGOs to succeed in developing capacity they need to be self-aware, self-critical and modest. INGOs do not possess an inherent capability to build the capacity of 'the poor' simply because they are based in the so-called developed world. Eade argues that:

> For INGOs to make a lasting difference means that they must reflect hard on their own role(s) and be alert to changes in the environment in which they operate. It also means a commitment to learning as intrinsic to their interventions to build the capacities of others. (p.634)

Relationship-building is an essential feature of the capacity development process. In his ethnography in Mozambique, Pfeiffer (2003) found that both aid workers and local people expressed that trusting and respectful personal relationships, based on long-term commitments to equity between the foreign aid workers, local communities and governments, led to more effective development programs. He suggests that project cycles should be lengthened to a minimum of four years. On the whole, Pfeiffer (2003) argues that INGO support should be dissociated from a focus on specific projects and should be part of a longer-term development vision initiated by the state.

INGO-Government Partnerships

Much of the literature shows relationships between INGOs and governments to be fraught with tensions as INGOs are viewed as competition by governments in developing countries (McLoughlin, 2011). Hence, relationship-building is an important aspect of forging strong partnerships between INGOs and governments. This requires organizations and their staff to understand the history and nuances of the contexts in which they operate.

J. Brinkerhoff (2002) argues that true partnership is necessary for long-term sustainability of capacity development efforts. She defines *partnership* in this context as:

> A dynamic relationship among diverse actors, based on mutually agreed objectives, pursued through a shared understanding of the most rational division of labour based on the respective comparative advantages of

> each partner. Partnership encompasses mutual influence, with a careful balance between synergy and respective autonomy, which incorporates mutual respect, equal participation in decision making, mutual accountability and transparency. (p.21)

Haque (2004) and J. Brinkerhoff (2002) outline three perspectives on INGO-government partnerships. The *normative* perspective, stressed by advocates of INGOs, holds that partnerships are inherently and ethically good for development, empowerment, participation and accountability. The *reactive* perspective, held by international donors, emphasizes partnerships to counter criticisms of aid practices, improve accountability, defend their activities and enhance public relations. The *instrumental* perspective, promoted by experts and advisors, sees partnerships as a strategic tool to enhance efficiency, effectiveness and responsiveness. While all three perspectives provide suitable justification for pursuing capacity development objectives, the instrumental perspective highlights the actual benefits that relationship-building has for long-term visions of development.

Synergy between INGOs and government can create a healthy environment for service provision (Obiyan, 2005). Watson and Khan (2010) found that INGO programs that partnered with already existing government programs proved to build more capacity in service provision over the long term. For example, in Bangladesh, a country well known for collaboration between INGOs and the government, partnerships in the health sector have become a common practice. The government, recognizing its inability to provide for all of its nearly 150 million people, contracts out responsibilities of health, nutrition and family planning to around 4,000 NGOs (Haque, 2004). Haque (2004) found that, as a result, there have been improvements in poverty rates, birth control usage, infant mortality rates and primary health care utilization.

However, there remains the risk that INGO-government partnerships can erode state capacity as the shift to service provision by INGOs may become further entrenched (Haque, 2004). This situation may also allow the state to place blame on INGOs when welfare services fail. It is thus crucial that INGOs be aware of how their practices impact the settings in which they work and actively strive to build strong, equal relationships in the pursuit of development visions set by local communities and governments.

Some contexts necessarily pose greater challenges to capacity development than others. In countries such as Haiti, it may not be immediately obvious where the existing capacity lies. As such, it can be tempting—and sometimes necessary—to forgo capacity development in the efforts of fulfilling immediate humanitarian needs. However, this paper argues that where capacity is less obvious and unable to meet development needs, it is even more essential to invest in capacity development initiatives.

Capacity Development in a Fragile State

Capacity development is a crucial aspect of state-building projects in fragile states, and it inevitably poses more acute challenges. Fragile states are characterized by low levels of personal security, inadequacy of essential welfare services and little or no legitimacy of the government. State fragility is essentially a problem of poor governance or weak state capacity (Hameiri, 2009). As such, humanitarian needs in fragile states are often extensive.

Because people in fragile states often have myriad unmet needs, the imperative is to address these short-term needs via direct provision of services by INGOs—feeding the starving, tending the wounds of the injured, repairing the damage to infrastructure—meaning long-term capacity development is often ignored or put on hold (Sollis, 1994). Within this humanitarian situation, it may seem more expedient for INGOs to bypass government channels (D. Brinkerhoff, 2010). However, it is important to consider that local communities are often the first to provide assistance to victims in times of emergency, before the international community is organized enough to step in (Sollis, 1994). War and disaster are not new phenomena and societies have their distinct ways of dealing with these situations, which must always be factored into humanitarian efforts.

To conceptualize the connectedness of humanitarian and development efforts, Sollis (1994) proposed the idea of a relief-development continuum. He contends that humanitarian efforts have a long-term impact on prospects for development and, subsequently, the level of development has an impact on a country's ability to manage disaster. Circumstances exist where the humanitarian situation is the way of life—as

evident in Haiti and other fragile states. Over the long term, this can evolve into a situation where the population is dependent upon INGOs for service provision, such as we see in Haiti. It is not always clear when humanitarian relief becomes part of the reconstruction effort; hence, a transition to the long term must be an integral part of any program.

D. Brinkerhoff (2010) outlines three steps for capacity development in fragile states that reflect Cliffe and Manning's (2008) components of capacity development. 1) Capitalize on existing capacities, no matter how small, to show a commitment to coordination. 2) Structure service-provider contracts in a way that creates incentives for local capacity development. 3) Develop relationships with community groups and local NGOs as soon as possible to reinforce their capacity. Furthermore, capacity development requires an intricate knowledge of the context, including an understanding of the society prior to the crisis. There should be needs-specific targeting to identify who receives the most local support and is likely to make the best use of external assistance, so resources are effectively utilized (D. Brinkerhoff, 2010).

The process of capacity development poses significant challenges for INGOs, particularly in fragile states. It takes time, patience and, most of all, a commitment to empowering the local people and governments to guide their own development process. This means INGOs must commit to providing resources and support, but allow the local people to ultimately guide the vision. This, in turn, requires long-term funding, which donors have been reluctant to supply. As INGOs have begun to engage in capacity development, a body of literature has emerged critiquing various approaches to capacity development in order to evaluate the lessons learned.

Critique of Current Capacity Development Approaches

Kaplan (2000) poses a profound question to the development community:

> Is it possible that capacity development demands such a radically new form of practice, such a radically new form of thinking, that our current approaches are doomed to failure not because we lack adequate models

> or 'technologies' but because our very approach to the issue is inadequate? (p.518)

Kaplan argues that capacity development requires a paradigm shift in development aid. It must be understood as a vision, or a set of principles, for development rather than a singular project. His major criticism of current approaches to capacity development is that there is too much focus on strategic planning and the tangible, or technical, aspects of capacity development, such as resources and skills, and not enough focus on the intangible aspects, such as concepts, vision and strategy. Waisbord (2006) agrees that there must be a shift from the focus on skill-building to the incorporation of a broader program of reinforcing enduring institutions. Hameiri (2009) views state capacity, not as an objective or technical measure, but as a political and ideological mechanism. Essentially, capacity development requires a fundamental change in the way INGOs approach development aid.

Waisbord (2006) cautions that narrow interventions such as training alone may be insufficient; there also needs to be a creation of educational opportunities for local people and investments in institution-building. Many training initiatives focus on developing skills for individuals to be able to engage in employment, markets and service provision. Organizations may hold training sessions and lay claim to capacity development; however, counting the number of attendees at a training session—who may be there for the per diem attached—gives little insight into any change in people's competencies or how they apply the knowledge they acquire (Britton, 2010).

If capacity development is—or is perceived to be—donor-driven, then fostering local ownership can be challenging and may damage long-term prospects for development. Like many other INGO projects, externally-funded capacity development tends to emphasize strategic planning and stresses achieving clear objectives and managing for results, rather than allowing patience for a long-term path (Brinkerhoff and Morgan, 2010). Waisbord (2006) claims that "sustainability can only occur when local institutions are strongly committed to the project. Chances for sustainability are higher when external actors basically act as catalysts in support of local initiatives" (p.234). Brinkerhoff and Morgan (2010) note that from a policy perspective, there is the crucial

question of whether capacity development can be effectively planned in advance and implemented by outside actors at all.

Capacity is not something that INGOs can endow upon the communities with whom they work. It must be nurtured and reinforced. One health care INGO, Partners in Health (PIH), demonstrates a long-term commitment to developing the capacity of the people it serves. This paper will now turn to a presentation of this organization's approach to developing local and state capacity with the optimism that the PIH model can serve as a model for future capacity development initiatives.

6. The Partners in Health Approach to Capacity Development

PIH is widely recognized for implementing programs that put the principles of capacity development successfully into practice. Zanotti (2010) recognizes PIH as a model for positive change. In her study of PIH in Haiti, Zanotti found that because the organization was locally accountable, internationally connected[10] and financially independent it was able to provide services while reinforcing state capacity. Using the framework constructed by the previous discussion of capacity development by INGOs, this paper will critically examine PIH's approach to capacity development.

The Organization

PIH was founded in 1987 in Boston; however, the seed was planted in 1983 when Paul Farmer, Ophelia Dahl and Haitian Yolande Lafontant established a community-based health care project called Zanmi Lasante—Kreyol for Partners in

[10] Two of the founders, Paul Farmer and Jim Yong Kim, are graduates of Harvard Medical School and the organization maintains ties to Harvard's Medical School, School of Public Health and Brigham and Women's teaching hospital. Farmer serves as UN Deputy Special Envoy to Haiti. Kim was recently appointed as head of the World Bank and has formerly served as director of the World Health Organization's (WHO) HIV/AIDS department and president of Dartmouth College (Lowrey, 2012). These connections with a diversified international network of supporters facilitates the transfer of economic and knowledge resources (Zanotti, 2010).

Health—in Cange, Haiti. PIH has been working to provide health care and build a health system in Haiti since its inception.

PIH is the Boston-based wing of the organization, and operates its projects in developing countries through sister organizations, such as Zanmi Lasante in Haiti, which are mainly staffed by nationals of the developing country. In Haiti today, PIH operates through Zanmi Lasante at 12 sites across the country serving a catchment area of 1.2 million people with a staff of 5,400 Haitians (PIH website, n.d.). Over the years, the organization has expanded and now supports projects and sister organizations in Mexico, Guatemala, Peru, Rwanda, Burundi, Lesotho, Malawi, Kazakhstan, Russia and the USA (PIH website, n.d.).

The Partners in Health Model

PIH operates with three overarching goals. First, it aims to provide health care to those most in need. Second, it strives to identify and alleviate the root causes of disease. This means they look beyond diagnosis and treatment to the structural causes of illness and barriers to receiving care. Third, it aims to share its lessons learned with other countries, governments and NGOs (PIH website, n.d.).

PIH is guided by five principles. The focus of this analysis will be on the two principles that relate directly to capacity development and are informed by a consequentialist understanding of action.[11] First, the organization emphasizes

[11] The other three principles of PIH are informed by a deontological understanding of action. The organization aims to provide universal access to primary health care. They believe health care should be free for the poor, and argue that fees for services can be barriers to seeking medical care. They believe that fighting disease means fighting poverty. The organization is not just providing health care directly but is involved in agriculture, housing, education, employment and water and sanitation projects (PIH website, n.d.).

community-based care and building community partnerships through local participation and the inclusion of relevant stakeholders at all levels of design and implementation of programs. The backbone of this principle is the hiring and training of community health workers to link the clinical practice to the community setting. Second, the organization believes in partnering with local and national governments to ensure the sustainability of its programs. The organization champions the public sector as the ultimate carrier of the national health system.

While INGOs can provide resources and technical assistance, PIH argues that any sustainable health system must be ultimately operated by local people, communities and the government (PIH website, n.d.). In Farmer's view:

> The problem [in Haiti] is usually that there's not enough focus placed on training in-country professionals. Global health can't be people like my students and trainees at Harvard going to Haiti to replace and filling (sic) in gaps. It has to be aggressively linked to train local providers. […] The more we can co-ordinate with the public health sector, the more we'll have a safety net. (quoted in Clibbon, 2010 September 27)

The PIH model is based on what the organization calls the 'Four Pillars Approach', bringing together service, training, advocacy and research. The service arm consults people and communities on their needs and aims to fulfill them, first through medical treatment, but also by addressing the root causes of poor health. The training arm is seen as a way to strengthen and replicate their model as they train physicians, nurses, health workers and administrators to work within the national health system. This involves in-depth training in collaboration with local Ministries of Health. The advocacy arm is based on the vision of health care as a human right and views current global health issues as violations of the Universal Declaration of Human Rights. Through their Institute for Health and Social Justice, PIH analyzes the impact of poverty and inequality on global health. Finally, the research arm translates the experiences of serving the poor into peer-reviewed research and, in turn, transforms research into action on global health issues. PIH collects data as it provides services to identify gaps in its provision, potential problems and further needs (Keusch, 2004).

PIH's model of care is rooted in a deep understanding of the specific contexts in which it works, a focus on continuity and a commitment to a long-term vision of capacity development. PIH invests in sustainable development, "recognizing that the ultimate measure of sustainability for [its] projects will be their ability to carry on without further assistance" (PIH, 2008a, p.10). This is no easy feat in a country as destitute as Haiti.

Financial Independence

One important feature of PIH that allows it to pursue a long-term vision of capacity development is the organization's relative financial independence and the diversity of its donors. PIH has reached a point where competition for funds is no longer a salient issue. In 2004, it relied almost entirely on one foundation grant and a single benefactor. By 2008, it was receiving gifts from 55 major foundations and 11,000 individual donors (PIH, 2008a). This number has grown rapidly in the wake of the Haiti earthquake, with 15,000 new individual donors added in the 2011 fiscal year alone (PIH, 2011a).

Typically, individuals and family foundations provide the majority of PIH's funds; in 2011, several of the individual private donations exceeded one million dollars each (PIH, 2011a). Governments and multilateral agencies contribute only one-quarter of its overall funding[12]. In 2011, 45 percent of funds came from individual or family foundations, 23 percent from foundations and corporations, 27 percent from government

[12] As a major thrust of its work is developing HIV/AIDS and TB treatment programs, PIH attracts support from high profile donors such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (which is included as multilateral agency funding) and the Bill & Melinda Gates Foundation. Other notable donors include Harvard University, the Center for Disease Control, Médecins Sans Frontières International, USAID, the World Health Organization and other UN agencies (PIH, 2008a).

and multilateral agencies and 5 percent as gifts in kind, such as medicines or office space (PIH, 2011a). Because of this, Zanotti (2010) recognizes PIH's approach as driven by the needs of local people, rather than the demands of donors.

Although this aspect of the model is difficult to replicate for less financially fortunate NGOs, this financial independence and donor diversity means that the actions of PIH are not sensitive to donor funding cycles or trends. Zanotti (2010) sees this as a key factor supporting the organization's capacity development goals. As mentioned, donors tend to show reluctance in investing in long-term visions. The PIH process begins with an infusion of resources and technical assistance, with programs eventually transitioned over to the communities or governments with whom it works.

Rather than planning for an 'exit strategy,' PIH incorporates a 'transition strategy'. Executive Director Ophelia Dahl articulates this strategy:

> Our goal is not to see how quickly we can leave a community but to rebuild public health systems and infrastructure, provide training and support for local medical staff, and employ community health workers as agents of change to break the vicious cycle of poverty and disease. Over time, our success in achieving these goals reduces our role in providing direct service but not our commitment. We continue to provide valuable technical and financial support, to bring more resources to bear on the problems we see, and to focus on filling the gaps in services where we are needed most. (PIH, 2008a, p.1)

This comment illustrates the organization's long-term commitment to the places they work, as well as its strategy for passing ownership on to the communities once they are able to take it on.

Capacity Development in Practice

As capacity development is a long-term vision, it cannot yet be determined whether PIH has reached its ultimate goal of developing the capacity of the Haitian people. In the development community, evaluations into the impact of capacity development initiatives have yet to be developed.[13] Regardless, it is useful to examine how the organization puts capacity development principles into practice. PIH has engaged in conscious capacity building in Haiti and other contexts for over ten years. Regrettably, much of this capacity was destroyed in the 2010 earthquake. The ways in which PIH engages in this practice are the focus of the subsequent evaluation of the organization.

The main thrust of PIH's capacity development efforts go towards building health care as an institution: strengthening health systems, training individuals to be medically competent and working in collaboration with governments to reinforce the public sector. The strengthening of health systems can be defined as "building capacity in critical components of health systems to achieve more equitable and sustained improvements across health services and health outcomes", which is precisely PIH's goal (Jerome and Ivers, 2010, p. 6).

According to the 2009 PIH Annual Report, "rather than establish parallel systems, PIH works to strengthen and complement existing public health infrastructure in all of the countries where [it] work[s]" (PIH, 2009, p.11). PIH states that true progress requires local partnership and a capacity building approach; however, at this time, it also requires long-term external financial and technical support (PIH, 2008a).

[13] The lack of impact evaluation is an issue that will be discussed further in the last section.

PIH and the people who lead it have been operating in Haiti through decades of political turmoil and ecological disasters. Zanotti (2010) notes the importance of the organization having local roots, which fosters local accountability and legitimacy in the eyes of the people. PIH has learned about the complexities of Haitian society and culture. Through periods of political violence in the 1990s, it provided primary health care in Central Haiti. In periods of stability, they took time to assess the effects of the conflict on medical and public health systems.

At the turn of the millennium, after fifteen years of work partnering with local organizations and churches in Haiti, PIH evaluated the impacts of its work, and found both positive and negative outcomes. Although it was improving the health of the people it served, the organization realized there was a decline of the public health system in the areas where it worked; since then PIH has worked to reinforce the public sector (Guy, 2011 September 19). PIH stopped sending short-term volunteers to Haiti altogether and now focuses on expanding services exclusively through the public sector (Adams, 2010, September 11).

Following the earthquake, PIH and its sister organization, Zanmi Lasante, made sure that Haitians led the recovery effort (Kidder, 2010). Dr. Alix Lassegue, a hospital director in Haiti, had a positive experience working with Zanmi Lasante following the earthquake. Zanmi Lasante worked to help the director resume hospital operations, behaviour he described as unusual in his experience with INGOs. As a result, he requested that representatives from Zanmi Lasante join his managerial team to make a plan to bring the hospital back to functionality. He expressed that it was the first time he had that kind of relationship with an INGO (Kidder, 2010).

As illustrated by the preceding example, PIH emphasizes building relationships in the contexts where they work. This is articulated by their focus on *accompaniment*, a major theme in the way the organization operates which, in Farmer's (2011, July 29) view, means "to go somewhere with someone, to be present on a journey with a beginning and end, openness and trust, sharing fate for a while, sticking together until the task is completed" (n.p.). PIH affirms that it consults local people and governments and builds its programs around their identified needs. It is this part of the model that

fosters local accountability and legitimacy to the intended beneficiaries of the programs (PIH website, n.d.).

PIH views health systems as embedded in the social and political structures of society, meaning that treatment and diagnosis are not the only means of addressing global health issues as poverty and poor health are intimately woven together. In 2002, PIH introduced Zanmi Agrikol—Kreyol for Partners in Agriculture—to address malnutrition in Haiti, one of the perceived root causes of the illnesses that plague the country. The 2008 PIH Annual Report states that, in that year, 240 families joined the Family Assistance Program which supports family-based production, gives agricultural training, seeds, tools, fertilizers and provides ongoing support from agricultural technicians and community agriculture workers (PIH, 2008a). This program works to reduce Haiti's dependence on foreign food since, prior to the earthquake, Haiti was importing 80% of its food, making it particularly vulnerable to price fluctuations such as those that occurred during the 2008 economic crisis (Zanotti, 2010).

A significant part of the PIH model is based on training and employing local people. Zanmi Lasante operates with a staff that is 98 percent Haitian, employing 5,400 people altogether (PIH website, n.d.). Of this staff, 1,192 are medical staff, 1,841 are non-medical and 2,378 are community health workers (PIH, 2011). Zanmi Lasante has proven that it can provide social and medical services and expand its operations with an entirely Haitian team of health workers and administrative staff, yet it asserts that it still requires technical, administrative and, especially, financial support from PIH and its donors (PIH, 2008a).

These strategies create an environment where capacity development visions are possible. As mentioned above, two of PIH's strategies particularly serve to build local and state capacity. First, through the training of community health workers, the organization strives to build confidence in the medical system and build the health care competencies of local people. Second, PIH builds partnerships with local governments with a clear vision of reinforcing the public sector; through this, PIH is helping to ensure the long-term sustainability of their interventions. These two approaches will now be explored in further depth.

Community Health Workers

Since the early 1990s, PIH has trained and employed local community health workers (CHWs) in order to build the health care capacity of individuals and communities in Haiti. The majority of the CHWs are, or were, patients themselves; many are HIV positive (PIH, 2005). CHWs greatly increase adherence to treatment regimens and support health care systems. Research shows that CHW programs are a successful means of instilling faith in the health care system and increasing local knowledge of modern medical practices (Jerome and Ivers, 2010).

There are three levels of CHWs in PIH's model: accompagnateurs, health agents and community health educators. *Accompagnateurs* receive a few days of training and their main duties are to bring medicines to patients, monitor their treatment progress and refer them to health centres when necessary. They connect the clinics to the communities and bridge some of the gaps in care. *Health agents* have some primary education and are given a minimum of six months of training. They support clinic activities in the community, giving basic support and preventative care to patients as well as administer immunizations. *Community health educators* are secondary school graduates who are given two weeks of initial training and attend monthly continuing education. They educate people on preventative methods and the uses of the clinics, spreading the message and serving about one million people (Jerome and Ivers, 2010). PIH describes CHWs as the backbone of their treatment programs and their goal to strengthen the national health care system (PIH website, n.d.).

There are various challenges to designing an effective CHW program. Solomon et al. (2008) conducted a study of rural villages in Mali with one particular INGO, the Ouelessebougou-Utah Alliance which utilizes CHWs in its programs. They observed myriad problems in their study of CHWs in this case. For instance, the organization ignored cultural practices in their selection of midwives, resulting in their underutilization. There was minimal follow-up and support of CHWs. Another major issue was the payment of CHWs. The INGO wanted the community to pay the CHWs and the community thought they should be paid by the INGO; in the end they were rarely paid. Solomon et al. ultimately argue that any CHW model should address cultural sensitivity,

incorporate local perspectives in the project design, set a pre-arranged method of payment for CHWs and include a follow-up process for feedback and accountability.

PIH's CHW program deliberately addresses the issues identified by Solomon et al. (2008). Their longstanding ties in Haitian communities and insistence upon a locally-driven process ensure that their programs are socially and culturally appropriate. Due to the rampant unemployment and poverty in Haiti, PIH finds it unethical to expect CHWs to act as volunteers and thus pays them locally appropriate wages for their services (PIH website, n.d.). Other INGOs have chosen to pay their CHWs with food, which PIH views as problematic as it does not contribute to individual economic independence (Zanotti, 2010). Additionally, through its staff at Zanmi Lasante, PIH ensures that CHWs are continuously supported by the organization.

As part of the 'Four Pillars Approach,' PIH conducts academic research into its programs to evaluate their effectiveness. Jerome and Ivers (2010), both affiliated with PIH, conducted a qualitative study of 462 CHWs in Haiti to glean their perspective on the benefits and challenges of their positions. They found that the benefits to the individuals included recognition from the community, status, remuneration and the satisfaction of contributing to their community. The challenges they faced were perceptions of insufficient resources to cope with obstacles, a high work load, the desire for a higher salary and the aspiration for ongoing and more advanced training. This interest in further training was also discussed in the study by Solomon et al. (2008), as CHWs expressed the desire to take on more clinic-based roles such as treatment and diagnosis. The aspiration of CHWs to learn more about the medical system shows that the local ambition to build a more comprehensive health care system exists. Jerome and Ivers conclude that CHW programs successfully build the capability of Haiti's health workforce and strengthen the overall health system in the country.

By training Haitians to become more medically competent, offering them employment opportunities that are complementary to the public sector and providing long-term support of the people that work for them, PIH builds the local capacity of the Haitian people. The CHW program is therefore an integral part of PIH's vision of building a sustainable health system in Haiti.

Partnerships with Local Governments

PIH invests in state capacity by working alongside the public sector in its development endeavours. Although the organization sees its role as discovering innovative approaches to treating disease and combatting poverty, it views a vital public sector as necessary to ensure universal and sustained access to health care (PIH, 2005). PIH professes that the overarching vision of the organization is to create sustainable projects, which would lead to a situation where their assistance is no longer needed (PIH, 2008a, p.10). Although this is the ultimate goal, in many of the contexts in which they operate, this day is a long way away; therefore, PIH views its role as providing financial and technical support until that day comes.

PIH has a long-standing relationship with the people and the government of Haiti. Since its inception in 1985, PIH has seen many governments come and go in Haiti, and has maintained the continuity of its projects. While the Haitian government is still lacking in strength and legitimacy, it is on a path to improvement. Currently, the culture of democracy is growing in Haiti and PIH supports this through its relationships (PIH, n.d.).

PIH works with the Haitian Ministry of Health to improve the national health system. Because of the longstanding presence of PIH in Haiti, the Haitian Ministry of Health asked the organization to help treat people in four settlement camps that emerged in the aftermath of the 2010 earthquake, as hundreds of thousands of people were displaced. PIH opened mobile clinics and successfully treated more than 150,000 people (PIH, 2010).

In addition, PIH is currently working alongside the Ministry of Health to build a teaching hospital in Mirebalais set to be finished in late 2012, but clearly states that ownership of the facility will be passed to the government (Adams, 2010 September 11). Upon completion, it will be the largest public hospital outside the capital, and will provide high quality education to the next generation of health care workers in Haiti (PIH, 2011b). Through this project PIH has shown a strong commitment to empowering local people to drive development efforts.

Investments in the public sector strengthened both PIH and the public sector's service provision capability. This proved to strengthen the resilience of both in the face of the devastation wreaked by the 2010 earthquake.

Capacity Development along the Relief-Development Continuum

Because of their long-term presence in Haiti, PIH was well-poised to address the monumental health needs that followed the 2010 earthquake. Although PIH is not a disaster relief organization, it was able to treat some of the immediate, acute health concerns as well as some of the more chronic and structural issues caused by the earthquake. The organization's actions adhere to D. Brinkerhoff's (2010) aforementioned criteria for reinforcing capacity in failed states and emergency situations: capitalizing on existing capacities; creating incentives for local capacity development; and, developing relationships with local NGOs and authorities to reinforce their capacity.

Within weeks of the earthquake PIH was implementing a $125 million, 2.5 year 'Stand with Haiti' plan for recovery and long-term reconstruction in partnership with the Haitian MSPP (PIH, 2011b). Through this partnership they worked to coordinate other INGOs, as well as over 700 individual volunteers (PIH, 2010). PIH responded quickly to the surprise cholera outbreak and, among the cacophony of aid, was a strong voice calling for the strengthening of public institutions (PIH, 2011b). Ultimately, half of all funds raised by PIH for reconstruction in Haiti went to strengthening existing care facilities (PIH, 2011b).

From the beginning of the crisis, PIH focused on the implications for long-term reconstruction. It found that the lessons it had learned, the relationships it had built and the investments it had made in developing local capacity provided a strong foundation for response to the health crisis perpetuated by the earthquake (PIH, 2010). Based on the success of this model, PIH strives to enhance the transferability of its acquired insight.

Transferring the Model: Sharing Lessons Learned

Part of the PIH vision is that its model be transferrable to other organizations and contexts. One measure of the model's success is its adoption by other countries and organizations. For example, a local health care organization in Haiti, GHESKIO, implemented a program in Haiti that modelled PIH's programs, which was an overall success (Keusch, 2004). PIH endeavours to share its lessons learned through training manuals and partnering with governments in countries that face similar health challenges to the ones that PIH faces in Haiti.

Training Manuals

To assist other NGOs in emulating their success, PIH creates easily accessible training manuals. With funding from the Bill and Melinda Gates Foundation, the organization developed a comprehensive training manual for CHWs in 2008 and a Program Management Guide in 2011 (PIH, 2008a and 2011). The PIH curriculum is used to train CHWs in South Sudan, Zambia, Pakistan and the Dominican Republic (PIH, 2009). Following the organization's experience in dealing with the cholera outbreak in Haiti, the World Bank partially funded the development and distribution of a PIH cholera training manual (PIH website, n.d.). Additionally, the organization launched an online resource for NGOs to share tools and lessons learned (PIH, 2008a). Free from the need to compete for funding with other organizations, PIH shares what it has learned over the years, with the goal of creating a more sustainable global health system.

Partners in Health in Rwanda

Based on the success of its HIV/AIDS treatment model in Haiti, PIH was invited by the Rwandan Ministry of Health to implement a similar program there in 2005 (Farmer and Garrett, 2007). The organization began by supplying technical assistance; the program has since evolved to employ a team that is 95 percent Rwandan (Farmer and Garrett, 2007). In 2011, PIH built a new, modern hospital in partnership with the Rwandan government, with the government currently supporting 40 percent of the operating costs (PIH, 2011a).

PIH now partners with its sister organization in Rwanda, Inshuti Mu Buzima—Kinyarwanda for Partners in Health—working to strengthen the overall health system. Part of the program includes the employment of 3,313 CHWs (PIH, 2011). The government of Rwanda adopted the PIH CHW training guide to implement its own CHW program to complement its health care system (PIH, 2009).

In Rwanda, the HIV/AIDS treatment program is implemented in conjunction with the Ministry of Health through a grant from the Clinton Foundation. PIH works with the public sector in Rwanda to ensure that the doctors and nurses it employs are not part of the brain drain from the government to INGOs (Farmer and Garrett, 2007). PIH is successfully transferring its capacity development model to the Rwandan context.

Partners in Health in Lesotho

In 2007, the government of Lesotho invited PIH to bring HIV testing and treatment to remote mountain communities, based on the success of its model in Haiti and Rwanda. In the process of implementing this program, PIH workers discovered a major epidemic of TB. The Lesotho Ministry of Health did not have the resources to address this issue but expressed a strong commitment to facing the challenge. In 2009, PIH partnered with the Lesotho government to develop a TB treatment program (PIH, 2009). PIH now operates in partnership with a sister organization, Bo-Mphato Litšebeletsong tsa Bophelo, employing local health professionals and staff, including 1,745 CHWs (PIH, 2011). The success of the TB program in Lesotho has provided training for medical workers in Ethiopia, South Africa, Swaziland and Tanzania and program staff have travelled to Namibia and Kenya to provide technical assistance (PIH, 2009).

The transferability of PIH's model is one testament to the effectiveness of its programs. However, the success of the model in actually building and sustaining local and state capacity proves difficult to determine, not least because capacity is difficult to define and depends on intangible factors that are difficult to measure with the current evaluation models.

Evaluating the Model: External Evaluations of Partners in Health

Evaluating the ultimate impact of PIH's programs on Haiti's local and state capacity proved to be a challenge for the scope of this paper. Although much data exists on improvements in health indicators for the people PIH serves, measures of capacity do not currently exist. This will be discussed in greater detail shortly. However, two independent organizations have reviewed PIH, as part of a broader effort to inform donors of INGO practices. These evaluations illuminate the values and actions of PIH from an outside perspective.

The Better Business Bureau (BBB) rates non-profit organizations according to accountability standards of governance, effectiveness, donor relations, financial responsibility and openness. PIH meets 19 of their 20 standards.[14] To meet the BBB standards, an organization must spend a minimum of 65% of its funds on programs activity. According to financial statements ranging from 2005-2011, PIH consistently spends 94% of its funds on program activities, spending on average of 6% of funds on administrative and fundraising activities, well above the standard (BBB website, 2010).

Give Well, the not-for-profit, independent, charity evaluation organization, rates PIH quite highly but states that the organization does not qualify for its highest rating. This is due to the fact that Give Well was not able to effectively evaluate the outcomes of PIH's capacity development policies. GiveWell feels confident that PIH's medical

[14] PIH loses one point for having paid executives on the Board of Directors. These paid executives are the founders of the organization and would likely want to remain in control of the vision and direction of the organization. In fact, it is written into the bylaws of PIH that the Executive Director will always be a member of the Board of Directors (PIH, 2008b). As the founders, such as Farmer, are such avid promoters of capacity development themselves, this could be an assurance that the issue stays at the forefront of the organization's efforts.

services are replacing those of very poor quality, but express concerns about implications for capacity (Give Well, 2010).

Long-term visions prove difficult to gauge—how do you measure an objective that is not yet achieved? This illuminates some of the challenges of monitoring and evaluating capacity development.

In Summary

This paper has presented a critical examination of one model for capacity development through an analysis of PIH's operations in Haiti. This model is evaluated based on adherence to the principles of capacity development outlined in the beginning of the paper. As stated by Cliffe and Manning (2008), capacity development requires three commitments from INGOs: 1) assess existing institutions and build on strengths; 2) always plan for the long-term; 3) encourage an open dialogue between INGOs and the local government. Furthermore, Brinkerhoff (2010) echoes these commitments in his principles for capacity development in humanitarian situations and fragile states: 1) capitalize on existing capacities, no matter how small, to show a commitment to coordination; 2) structure service-provider contracts in a way that creates incentives for local capacity development; 3) develop relationships with community groups and local NGOs as soon as possible to reinforce their capacity.

This examination of PIH serves to illuminate how the organization puts these principles of capacity development into practice. As such, the focus has been on assessing the *process* of working towards the goal, rather than measuring the end results. PIH has not yet achieved the ultimate result where the Haitian people are able to function completely without outside assistance; this long term capacity development vision has not yet advanced to the stage where results can be measured. As current evaluation models are mainly designed to measure tangible results (Huyse et al., 2012), the potential for future research lies in creating effective tools to evaluate the process, as well as the relatively intangible result of achieving capacity.

7. Moving Forward: Challenges to Evaluation

Many INGOs claim to be implementing capacity development initiatives but it is unclear what they are actually doing and whether it is ultimately effective (Huyse et al., 2012). Kuhl (2009) warns that, as capacity development becomes increasingly recognized as an ethical imperative, INGOs may promote capacity development goals simply to establish or maintain relevance and legitimacy. Unfortunately, capacity development proves to be an objective that is difficult to assess, monitor and evaluate (Brinkerhoff and Morgan, 2010). It poses the challenge of assessing delayed causality, as the long-term effects play out long past the time frame of the intervention (Huyse et al., 2012). As capacity development is a long-term process, it may not be evident when capacity is achieved and at what point this can be determined. Consequently, capacity development programs may not, at first glance, appear successful, but this does not preclude the possibility that success may be achieved further down the road. As such, it is necessary to devise monitoring and evaluation models that can assess the process, rather than the end result.

Potential Models for Monitoring and Evaluating Capacity Development

Huyse et al. (2012) note that there are few evaluation models that focus exclusively on capacity development. They call for an enhanced evaluation framework to address delayed causality and capture the complexity of the process. They propose three measurement models that will be explored in this section: 1) the Ripple Model, 2) the Most Significant Change (MSC) Model, and 3) the Five Capabilities Model.

The Ripple Model is actor-centred and views organizations as open systems. The outcomes of INGO activities do not necessarily flow in a linear fashion, but trigger

effects (ripples), which may be intended or unintended. These ripples initially impact people directly involved in the organization's activities, but then spread further into society. The evaluation thus centres on following the path of a particular ripple and assessing the value of its effects. However, the challenge with this model is in determining causality, namely, whether observed changes can be attributed to the initial intervention (Huyse et al. 2012).

The MSC Model involves collecting stories of major change from the communities, followed by a selection of the most significant stories by a panel of stakeholders. This model may obtain the perspective of those most affected by the practical application of capacity development visions. However, here too it can be difficult to attribute causality to INGO operations and programs (Huyse et al., 2012).

The Five Capabilities Model—introduced above as a means of defining capacity—shows the most potential for evaluating the process of capacity development. This approach to evaluation breaks capacity down into five categories and assesses progress in cultivating them: the ability to engage, to carry out technical tasks, to mobilize support, to adapt to change and to manage diversity. With a standardized methodology, this model has considerable potential for comparing results across various organizations. The challenge with this model is that, as many evaluations are done by the INGOs themselves, rather than independent bodies, there exists the danger that evaluations could be self-serving. Moreover, there is the potential for INGOs to prioritize the elements of capacity differently, depending on their mandates and areas of focus, making comparisons difficult (Huyse et al., 2012). This highlights the importance of having independent, objective bodies to engage in the monitoring and evaluation of INGO programs.

Measurement and evaluation pose the key hurdles to determining how effective INGO approaches to capacity development really are; however, each of these evaluation models has a potential contribution to make. The Ripple Model has the potential to evaluate intended and unintended consequences of evaluations. The MSC model provides an opportunity to hear the voice of those most affected by the interventions—

those whose capacity is to be fostered. The Five Capabilities Model provides a systematic approach for measuring various capabilities within and across contexts.

Huyse et al. (2012) argue that these models are rarely employed in practice however and evaluations tend to cater to accountability concerns of donors, rather than accountability to the supposed beneficiaries. A report from the Humanitarian Policy Group at the Overseas Development Institute (2004) reveals that the evaluation of humanitarian operations rarely includes a survey of the affected population, resulting in discrepancies between an organization's perception of its success and that of the intended beneficiaries. Ultimately, monitoring and evaluation procedures must incorporate local people, and be adaptable to new and unforeseen circumstances.

A Final Thought on Impact Evaluations

It can be argued that the monitoring and evaluation of organizations and their practices is not sufficient, in and of itself, to measure the success of development aid. In 2006, the Center for Global Development (CGD) produced a report that identified an 'evaluation gap' in aid practices: why are billions of dollars of aid spent on development programs without a sufficient understanding of what works and what does not? The CGD report emphasized the importance of rigorous impact evaluations, which they define as "studies that document whether particular programs are actually responsible for improvements in social outcomes relative to what would have happened without them" (CGD, 2006, p. 2). According to the report, these evaluations are rarely conducted by INGOs.

The CGD report claims that these evaluations will serve to construct an evidence base that can be shared amongst stakeholders pursuing development goals. The knowledge that is created will become a public good. This practice should logically appeal to results-oriented donors and therefore improve fundraising capabilities. Like capacity development, impact evaluation requires long-term thinking and should be incorporated into the initial planning and implementation stages of development programs (CGD, 2006).

As integrity and credibility are enhanced when evaluations are independent and external, the International Initiative for Impact Evaluation—known as 3ie—was created in 2009 to act as oversight for impact evaluation. The standard practice of INGOs conducting their own evaluations is problematic as there are obvious issues with accountability. This council sets quality standards and provides grants to organizations to conduct impact evaluations. The goal is to make effective and rigorous impact evaluations into a standard practice in development aid (International Initiative for Impact Evaluation, n.d.). This is one method of improving the monitoring and evaluation of a long-term process and a broadly-defined end result.

It is necessary for INGOs engaged in development work to reflect upon and assess the impact of their operations. Many INGO operations have served to reduce the capacity of the people and communities they serve. They have fostered dependence, rather than independence. Establishment of effective monitoring and evaluation models, as well as the incorporation of impact evaluation systems into the planning of development programs, will ultimately help to build an evidence base that can better inform capacity development programs in the future.

Conclusion

This paper has examined the rise of capacity development as an increasingly important development goal and the challenges associated with implementing it. The case study of Haiti illustrates the implications that INGO operations can have for local and state capacity. The PIH approach presents one model for putting the principles of capacity development proposed by the literature into practice. PIH shows that through a strong commitment to relationship-building and a long-term presence, INGOs can work to foster the capabilities of individuals and communities, reinforce existing institutions and invigorate the public sector.

The relationship between INGOs and the capacity of the people they serve is inherently complex. In the past, misguided action by INGOs has too often undermined local and state capacity. But as the PIH programs demonstrate, well-planned INGO programs can serve as catalysts for developing the capacity of the communities and governments with which they work. This is an essential element in building true and lasting development for impoverished countries.

However, further research is required to determine the long-term effectiveness of the PIH approach and the impact it has on the Haitian people and their government. Traditional monitoring and evaluation models are not up to the task of measuring the long-term process and intangible goal of capacity development. The true assessment of capacity development initiatives is whether the intended beneficiaries eventually take ownership of the project and endure without INGO assistance (Huyse et al., 2012).

Will INGOs really work themselves out of a job? Will they truly teach the man to fish? The success of capacity development will ultimately be measured by achieving the goal of full and self-sustaining development.

References

Adams, P. (2010, September 11). Health-care dynamics in Haiti. *The Lancet,* 376, 859-860.

Adelman, C. (2011). Haiti: Testing the limits of government aid and philanthropy. *Brown Journal of World Affairs* 17(2), 89-97.

Amnesty International. (11 January 2012). Haitian Authorities forcing quake victims into homelessness. Retrieved from http://www.amnesty.org/en/news/haitian-authorities-forcing-quake-victims-homelessness-2012-01-11.

Anderson, M. (1999). *Do no harm: How aid can support peace—or war.* Boulder, CO: Lynne Rienner Publishers.

Barber, M., and Bowie, C. (2008). How international INGOs could do less harm and more good. *Development in Practice*, 18(6), 748-754.

Batha, Emma. (2011, January 14). Haiti loses doctors and nurses to aid groups—report. *AlertNet.* Retrieved from http://www.trust.org/alertnet/news/haiti-loses-doctors-and-nurses-to-aid-groups-report/.

Beaubien, J. (2010, November 10). Hope fades as recovery drags on in Haiti. *National Public Radio.* Retrieved from http://www.npr.org/templates/story/story.php?storyId=131222588.

Better Business Bureau. (2010). *BBB Wise giving report for Partners in Health.* Arlington, VA, US. Retrieved from http://www.bbb.org/charity-reviews/national/health/partners-in-health-in-boston-ma-886

Brinkerhoff, D. (2010). Developing capacity in fragile states. *Public Administration and Development* 30, 66-78.

Brinkerhoff, D. and Morgan, P. (2010). Capacity and capacity development: Coping with complexity. *Public Administration and Development* 30, 2-10.

Brinkerhoff, J. (2002). Government nonprofit partnership: A defining framework. *Public Administration and Development* 22, 19-30.

Britton, B. (2010). Self-reflection: Monitoring and evaluation for personal learning. In Ubels, J., Acquaye-Baddoo, N., and Fowler, A. (Eds.), *Capacity Development in Practice* (pp. 264-276). London, UK: Earthscan Limited.

Brookings. (2008). *Index of state weakness in the developing world.* Washington, DC. Retrieved from http://www.brookings.edu/research/reports/2008/02/weak-states-index.

Center for Global Development. (2006). *When will we ever learn? Improving lives through impact evaluation*. Washington, D.C. Retrieved from http://www.cgdev.org/files/7973_file_WillWeEverLearn.pdf

Central Intelligence Agency. (2012). The World Factbook: Haiti. Retrieved from https://www.cia.gov/library/publications/the-world-factbook/geos/ha.html

Clibbon, J. (2010, September 27). Paul Farmer: Rebuilding Haiti, but 'building back better'. *CBC News.* Retrieved from http://www.cbc.ca/news/world/story/2010/09/27/f-haiti-paul-farmer.html

Cliffe, S and Manning, N. (2008). Practical approaches to building state institutions. In C.T. Call with V. Wyeth (Eds.), *Building States to Build Peace* (pp.163-183). Boulder, CO: Lynne Riener Publishers, Inc.

Dowell, S., Tappero, J., and Frieden, T. (2011). Public health in Haiti – Challenges and progress. *New England Journal of Medicine,* 364(4), 300-301.

Dupuy, A. (2008) From Jean-Bertrand Aristide to Gerard Latortue: the unending crisis of democracy in Haiti. *Journal of Latin American Anthropology,* 10(1), 186-205.

Eade, D. (2007). Capacity building: Who builds whose capacity? *Development in Practice* 17(4-5), 630-639.

Farmer, P. (2011, July 29). Partners in help. *Foreign Affairs*. Retrieved from http://www.foreignaffairs.com/articles/68002/paul-farmer/partners-in-help.

Farmer, P. and Garrett, L. (2007, March/April). From "marvelous momentum" to health care for all: Success is possible with the right programs. *Foreign Affairs.* Retrieved from http://www.foreignaffairs.com/articles/62458/paul-farmer-and-laurie-garrett/from-marvelous-momentum-to-health-care-for-all-success-is-possible.

Fisher, W. (1997). Doing good? The politics and antipolitics of INGO practices. *Annual Review of Anthropology,* 26(1), 439-455.

Fowler, A. (1995). INGOs & the globalisation of social welfare: Perspectives from East Africa. In J. Semboja and O. Therkildsen (Eds.), *Service Provision Under Stress in East Africa*, (pp. 51-69). Copenhagen, Denmark: Centre for Development Research.

The Fund for Peace. (2011). *2011country profile series: Haiti.* Washington D.C., US: Kristen Blandford.

Gariyo, Z. (1995). INGOs and development in East Africa: A view from below. In M. Edwards and D. Hulme (Eds.), *Non-Governmental Organisations – Performance and Accountability. Beyond the Magic Bullet* (pp. 131-139). London, England: Earthscan Publications.

Ghosh, S. (2009). NGOs as political institutions. *Journal of Asian and African Studies,* 44(5), 475-495.

GiveWell. (2010). *Partners in Health.* Brooklyn, US. Retrieved from http://www.givewell.org/international/charities/PIH

Globalsecurity.org. (2012). Haiti politics. Retrieved from http://www.globalsecurity.org/military/world/haiti/politics.htm

Hameiri, S. (2009). Capacity and its fallacies: International state building as state transformation. *Millennium: Journal of International Studies* 38(1), 55-81.

Haque, M. (2004). Governance based on partnerships with INGOs: implications for development and empowerment in rural Bangladesh. *International Review of Administrative Sciences,* 70, 271-290.

Heins, V. (2008). *Nongovernmental Organizations in International Society: Struggles over Recognition.* New York, US: Palgrave Macmillan.

Horton, D. (2002). Briefing paper: Planning, implementing and evaluating capacity development. *International Service for National Agricultural Research.*

Huyse, H., Molenaers, N., Phlix, G., Bossuyt, J. and Fonteneau, B. (2012). Evaluating INGO-capacity development interventions: Enhancing frameworks, fitting the (Belgian) context. *Evaluation* 18(1), 129-150.

International Initiative for Impact Evaluation. (n.d.) Strategy & Vision. Retrieved from http://www.3ieimpact.org/en/about/strategy-vision/.

Jerome, J. and Ivers, L. (2010). Community health workers in health systems strengthening: A qualitative evaluation from rural Haiti. *AIDS,* 24(Suppl 1), S67-S72.

Kaplan, A. (2000). Capacity building: Shifting the paradigms of practice. *Development in Practice* 10(3/4), 517-526.

Keusch, G. (2004). Commentary: Spreading effective AIDS care in poor countries, thoughts on Partners in Health/Zanmi Lasante experience in Haiti. *Journal of Public Health Policy,* 25(2), 159-161.

Kidder, T. (2010, March 4). Recovering from disaster — Partners in Health and the Haitian earthquake. *New England Journal of Medicine*, 362(9), 769-772.

Kuhl, S. (2009). Capacity development as the model for development aid organizations. *Development and Change* 40(3), 551-577.

Lister, S. (2003). NGO legitimacy: technical issue or social construct? *Critique of Anthropology* 23(2), 175-192.

Lowrey, A. (2012, March 23). College president is Obama's pick for World Bank chief. *New York Times.* Retrieved from http://www.nytimes.com/2012/03/24/business/global/ dartmouth-president-is-obamas-pick-for-world-bank.html?_r=2

Mackay, R., Horton, D., Dupleich, L. and Andersen, A. (2002). Evaluating organizational capacity development. *The Canadian Journal of Program Evaluation,* 17(2), 121-150.

Mangones, K. (2001). Alternative food aid strategies and local capacity building in Haiti. In I. Smillie (Ed.), *Patronage or Partnership: Local Capacity Building in Humanitarian Crises* (pp. 51-76). Bloomfield, US: Kumarian Press, Inc.

McLoughlin, C. (2011). Factors affecting state-non-governmental organisation relations in service provision: Key themes from the literature. *Public Administration and Development,* 31, 240-251.

Obiyan, A. (2005). A critical examination of the state versus non-governmental organizations (INGOs) in the policy sphere in the global south: Will the state die as the INGOs thrive in sub-Saharan Africa and Asia? *African and Asian Studies* 4(3), 301-325.

O'Connor, M. (2012, January 12). Two years later, Haitian earthquake death toll in dispute. *Columbia Journalism Review.* Retrieved from http://www.cjr.org/behind_the_news/one_year_later_haitian_earthqu.php?page=all

Overseas Development Institute. (2004). *Measuring the impact of humanitarian aid.* London, UK: Hofman, C-A., Roberts, L., Shoham, J. and Harvey, P. (2004).

Partners in Health. (2005). *2005 annual report*. Retrieved from http://parthealth.3cdn.net/2dddca19219075faf3_urm6vippe.pdf

Partners in Health. (2008a). *2008 annual report*. Retrieved from http://parthealth.3cdn.net/6462a6bb2e1fdbca3c_1im62zz0t.pdf

Partners in Health. (2008b). *Amended and restated by-laws of Partners in Health, and non-profit corporation.* Retrieved from http://act.pih.org/page/-/financials/PIH_By-laws%20_revised_9-2-08.pdf

Partners in Health. (2009). *2009 annual report.* Retrieved from http://parthealth.3cdn.net/25417a698b70daf528_8tm62g01p.pdf

Partners in Health. (2010). *2010 annual report.* Retrieved from http://parthealth.3cdn.net/fdb20a0a7ef6b71153_o6m6icn3q.pdf

Partners in Health. (2011a). *2011 annual report*. Retrieved from http://parthealth.3cdn.net/283c794b2e83589919_b4m62spy6.pdf.

Partners in Health. (2011b). *Stand with Haiti: One year report*. Retrieved from http://www.pih.org/haiti/one-year/stand-with-haiti-one-year-report

Partners in Health. (n.d.). Main website. Retrieved from www.pih.org.

Pfeiffer, J. (2003). International INGOs and primary health care in Mozambique: The need for a new model of collaboration. *Social Science & Medicine* 56, 725-738.

Pierre-Louis, F. (2011). Earthquakes, nongovernmental organizations, and governance in Haiti. *Journal of Black Studies,* 42(2), 186-202.

Ridde, V. (2010). Per diems undermine health interventions, system and research in Africa: burying our heads in the sand. *Tropical Medicine and International Health,* 1-4.

Schuller, M. (2009). Gluing globalization: INGOs as intermediaries in Haiti. *Political and Legal Anthropology Review*, 32(1), 84-104.

Schwartz, D. (2012, January 13). Michaelle Jean: 'You cannot build a sustainable economy on charity'. *CBC News.* Retrieved from http://www.cbc.ca/news/world/story/2012/01/13/f-haiti-michaelle-jean-q-a.html

Slim, H. (1997). Doing the right thing: Relief agencies, moral dilemmas, and moral responsibility in political emergencies and war. *Disasters* 21(3), 244-257.

Sollis, P. (1994). The relief-development continuum: some notes on rethinking assistance for civilian victims of conflict. *Journal of International Affairs* 47(2), 451-471.

Solomon, Y., Ballif-Spanvill, B., Ward, C., Fuhriman, A., and Widdision-Jones, K. (2008). The dynamics of community and INGO partnership: primary health care experiences in rural Mali. *Promotion and Education,* 15(4), 32-37.

United Nations Development Program. (2006). *Capacity development and the MDGs*. Workshop Presentation. Bangkok, Thailand: Aidan Cox.

United Nations Development Program. (2009). *Frequently asked questions: The UNDP approach to supporting capacity development*. New York, US.

World Bank. (n.d.). DataBank. Retrieved from http://data.worldbank.org.

World Health Organization. (2012a). *Dominican Republic: health profile.* Retrieved from http://www.who.int/gho/countries/dom.pdf

World Health Organization. (2012b). *Haiti: health profile.* Retrieved from http://www.who.int/gho/countries/hti.pdf

World Health Organization. (2012c). *Structural adjustment programmes (SAPS).* Retrieved from http://www.who.int/trade/glossary/story084/en/index.html.

Waisbord, S. (2006). When training is insufficient: Reflections on capacity development in health promotion in Peru. *Health Promotion International,* 21(3), 230-237.

Watson, D. (2010). Measuring capacity development: Combining the 'best of two worlds' in monitoring and evaluation of capacity development. In Ubels, J., Acquaye-Baddoo, N., and Fowler, A. (Eds.), *Capacity Development in Practice* (pp. 239-249). London, UK: Earthscan Limited.

Watson, D and Khan, A. (2010). Capacity development for education service delivery in Pakistan: Top-down devolution. *Public Administration and Development* 30(1), 11-26.

Winters, M. (2010). Accountability, participation and foreign aid effectiveness. *International Studies Review* 12(2), 218-243.

Zanotti, L. (2010). Cacophonies of aid, failed state building and INGOs in Haiti: Setting the stage for disaster, envisioning the future. *Third World Quarterly,* 31(5), 755-771.