who participate in public health. The 15 case studies of this book illustrate anthropological concepts and methods that can help us understand and resolve diverse public health problems around the world. One case study shows how differences in concepts and terminology among patients, clinicians, and epidemiologists in a southwestern U.S. county hinder the control of epidemics. Another case study examines reasons that Mexican farmers don't use protective equipment when spraying pesticides and suggests ways to increase use. Another examines the culture of international health agencies, demonstrates institutional values and practices that impede effective public health practice, and suggests issues that must be addressed to enhance institutional organization and process. *Anthropology in Public Health* provides practical models and anthropological tools to improve the effectiveness of public health efforts around the world.

About the Editor

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Bridging Differences in Culture and Soc

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16

Bureaucratic Aspects of International Health Programs

GEORGE M. FOSTER

Since the end of World War II, great strides have been made in meeting health needs, particularly in Third World countries, which historically have lagged behind industrialized regions. Death rates have fallen significantly, longevity has markedly increased, environmental sanitation has improved, maternal and child health facilities have multiplied, immunization programs increasingly protect children against common childhood diseases, and the incidence of many other diseases, such as malaria, has been notably lowered.

At the same time, enormous health problems still confront most of the world, and it is highly unlikely that "Health for All by the Year 2000" will be achieved (WHO, 1979). Why should this be? In public health we have long since acquired the skills needed to provide pure water and environmental sanitation, to immunize against the common childhood diseases, to design nutritionally balanced diets, and to teach personal hygiene and food safety. These skills, as Ramalingaswami notes, "were largely responsible for the great transformation in health that took place in the industrialized world at the time of the First Industrial Revolution" (Ramalingaswami, 1986:1097). They are also the skills that can effect a comparable revolution in Third World health conditions. But we are failing fully to utilize these skills, according to Ramalingaswami, because of political, cultural, ethical, and bureaucratic factors.

These factors are marked by a common characteristic: they are all sociocul- ... medical. In other words, medical knowledge and

medical research alone cannot bring health for all. Our problems lie in th
of politics and commitment, of planning for health needs, and of admini
of programs and projects.

This is not the first time in history that administrative and planning
have been called on to help meet perceived health needs. Perhaps the
"international" health agencies were the Public Health Boards establish
north Italian city-states to meet the threat of the Black Death (1347–135
only did the boards monitor the incidence and progress of illness within
boundaries; they also exchanged information with their counterparts in
cities with a view to establishing quarantine measures. Considering the lo
of medical knowledge at that time, it is perhaps not surprising that "the
development of the Health Boards and of related health legislation were
much the brainchild of the medical profession as they were the products
administrative talents of Italian Renaissance society. . . . From their begin
the Boards were in the hands not of the medical men but of administrators
of course, made use of the knowledge and skills of physicians and sur
whenever the situation demanded" (Cipolla, 1976:20–21).

History repeats itself today, for knowledge and skills beyond those of
cine alone are needed to make progress in meeting health needs. Specific
administrative, political, economic, sociocultural, and ethical factors mus
taken into account in the planning and conduct of health programs. With
field of international health this fact is appreciated in varying degrees. Th
generally agreed that knowledge of the sociocultural characteristics of reci
groups is essential to the best planning and execution of health programs
widely accepted is the fact that the structural and dynamic characteristi
health agencies profoundly influence the planning and mode of operation
international health programs. Health bureaucracies are therefore just as
cal objects of scientific investigation as traditional communities.

To study bureaucracies, of course, is hardly a novel idea. Since the ti
the German sociologist Max Weber (1864–1920), social scientists have stu
administrative organizations to understand how their structure and dyna
influence the societies of which they are a part. Empirical research has confir
the obvious: informal relations and unofficial practices are widespread in
bureaucracies, and are essential to their activities. Far from detracting from
efficiency of the organization (as Weber's model postulated), these relations
and practices often contribute to more efficient operations (e.g., see discus
of Simmons, below).

Although the health field has provided the arena for a number of studies
bureaucracies and the health professions within national boundaries, relati
little research on health agencies—in contrast to the communities they ser
has been carried out in the international setting. Among exceptions is Simmo

ghly useful but unofficial function health center nurses performed in mediat-
ng between doctors and patients (Simmons, 1955). When in a routine adminis-
ative shift of duties the nurses were assigned full-time to home visiting, com-
unication between doctors and patients virtually broke down. Equally revealing
Philips's review of the Rockefeller Foundation's hookworm campaign in Ceylon
om 1916 to 1922 (Philips, 1955). The study is important because it demon-
rates how the physicians' misconceptions about appropriate innovative roles
nd their lack of knowledge of what their activities meant to the tea coolies were
sponsible for the failure of the program. Practically all of the problems in plan-
ning and operating international health programs encountered 50 years later in
he post–World War II period emerged during those six years.

Methodology

This study is based on information acquired through participant observation. In
ommon anthropological usage, the term implies that researchers speak the lan-
guage of and participate as fully as possible in the life of the members of a group—
peasant community, urban ghetto residents, staff of a hospital, or a govern-
ment agency—with specific goals in mind, such as writing a scientific monograph,
popular book, or a committee report. Information gathered in this fashion tends
o be "interpreted" rather than "analyzed." Anthropologists ask of their data,
What does this all add up to? What do the data tell us about human behavior,
bout social organization and culture?" Competing interpretations are the rule;
here are no ways to repeat a study under controlled conditions duplicating the
first anthropologist's work, no simple way to prove or disprove a hypothesis. The
nterpretation that seems most plausible to most anthropologists is generally
accepted until and unless a more plausible hypothesis appears.

Reflection upon 40 years of personal observations and experiences in the field
of technical aid, especially international health programs, augmented by exami-
ation of the published record and discussions with colleagues in many fields,
has led to the conclusions in this study. During my professional life I have
observed and participated in the development of a number of international multi-
and bilateral technical aid programs, beginning in 1943 when, as a "social sci-
ence analyst," I joined the US Institute of Inter-American Affairs (IIAA), which
had been established a year earlier to help Latin American countries develop
their agricultural, health, and educational systems. The IIAA was the forerun-
ner and prototype of today's United States Agency for International Develop-
ment (USAID). In 1946, after two years as a Smithsonian Institution (SI) visit-
ing professor in Mexico City, I returned to Washington. There, in 1951, my
contact with the IIAA was renewed when SI colleagues in several Latin Ameri-
an countries and I carried out an initial study of aspects of the institute's work

in public health. Our report (Foster, 1951), which stressed the cultural and so-cial "barriers" that inhibited acceptance of much of the American program, was enthusiastically received by IIAA health personnel. It appeared to answer many questions that had puzzled them, especially why new public health centers failed to attract the clients for whom they were designed. As a result, SI anthropologists were invited to join an IIAA evaluation team formed to appraise the results of the first 10 years of its health programs (Foster, 19—; 1982a).

In 1953 I accepted a professorship in the Department of Anthropology at the University of California, Berkeley, where, during the following 30 years, I served as consultant in a number of overseas technical aid projects and programs: for USAID in community development and health education in India, Pakistan, the Philippines, Indonesia, Afghanistan, Nepal, and Northern Rhodesia (today Zambia), for periods of several weeks to six months; for UNICEF and, especially, WHO, for periods of two weeks to three months in Geneva, Indonesia, India, Sri Lanka, Malaysia, Thailand, and the Philippines, with shorter stays in Nepal, Nigeria, Cameroon, and Kenya.

A considerable number of stateside and international workshops, committee memberships, and meetings also gave me opportunity to interact with international health specialists, and to observe them in action. All these experiences added to my understanding of the bureaucratic aspects of international health agencies and programs.

Types of International Health Agencies

Organizations working in the international field may be classified as follows:

1. Multilateral organizations, exemplified by the specialized United Nations agencies such as the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). The critical characteristic of these agencies is that membership is open to all countries, whose representatives collectively set policy.
2. Bilateral governmental agencies such as the US Agency for International Development (USAID), based on working agreements between the donor organization and the ministries of health of recipient countries. Although improved health is also the goal of such agencies, basic policy is set largely by the donor organization, and its activities constitute an arm of the foreign policy of the supporting government.
3. Private secular organizations such as the Rockefeller, Ford, and other large multipurpose foundations, and myriad smaller and more specialized groups that depend on charitable contributions for support. Historically, th[illegible]

organizations have stressed preventive medicine and public health measures rather than clinical activities.

4. Private religious organizations such as the medical missions that have been supported by Western European and North American Christian denominations for a century and a half. Historically, medical missions have been more concerned with curative activities than with preventive measures. They differ from the other organizations in that meeting health needs often is not a primary aim in itself, but rather a strategy to help achieve the ultimate goal of making converts. Medical missions and private secular organizations are usually grouped under the rubric private voluntary organizations (PVOs) or nongovernmental organizations (NGOs).

This chapter focuses on the multi- and bilateral organizations. Although distinctive in important ways, as huge bureaucracies conforming essentially to the procedures of governments, they are sufficiently similar to one another to permit joint analysis and comparison. Almost without exception they conform to a "donor–recipient" pattern in which specialists from technologically advanced countries work with "counterparts" in less developed countries in improving health services in the latter regions. This pattern is largely a product of the past 50 years.

By the end of World War II it was clear that war-ravaged Europe required major financial help to rebuild. This came largely in the form of Marshall Plan aid from the United States. It was also clear that during the war the rest of the world had changed significantly, and that even greater changes were an immediate prospect. European colonies were soon to become independent. They, and other countries little if at all industrialized, would need major financial and technological help in their developmental efforts, essential to achieve higher standards of living and, it was hoped, political stability. Thus was born the concept of huge technical aid programs in such fields as health, agriculture, and education, as a major arm of foreign policy of the industrialized countries, and as a field of cooperation within the United Nations and its specialized agencies (Basch, 1978).

Evolving Models of Technical Aid

From their beginning, technical assistance programs have been based on underlying assumptions judged to be self-evident by the program personnel. Tendler states the basic assumption: "Development assistance was established on the premise that the developed world possessed both the talent and the capital for helping backward countries to develop. Development know-how was spoken about as if it were like capital—a stock of goods capable of being transferred

From this it logically follows that if some people have "know-how" and others do not, those with the know-how are the proper ones to plan and execute the transfer. Technical aid and developmental planning in general are, as Korten and Alfonso point out, "based on an organizational model which assumes that the major planning decisions will be made centrally based on economic analyses prepared by highly trained technicians. . . . The decisions are made by experts far removed from the people and their needs, and implemented through structures intended to be more responsive to central direction than local reality" (Korten and Alfonso, 1981:2).

Premises change over time. This is as true of premises underlying international health organizations as of other large bureaucracies. Over the past 50 years three sequential models of the perception of problems encountered in delivering technical aid can be identified: the "silver platter" model, the sociocultural model, and the bureaucratic model.

The Silver Platter Model

In the early years of technical aid, planners and technical specialists—health personnel included—felt that their task was to attack problems with the techniques and institutional forms that worked well in industrialized countries. Although speaking only of higher education in (then) British Africa, Ashby aptly described the picture for all technical aid:

> Underlying British enterprise in providing higher education for her people overseas was one massive assumption: that the pattern of university appropriate for Manchester, Exeter and Hull was ipso facto appropriate for Ibadan, Kampala, and Singapore. . . . As with cars, so with universities: we willingly made minor modifications to suit the climate, but we proposed no radical change in design, and we did not regard it as our business to enquire whether French or American models might be more suitable. (Ashby, 1966:244)

The result was universities often poorly suited to the needs of developing countries.

In the history of international health programs, the same underlying assumption repeats itself continually: the health strategies that have served the West are universals, equally suited to Boston or Bombay. Health programs have been seen as exercises in the transfer of techniques, in the implantation of educational, preventive, and curative services based on the biomedical model, in which the major challenge is to persuade people to abandon their traditional beliefs and practices in favor of the new. As with British higher education, this assumption often has produced inappropriate and ineffective health services in Third World countries.

It was further assumed that people in less developed countries, the recipients of help, would immediately appreciate the advantages of the new ways, once

exposed to them, and that given the opportunity they would quickly adopt them. The errors underlying this "transfer of techniques" approach are beautifully illustrated by the early health program of the US Institute of Inter-American Affairs, established in 1942. The centerpiece of the program was American-type public health centers, emphasizing preventive activities in such fields as maternal and child health care and environmental sanitation. Initially these centers failed to attract anticipated patronage. Behavioral research revealed that in countries where people have limited access to modern health care, they are uninterested in prevention until their first priority (treatment of illness) has been satisfied. Only after curative services—initially lacking—were added did health centers begin to play an important health role (Foster, 1952).

The Sociocultural Model

By the mid-1950s this early ethnocentric view of technical aid began to give way to a new approach which postulated that the major problems in the transfer of advanced technologies, including those of the health sciences, are rooted in the society and culture of the recipient peoples, and that programs and projects aimed at redressing poverty, poor health, inefficient agriculture, and illiteracy must be designed to fit the needs and expectations of these people. The populations toward whom these programs are pointed, it is argued, want to raise their standards of living and are willing to modify their behavior when they perceive advantage in the new ways. But psychological, social, and cultural "barriers" inhibit these changes. Consequently, if these barriers can be identified through sociocultural research, and if the motivations to change can be identified, then developmental assistance can be presented in such a way that client peoples will eagerly accept it. This model represents an enormous advance over the silver platter model. As far as it goes, it is correct. Without an understanding of the local community, its worldview, and its comprehension of the innovative alternatives presented to it, planners and technical specialists are working blindly.

The Bureaucratic Model

Even the most sophisticated applications of the sociocultural model, however, often failed to produce the desired results. Little by little we have come to realize that not only is it important to understand the recipient's culture, but it is equally important to understand the sociocultural forms of innovating organizations. Just as barriers to change are found in peasant communities, so are they found in the structure, values, and operating procedures of development bureaucracies, and in the individual personal qualities of planners and change agents. In other words, the bureaucratic model says that to develop the most effective aid programs it is essential to understand the culture of the agency

developing and guiding a program, as well as the national and internatio[illegible] sumptions (both conscious and unconscious) that shape bureaucratic cu[illegible]

For many reasons, the bureaucratic model has been less completely a[illegible] than the sociocultural model; many health personnel still reject it, insisti[illegible] the community, and the community alone, is the problem. It is easy to [illegible] the sociocultural model has been so readily accepted: it is nonthreaten[illegible] agency personnel, for the problem is defined as "out there," away from the [illegible] ters of policy, planning, and program operations. No one in the innovating [illegible] nization need feel responsible, or on the spot, in accepting this model.

Even for those who realize the validity of the bureaucratic model, it is [illegible] psychologically difficult to admit that "we are a part of the problem." [illegible] reluctance to attempt the innovative action that the bureaucratic model calls [illegible] of course, is psychological. Staff members of bureaucracies fully understa[illegible] limits of their organizations, of their inherent rigidity, and of the many cons[illegible] they place on reflective thinking and action. Since efforts to bring about [illegible] organizational changes so often seem futile, staff members find it easie[illegible] cept organizational norms as a given, and to place their hopes on chang[illegible] community forms that will make clients more receptive to their programs. [illegible] haps they are realistic in taking this position. Certainly the changes in tradi[illegible] communities since the end of World War II suggest that they can indeed cha[illegible] more rapidly than entrenched bureaucracies.

Bureaucracies as Sociocultural Systems

In their structural and dynamic aspects, bureaucracies are much like commu[illegible] ties. Normally they are composed of people of both sexes and different ag[illegible] organized in a hierarchy of authority, responsibility, obligations, and functio[illegible] tasks. They also have social structures that define the relationships, roles, [illegible] statuses of their members. Through formal and informal educational metho[illegible] new members of bureaucratic societies learn appropriate role behavior and th[illegible] values, routines, and premises that guide the organization.

Bureaucracies further resemble communities in that they are integrated, fun[illegible] tional units in which the parts fit closely together; consequently, no chang[illegible] occurs in isolation, without rearrangement in the role relationships of the mem[illegible] bers, without increasing the responsibilities and authority of some and dimin[illegible] ishing those of others. Like community members, the personnel of large orga[illegible] nizations jealously guard their traditional perquisites and privileges; they do no[illegible] easily surrender their vested interests, except in exchange for something as goo[illegible] or better. They rationalize their positions by assuring themselves that what is good for them is best for the organization.

Bureaucracies also resemble communities in that, within norms of behavior [illegible]values, individual members exhibit great variation in ability, character, per[illegible]ality, views, and judgment. The personnel of bureaucracies are not simply [illegible]riers of their organizational cultures; they are also psychological beings need[illegible] ego gratification and satisfaction from their performances. They are charac[illegible]ized by emotional securities and insecurities, likes and dislikes, hopes and [illegible]oubts. Sometimes they feel successful in their accomplishments, and at other [illegible]mes they feel threatened or rejected. To understand the working of bureau[illegible]acies, it is essential to pay attention to the ever-present psychological dimen[illegible]ion of personnel.

Evaluating International Health Agencies

The identification and evaluation of the strengths and weaknesses of interna[illegible]onal health organizations is a highly subjective exercise. A pessimist will look [illegible] the world's unmet health needs and conclude that, a half century after their [illegible]ounding, these agencies fall far short of what was expected of them. An opti[illegible]mist, comparing contemporary world health levels with those prevailing at the [illegible]nd of World War II, can only conclude that the agencies have accomplished much more than might have been anticipated. For the fact is, as pointed out earlier, enormous strides have been made in meeting the world's health needs, particularly in developing countries. That much remains to be done is more an indication of the magnitude of the task than of the shortcomings of health organizations.

International health agencies have helped significantly in raising world health levels by a variety of means: they have attracted able and dedicated administra[illegible]tors and technical specialists and they have drawn on the latest biomedical knowl[illegible]edge of the world's medical research institutions. By means of travel grants, traineeships, and fellowships for Third World health personnel, they have helped strengthen indigenous ministries of health and health care facilities in the coun[illegible]tries concerned.

It is widely assumed that multilateral agencies have major advantages over bilateral ones. In the case of WHO, for example, all member nations can feel that this is *our* organization, no longer dominated (as in the early years) by the West. In the WHO annual General Assembly there is opportunity for broader input and discussion of a wider variety of concerns and ideas than in any bilat[illegible]eral program. Moreover, the continuing interaction of personnel from many countries in the same office permits dialogue on a wide spectrum of ideas that cannot be achieved in an organization largely representing a single cultural tradition.

Worldwide campaigns such as smallpox eradication, immunization against childhood illnesses, and oral rehydration therapy to treat infant diarrheal diseases can be pursued with a vigor and degree of support impossible for any bilateral agency. And, with respect to educational and legal efforts to persuade mothers to nurse rather than bottle-feed their infants, the multilateral organizations do not suffer the political constraints imposed on some of the bilateral agencies. There are problems, of course, as when member nations insist that specific diseases are not found within their borders. For example, when the first cases of AIDS were recognized in 1983, many African governments refused to acknowledge cases within their borders. Yet it has proven easier for WHO to persuade these countries that they must be involved in AIDS control than it would have been for any bilateral agency.

For reasons like these, increased channeling of health aid through multilateral institutions has emerged as an attractive solution to many of the problems encountered in bilateral programs. Yet the evidence is not all one-sided. Basch states the problem: "This step, it is asserted, would reduce many of the tensions and obligations implicit in bilateral arrangements, distribute aid on the basis of need rather than political loyalty, and make assistance contingent on policy reforms backed by world opinion." Yet, he continues, "while this may be so, multilateralization introduces into the ODA [official development assistance] picture at least a third bureaucracy with its inherent red-tapism, delay, and administrative expense, and it blurs the special relationships and specific mutual interests of the parties concerned" (Basch, 1978:339). Moreover, at times, bilateral organizations can innovate in ways that the multinational organizations, for all their strengths, cannot attempt for policy reasons.

Problems Encountered in International Health Agencies

In considering the problems encountered in international health agencies, and in looking for ways in which their effectiveness may be increased, we are dealing with "the art of the possible" (Ramalingaswami, 1986:1097). Some of the factors that prevent health agencies from realizing their full potential are inherent in all bureaucracies and little can be done about them. Other problems, however, seem self-imposed; with innovative action from within the organization they can be significantly reduced, to the benefit of the agency and its clients. Examples of both follow.

Rationalizing Budgets

Agencies never have all the financial resources they believe they can spend profitably. Hence officials of all bureaucracies do the natural thing: in requesting

funds for future activities they cast their past achievements in the best possible light and describe future plans in the most glowing terms. International health agencies are not immune to this exercise. To justify their budget requests they need quick results, especially results that can be counted: numbers of latrines installed, children vaccinated, and family planning methods demonstrated. Long-range strategies that take time to produce results suffer in comparison to programs such as these. Again, the need to show that the organization is forward-looking creates pressure to generate new projects simply for their own sake, often without adequate research and evaluation of all of the implications of the proposal. Moreover, the launching of new projects may necessitate the dropping of promising ongoing projects before they have had time fully to demonstrate their potential.

Limited Corporate Memories

Health agencies, like other corporate groups, often seem marked by what can be called a "limited corporate memory"; only with difficulty do they learn from their own past, and they fail to draw on the relevant prior experience of others. For example, by the end of World War II the history of medical missions, and data from the early Rockefeller international health programs and other cross-cultural health activities, contained invaluable information about strategies most likely to produce results in designing and carrying out health projects in developing countries. Yet when the major multilateral and bilateral agencies began their work 50 years ago, they paid little attention to this wealth of experience. Consequently, they repeated mistakes made many times in the past, mistakes which might have been avoided.

More recently, the concept of primary health care (PHC) offers a similar picture: the reinvention of the community development (CD) wheel of 20 years earlier. In this process international health agencies have made many of the same mistakes and suffered the same disappointments as the earlier enthusiastic CD advocates (Foster, 1982b; Muhondwa, 1986). As Bichmann writes,

> There are surprising analogies between the PHC and the CD approach . . . but in the documents promoting the PHC-strategy, no clear reference to this fact is given. . . . As PHC with its comprehensive approach encompasses sector-external health-related subjects like agricultural development, road infrastructure, education, etc. so did the CD programmes of the fifties and sixties aim at integrated rural development including health-related activities. . . . Generally speaking, CD did not yield the expected results on a nation-wide scale. . . . Why then should PHC produce a better outcome than CD? (Bichmann, 1983:7)

It is difficult to tell whether failure to consider prior relevant experience is inherent in bureaucratic structures, or whether it reflects a reluctance of per-

sonnel to diminish the appearance of their creativity by giving credi[illegible]
Whatever the explanation, in contrast to budgeting problems, whi[illegible]
insoluble, appropriate research resources *can* improve the corpora[illegible]
problem. After all, learning from experience is commonplace.

Constraints Imposed by Agency Doctrines

Bureaucracies usually must develop policy in the absence of much of [illegible]
mation that ideally should be available. The dangers inherent in this [illegible]
can be guarded against partially by periodic reviews of progress and by [illegible]
policy as flexible as possible so that course corrections can be made as [illegible]
Policies, like engineering designs, should not be frozen until all the pro[illegible]
have been solved. In international health agencies, however, it sometim[illegible]
as if ideologically attractive but untested policies are raised to the level [illegible]
trine more because of the enthusiasms and special professional interes[illegible]
in a position to make such decisions than because of objective conside[illegible]
what is known. And, once policy becomes doctrine, it is the rare staf[illegible]
who can afford to question it. The life expectancy of whistle-blowers in [illegible]
cracies is not long.

The concept of community participation (CP) as a major componen[illegible]
mary health care strategies illustrates this point. First broached as a [illegible]
ing PHC approach in 1975 in WHO's widely quoted *Health by the* [illegible]
(Newell, 1975) and in the study *Alternative Approaches to Meeting Bas*[illegible]
Needs in Developing Countries (Djukanovic and Mach, 1975), CP was ele[illegible]
to the level of doctrine on the basis of the 1977 UNICEF–WHO Joint [illegible]
mittee on Health Policy report, "Community Involvement in Primary [illegible]
Care. A Study of the Process of Community Motivation and Continu[illegible]
ticipation" (WHO, 1977).

This study illustrates a common bureaucratic practice: the use of res[illegible]
to legitimize previously decided-upon policies rather than to provide da[illegible]
judging the desirability of the policies. There are good things about the [illegible]
analyzes, and draws conclusions from, case studies of projects in each [illegible]
countries in which it can be argued that the community had indeed bee[illegible]
volved." However, a tenth case study was excluded from the final draft [illegible]
its findings were contrary to the desired conclusions. In fact, in no sens[illegible]
the sample random, and no serious effort was made to consider nega[illegible]
dence. The study disingenuously notes that "time did not permit an exh[illegible]
study," and the methodological weaknesses of the report are made clear. In spi[illegible]
of these obvious limitations, the report was accepted as the solid eviden[illegible]
which the role of CP was spelled out in the 1978 Alma-Ata Conference on [illegible]
mary Health Care (WHO, 1978).

[illegible]ommunity participation has been the subject of a number of subsequent [illegible]O meetings and studies, none of which has seriously questioned the validity [illegible] the idea. It continues to receive ritual obeisance within the organization, in [illegible] of the fact that this approach—as with community development—usually has produced meager results in the Third World.

Constraints Imposed by Western Ideologies

[illegible] international health agencies, basic policies, program priorities, and doc[illegible]nes are presumed to reflect the considered judgment of objective and dispas[illegible]onate health professionals. Often they do. Yet there are always supraorganizational influences underlying the policy-determining process, the impact of which is not always appreciated. Stone suggests that the "cultural imprint of the West" is manifest and expressed in "the rhetoric and the fads," and in the style and ap[illegible]roach of development. "It is as though the world of international develop[illegible]ment, although ostensibly geared toward maximizing its relevance to the poor [illegible] the Third World, has become like a mirror in which the values, interests and philosophies of the West are found reflected" (Stone, 1989:206). Com[illegible]munity participation, which "now stands as an established development strat[illegible]egy," is an example: the concept entails the Western values of self-reliance, equality, and individualism, values to which most of us subscribe. Yet, she points [illegible] it is a mistake to assume that these values equally characterize Third World communities.

Contemporary international concerns with nutrition and interest in "women in development" also reflect a contemporary Western ideology, Stone believes:

> Nutrition is now a major and growing focus in development programs. And regardless of the scientific soundness of this focus, the fact remains that nutrition loomed as a major thrust in international development circles at the same time as "nutrition" became a subject of great popular fascination in the United States. Nutrition programs multiplied in the Third World around the time that the Americans began to criticize their junk food, measure their cholesterol, and to perceive sound nutrition as a solution to *their* problems.
>
> Another, perhaps more pointed, case is "Women in Development" (WID), now a major concern within virtually every development agency in the world. Again, regardless of the value or soundness of WID programs, they did not arise from the expressed interests and felt needs of the masses of the Third World poor. Rather, a development focus on women grew from the fact that the status of women, and attendant questions of sexual equality, became burning issues in the West. (Stone, 1989:206)

Of course, the cultural ideology of the West as reflected in the international

in development." It constitutes a basic statement about a sociopolitical and economic system, the correctness of which is self-evident to its leaders and most of its people. The bilateral health agencies must operate within the constraints of this ideology. They must be cautious in advocating policies such as major land reform and wealth redistribution, even though sociopolitical and economic changes in much of the world are seen by program planners as necessary to achieve higher health levels. The multilateral organizations are somewhat more flexible on these points; they can advocate socialist as well as capitalist responses to health needs. Yet they, too, can go only so far, since withdrawal of the financial support of the West would render them impotent; they must walk a fine line indeed.

Constraints Imposed by Professional and Personal Characteristics of Agency Personnel

Bureaucrats do not, and cannot be expected to, function with formalistic impersonality. They have likes and dislikes, prejudices, friendships, and enmities. These, and many other personal characteristics, influence their role performances, and hence the functioning of their organizations. Personality traits like these are individual. Other personality traits may be thought of as group-based, characterizing the members of professions, and professionals as a class. These also affect the performance of individuals and, consequently, organizational activities. Competent professionals have a positive self-image; they have confidence in their ability and they take pride in their work. Some professionals work quietly, satisfied with the knowledge that they are doing a good job. But many more exhibit—or conceal with varying degrees of success—a need for ego gratification, which comes from recognition by their peers. Hence they like to promote activities in which they can demonstrate their professional skills. Sometimes this leads to confusion of personal and organizational needs.

Pride in performance and a positive self-image obviously are important elements in stimulating the best possible work. But when present in excess, in projects where cooperative efforts and intersectoral policies are desirable, these personal-professional factors can jeopardize planning and program operations. For, carried away with enthusiasm, some professionals readily believe that their contributions are the key to program success and that they should have first call on resources. In primary health care, for example, lip service is paid to the importance of integrated programs that include agriculture, education, access to water, and the like. Yet few whose primary field is health doubt that health activities—and particularly their own specialties—should receive first attention.

The policies, programs, and priorities of large organizations, including those concerned with international health, reflect a pair of processes: a public and explicit planning mechanism, *and* the often private professional concerns and enthusiasms of powerful individuals and groups within the organization.

Competition for Clients

Bureaucracies, international health agencies included, need clients to justify their existence. The worst thing that can happen to such a bureaucracy is to solve the problems it was set up to solve, and thus to be left without clients. At least two groups of clients of international health agencies can be identified. The first is the individual community member, a human being in need of health protection and care. There are adequate numbers of these clients, enough for everyone searching for a client, and the supply will not dry up. But help to community members is filtered through intermediate clients, the health ministries and services of the countries receiving developmental aid. In contrast to community members, these clients *are* limited in number; there are not always enough of them to satisfy the needs of all organizations involved in international health work. This leads to competition among donor agencies, with results sometimes inimical to the host country's best interests.

Sterling gives a vivid picture of such competition in Kathmandu in the mid-1970s:

> At last count when I was there, about 700 missionaries of progress were racketing around town in their Land Rovers and Toyota jeeps, representing some fifty donor-states and agencies, all urging assorted projects on a nation the size of Arkansas. Among the foreign benefactors are USAID, the Indian Cooperation Mission, the Chinese, Russians, British, Canadians, Australians, New Zealanders, Pakistanis, and Swiss, the Japanese Overseas Cooperation Volunteers, the German Volunteer service, the Ford Foundation, the Rockefeller Foundation, the Dooley Foundation (using volunteer airline hostesses who take six months off for good works), Anglia University, Cornell University, [and] the World Bank. (Sterling, 1976:14)

And these are only a few examples. Such an abundance of foreign aid stresses the capacity of many Third World governments to provide the counterpart services and personnel expected by most development agencies.

The Workshop Syndrome

Meetings are the lifeblood of bureaucracies. The simplest form is that well-known bureaucratic phenomenon, the staff meeting. At higher levels meetings take the form of longer regional and international conferences and workshops. The numbers, varieties, and frequencies of such meetings in international health organizations are quite dazzling: USAID meetings in Washington, UNICEF meetings in New York, WHO meetings at headquarters in Geneva and in the regional offices.

One is led to speculate as to their raison d'être. Some justifications are obvious: it is important that world leaders in various health fields meet and discuss common concerns, that they assess the gravity of health threats (such as AIDS),

that they take stock of progress in controlling diarrheal diseases, and that they plan future activities. Major workshops can play another important role, that of validating organization policies and programs. For example, Justice writes of Nepal that "Kathmandu officials place great importance on high-level conferences because they are a visible activity that extends legitimacy to programs such as ICHP [Integrated Community Health Program]" (Justice, 1986:78).

Beyond these obvious justifications there are latent reasons why the pattern is so popular, particularly in multilateral organizations. This has to do with the nature of professional employment in Third World countries, and with the attraction of a career in the United Nations agencies. In developed countries employment in international health organizations can be challenging and interesting, and professionally desirable. But whether the agency is public or private, compensation is comparable to that in many other lines of work. To land a job with USAID is not, for an American, a particular financial plum and if, for any reason, a technical specialist leaves the organization, comparable employment elsewhere is a reasonable expectation.

But the picture is quite different in WHO, for example, where a majority of the professional jobs are now held by physicians and other health specialists from Third World countries. For them a WHO (or UNICEF, or World Bank) appointment *is* a financial plum. At international salary levels they enjoy a standard of living far above what they might otherwise expect, in addition to early retirement, a generous pension, international travel, and association with colleagues on a regional and worldwide basis. Consequently, such appointments are eagerly sought after. In comparison to professional colleagues in their home countries, Third World UN staff members are a highly privileged group. They are, however, vulnerable: to dismissal because of poor performance, or performance deemed dangerous to the well-being of the organization; and to the envy of their less fortunate national colleagues.

Vulnerability, of course, leads to cautious behavior. Tendler illustrates this point in her analysis of USAID, where she found that "outpost-level" employees responding to the uncertainties of Washington political and interagency constraints opted for "a kind of safe-for-all-occasions, problem-avoiding" approach to their jobs (Tendler, 1975:25). But what is safe behavior? Talk and discussion rather more than vigorous action. I believe that multilateral health organization meetings, many on the same topic, repeating similar general recommendations (always calling for further study of the problem), at least to some extent fulfill the role of providing visible evidence of concern with health problems, in an activity that carries minimal risk to participants.

I have noted, particularly in the regional offices of WHO, that, in addition to providing safe-for-all-occasions activities for permanent staff members, conferences and workshops also fulfill an envy-reducing role vis-à-vis national colleagues who would like to, but do not, hold similar appointments. For the latter

occasional participation in WHO regional meetings is attractive for financial and prestige reasons. Temporary appointees receive both a daily honorarium for services rendered and a per diem to cover away-from-home expenses. These payments are very attractive to health personnel in many Third World countries, where salary scales are low by international standards. Especially when participants stay with local friends (often the case), thus saving most of the per diem, payment for a two-week meeting may equal several months of regular salary. National participants of regional meetings also have the satisfaction of feeling that they are a part of the international action and that, although they lack the status and salary of permanent WHO employees, at least they share peripherally in the good life provided by the organization.

Unfortunately, this pattern of sharing may reflect patronage behavior not consistent with the highest levels of professional practice. Since regional conference participants usually are nominated by national health authorities rather than the meeting organizers, administrators often appoint faithful staff members whose turn to travel has come, rather than individuals whose qualifications best fit the conference specifications. Consequently, workshop participants often have little notion as to the goals of the meeting; at best they are dead weight, and at worst they squander valuable time with extraneous talk.

Poor Quality of Behavioral Research

A good deal of the behavioral research carried out by international health organizations has been of poor quality. I have described (Foster, 1987) how in WHO in the early 1980s bureaucratic constraints and the research assumptions of the medical profession significantly inhibited first-class investigations. I suggested that "even the most comprehensive statements on the importance of behavioral research stress communities, not health services. Health bureaucracies operate on the assumption that the purpose of behavioral research is to find out how to persuade target populations to change their behavior more nearly to conform to what health projects call for" (Foster, 1987:711). It is taken for granted that health care delivery programs, in spite of minor shortcomings, are the appropriate vehicle for raising health levels.

Probably it is unrealistic to expect that behavioral analysis will ever play much of a role in policy and planning activities. One part of the problem is that behavioral research rarely is concerned with administrative organizations. To illustrate, the concept of "community participation," an often-enunciated international health doctrine, sounds attractive as a basic policy. What could be more democratic than inviting villagers to join government administrators and planners in deciding how best to meet local health needs? Yet experience shows that those in positions of power in centralized governmental systems are rarely willing to

not the concept of community participation is diametrically opposed [illegible] istrative policies, which do not change easily.

A second part of the problem is how to incorporate behavioral [illegible] into the planning process. Time constraints inherent in the bure[illegible] cess place a premium on rapid decisions. Although good behavior[illegible] can be done more rapidly than is sometimes thought, it takes time for [illegible] mation to work its way up the ladder. In any event, high-level officials [illegible] the utility of behavioral information. To illustrate, in Nepal Justice [illegible] officials in donor agencies and in government "generally agreed that [illegible] information is rarely used in planning." Among the reasons given was [illegible] that such information was not available, and "when it was available, [illegible] very useful" (Justice, 1986:111). In the case of USAID's project paper [illegible] its Nepal health and family planning programs, Justice found that the "social [illegible] ness analysis" was condensed to three pages (plus eight in the appendix). [illegible] representatives whom I interviewed implied that it was included primarily [illegible] formality to fulfill the requirements specified by Congress" (p. 116).

For reasons such as these, behavioral research in international health [illegible] zations probably will continue to play a minor role, largely limited to the [illegible] fication of social and cultural factors that are relevant to community accep[illegible] or rejection of health programs decided upon by distant planners, prog[illegible] which the community has had little input.

Rebuilding Agencies for International Health

This chapter raises a number of questions that must be addressed by interna[illegible] tional health agencies if they are significantly to improve their performan[illegible] They include, but by no means are limited to, the following:

1. Can the reflexive bureaucratic model be institutionalized so that [illegible] realistic premises will underlie the definition of problems in health pro[illegible] gram planning?
2. How can corporate memories be strengthened? How can the necessary resources be built into large organizations so that they are better able to profit from their own past experience, and from relevant experiences of other organizations?
3. How can the dangers of the early enunciation of policy doctrines restrict[illegible] ing innovative thinking in international health organizations be avoided?
4. How can the threat of attempting to satisfy Western ideological concerns by incorporating them into international health planning be controlled?
5. To what extent do professional-personality factors impinge on planning processes? Does overall balance in projects suffer because of the influ[illegible]ence of powerful personalities? Or is an occasionally adversarial process the appropriate way to determine organizational policies?
6. How serious is the "competition for clients" syndrome in development assistance programs? Can, or should, anything be done about this problem?
7. Does the "workshop syndrome" divert international health agencies' personnel from other activities to the extent that overall goals of the institutions are compromised? Should the number of meetings be limited?
8. How can the scope of behavioral research in international health agencies be broadened to include not only client groups but also the agencies that plan and carry out assistance programs? What can be done to ensure greater use of such research in setting policy and in program operations?

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APPENDIX

Resources in Anthropology

Medical Anthropology

General

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