

LAT  
614  
U26

PA-ACI: 6/6

PA 72575

POLITICAL AND ORGANIZATIONAL ISSUES IN ASSESSING  
HEALTH AND NUTRITION INTERVENTIONS

Antonio Ugalde,<sup>1</sup>  
Robert Emrey,<sup>2</sup>

Paper Prepared for The  
CONFERENCE ON THE MEASUREMENT OF THE IMPACT OF NUTRITION  
AND RELATED HEALTH PROGRAMS IN LATIN AMERICA

1-4 August 1977

Panama City, Panama

1- Department of Sociology  
University of Texas, Austin, Texas

2- Health Education and Welfare  
Rockeville, Md.

POLITICAL AND ORGANIZATIONAL ISSUES IN ASSESSING  
HEALTH AND NUTRITION INTERVENTIONS

by

Antonio Ugalde, University of Texas,

and

Robert Emrey

Health and nutrition assessments are part of the policy process. Research in health and nutrition policymaking is severely constrained in Latin America by the relatively few studies of the Latin American political process. It is difficult to single out causes for this academic apathy, but it could be conjectured that the very nature of the social structure, the hispanic heritage of caziquismo, and the military prevalence are all contributing causes for the absence of the scientific study of political systems. The few available studies by national intellectuals either are traditionally oriented toward constitutional and legal aspects of society or are heavily influenced by the work of foreign scholars.

In fact, much of the political research available has been conducted by foreign researchers. In the same way that in the Nineteenth Century British anthropological studies in Africa were promoted and supported because of England's interest in controlling the colonies, today's foreign political research in Latin America responds to economic and political interests, if not of the scientists at least those of their governments. The asymmetric research relation between the United States and Latin America has been pointed out by many scholars (1). For every Latin American studying the United States, there are hundreds of North Americans studying their southern neighbors. The asymmetry extends to library facilities, research centers, and manpower resources.

Leaving aside the very important question of the political and economic effects of this intellectual dominance, there are some very practical implications for those who want to do health and nutrition planning analyses. Foreign researchers have brought with their research designs that are more applicable to the study of their own policy process and have chosen topics which fit well within the political interests of Western democratic systems. An emphasis has been placed on the study of political parties, voting behavior, and legislative bodies. Other areas more important in the Latin American political process have remained less investigated, for example the role of the bureaucracy in policy making or the political dimensions of programming and implementation (2). Distortion of the Latin American policy process has also resulted from the cultural ethnocentrism or political culture of foreign scholars who assumed that by definition Western political systems were superior to all others.1/

The effects of foreign influence can be appreciated by the following discussion. In advanced Western societies it was believed until very recently that the most important aspect of the policy process was policy formulation.<sup>2/</sup> It is there that the political fight concentrates and where lobbying plays an important role in policy outcome. Based on the doctrine of division of powers, implementation was seen as a routine and bureaucratic matter. Failures in implementation were considered administrative anomalies which could also be remedied by administrative actions. By definition, anomalies are rare and consequently there has been very few studies of the implementation process. For example, Pressman and Wildavsky (3) after an exhaustive study of the literature concluded that there were only a handful of relevant studies on implementation. Obviously, in almost all Latin American countries the division of power does not exist; policy formulation takes place under very different circumstances. The concept of lobbying, for example, has not been institutionalized. Health policy formulation in most Latin American countries is the responsibility of the executive branch. Even in countries with constitutional separations of power, congresses have seldom had an input on health matters. For example, in Colombia with an elected congress and departmental assemblies, one of the coauthors uselessly researched through the congressional records to find any references to health. A departmental health secretary was asked how many times he had been summoned by the departmental assembly for health hearings during his four-year term and he instantaneously replied: Never!

Outcome measurement (the concern of this entire conference) is related to organizational and political factors in a complex of ways which is poorly understood and which can be described only in rough terms. A simplified version of a systems model is introduced in the following section of this paper to facilitate understanding of these complex interactions in organizations. Elements in this model are then discussed as to their feasibility of measurement for evaluation purposes, based on two social science perspectives: the sociology of knowledge and political sociology. Then, an attempt is made to apply the framework to the study of health policy process, and a short case study is presented to illustrate these points. Finally, conclusions are presented regarding the usefulness of further studies of policy making and ways in which social science models may be used to encourage evaluation in operating agencies.

#### Organizational model

The ultimate purpose of program evaluation is to confront program outcomes with the manifest intent of the policymaker. A narrow view of outcome measurement might produce results that satisfy the technician but which are irrelevant for the solution of social problems in developing nations. At times such measurements could even be contrary to the welfare of the majority of the population. Evaluative measurements cannot be taken in a political or organizational vacuum. In this section we provide a tentative model of organizational activity relating political and administrative factors to program impacts and outcomes.

The focus of attention in program evaluation is assumed to be on a particular organization and a particular population served. These organizational units of analysis may be international, national, or local agencies and may come under public or private control. A view of that organization as a living system would reveal certain, more or less, permanent features such as money provided to operate it, people employed, services produced, and a variety of other less tangible phenomena which influenced the ways the organization operated over time. These intangibles would include enacted policies, worker attitudes, political support, and economic conditions. The organization viewed from this perspective contains a variety of complex, interacting elements. In the simplified form shown in Figure 1, the organization takes on a structure in which certain elements are within the organizational boundaries, but where many significant parts are in the environment outside.<sup>3/</sup> The administrative and political characteristics of the organization will

PUT FIGURE ONE HERE

influence the policies adopted and services provided as do policies and funds from agencies outside the organization. As programs are implemented, various changes occur within the organization, including effects on services provided and the working conditions of employees. These changes we will call program impacts. As services are produced, various changes will occur also in the outside community. These changes we will call program outcomes, meaning those changes in the population served which are being discussed at this conference. These population outcomes occur in the larger context of a country's social and economic conditions, cultural patterns, and historical experiences which constantly influence the manner in which the organization operates. Program evaluation is usually defined as the systematic comparison of a social intervention policy with the resulting impacts and outcomes.<sup>4/</sup>

A brief description of how the model may be applied will illustrate these features. An imaginary Ministry of Health operates a limited program to immunize children against polio. The people served by this agency may be characterized as having low incomes and not experienced in seeking immunization services. A recent rise in the incidence of polio is discovered. News of the polio outbreak is viewed with alarm by some Ministry personnel and with indifference by others. Political and administrative factors, including the availability of funds, the interest of the President in the outbreak, and the other demands requiring Ministry attention, will help determine the response of the Ministry to the outbreak. Also, significant policies of other organizations will influence the Ministry, such as availability of international agency vaccine supplies. Within the general policies and procedures of the Ministry, a policy which gives major attention to polio immunization might be adopted. The policy will probably have some effect in providing people with immunizations, but the policy may not be implemented in the way one might expect. When the policy is being implemented, the working conditions of the Ministry may change drastically, such as in the event of a rapid

effort to immunize many communities in a short time. The outcome of the changed policy toward polio immunization may include a reduction in polio incidence, a rise in request for other medical services, and a deterioration in other aspects of community life. The measurement of program effects (impacts and outcomes) is always part of this larger complex of factors. With this perspective on the components of program evaluation and measurements of program effect, let us turn to the applications of such evaluation.

Social measurements are of growing interest to international agencies, bilateral donor agencies, private and voluntary organizations, and developing country governments. For purposes of this paper, these organizations will be our units of analysis. The evaluation methods developed in North American organizations have served purposes which may or may not be present in the agencies discussed here.

The exportation of evaluation technologies from one country to another needs to take into account among other factors, the differences in political and administrative systems (4). Two of the ingredients driving North American evaluation efforts are missing or less influential in Latin America: legislative interest and university involvement. Latin American legislatures often are not influential, are without investigative resources, and may hold office for only brief periods. University researchers may have little access to opportunities for study of social conditions or governmental processes, have few resources for systematic data collection and analysis, and may not be encouraged to produce theories of social or governmental process. The importation of evaluative technologies to Latin American settings faces very real differences in social, economic, and political conditions which may greatly affect the uses of evaluative information. Further elaboration of the internal dynamics of the model is presented below in a discussion of policy goals and program implementation.

#### Social and Political Criteria for Outcome Measurement: A Frame of Reference.

In every facet of nutrition and health planning, the planner encounters dimensions of social behavior. It is known for example, that the utilization of health care facilities responds to social norms, that it differs from social class to class and from culture to culture (5). Similarly, modalities of purchasing health care are related to each society's understanding of the role of the state, the dignity of life and human rights, and of the nature of the economic system. As Hamilton (6 p.64) put it: "Wants are social phenomena, the product of cultural conditioning." The anthropological literature contains a myriad of examples describing food taboos, eating habits, symbolic and ritual uses of food in different cultural settings which health professionals and nutritionists have decried as inimical to normal physical growth, and western economists from their cultural vantage point have considered highly irrational. Community organization--the very essence of social behavior and community participation--

-the very essence of political behavior--are now considered more and more by health planners to be fundamental for the expansion of health care coverage, for the administration of preventive health programs such as rural aqueducts, and for the improvement of the nutritional status through community gardens and other modalities of collective organization.

Latin America health planners have been extracted predominantly from the medical profession, and medical training has not prepared its professionals--there is no reason why it should--with a solid background in the behavioral sciences. As a result, an important dimension of health planning has been left out, and only after trial and error have medical health planners "rediscovered" that values, norms, and ideologies condition human and social behavior. It should be acknowledged that health planners are now aware of the social dimensions of planning and various social sciences are being incorporated--albeit in secondary roles--into the health and nutrition planning efforts.5/

What perhaps is less known, and it will be equally unfortunate if health planners take ten more years to rediscover it, is that social science theory is influenced by the values and ideologies of the scientists and that a value free social science, although highly desirable does not exist at this point in the history of mankind. Sjoberg and Nett (11, p. 3) have pointedly observed: "The researcher himself is a variable in the research design. He influences the course of any research venture he undertakes and his actions are in turn structured by the broader society in which he lives." Myrdal (7, p. 13ff) is more blunt when he says: "What must be emphasized is that all knowledge and all ignorance tends to be opportunistic... A disinterested social science has never existed and never will exist." Of course, it was Mannheim (8) who some years ago made the disturbing claim that the scientist's own social class conditions his knowledge. Mannheim's own advice to intellectuals to detach themselves from their social class trappings is worth noting and advocating even if it does not guarantee a value free science.

The selection of research tools, including data collection techniques and analytical procedures, are themselves a reflection of the conceptualization that the scientist has of the social reality.6/ The traditional conflict between soft and hard techniques goes deeper than the researchers' own preferences and likes. Methodologies reflect theoretical constructs which in turn reflect philosophical views of reality. For illustration, let us consider two differing approaches to the study of social situations: the "symbolic interactionist" and the "empiricist". Whereas symbolic interactionists would study actors' behavior without use of survey instruments, empiricist would look at response to given survey questions without examining the effects of survey on the respondents.7/ Many social scientists, now agree that theory influences the choice of methodologies and that different methodologies are instrumental in the development of different theoretical approaches (9-11).

Following this reasoning, two logical conclusions can be made: (1) if social planning, within which health and nutrition should be placed, includes

an important social science component, then social planning is influenced by the values, ideologies and conceptualizations of reality held by the actors (planners). For example, whether a social plan is based on structural-functional or conflict theory, depends on the understanding of social reality of the actors.<sup>8/</sup> If program evaluation is part of social planning and social planning is part of the policy process, then program evaluation is influenced by the values, ideologies and the conceptualization of reality of actors (evaluators). For example, in his interesting study of contemporary politics of public health in the People's Republic of China, Lampton (12, p. 202) shows that evaluation procedures responded to the perception of the nature of sanctions held by subordinates. Since perception is influenced by socio-cultural factors and sanction is a concept defined by cultural and political norms it is easy to understand the subjective foundations of evaluation.

The above considerations have paramount practical consequences. For example, it can be suggested that the selection of pilot projects and the techniques for their evaluation correspond: (a) the researcher's and evaluator's understanding of the nature of the social problem; (b) his expectation of the funding agency's response to some orientations and issues, a subtle but real political constraint to objective inquiry; (c) accessibility to data and information, a practical but also a political constraint, data could exist, but not be made available, or data are not collected or processed because some interest groups of decision makers prefer not to,<sup>9/</sup>; (d) support or authorization from the government which is heavily influenced on political-ideological grounds.

Moving to a more practical level in the Latin American scene, the sociology of knowledge approach allows us to understand why pilot projects in health and nutrition have studied almost exclusively the poor communities and the behavior of their inhabitants and much less the behavior of decision makers, interest groups and their institutional setting. It can be hypothesized that actors (researchers and evaluators) are by and large members of the middle and upper classes who tend to see the nature of the social problem (in this case poor health status and malnutrition) from their own social class perspective and from their own cultural vantage point. To avoid incrimination of one's own social, cultural, or professional group the best course of action is to study the poor, among whom social problems exist and whose value and cultural system can be changed with the least expected resistance. Their poverty is integral and includes political powerlessness.<sup>10/</sup> Social scientists who attempt to look at social problems outside their physical habitat, who prepare proposals to study the overfed (decision makers) instead of the undernourished, or the super-participant (political and economic elites) instead of the marginados will encounter difficulties in financing the research. Funding agencies are also controlled by middle and upper classes who do not see much promise and at times for obvious reasons, do not have much interest in promoting changes of their own values and cultural norms or to affect the present power arrangements.<sup>11/</sup>

An additional point which promotes the study of poor communities is that it allows extensive survey research and the use of quantitative analytical techniques. The use of control groups in poor communities facilitates sophisticated evaluation measurements which create an impression of objectivity for the funding agencies, the supporting institutions, and the researchers themselves. Studies of less quantifiable topics have less research appeal and less funding possibilities.

Two recent contrasting nutrition research projects are illustrative of the above discussion and of the influence of ideologies in the research design and the selection of pilot projects. The cases are particularly interesting because the two were conducted in the same area in rural communities in northern Cauca, Colombia, in the vicinity of Cali, a major center of nutrition and health research in Latin America. In one case a highly competent research team assumed that the causes of malnutrition were within the rural communities to be studied, an assumption which could be considered ideological or based on the perception of the nature of a problem by the researchers. Political views, professional orientations, cultural values separately or in some degree of interaction, could have led the researchers to formulate the assumption. The researchers made a logical deduction from the assumption: if the causes of malnutrition are to be found in the communities, then the implementation of solutions will require changes in the behavior of the communities. As the report indicates (13, p. 1-1): "... the implementation of the remedies for malnutrition will depend to some extent in their acceptability by the community as well as in the community's willingness to adapt itself to the required changes" (emphasis added). Once this frame of reference was established, the research design followed two logical steps: first, the preparation of survey instruments (nine in all) to identify within the community the causes of malnutrition and to determine the habits and customs of the population, and second, the identification of required changes and the design of mechanisms to insure the implementation of changes. Quantitative techniques were justified to evaluate "the accuracy of the diagnostic procedure in order to predict the outcome of the solutions" (13: 1-9).

In an independent research project, Taussig (14) a social anthropologist, did intensive field work in the same region. His point of departure was quite different from that of the FES study. Taussig assumed that the causes of malnutrition were outside the community. As could be expected, his research topic and design also were different. Instead of looking at the value system of the community, at its organization and internal dynamics, Taussig considered it more appropriate to identify the causes of malnutrition through an "... historical analysis of the politico-economic development of agriculture" in the region (15, p.15). Taussig's critical comments on the FES project are instructive:

It is most impressive how pilot projects like this one can rarely be proved to have failed ..... Couched in the positivistic experimental idiom appropriate to study caged rats, these "human laboratory" studies inevitably evade the strict test of hard science .... the results ..... can rarely be analyzed to prove that the project

has failed (or succeeded). Thus, the leapfrogging of one successive pilot project on top of the other owes far more to the greed and political skills of the professionals and academic entrepreneurs involved, and to the political needs of governments, than to scientifically convincing results (15, p. 15)

Within his frame of reference the utilization of survey techniques was inappropriate. The evaluation would be only at the macro level, and there is no possibility of control groups or quantitative measures of change.

We are faced, then, with a set of political and organizational issues which are crucial to the effective development and use of impact and outcome measurement techniques:

- (1) Under what circumstances can the research tools of the physical sciences be adapted to these social situations? It is precisely for purposes of measurement and evaluation that we social scientists have for some time attempted to borrow the more precise tools of physical science, but this in itself reflects a conceptualization of reality according to which the physical and the social world can be manipulated in similar ways. Obviously, many social scientists do not agree with this view, and their own research topics and designs reflect it.
- (2) What are the consequences when social scientists follow verification procedures and evaluation measurements which do not adhere strictly to the principles of scientific experimentation as is the situation in practically all social science research? It is possible that the research and evaluation results are interpreted by criteria other than scientific, by conjecture or intelligent guesses, and values and ideologies of actors might exercise a hidden influence. It is also possible as Taussig suggests that the professional and financial interests of the researchers biased the interpretation of findings. Alford (16) illustrated in his study of health care in the state of New York that the inconclusiveness of such research is utilized by political interests to postpone decisions which are contrary to the wishes of the decision makers. It is perhaps in this sense that Myrdal calls all social science opportunistic.

In the following section we consider the implications of this frame of reference by exploring the relationship between policy goals and program implementation.

#### The relationship between policy goals and program implementation.

Up to the present, the rate of implementation of social programs including health and nutrition plans in Latin America, have been very low.

There are probably several dozen national health plans, but very few have been carried out to any appreciable extent, and many have never even been implemented. A former Venezuelan Minister of Public Health suggests that if only a fraction of health plans would have been implemented, health conditions in Latin America would be very different (17). The question of why plans and programs which have been prepared by the bureaucracy with minimal interference from legislative bodies or pressure groups fail to be implemented by the bureaucracy itself is an intriguing one. In Western parliamentary political systems, it could be argued that the failure of implementation could be caused by the lack of interest of the bureaucracy to carry out a plan prepared by someone else. In the case of plans originated in the executive branch, compromises may have taken place during the parliamentary debates which also modify bureaucratic incentives for implementation. But, this is hardly the case in Latin America where health plans are prepared by the inner group of a centralized bureaucracy with little interference from the "outside world." Several explanations have been advanced for the dismal rate of implementation: (1) lack of planning experience--health planning is relatively new in Latin America, and very few published plans existed before 1960; (2) health planning, like planning in general, was imposed from abroad, and without internal impetus success is problematic; (3) developing countries are confronted with serious administrative deficiencies, such as shortage of qualified personnel, limited financial resources, poor physical facilities, and little administrative know-how. These limitations are real, and as we will see later, they affect the quality of planning and programming which in turn makes implementation and evaluation difficult.

It is our position that the main reason for implementation failure is to be found elsewhere, for decision makers in many countries do not utilize adequate and available data. In some cases, well trained nationals have successfully adapted PERT programming techniques only to find that they did not facilitate implementation. In the words of a health agency administrator who promoted PERT programming, "it had to be discontinued because it did not fit the political realities of our society." Our respondent touched the core of the problem. Soon after the planning epidemic had spread over Latin America, Waterston (68, p.3) in his monumental work made the observation that, in his opinion, most technical planning problems had been solved and what remained unresolved were the political dimensions of planning. Unfortunately, health planners paid little attention to his warning.

It is our view that implementation failures are to a great extent the result of health planners' misunderstanding and disregard for the policy process and their attempts to plan in a political vacuum. To say it differently, the separation between the planning and the policy process is artificial. The problem is exasperated when planning is prepared with the assistance of foreign experts who either are unaware of the political context or have a distorted view of this reality. It will be difficult if not impossible to understand that implementation failure until a better understanding of the policy process is achieved. We will need more systematic studies of the political factors affecting the formulation, programming, implementation, and evaluation of policies. Recent studies of health systems

from the perspective of political sociology are beginning to provide useful insights using research techniques which we believe are applicable to Latin America (12, 16, 18, 19).

It is understandable that a properly defined and designed policy and plan have a higher possibility of implementation than those poorly conceived. A first task is to develop evaluation guidelines for political, economic, technical, and organizational viability of policies and plans. We do not want to take the time in the analysis of some obvious traits that a policy should have such as clarity, internal and external consistency, and specificity. It should be recognized that many health and nutrition plans are very weak in each one these characteristics. Frequently, factors affecting political, economic, technical and organizational viability overlap or are different aspects of the same phenomenon. For analytical purposes we believe it is justified to treat them separately. Our main emphasis in this paper will be the study of the political and organizational dimensions, but even within these we are only attempting to outline what hopefully might be an area of increasing research interest.

Political viability. The formulation of a policy and the preparation of a plan or program could be relatively easy and rapid when activities are produced by a small inner group of a centralized ministry without inputs from groups whose interests and lives are affected by them. These groups include: labor unions, peasant leagues, professional associations, community organizations, business concerns, political parties or factions, and bureaucratic cliques. The Latin American experience has been characterized by an outpouring of hastily conceived policies, plans and programs to satisfy immediate political needs or the will of international loaning agencies. However, what was gained at this phase of the policy process was lost during the implementation phase. It is not possible to avoid political debate, and if the parliamentary forum does not exist or is not a functioning one, the decision makers need to provide the mechanisms for debate in order to achieve a minimum of consensus among the future recipients of services and those whose interests are affected.<sup>12/</sup> It should be clear that we are not advocating necessarily the incorporation of interest groups in the health policy formulation or planning: in some cases, it might be desirable, in others less so. In some countries some groups are well organized and extremely powerful, and the health planner needs to make a political decision to incorporate them or not to incorporate them in the policy process. A decision has to be made also in regard to the modality of incorporation and the selection of the groups to be incorporated. All these are political decisions, and in Latin America in the absence of parliamentary forms the bureaucrat makes many political decisions. His political acumen is as important as his technical abilities.

The failure to achieve a minimum consensus through some mechanisms of accommodation or to delineate clearly the points of conflict leads to various results:

- (1) Increase of authority leakages in the implementation process and lack of compliance within the bureaucracy itself. For example, these changes may occur among the medical doctors or nurses or

among the bureaucrats at the provincial level, which is almost impossible to correct by supervision alone.13/

- (2) Poor utilization or misuse of health and nutrition services for lack of interest, knowledge, and at times indignation by clients. This has frequently been the case in some rural health and nutrition programs or in social security systems.
- (3) Lukewarm cooperation and eventual withdrawal of other public agencies whose participation was necessary for the successful completion of a plan.
- (4) Opposition and eventual destruction of parts of a plan or program by interest groups.14/

In Latin America the need to achieve some degree of consensus is particularly important in view of the political instability that characterizes the continent. Obviously, the implementation of a plan or program prepared under one government will have no viability if the new government represents a complete ideological brake with the past, for example, in the case of Cuba or the more recent coup in Chile. However, the political instability in Latin America frequently is manifest only by a change of guards or of political groups with similar ideologies. The political crisis which characterized political instability produces ministerial shuffles or changes of ministers whose life expectancy is low (a two-year term will be a good average in many countries). It should be noticed that it is not so much the change as the unpredictability of the change, its nature and timing which makes implementation uncertain. Each minister even in cases in which the new appointment does not represent an ideological brake with the past comes to the ministry with his own ideas, projects and personnel. How much the health bureaucracy changes with changes of ministers differs from country to country and according to the political factors which forced the change. In Colombia, one of the few countries with a relatively high constitutional continuity in the last 20 years, every minister brought to the ministry his own planning director. As a former director general of a ministry of health once commented: "Our problem is that in our society the first thing that a person does when he comes to office is to undo whatever his predecessor has done." Frequently the undoing is not an aggressive attack but rather letting the plan or program die of natural causes while efforts of the bureaucracy are directed in other directions.15/ If there is little support at the implementation level (their opinions were not taken into account) and little interest at the top administration level in carrying out programs designed by a different team, then implementation will not take place. Furthermore, in health and nutrition a great majority of plans and programs require the participation of other public agencies in which similar continuity characteristics are present: under these conditions implementation will be problematic unless a minimal consensus is achieved. In sum, and contrary to what is found in some other Western democracies where policy is formulated at the lower bureaucratic units and flows upward for approval (20,p. 71ff) in Latin America the flow often is the opposite. Low stability of

top personnel produces discontinuities in programming, implementation, and evaluation.

In some societies in which some historical events have produced an ideological homogeneity, the necessary consensus might be easy to achieve; in others with great social problems and profound ideological cleavages, a minimum understanding might not be possible. In the latter cases planning might be a futile exercise. What seems clear is that expanding the participation of persons and groups with conflicting interests will probably increase the time and energies to prepare an implementable plan. According to this criterion, the quality of a health plan can be evaluated by the consensus given to the plan or identification of conflicting interests by groups. The degree and the nature of participation in policy formulation and planning might also be a good measure of quality.

In the same way that one should be suspicious of a plan hastily put together with few inputs, the timing of a policy and plan might also be good determinants of its implementation capabilities. Policies issued hurriedly during a political campaign might not survive election day in some Latin American countries.

Economic and technical viability. Another dimension which has not been given adequate attention by Latin American health policy makers is the economic viability of a policy or plan. Zschock and Robertson (21) in their study of health finances in Latin America have shown frequently that plans and programs are prepared without securing the funding for operation and maintenance. Similarly, plans are approved without consideration of the manpower or other technical needs for operation and maintenance. Thus, it is not unusual to see rural health clinics without medical or paramedical personnel, or if they have the personnel, the equipment may not be available. At times these deficiencies are administrative flaws but other times the deficiencies are the result of the lack of adequate financing. It is well known that for a variety of reasons policymakers have a preference for the construction of physical facilities. Hospitals are inaugurated only to be closed down a few months later because of insufficient funding for their operation. Health surveys are designed and executed without securing the means and the technical knowhow for processing and analysis of data. A recent Latin American national health survey was carried out at the cost of 80,000 dollars before preparing the design and obtaining funds for its analysis. It took three years to get the crosstabs. Immunization campaigns are launched without firm financial commitments for maintaining the immunization levels.

If funding for a plan or part of a plan is to be financed and/or disbursed by one or several other agencies then a firm commitment needs to be previously reached before beginning plan implementation. In one country, for example, a well designed multimillion dollar immunization campaign failed half way through when the ministry of finance stopped salary payments of campaign workers who finally decided to find employment elsewhere.

We can conclude by saying that there are two basic principles which could be used to determine the quality of a plan in reference to its economic viability: (1) whether it has secured funding for maintenance and operation of new facilities and the degree of commitment by the funding agency, and (2) whether the funding agencies have or have not guaranteed the smooth flow of fund disbursement, and the degree of commitment.16/

Administrative viability. It is not possible within the limits of this paper to discuss the multiple dimensions that make a plan from an administrative point of view more likely to be implemented. We will concentrate in the area of policy coordination, some aspects of which have already emerged in the two previous discussions. Health and nutrition plans are particularly multisectorial. It will be impossible to prepare a nutrition plan without the participation of the agricultural, the educational and the economic sectors in each of which several agencies and divisions participate. The problem of policy coordination in nutrition plans has recently been underlined by a group of PAHO experts (22). Three modalities have been advanced to facilitate horizontal and vertical coordination: (1) reducing the number of agencies responsible for health and nutrition, for example, by merging social security with the health ministry, (2) the organization of an interministerial council or board, for example, the national health council which is presided by the health minister or by the director of national planning, and (3) the organization of a superministry with decision making power in one field.17/ A plan in which the coordination mechanisms are established will tend to have more possibilities of implementation than one which leaves the inter and intra coordination to the good will of the actors.

The establishment of coordination mechanisms does not by itself insure coordination (19, p. 119ff). The Pan American Health Organization discussion on national nutrition policies (22, p.12) observed: "Uno de los mayores obstáculos para la formulación y ejecución de planes nacionales de alimentación y nutrición ha sido la falta de decisión política por parte de los gobiernos para establecer la necesaria coordinación intersectorial." Thus, the coordination mechanism might exist, but without the political support it may be operative. The PAHO comment is illustrative of the political dimensions of coordination; it will be difficult for a plan or program to be administratively viable unless first it is politically viable. In other words, when the implementation of plan fails, the apparent causes might be administrative flaws, but the real causes are in many cases political. Besides the existence of coordination mechanisms the measurement of viability should consider the institutionalization of the interaction among agencies, the frequency of interaction, the approval of formal agreements by heads of agencies to abide by the decisions taken by the coordinating councils or boards, and the existence of legal mechanisms for bureaucratic compliance.

Relationship between policymaking and the administrative process: the discretionary power of the bureaucracy.

As it has been indicated in most Latin American countries, health

policies and plans are prepared by small groups in ministries of public health or national planning agencies. An important part of the policy process is the translation of policies and plans into programs, and the translation of these programs into outputs through the implementation process. It is in these translations where the discretionary power of the bureaucracy is exercised. For example, a national health plan calls for the development of preventive health activities, and a technical council of the ministry makes the budgetary decisions. A technical council made up by a majority of medical doctors might interpret mother and child care programs as the ones to be promoted while a technical council controlled by sanitary engineers could decide that aqueducts are the first priority. The relation between professional background and decisions in Latin American public health systems has yet to be explored. Our limited studies suggest that selection of programs and allocation of funds represent the career background and professional ideologies of decision makers, mostly medical doctors. For example, in spite of the overwhelming evidence against the need for highly specialized hospitals many countries continue to build expensive hospitals. In Colombia for example, 29 percent of public health expenditure went to university and specialized hospitals.<sup>18/</sup> Studies of one university hospital in the same country showed that normal birth continued to be commonly attended there in spite the established regionalization and referral system.

Translating policies into programs: the case of Honduras. In order to illustrate the decision making power of the bureaucracy and the possible causes of implementation failure, the 1974-1978 National Health Plan of Honduras will be discussed.<sup>19/</sup> In this country the national development plans are prepared by the High Council for Economic Development (CONSUPLANE) an office of the President. The preparation of the development plans does not allow for public debates or hearings; it is based on the evaluation of the socioeconomic conditions of the country. The evaluation responds to the values and ideologies of members of CONSUPLANE. In the case of the health sector, the four-year plan is prepared with the assistance of the Ministry of Health and its decentralized institutes.

The national development plan presents an elaborate socioeconomic analysis of Honduras which could be considered avant-garde. According to the plan, the social problems are mainly caused by foreign economic dependence, unequal distribution of wealth, and the absence of integral land reform. On the basis of this diagnosis the plan establishes two basic goals: first, to improve wealth distribution, and second, to bring development to the rural areas where 75 percent of the population lives. The health component of the plan follows a similar orientation. It points out to the undesirable effects of the heavy concentration of manpower and hospital facilities in the cities: about 72 percent of hospital beds are located in the two largest cities (Tegucigalpa and San Pedro) and only three of the 145 specialized doctors reside outside of these two cities. Public expenditures are equally concentrated in the cities and the distribution of sanitary services follows the same pattern: 65 percent of urban households have piped water but only 5 percent do so in the rural areas. The analysis of the administrative constraint of the public sector is

equally critical and accurate. For example, the plan condemns the inefficiency of the administrative machine, the lack of congruence between programs and budgets and the lack of coordination between government agencies.

The national health plan reflects the priorities of the development plan. Specifically, it says that efforts should be directed "... to provide basic health services particularly in the rural areas .. (23, p.44)" Priority should be given, it also states, to preventive environmental health services and the control of transmissible diseases. Health policies are, therefore, well defined, clear, specific, and in agreement with the national development plan.

One possible way to evaluate the concordance between policies and programs is by analyzing expenditures and manpower training programs. For example, in the case of Honduras in which the health plan calls for basic health services in rural areas, it can be presumed that the implementation of this policy implies programs for training paramedical and auxiliary personnel and less for medical specialists. The available data limited us to the study of investment expenditures for the 1974-78 period. Table 1 presents public health investments separating the projects which were under construction. Some of them had been initiated during the previous plan. The figures of Table 1 are self-revealing: 91 percent of investments are allocated to urban projects, and the tendency towards urban projects persists in each column. An examination of each investment program shows that of the urban investments, 73 percent are for the two largest cities, and the rest for the intermediate size towns.

Table 2 presents investments categorized as to curative or preventive focus. There is more congruence between the policy favoring preventive measures and investment expenditures. About 66 percent of investments are earmarked for sanitation (mostly aqueducts in cities). However, there are two major investment projects which do not appear in the investment budget but were scheduled for construction before 1978: two, three hundred-bed hospitals for San Pedro Sula, one for the Institute of Social Security and the second for the Ministry of Health. The construction of the Social Security hospital had been planned for 1973, but it had been postponed until CONSUPLANE could find a solution for a possible integration of the two hospitals. Interviews with personnel of the Institute and the Ministry suggests that the two hospitals will be built. In this case, investments for curative health will be 55 percent of the total.20/

Programs in the Institute of Social Security. The study of the health programs of the Institute also illustrates the gap between policy and programs. Social Security coverage is mandatory in Honduras for all salaried workers.21/ Some groups are temporarily excluded, such as domestic workers, seasonal laborers, and peasants working for employers with less than ten employees. Until 1972, Social Security was limited to the capital city, Tegucigalpa. In that year coverage was extended to the workers of the second largest city, San Pedro, and later Social Security reached four

middle-size towns including employees of the near-by agrobusinesses. The 1974-78 Institute development program estimates 100,000 members for 1978, half of them in Tegucigalpa, 38,000 in San Pedro and the rest in the other four towns. Clearly, the Institute's program is not tuned to the national development plan, rural emphasis.

Explaining the disparity between policy and programs. The contrast between policies and programs is so pronounced that a rationalization is of necessity. Personnel of the Ministry do not see a contradiction between the construction of urban hospitals of high technology in the cities and bringing basic health services to the peasantry. In their view, the specialized hospitals in Tegucigalpa are national hospitals and as such serve the referrals from urban and rural areas. Similarly, regional hospitals in other cities are also built to serve their area of influence including rural zones. However, a study of discharges from the "national" hospitals of Tegucigalpa shows that between 70 to 80 percent of patients are residents of Tegucigalpa and its province (similar data were found in Colombia). Information about place of residence of other regional hospitals was not available (the lack of information is by itself indicative), but interviews and field visits to one regional hospital indicates that the area of influence is limited to the urban center and its most immediate surroundings (estimated by the director of the hospital to be about 5 kms). The regionalization system is neither implemented nor functioning.

The Board of Directors of the Institute of Social Security is the highest decision making organ of the Institute. One of the functions of the Board is to implement the social security law through the issuance of executive rulings (reglamentos). The rulings determine among other things which of the eligible population groups are to be covered by Social Security. According to personnel of the Institute eligible rural workers are excluded because of their low income. However, an analysis of the National Survey of Household Income and Expenditures (24) raises some questions about the alleged inability of the peasantry to pay health insurance premiums. We aggregated health expenditures of lowest income groups and concluded that a simplified health insurance scheme might be feasible. In fact, some rural cooperatives already have organized their own group insurances contracting with private physicians. The National Federation of Savings and Loans Cooperatives has also begun to facilitate health care loans to organized peasant groups.

Political and ideological factors affecting programming. We have seen that the national development plan advocates an advanced social platform. Perhaps, it reflects the views of national planners or perhaps merely echoes the current academic literature. It has also been noted that as bureaucrats translate policies into programs they rationalize the apparent incongruence of urban hospitals being national hospitals. If there are failures in the referral system, bureaucrats at the implementation level are to blame. Conveniently policy evaluation is no one's responsibility, and the incongruence is thus ignored. While this explanation clarifies the failures of the policy process it does not explain the forces behind it. It is at this point of analysis that in-depth studies of the policy process

are necessary. Through participant observation, unstructured interviews and archival research studies are needed of the bureaucracy, of interest and political groups, of military cliques, and of consumers. A closer picture of the policy process could thus be obtained.22/

A number of studies of the health sector (18, 25-27) have presented the political role of the medical profession. In Honduras, observations at the Health Division of CONSUPLANE suggest that the medical profession does influence policy formulation. The controls take place at the Ministry. The decision making power at the Ministry is entirely in the hands of physicians who have very close ties with their colleagues in the private sector. It is at the Ministry where policies are translated into programs, and the medical doctors at the Ministry see that these programs satisfy the professional and economic interest of their colleagues and eventually their own. For example, the Director of the Office of Manpower Resources was also a professor at the medical school, and most of his administrative time at the Ministry was spent in the organization of the new university hospital staff. It is in the economic interest of medical doctors that high technology hospitals are built where they can learn and practice the highly remunerative specialties. It is also in their interest that the hospitals are built in the large cities where wealth is concentrated and the potential for private clientele is the largest. In the large cities the medical doctors also find a more attractive cultural milieu, more social amenities, better schools for their children, and in general better services. Thus, we see the influence of professional ideologies exercised through a professional group in the location of health care facilities.

Political factors explain much of the reason for Honduran sanitation investments being concentrated in the cities. The national policy statements would require an opposite allocation of resources. Sanitation projects located according to the policy, would have produced water supply restrictions in the cities where the most powerful organized groups reside and where political mobilization for protests is easier and more visible. No government, much less a military government, is willing to take this risk. The first needs to be satisfied are those with political power. Who should be concerned if peasants have to walk half an hour for water and who will think that this is acceptable in the cities? Programming is based on a realistic appraisal of the power held by different population groups.

The Board of Directors of the Institute of Social Security is composed of representatives of industrial interests, labor unions, medical profession and the government--all of whom represent urban interests. Then it is easy to understand that new memberships for 1974-1978 period are to be extended almost exclusively to urban workers. The peasantry does not have representation on the Board, and without access to decision making positions in the institute, it is difficult to pressure for programs to meet the priorities of the development plan or to remove the discriminatory restrictions of the social security law against the peasantry. The Institute of Social Security has limited administrative capabilities, and under the pressures of the medical profession and the urban labor unions its efforts will continue to serve primarily urban groups.

## Conclusion

In conclusion let us examine the evidence we have cited for constraints on expansion of program evaluation efforts and for possible approaches to a form of program evaluation suited to Latin American political and administrative life.

1. Current attempts at health and nutrition program evaluation in Latin America are almost solely the result of international agency stimulation. These evaluation activities concentrated on donor-sponsored pilot and demonstration projects and to date have incorporated only simple measures of target achievement. As with other aspects of the political relationship and interdependence between Latin American governments and donor agencies, Latin Americans have learned ways to accommodate the evaluation demands of donors into operations of their programs. The evidence suggests that little if any of the foreign versions of program evaluation would fit comfortably into Latin American practice.

The absence of Latin-originated program evaluation models is the combined result of technical, administrative, and political factors. Technically, evaluation models now available depend on complex measurement and analysis routines which are difficult to apply in the geographic and organizational conditions of Latin America. The political constraints under which the Latin American bureaucrats operate, preventing use of resources as they see fit, again limits the usefulness of methods to assess the effects of interventions. The closed nature of many political regimes in Latin America also prevents an outside evaluation cadre, such as university or independent consultant teams, (except through international agencies) from being created where methods and experiences easily could be compared among evaluators and improved.

2. The choice of evaluators is intimately connected to the objectives assigned to the work. Insofar as evaluation is applied to donor-sponsored government activities, the evaluators are now chosen by the donor agency. The possibility of Latin American agency selection of these evaluators seems remote in the short term. (The approach used to select and supervise government auditors in each country might be studied to determine the factors which influence the selection.) The possibility that academics or consultant assessors would be used routinely for this purpose seems remote.

3. Evaluative findings are a threat to accomplishment of many legitimate objectives, and the presentation of such new information sometimes provokes reactions leading to the discrediting or hiding of evaluation results. The sources of evaluative data may be suspect in the minds of people receiving evaluation findings. Also, evaluation findings prepared through international agency sponsorship are an intrusion on the policy-making activities of the Latin American government and may question established government standards and practices. In a context where such questioning is considered unethical behavior, as is the case in some parts of Latin America, bureaucrats are unlikely to adopt such practices.

Given the above evidence, how can a Latin American style of program evaluation eventually come into being? There are probably several different approaches to the problem, such as by changes in legislative influence or management retraining, but one approach is especially appealing to us. It centers on increasing the degree of bureaucratic control and client participation in programs. Current practice in the countries we have studied is for control arrangements to be arranged with almost all assignments emanating from a few points administratively high in the government. Even in so-called autonomous agencies which are separated from the central government this pattern of control exists. As an intermediate step, we hypothesize that health and nutrition program evaluation methods would be adopted more likely in agencies which had implemented already less sweeping analytical and control arrangements. Some of the presumed benefits of program evaluation could be accruing to programs adopting such intermediate steps. Using an approach from the recent literature of organizational design (28), several changes come to mind which seem worth pursuing along these lines:

- + Information and Decision Systems: Study methods by which program expenditure and cost data could be developed and published more widely than at present; study budget-making processes to determine the political and social factors which most influence current expenditure outcomes; study methods to establish low cost data series for health and nutrition indicators; study low cost methods for evaluating accuracy of data series now collected; study methods for low cost data analysis routines.
- + Organizational Structure: Study the possibility of establishing an evaluation division within the health ministry planning department (as is being done in Colombia), or other central location.
- + Personnel: Study the possible effects of expanding bureaucrats' and community members' participation in various policymaking processes, including personnel selection, budget preparation, program design, and evaluation.
- + Organizational Tasks: Study the arrangement and assignment of health and nutrition tasks among agencies in ways to produce greater control over health and nutritional factors.
- + Technologies: Explore the development of low cost measurement and data analysis technologies for use in clinical and administrative activities which could eventually be used also for program evaluation purposes.

In the long run, these changes offer promise of providing strengthened evaluation efforts within an approach that is appropriate to political and organizational conditions in Latin America.

Professor Antonio Ugalde  
Department of Sociology  
University of Texas, Austin  
Austin, Texas

Robert Emrey  
Parklawn Building, Room 18-82  
5600 Fishers Lane  
Rockville, Maryland 20857

FIGURE 1  
Program Evaluation Model of Organization and  
Environment in Procedures

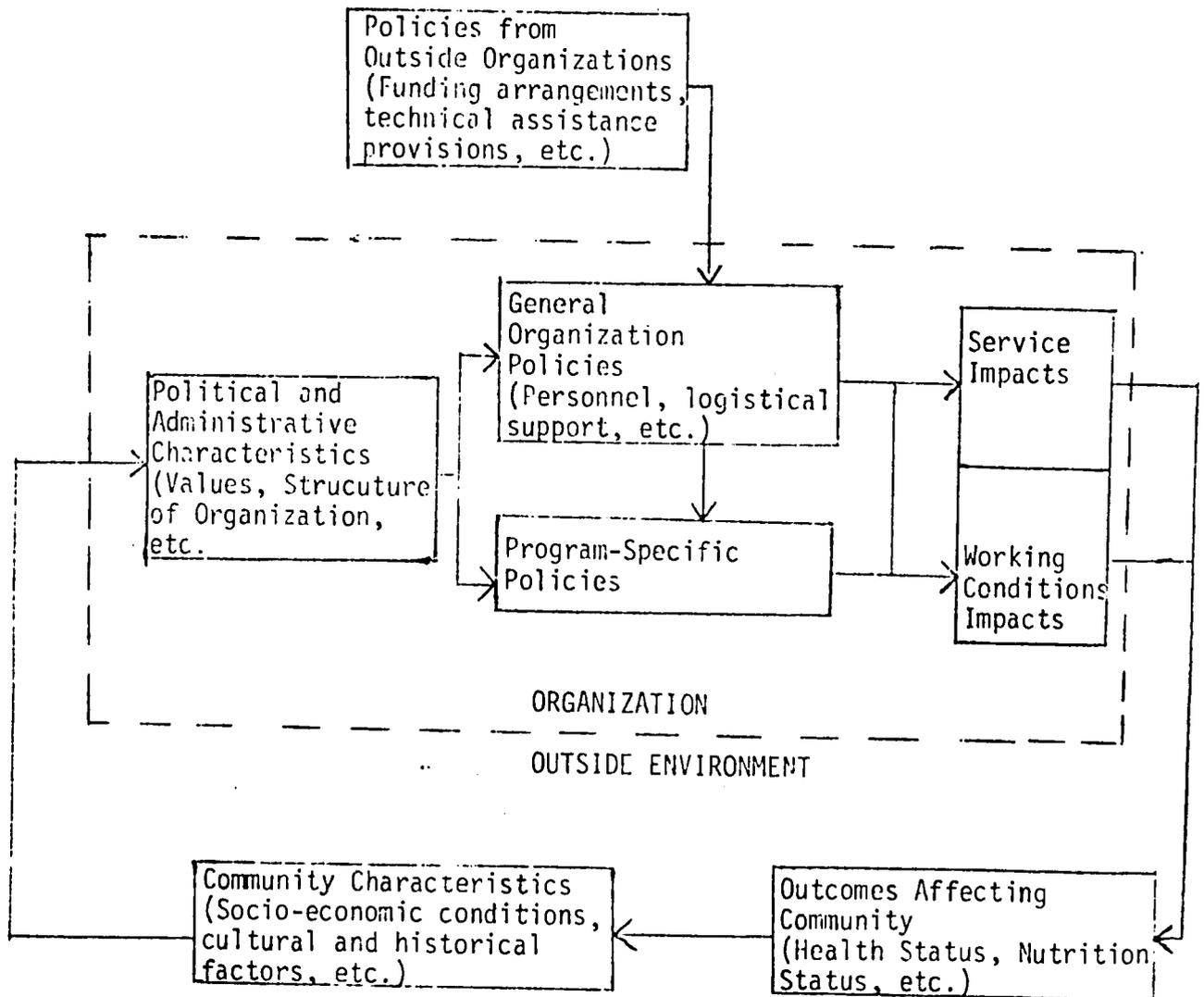


TABLE 1

Proposed Investments in Health in the National Health and Nutrition Plan For  
1974-1978, Republic of Honduras (in millions of Lempiras)

Investments	A		B		C		D		Total	
	Projects Under Construction	%	Projects With Approved Financing	%	Projects With Financing Being Negotiated	%	Projects Without Financing	%		%
Urban Areas	19.6	87.5	13.5	79.0	18.9	100.0	8.8	100.0	60.8	91.0
Rural Areas	2.8	12.5	3.6	21.0	0	--	0	--	6.4	9.0

Source: Prepared from Secretaria Tecnica del Consejo Superior de Planificacion Economica (29, p.85). For those investments which do not distinguish between urban and rural an approximate calculation was made. For example, a sum for hospital equipment was divided proportionate to the amount spent in hospital construction for the urban and rural areas respectively. The same has been done with respect to the preliminary studies for the construction of aqueducts. These sums are relatively small and the error that may have been committed in their distribution does not alter the trends which appear in the Table.  
1 lempira = 0.5 US \$.

TABLE 2

Proposed Investments in Health in the National Health and Nutrition Plan for  
1974-1978, Republic of Honduras, By Types of Investments  
(in millions of Lempiras)

Type of Investments	A		B		C		D		Total	
	Projects Under Construction	%	Projects With Approved Financing	%	Projects With Financing Being Negotiated	%	Projects Without Financing	%		%
Environmental Health (preventive)	7.3	34.6	7.6	49.4	18.9	100.0	8.9	100.0	42.7	65.4
Health Care (curative)	13.8	65.4	7.8	50.6	0	--	0	--	21.6	33.6

Source: Prepared from Secretaria Técnica del Consejo Superior de Planificación Económica (29, p. 85). The discrepancy in totals between Tables 1 and 2 is due to the fact that in the latter investments for social well being such as child care and children's homes have not been included.  
1 lempira = 0.5 US \$.

FOOTNOTES

1/ Earlier works about political development by Almond and Coleman (30) and by Pye and Verba (31) exemplify this approach. The more recent use of a policy approach to study political development and change emphasized a problem orientation. This newer approach focuses on values, the context of the problem in a broad framework, and the necessity of using multiple research methods. The several papers in Brewer & Brunner (32) mark a bold attempt to deal with these previous research difficulties.

2/ This view is changing rapidly. According to Glazer (33) social problems are unimplementable. See also Bardach (34) for a discussion of implementation problems for mental health programs in California.

3/ This model draws on systems theory notions. Applications of similar models to organizational processes in local government agencies are found in Kraemer, et al., (35) and to the United States Department of State in Warwick (36).

4/ The literature of program evaluation is voluminous. The relationships discussed here are explored at length in Suchman (37), Van Maanen (38), Caro (39), and Berstein & Freeman (40).

5/ Decision making in most ministries is still in the hands of medical doctors. The same applies to health related international agencies. In Latin American Missions, it is common, for example, that health matters fall under the responsibility of a medical officer in the Agency for International Development.

6/ This point heavily reflects the influence of Sjoberg and Nett (11).

7/ Symbolic interactionism can be defined as a: "form of social behaviorism ... that stresses linguistic and gestural communication, especially the role of language in the formation of the mind, the self, and society" (41, p. 430). Symbolic interactionism could be related to neo-idealism, and empiricism to positivism. It is understandable that symbolic interactionists are inclined to use qualitative methods while empiricists tend towards quantitative techniques.

8/ "Structural-functional analysis presumes that social units (groups, institutions, etc.) that are in the interaction mutually influence and adjust to each other, so that through the various social processes, including cooperation, competition, conflict, and accommodation, the various groups and segments of a society form a relatively unified social system" (41, p. 422). Structural-functionalists perceive social reality the same way biologists perceive living organisms. The possibilities of value-loaded orientation of structural-functionalism is stated by Mayntz and Scharpf (20, p. vii): "... this approach permits to stipulate normative reference points for an empirical analysis, whether these are derived from the values of system members of some value standard of the analyst." Conflict theory on the other hand views social process not "in terms of the cooperation of

social groups but in terms of man's aggressiveness. Emphasis is placed on conflict as a creative or at least an inevitable fact of social life..." (41, p. 71).

9/ For an enlightened discussion of political and ideological influences of data selection, analysis, and utilization, see the Introduction of Littrell and Sjoberg (42).

10/ See examples in Alfort (43) for critical study of poor people in the U. S. A.

11/ A provocative discussion of this political and ethical problem can be read in Glazer (69).

12/ We have decided to use the term "interest group" to refer in general to any formally or informally organized group which attempts to influence the policy process. We are aware that interest group has a defensive connotation toward economic interests and as such might not exist in socialist economies. Our definition is broader and encompasses bureaucratic cliques which might attempt to influence the policy process for other economic self-interests.

13/ Downs (44) has documented well this phenomenon in the Pentagon and Lampton (12) for the health system of China during the Cultural Revolution. Allison (45) has shown that such processes may be viewed from several points of view: rational actors, organizational routines, and bureaucratic politics.

14/ As examples of the last point, programs of government drug manufacturing and distribution frequently come under the attack of the pharmaceutical industry, and environmental health plans face opposition from multinational firms. Conversations with an employee of an international agency reported that in Brazil the multinational pharmaceutical firms destroyed a government attempt to manufacture generic drugs. In Colombia, the Association of Pharmaceutical Industries (AFIDRO) influenced the government of President Pastrana, who had been its head, to dismantle a timid attempt to manufacture non-patent drugs. In another country, a knowledgeable person at the Ministry of Public Health indicated that any attempt by the Minister to tangle with the pharmaceutical industries would cost him the job. The policy of moving polluting industries from developed nations to the developing countries is advocated in one of the industry's main journals (46). Many multinationals are politically and economically more powerful than most Latin American national governments.

15/ This phenomenon was documented in Wilkie (47, 48) for Mexico and Bolivia.

16/ See, for further discussion and examples, the articles and comments in Beithman (49) by Hinrichs (50), Bird (51), Musgrave (52), and Wilkie (53) and in Caiden and Wildavsky (54).

17/ In many countries national planning has with more or less success attempted to carry out the role of a superministry. In some countries one ministry has been assigned the job of a superministry. Such is the case of the ministry of rural development in Malaysia. For the advantages and limitations of the idea of a superministry, see Ness (55).

18/ The first study of public health expenditures in Colombia was published in 1975 at the initiative of a group of industrial engineers (56).

19/ Fieldwork in Honduras was carried out by one of the authors (Ugalde) in 1975 under the auspices of the United Nations Development Programme. The materials presented here reflect the situation of the health sector in that year and the authors recognized that changes might have taken place since then. As in many cases studies a critical view is presented here. To avoid a one-sided view of the public health sector of Honduras it is fair to say that health officers were dedicated and innovative, and they were searching sincerely for solutions to health problems of their country. The case study is based on more than 25 interviews with top health administrators and several field visits to institutions and health agencies. The following sources were consulted: Secretaría Técnica (23 and 29), República de Honduras (57), among many others.

20/ This example shows the difficulties of looking at public financing only through official records.

21/ The following sources were consulted for the study of the Institute: Instituto Hondureño de Seguridad Social (58-63).

22/ Participant observation of public institutions is extremely difficult and time consuming. Bureaucrats rarely have an interest in being studied, and authorization is seldom granted to social scientists. As Benveniste (64, p. viii) observed: "Doors are more often closed than open. Access to policy making bodies is rarely given, particularly when it is known that a book will be published..." Similar sentiments have been expressed by other researchers (65-67).

REFERENCES

- (1) Collier, J.C. and R. C. Fagen (eds.) Latin America and the United States: The Changing Political Realities. Stanford: Stanford University Press, 1974. Also available in Spanish, Relaciones políticas entre America Latina y Estados Unidos. Buenos Aires: Amorrortu Editores, 1974.
- (2) Silvert, H., Politics and the Study of Latin America. In Lucian W.Pye (ed.), Political Science and Area Studies, Bloomington: Indiana University Press, 1975.
- (3) Pressman, J.L. and A. Wildavsky. Implementation. Berkeley: University of California Press, 1974
- (4) Ramos, A. G. The new ignorance and the future of public administration in Latin America. In C.E. Thurber & L.S. Graham (eds.), Development administration in Latin America. Durham, North Carolina: Duke University Press, 1973. Chapter 15.
- (5) Glaser, W.A. Social Settings and Medical Organization. A Cross-National Study of the Hospital. New York: Atherton Press, 1970.
- (6) Hamilton, D. The Consumer in Our Economy. Boston: Houghton Mifflin, 1962.
- (7) Myrdal, G. The Asian Drama. An Inquiry into the Poverty of Nations. Abridged Edition. New York: Random House, 1972.
- (8) Mannheim, D. Ideology and Utopia, New York: Harcourt, Brace and World, 1949.
- (9) Olson, S.P. Ideas and Data. The Process and Practice of Social Research. Homewood, Ill.: Dorsey Press, 1976
- (10) Smith, H.W. Strategies of Social Research. The Methodological Imagination. Englewood Cliffs, N.J.: Prentice Hall, 1975
- (11) Sjöberg, G. and R. Nett. A Methodology for Social Research. New York: Harper and Row, 1968.
- (12) Lampton, G.M. "The Politics of Public Health in China: 1949-1969". Unpublished Ph.D. Dissertation: Stanford University, 1973.
- (13) Fundación para la Educación Superior y Community Systems Foundation, "Metodología para el Diagnóstico de la Desnutrición en Comunidades", Primer Informe de Progreso, June 30, 1974-June 30, 1975 (mimeo n.p.), 1975.

- (14) Taussig, M. "Rural Proletarianization: A Social and Historical Enquiry into the Commercialization of the Southern Cauca Valley, Colombia" Ph.D. Dissertation, University of London, 1974
- (15) Tussig, M. "Nutrition, Development, and Foreign Aid: A Case Study of US-Directed Health Care in a Colombian Plantation Zone (n.p. manuscript,) no date.
- (16) Alford, R.R. Health Care Politics, Ideologies and Interest Group Barriers to Reform. Chicago: University of Chicago Press, 1975
- (17) Gabaldon, A. Una Política Sanitaria (two volumes). Caracas: Publicaciones del Ministerio de Sanidad y Asistencia Social, 1965
- (18) Krause, E.A. Power and Illness. The Political Sociology of Health and Medical Care. New York: Elsevier, 1977.
- (19) Ugalde, A. "Los procesos de toma de decisiones en el sector sanitario y sus implicaciones políticas", Papers, Revista de Sociología, No. 5: 101-124, 1976.
- (20) Mayntz, R. and R.W. Scharpf. Policy-Making in the German Federal Bureaucracy. Amsterdam: Elsevier, 1975.
- (21) Zschock, D.K. and R.L. Robertson, "Health Sector Financing in Latin America: Conceptual Framework and Case Studies". Unpublished report prepared for the Office of International Health, U.S. Department of Health, Education and Welfare, Washington, D.C. 1976
- (22) Pan American Health Organization. Políticas nacionales de alimentación y nutrición. Discusiones técnicas de la XXIII Reunión del Consejo Directivo de la OPS. (Publicación Científica No. 328) Washington, D.C. 1976
- (23) Secretaría Técnica del Consejo Superior de Planificación Económica. Resumen del Plan Nacional de Desarrollo 1974-1978. Tegucigalpa (mimeo), 1974.
- (24) Secretaría de Economía y Hacienda, Dirección General de Estadística y Censos. Encuesta de Ingresos y Gastos Familiares 1967-1968 Tegucigalpa, 1970.
- (25) Rayack, E. Professional Power and American Medicine: The Economics of the American Medical Association. Cleveland: World Publishing Co., 1967
- (26) de Miguel, A. "La profesión médica en España", Papers, Revista de Sociología, No. 5: 147-182, 1976

- (27) Eckstein, H. Pressure Group Politics: The Case of the British Medical Association, Stanford: Stanford University Press, 1960.
- (28) Galbraith, J. Organization design. Reading, Mass.: Addison-Wesky, 1977.
- (29) Secretaría Técnica del Consejo Superior de Planificación Económica. Plan Nacional de Desarrollo 1974-1978. Tomo VII. Plan de Salud y Nutrición. Tegucigalpa (mimeo), 1973
- (30) Almond, G.A. and J. Coleman (eds.), The politics of the Developing Areas. Princeton: Princeton University Press, 1960.
- (31) Pye, L.W. and S. Verba (eds.), Comparative Political Culture, Princeton: Princeton University Press, 1965.
- (32) Brewer, G.D., & R.D. Brunner (eds.), Political development and change: A policy Approach. New York: Free Press, 1975.
- (33) Glazer, N. "The Limits of Social Policy", Commentary, 1971
- (34) Bardach, E. The Implementation Game: What Happens After a Bill Becomes Law, Cambridge: The MIT Press, 1977.
- (35) Kraemer, K.L., J.N. Danziger, W.H. Dutton, A.M. Mood, & R. Kling. A future cities survey research design for policy analysis. Socio-Economic Planning Sciences, 1976, 10, 199-211
- (36) Warwick, D. A Theory of Public Bureaucracy, Politics, Personality and Organization in the State Department, Harvard University, Cambridge, Massachusetts, 1975
- (37) Suchman, E.A. Evaluation research: Principles and Practice in Public Service and Social Action Programs. New York: Russell Sage Foundation, 1967.
- (38) Van Maanen, J. The process of Program Evaluation. Washington: National Training and Development Service Press, 1973.
- (39) Caro, F.G. (ed.), Readings in Evaluation Research. New York: Russell Sage Foundation, 1971
- (40) Bernstein, I.N., & H.E. Freeman. Academic and entrepreneurial research: The consequences of diversity in Federal evaluation studies. New York: Russell Sage Foundation, 1975.
- (41) Theodorson, G.A. and A.G. Theodorson. Modern Dictionary of Sociology, New York: Thomas Y. Crowell Co., 1970.

- (42) Littrell, W.B. and G. Sjoberg (eds.), Current Issues in Social Policy. Beverly Hills, California: Sage Publications, 1976
- (43) Alford, R.R. Political Participation and Public Policy. Annual Review of Sociology, Vol. 1, 1975, pp. 429-479.
- (44) Downs, A. Inside Bureaucracy. Boston: Little, Brown, 1967.
- (45) Allison, G.T. The essence of decision: Explaining the Cuban Missile Crisis. New York: 1971.
- (46) Rose, S. Third World commodity power is a costly illusion. Fortune, 1976 (Nov.), 147-162.
- (47) Wilkie, J.W. The Mexican Revolution: Federal expenditure and social change since 1910. Berkeley: University of California Press, 1967.
- (48) Wilkie, J.W. The Bolivian Revolution and U.S. aid since 1952. Los Angeles: Latin American Center, University of California, Los Angeles, 1969.
- (49) Geithman, D.T. (ed.), Fiscal Policy for industrialization and development in Latin America. Gainesville: University of Florida Press, 1974.
- (50) Hinrichs, H.H. Tax reform constrained by fiscal harmonization within common markets: Growth without development in Guatemala. In (49), Chapter 4.
- (51) Bird, R.M. Agricultural taxation in developing countries: Theory and Latin American practice. In (49), Chapter 5.
- (52) Musgrave, R.A. Expenditure policy for development. In (49), Chapter 6.
- (53) Wilkie, J.W. Recentralization: The budgetary-dilemma in the economic development of Mexico, Bolivia, and Costa Rica. In (49), Chapter 7.
- (54) Caiden, N. and A. Wildavsky, Planning and budgeting in poor countries. New York; John Wiley, 1974.
- (55) Ness, C. Bureaucracy and Rural Development in Malaysia, Berkeley: University of California Press, 1967.
- (56) República de Colombia, Ministerio de Salud Pública. Gasto Institucional en Salud 1973. Bogotá, Imprenta del Instituto Nacional de Salud, 1975.
- (57) República de Honduras, Presupuesto General de la República Integrado por Programas. Gobierno Central. Ejercicio Fiscal 1975 (n.p.), no date

- (58) Instituto Hondureño de Seguridad Social, "Presupuesto por Programas. 1975", (Manuscript, n.p.), no date.
- (59) Instituto Hondureño de Seguridad Social, Departamento de Estadística y Procesamiento de Datos, Anuario Estadístico Año 1973, Tegucigalpa (mimeo), no date.
- (60) Instituto Hondureño de Seguridad Social, Departamento de Estadística y Procesamiento de Datos, Costos Globales y Unitarios de la Seguridad Social en Honduras, 1970, Tegucigalpa (mimeo), no date.
- (61) Instituto Hondureño de Seguridad Social, Planeación Física, (n.p. mimeo), no date
- (62) Instituto Hondureño de Seguridad Social, Clínicas de Consulta Externa de Tegucigalpa, (n.p. mimeo), 1975
- (63) Instituto Hondureño de Seguridad Social, Ley del Seguro Social y Reglamentos de Aplicación de la Ley del Seguro Social, Tegucigalpa, 1972
- (64) Benveniste, G. Bureaucracy and National Planning. A Sociological Case in Mexico. New York: Praeger, 1970.
- (65) Redford, E. Democracy in the Administrative State. New York. Oxford University Press, 1969.
- (66) Greenberg, M.S., Bureaucracy and Development: A Mexican Case Study, Lexington, Mass.: Heath, 1970.
- (67) Ames, Barry, "Bureaucratic Policy Making in a Militarized Regime: Brazil After 1964," Ph.D. Dissertation, Stanford University, 1972.
- (68) Waterston, A. Development: Planning: Lessons of Experience. Baltimore: Johns Hopkins Press, 1965.
- (69) Glazer, M. The Research adventure: Promise and problems of field work. New York: Knopf, 1972

LAT Political and organizational issues in  
614 assessing health and nutrition interventions.  
U26 Ugalde, Antonio.

Political and organizational issues in  
assessing health and nutrition interventions.  
Antonio Ugalde and Robert Emrey. 1977.  
Card 1 30 p.

Paper prepared for the Conference on the  
Measurement of the Impact of Nutrition and  
Related Health Programs in Latin America,  
Panama City, 1977.

Includes bibliographical references.

1. Politics and development - LAT. 2. Health  
planning - LAT.

LAT Card 2  
614 Ugalde, Antonio.  
U26 Political and organizational issues in  
assessing health and ... 1977.

3. Nutrition planning - LAT. 4. Nutrition policy  
- LAT. 5. Evaluation - Nutrition and health - LAT.  
6. Intervention - LAT. I. Emrey, Robert.  
II. Title.