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Introduction

The relationship between planning and performance can be perplexing, even in simple situations where few people are involved. It becomes much more complicated when plans are made on a vast scale for the benefit of people whom the planners themselves may never meet and whose view of their own most pressing needs may never be asked. How can the gap between the people on the receiving end of planning and the well-intentioned designs of planners often far removed from the recipients best be bridged, so that imagination and resources may achieve the most beneficial result?

Since the 1940s international health agencies, in cooperation with national governments, have achieved some remarkable successes in developing hospital-based health services and in attacking communicable diseases. The worldwide eradication of smallpox presents the most dramatic example of what has been accomplished through international expertise and technical assistance. The incidence of malaria has been checked, though not eradicated, and health conditions in general have improved considerably. During the 1960s, however, international attention focused on the rapidly growing need to extend basic health services, both preventive and curative, to more people, and especially to rural populations in developing countries. The new approaches

designed to meet this need—originally called basic health services and now called primary health care—require close, long-term relationships between health care providers and rural communities. Unlike smallpox and malaria workers, who could arrive in a village, conduct an immunization clinic or spray with DDT, and then leave, the primary health care worker must live in the village, establish bonds of trust, and work with the villagers to introduce more healthful behavioral patterns. In short, he must become part of the community.

Thus, international health efforts have entered a new era, one in which the efficient application of technical expertise alone is not sufficient. The shift has been difficult to make. All too often the massive infusion of effort and funding from international health agencies has had disappointing results at the grass roots level. Health planners and administrators generally acknowledge that their policies and plans have not always produced effective services, in part because social and cultural information about the people to be served has not received adequate attention. Although awareness of the links between health and social dimensions has been increasing, taking social and cultural variables into account is by no means an easy matter. In recent years international agencies have been attempting to accomplish this by working closely with the national governments concerned and by hiring social scientists to advise them on the social and cultural appropriateness of their plans. But these attempts have yet to produce a noticeable improvement in the health services provided in many rural areas.

My own interest in the use of social and cultural information in health planning has been developing for more than fifteen years. It started during my first experiences as a program officer with training in public health and community development for United Nations agencies; it intensified during my research as an anthropologist; and it has broadened during my recent work as a consultant on primary health care for international health agencies.

This book began with the frustrations I experienced in 1973–75 when administering a large nutrition education program in India. Planned by the Food and Agriculture Orga-

nization (FAO) in Rome and the United Nations Children's Fund (UNICEF) in New York, the program was implemented by the Indian government. I quickly realized that although it was well intentioned, it was ill suited to the social and cultural realities of Indian life at that time. Yet there has been a great deal of social science research in India. The cultural patterns of virtually every major group in the population have been studied by both Indian and foreign researchers. Furthermore, a vast literature—much of it based on the Indian experience—exists on health-related behavior and on the problems resulting from the introduction of modern medical technology in developing countries.

I wondered why this information had not been used to plan a program that would be more appropriate to Indian culture. Perhaps the information had not been made available to planners at the right time or in the right way. No doubt different kinds of information would be needed at the various levels and stages of planning. If social scientists knew more about what planners needed and how to present their findings, could their information be more effective? Of course, many factors—notably, economic and political considerations—shape health policies and plans, but within these parameters there should be ways for planners to take social and cultural realities into account.

In order to discover what kinds of information planners needed and at what stage in planning they needed it, I decided to investigate Nepal's rural health program, officially known as the Integrated Community Health Program (ICHP). I selected Nepal as a testing ground because it was in the Asian area with which I was already familiar and also because it was a recent and important focus for international agencies in primary health care. Since primary health care was being presented by international policymakers as the most socially sensitive approach to serving rural areas, it seemed to me that planners would need social and cultural information about rural Nepal.

Nepal had already adopted an Integrated Community Health Program that was initially designed to combine five existing "vertical" (disease-specific) health programs—smallpox, malaria, leprosy, tuberculosis, and family planning/ma-

ternal and child health—to forge a community health structure for providing basic health services. During the late 1970s, ICHP was gradually being transformed into primary health care, which provided an opportunity to study planning and implementation during the transitional phase. I examined ICHP in 1977–79 from the top down—that is, from its international antecedents to the village level—to find out to what extent social and cultural information was used in its planning. By studying its implementation, I was able to compare the plan formulated by Nepali and foreign planners with the results at the grass roots level and to evaluate its cultural appropriateness.

My earlier observations in India were repeated in the first stages of this new research. Most health planners dealing with Nepal were not seeking social and cultural information, nor did they consider it necessary. More significant, they did not appear to be influenced by what they already did know about social and cultural conditions. Why weren't they?

This question prompted me to extend my research beyond the kinds of information health planners needed to the planning environment itself, in order to see whether there were barriers to using information about local conditions in planning at the national and international levels. How do the bureaucratic cultures in which planning takes place affect the way planners perceive and use information about the people they are trying to serve?

In attempting to study the culture of a health planning bureaucracy, one enters terrain largely unexplored by anthropologists. Although the recent anthropological literature reflects a growing recognition of bureaucracies as social and cultural systems and provides a number of studies of complex organizations,[1] anthropologists working on bureaucracies have yet to develop a strong theoretical tradition. Few guidelines exist for studies in this emergent field. A growing body of literature by political scientists on the politics of non-Western societies focuses on bureaucracies as administrative structures and on the bureaucrats themselves (Rose and Landau 1977). Much of the sociological literature on bureaucracies is addressed not to the culture of bureaucracies but

rather to their structure. I am dealing with both the Nepali and international bureaucracies as cultural systems. This study thus contributes to a new anthropology dealing with one of the major institutions now influencing our lives—the multinational organization, with its own goals and culture.

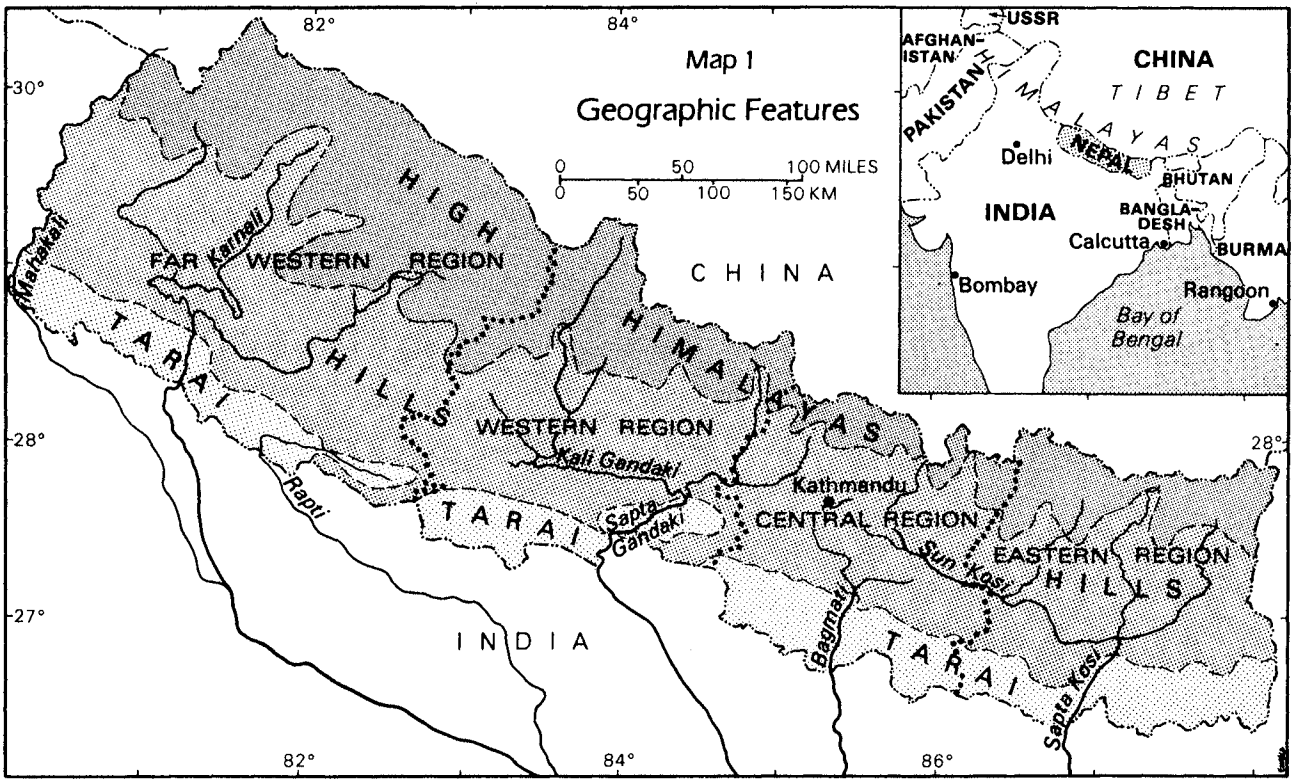
Nepal: The Setting

Nepal lies in the central Himalayas, wedged between India and China (see map 1). A small country, some 500 miles long and no more than 110 miles wide, it has a population of approximately 14 million.* The flat Terai plains in the south, the central hills, and the high Himalayas in the north divide the country into three areas. The Kosi, Karnali, and Gandaki river systems, which traverse it from north to south, are uncrossable when swollen by monsoon rains and melting snows, as they are during much of the year. The mountainous terrain and distinct geographic divisions isolate the rural areas from the central government in Kathmandu Valley and have hindered the development of transportation, communication, and other infrastructures, including health facilities. Ninety-six percent of the population lives in rural areas, most of which are so inaccessible from Kathmandu that they can be reached only by walking for hours or even days along steep, winding trails.

Nepal has few natural resources. Although 90 percent of the population depends on agriculture for a living, only 12 percent of the land is arable. Declining soil fertility, erosion, and variable climatic conditions complicate agricultural development. Food, fodder, and firewood are scarce in the hills and mountains, where 60 percent of the population lives. Because of increasing deforestation, firewood is becoming even more scarce, and overgrazing has exacerbated erosion. Drinking water is polluted in many areas and often must be carried long distances.

The annual per capita income is $120, among the lowest in the world, and in the hill communities it is estimated to

*Statistical data cited in this book describe conditions at the time of the research in 1978-79.


Map 1
Geographic Features
0 50 100 MILES
0 50 100 150 KM
82°
84°
86°
30°
28°
27°
Mahakali
FAR WESTERN REGION
Karnali
HIGH HIMALAYAS
CHINA
TARAI
HILLS
WESTERN REGION
Kali Gandaki
Rapti
Kathmandu
Sapta Gandaki
CENTRAL REGION
Sun Kosi
EASTERN REGION
HILLS
Bagmati
TARAI
Sapta Kosi
INDIA
USSR
AFGHAN-ISTAN
PAKISTAN
CHINA
TIBET
HIMALAYAS
Delhi
NEPAL
BHUTAN
INDIA
BANGLA-DESH
Calcutta
BURMA
Bombay
Rangoon
Bay of Bengal

be only $25 (World Bank 1978:2). Since most of the population lives at a subsistence level, landholdings are a more significant indication of the standard of living than income. The average family in the Nepali hills has only one acre of arable land, even less than the average family in Bangladesh (Rose and Scholz 1980:94). The population comprises approximately 75 ethnic groups, and more than thirty languages are spoken. Eighty-one percent of the population is illiterate. Although officially a Hindu kingdom, Nepal has religious diversity, with substantial Buddhist and Muslim minorities in certain areas. Thus, rural isolation, poverty, and illiteracy along with linguistic, ethnic, and religious divisions hinder the extension of government services.

While much has been accomplished in Nepal in combating some diseases (for example, smallpox and malaria), morbidity and mortality rates are still very high, especially for infants and children. Childhood diseases constitute the country's major health problem. Although the accuracy of available statistics is questionable, it is estimated that 54 percent of all deaths are among children under five and that between 134 and 260 infants per 1,000 live births die in their first year, one of the highest rates in Asia. Because of the high infant mortality rate, life expectancy at birth is low: 46 years for males, 43 for females (Nepal Ministry of Health 1979).

The main causes of infant and child death are diarrhea from impure water and foodborne diseases, nutritional deficiencies, chest infections, other communicable diseases, and accidents. Many of these diseases are preventable, as are the major causes of adult death, which include communicable diseases such as malaria, leprosy, and tuberculosis; accidents; and maternity-related diseases. Maternal morbidity and mortality, which rank second among Nepal's major health problems, are caused by poor nutrition, frequent pregnancies, lack of proper prenatal care, complications of pregnancy and delivery, and medically unsupervised abortions (UNICEF 1978). Nepal's crude birth-

rate per 1,000 population, estimated from the 1976 National Fertility Survey, was 43.6—again, one of the highest in Asia.

Until the early 1950s most health care was provided by family members and indigenous practitioners of several kinds, including herbalists and spiritualists. A multiplicity of medical traditions still exists in Nepal, and these traditions are used interchangeably and in varying combinations. *Jharfuknes, jhankris,* and *dhamis* exorcise evil spirits with a combination of chants, mantras, drumbeating, and animal sacrifices. Buddhist lamas use prayers to avert catastrophe. Ayurvedic specialists practice Hindu herbal medicine. Practitioners of homeopathy, acupuncture, Yunani (Greco-Arabic medicine), and Tibetan medicine are also available. Traditional midwives—*sudenis* and *dhais*—attend births in some regions. Among the traditional practitioners, however, only the government-trained Ayurvedic doctors *(Vaidya* and *Kabiraj)* are officially recognized and supported by the government.[2]

Western scientific medicine—or allopathic medicine, as it is called throughout South Asia—came to Nepal relatively late. Unlike other South Asian countries (Sri Lanka, Pakistan, Bangladesh, and India), Nepal was never colonized. It remained closed to most outsiders and to foreign health systems until 1951, when a revolution restored the monarchy and led to the opening of the international airport at Kathmandu.

International health assistance soon followed, provided first by a number of Christian missions, foundations, and trusts. By 1951, Nepal had a few mission and government hospitals, located mainly in Kathmandu Valley. It also had twelve Nepali physicians trained abroad in allopathic medicine, along with some paramedical assistants who dispensed medications, gave injections, and dressed wounds (USAID 1975:8). During this period, Indian and other foreign drug firms began to promote allopathic drugs. In 1954, India, the United States, and the World Health Organization (WHO) were among the first external donors to give assistance to Nepal for health-related activities. The Soviet Union and China were also early contributors.

With technical advice and financial assistance from var-

ious external sources, a government health system was organized and expanded by the newly formed Ministry of Health. In 1956, planned development of health services began with the government's first five-year development plan. Between the 1950s and the late 1970s, Nepal expanded its health services to include nearly 70 hospitals with 15 to 300 beds each; approximately 450 medical doctors, of whom only 25 percent are located in rural areas; 350 nurses, with 14 percent in rural areas; and 550 health posts, staffed by paramedical workers and distributed throughout Nepal's 75 districts.

By 1978, despite the impressive gains made by several disease-specific programs and in the expansion of hospital-based services, broad community health needs in Nepal were still only partially being met, especially in mountainous rural areas remote from Kathmandu. The health budget was largely consumed in providing hospital services that served urban people, who made up only 4 percent of the total population. Over 50 percent of the country's 1,500 hospital beds were located in Kathmandu, and most rural hospitals were small fifteen-bed units that were relatively expensive to equip and staff, and unable to provide comprehensive hospital services (World Bank 1978:18). Rural health facilities were generally understaffed, undersupplied, and underutilized. Because the health service system did not tackle the underlying causes of illness, such as poor nutrition, polluted water, and lack of education in hygiene and sanitation, scarce resources were being inefficiently used (World Bank 1978:18).

In addition to the obvious need for health services, Nepal's strategic location between two major Third World powers, its political neutrality and stability, its poverty, and its beauty make it an attractive focus for international health aid. During the past twenty-five years, the number of donors has multiplied. In April 1979, thirty-seven donors[3] were contributing funds and/or equipment and personnel for health purposes (Health Associates 1979).

With so many donors operating in Nepal, aid-assisted programs inevitably overlap. In some instances, donors have cooperated in funding and staffing particular projects. Ma-

laria eradication, for example, is funded by both the World Health Organization (WHO) and the United States Agency for International Development (USAID). The rural health program, the focus of this study, was being funded jointly by at least fifteen agencies in 1978–79. It had two major donors, however: WHO and USAID. They regarded it as a test case of how to bring about the integration of the vertical projects to provide basic health services, and subsequently, to incorporate the concept of primary health care—a high priority among international health policymakers.

Research Methods

To examine the planning and implementation of primary health care in Nepal, I started at the international level and progressed to the delivery of services at the local level, the rural Nepali village. By using traditional anthropological methods—in-depth, open-ended interviewing and participant observation—I studied the activities of international planners involved with Nepal, the formulation of government priorities and programs in Kathmandu, and the delivery of health services in outlying districts and villages. Because Nepal is a small country with relatively centralized decision making at the national level, it was possible to trace the flow of information between the international, national, and local levels.

The first research challenge was to gain access to the bureaucracies in order to understand how planners work and how their perceptions and social interactions influence the decisions they make. My previous experience of working in international agencies (one year with the United Nations in New York and two years with UNICEF in India) had provided me with some understanding of the internal structure of international aid agencies and of how these agencies interact with national governments.

In July 1976, I visited the headquarters of several international aid agencies and foundations in New York and Washington to interview staff about official priorities with

respect to health, the utilization of local health resources in the projects they sponsored, and the assistance they gave to South Asian countries. These exploratory visits gave me some understanding of the genesis of international health policy as well as confidence that it would be possible to obtain the agencies' cooperation.

I spent seven weeks in Nepal in July and August 1977, primarily to study the Nepali language and to carry out some preliminary research on the Nepal government's priorities and programs in health. I also met with field staff members of various international organizations to discuss their support for Nepal's health programs and to learn how they adapted international policy to the Nepal government's priorities. This short visit was very useful, for it enabled me to meet many of the officials concerned with health services in Nepal and to become acquainted with some of the background documentation for the rural health program.

In order to find out who the planners were and how they worked, I made contact with the major international agencies supporting rural health programs in Nepal in 1978, including WHO in Geneva and New Delhi, UNICEF and the United Nations Development Program (UNDP) in New York, USAID and the World Bank in Washington, the Canadian International Development Agency (CIDA) and the International Research Development Centre (IDRC) in Ottawa, the Britain Nepal Medical Trust (BNMT), the Dooley Foundation, and consulting groups contracted for the Integrated Community Health Program under USAID.

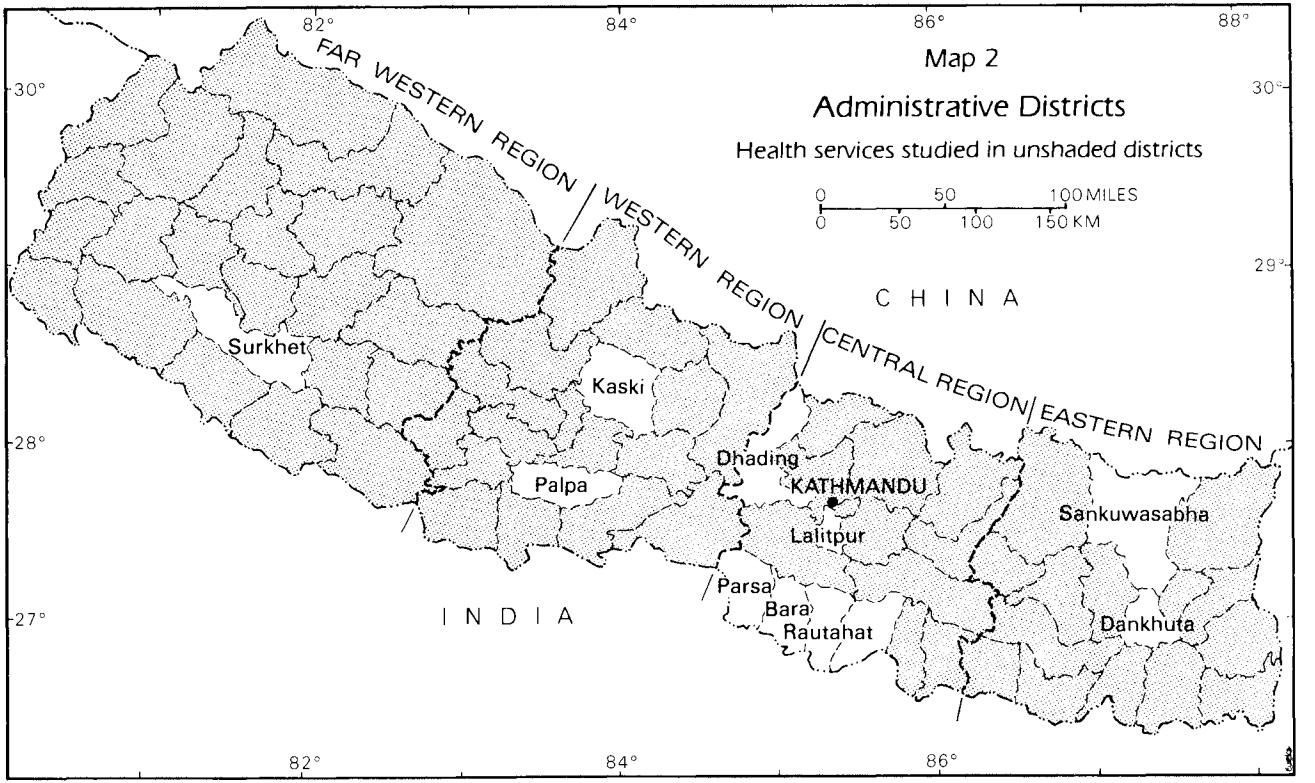
I visited the headquarters of these agencies in May and June 1978 on my way to Nepal to review documentation and interview staff members who formulated agency health policy or were associated with work in Nepal. I also interviewed staff social scientists. I wanted to find out from them what their roles had been in planning the donor agency's assistance to Nepal's health program and what kinds of social and cultural data had been available.

From June through September 1978, I interviewed Nepali officials in the Ministry of Finance, the Planning Commission, and the Ministry and Department of Health in Kathmandu, including people employed in ICHP and other

health programs. I met with people who had worked on Nepal's long-term health plans as well as those implementing integrated health services. I also interviewed staff members and consultants with the various international agencies and reviewed available documents.

In order to understand the actual workings of ICHP in Nepal, I interviewed government officials, administrative health officers, health service practitioners, and patients, and observed activities at the district and health post levels over a period of twelve months. For this last step, I made trips to ten districts that had different geographical characteristics and represented different phases of ICHP: Surkhet in the far west; Palpa and Kaski in the west; Dhading in the central region; Lalitpur in Kathmandu Valley; Sankhuwasabha and Dhankuta in the east; and Parsa, Bara, and Rautahat in the Terai, the southern plains (see Map 2). During these visits I familiarized myself with government activities at the district level, with the role of the local and district *panchayats* (government councils) and health post committees, with health facilities, and with the local operation of ICHP.

In addition to interviewing health officers and administrative officials in the district centers, I visited twenty-four health posts to meet health workers and patients using the services. It took me several days of walking to reach many of these locations. I spent a number of days at each post, accompanied village health workers on their home visits, and made follow-up visits to the homes of patients who came to the posts. I also visited several small community projects sponsored on a pilot basis by religious missions and voluntary organizations. On some of these field visits I was alone or with my Nepali research assistant, a Thakali from the western hills. On others I was accompanied by local health workers, by officials from the central or district level, or by foreign health advisors. The latter visits enabled me to understand what kind of information health officials sought and how they obtained it. By moving back and forth from the local to the national level, I was able to observe how information was transmitted in both directions and what factors facilitated or constrained the flow. Although I tried to understand the functioning of the health programs


Map 2
Administrative Districts
Health services studied in unshaded districts
0 50 100 MILES
0 50 100 150 KM
FAR WESTERN REGION
WESTERN REGION
CENTRAL REGION
EASTERN REGION
CHINA
INDIA
Surkhet
Kaski
Palpa
Dhading
KATHMANDU
Lalitpur
Parsa
Bara
Rautahat
Sankuwasabha
Dankhuta
82°
84°
86°
88°
30°
29°
28°
27°

I observed, I was not in a position to evaluate their medical effectiveness, and this was not my intention. My aim was to see how appropriate these programs were to the local culture.

By visiting rural health posts and accompanying health workers on their daily rounds, I acquired some understanding of local conditions and of the problems faced by health workers, usually of urban origin, in an isolated rural environment. The difficulties of travel and communication made me more sensitive to the obstacles faced by Nepali and foreign planners based in Kathmandu in obtaining information from the local level.

During my research, my original question—What kinds of information do planners need, and when do they need it?—evolved into the question, What contribution can an anthropologist make to health planning? The answer must come from an understanding of the planning process—the complex cultural settings in which policies and plans are made and applied, how these settings affect the planner's priorities and point of view, and how policies and plans filter down through stages of implementation to interact with cultures at the local level. Using the traditional anthropological approach of studying a culture through the perceptions of participants, I hoped to enhance our understanding of this process and thus to find more effective ways of assisting planners in their difficult undertaking of designing programs that will eventually provide services for all.