Assessment Viewpoints and Procedures

Problem: How to judge the effectiveness of technical programs in health and sanitation undertaken during a decade of social, economic, and political complexities. The following is a résumé of criteria and methods used in calculating the values of the bilateral efforts of the Western Hemisphere to help good neighbors help themselves.

TWO BROAD AREAS of analysis lay within the problem of evaluating the *Servicio* effort. They were:

Analysis of the health activities sponsored by the cooperating Latin American countries and the Institute of Inter-American Affairs, with special reference to their role in raising standards of living.

Analysis of the Servicio as an administrative mechanism and of its principal operational techniques, with special reference to its role in strengthening indigenous health services.

The overall question to be answered in the first area was: How well did the health activities sponsored by the Institute assist host countries to make the best use of existing health improvement resources, and how soundly planned was the addition of new health resources?

The second area called not only for the collection of information on the variations in the patterns of the *Servicio* and the operational techniques used, but also for analysis of these devices both in relation to their adequacy in carrying out the individual projects and as forces in strengthening and increasing health improvement resources in the host countries.

In any broad judgment of the performance of the men and women whose responsibility was the planning and execution of programs, three factors would have to be considered:

1. No blueprint based on experience existed for the systematic development of health service with foreign financial and technical assistance.

2. The selection of projects was a cooperative undertaking—the Institute and representatives of the host country sharing the responsibility.

3. There had been considerable pressure, because of the exigencies of World War II, to waste no time in getting projects under way and to obtain as obvious results as possible.

Analysis of Health Activities

For the purposes of analysis, health activities could be grouped with little overlapping as: (*a*) auxiliary to military projects; (*b*) auxiliary to individual economic projects; (c) basic health projects.

The problem of evaluating any one of the groups varied considerably from the problems of the others. But for no group was it seen to be the task of the evaluators to measure the value of health activities in relation to balanced economic development programs in the host country. In fact, in no one of the countries included in the survey was it claimed that there existed such a balanced program, with proper weighting given to advancing living conditions and increasing economic production. This is not to say that the Institute had recognized no relation of health activities to the economic systems of the host governments. To the contrary, it was part of the record that health activities, together with those in education, housing, nutrition, transportation, and irriga-

tion, had been regarded as most important for bringing about the progress that must be realized to enable economic development to take place. For a number of years a division of the Office of the Coordinator of Inter-American Affairs, which included the Institute, had been charged with the development of health and allied activities and had been designated as its "basic economy department."

Services Auxiliary to Military Projects

Little time was given to the evaluation of the health services developed in relation to military projects. These had been terminated even before the end of World War II. Of most of them, scarcely any physical vestige remained locally to bear witness to their accomplishments.

Services Auxiliary to Economic Projects

Typical of undertakings to further specific economic activities was the medical care and malaria control work in the railroad construction camps in the Rio Doce Valley in Brazil. This work helped to make possible the relocation and repair of the railroad connecting the rich iron ore region to the coast. Another example was the medical care and environmental sanitation work in the camps established in Central America in connection with work on the Pan American Highway.

The problem of the evaluators was not to weigh the cost of the overhead services in relation to increased productivity in the area, for if it should be found, for example, that development of the iron ore industry was delayed until the railroad should be reconstructed, the fault would lie with the original economic planning or other factors. The health project evaluators could concern themselves only with the technical qualities of the projects and the question of whether immediate objectives were achieved. Again, since most of these projects had long since been completed, reliance had to be placed on the written record and eye-witness testimony.

Basic Health Projects

Basic health projects constituted about 90 percent of all the health projects sponsored by the Institute and the cooperating countries. Adequate evaluation required that they be reviewed (*a*) in relation to the total social development resources and needs of the area they were established to benefit; and (*b*) as to their technical competence and adaptation to media in which they were introduced. The steps required in the analysis were:

Survey of resources, those existing in the countries as well as the funds and technical personnel available from the Institute.

Survey of needs and assignment of priorities to most urgent needs.

Evaluation of allocation of resources to needs.

Survey of Resources

In underdeveloped countries social development resources are always fewer than social needs, just as economic development resources are always fewer than economic needs. A corollary consideration in evaluation is that social needs in underdeveloped countries are always much greater than resources. Yet resources, and not merely needs, must be the basis for judging as well as for planning social development programs.

Among the most important items of information needed in the survey of resources were: national income and its trend over the 10-year period; proportion of government budget allocated to health and medical services; revenue for health and medical activities from other than public sources; existing health and other social facilities and services; capacity and rating of training institutions for physicians, nurses, and engineers; existing professional and auxiliary medical and allied manpower; compulsory and voluntary prepayment medical care plans; private medical and hospital services; income maintenance resources; and public assistance resources.

Survey of Needs

Throughout the 10 years of operation considerably more work had been done concerning needs than concerning resources. Not only the disease situations but the behavior of the general population in relation to healthful living practices could be used as broad indicators of the most urgent needs.

Allocation of Resources to Needs

Evaluation of the allocation of resources to needs was, of course, the most difficult step. The approach could not be based entirely upon the historical experience of those countries which, through several centuries, had evolved more adequate health services. The Latin American countries had not evolved organic services based on strong, long-evolving medical tradition following or paralleling economic expansion. Important health services in Latin America could not be delayed until adequately financed through successful industrialization, but had to be conceived as a necessary overhead or as a mortgage to accelerate economic expansion. Whereas in the more highly developed countries the growth of health services came about from the almost uninterfered-with operation of the law of supply and demand, many of the Latin American countries for several decades had attempted, within their limited resources, to make these services available to those unable to provide for themselves. Moreover, application of the experience of other countries to the problem in Latin America was limited by the fact that there was no broad pattern within which a blueprint could be developed.

Another positive factor limiting the application of the health services found in more highly developed areas was that Latin American countries desired to take shortcuts and make across-the-board use of the great body of technical knowledge that had become available. But, with necessary modifications, the experience of the more highly developed countries could be used for evaluating allocation of limited resources to meet great needs.

It was further recognized that weighing the allocation of resources to needs required consideration of cultural as well as fiscal and technical factors. Cultural factors must include the ways of life, the value standards, and particularly the beliefs and customs of the people with respect to health and illness. Also, the motivation of those nationals whose responsibility was the formation and execution of the health programs in the country must be understood. Without such data, obtained by the application of techniques developed by the social anthropologist and other workers in the social sciences, it would be impossible to determine the major aids and obstacles to accomplishing the objectives of the Institute's health program.

Analysis of the Servicio

Building up health services in a given country with financial and technical assistance from another country immediately introduces a factor that is not present where the development is totally indigenous. This had to be taken into account in the analysis.

Although the same general pattern of operation through a *Servicio* had been recommended to all 18 host countries, in actual operation there had developed about as many patterns as there were *Servicios*. On one hand this wide variation complicated the problem of assessing the *Servicio*, but on the other it increased the experience available for testing the value of different administrative relationships of the *Servicio* to the host governments. It was necessary, therefore, to analyze the effect of the most differing patterns from the following positions: (*a*) relationship of the *Servicio* to the host government; (*b*) relationship of the field party to the *Servicio* and to other parts of the host government; (*c*) organizational structure of the *Servicio;* and (*d*) principal operational devices employed by the *Servicio* in the execution of projects.

Relationship to Host Government

Analysis of the relationship of the *Servicio* to the host government included consideration of whether the position of the *Servicio* was actually that of a unit in the host government or that of merely an intermediary agency recognized by the host government as a subsidiary office of the Institute of Inter-American Affairs.

If the *Servicio* was actually a part of the host government and not merely an intermediary agency, the relationship had to be studied still further to determine if the program of the *Servicio* was coordinated with that of the indigenous health or allied service "on paper" only, or if the *Servicio* actually did function to stimulate and strengthen the growth of the indigenous service in which it was located.

This included consideration of the relationship of the *Servicio* to the head of the ministry or division of the ministry in which it was located.

Field Party Relationships

Examination of the relationship of the North American field party included reviewing the administrative relationship not only of the chief of the field party to the representative of the host government, but of all the technical members of the field party to the nationals with whom they were associated.

It was necessary to know if these technical personnel from the United States served as project directors, heads of functional divisions in the *Servicio*, or as consultants. If they served as consultants, did they serve as consultants to nationals acting as directors of projects executed by the *Servicio* or as consultants to other professional personnel in the structure of the indigenous service? Over the 10-year period had there been changes in the administrative relationship of the North American personnel to the nationals with whom they worked?

It was also important in the evaluation to determine whether the organizational plan of the *Servicio* was primarily for the execution of projects, or whether planning and evaluation was also recognized as a necessary function. This involved examination not only of the organization of both the *Servicio* and the field party, but also of the training and duties of the personnel.

The degree to which the *Servicio* succeeded in strengthening indigenous health services was also influenced by the operational devices employed in executing the individual projects. A possible measure of success in any given field in which continuous effort was exerted would be the rate with which change had been made from execution of projects almost entirely by the *Servicio*, with North American personnel serving as directors of projects, to execution entirely by the appropriate agency of the host government. Steps in between would include, of course, execution of projects by the *Servicio*, with nationals serving as project directors, and execution of projects by units of the indigenous health service other than the *Servicio*, with North American technicians serving as consultants.

Unless the planning and operation of projects are truly the result of teamwork between the North American field party and the host government, the activity may be, on the one hand, an almost direct service by the field party, or, on the other, a grant-in-aid or quasi-grant-in-aid from the United States to the host government.

New Foreign Operations Administration

The Foreign Operations Administration, a new agency in which are centralized foreign assistance and related economic operations formerly dispersed among several agencies, came into being on August 1, 1953, in accordance with provisions of the President's Reorganization Plan No. 7. It is responsible for the administration of the two major related assistance programs previously administered separately by the Mutual Security Agency and the Technical Cooperation Administration, as well as for the performance of other foreign aid and related economic functions formerly carried out by the Director for Mutual Security and the Secretary of State. The names "Mutual Security Agency" and "Office of the Director for Mutual Security" have been abolished.