



# Reclaiming the Authority to Plan: How the Legacy of Structural Adjustment Affected Bolivia's Effort to Recentralize Nutrition Planning

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**Summary.** — Thirty years after structural adjustment led to the widespread decentralization of developing country governments, signs are emerging of a slow return to centralized state authority. What is not apparent is how, and how well, national governments can implement actions after reclaiming the authority to plan. I answer this question through a case study of recentralization—Bolivia's Zero Malnutrition Program (ZM). My data come from ongoing fieldwork I conducted in Bolivia since the launch of the ZM program in 2007, but focus on additional, in-depth fieldwork I carried out over a period of 13 months during the program's fourth and fifth year of implementation. Data collection methods included semi-structured interviews, participant observation, document review, and secondary data analysis at local, regional, and national levels of the program. I argue that national planners may find it difficult to avoid replicating the fragmented planning model recentralization is often working against. In the Bolivia case, when ZM planners were given the rare opportunity to lead national-level health reform, they believed the fastest way to act was to rely primarily on short-term consultants. This allowed for fast action on the ground, but at the cost of constant staff rotation and loss of momentum, training gaps, turf wars, and eventually, a loss of accountability and credibility for the program overall. How ZM staff at different levels of the program overcame these added challenges, however, is perhaps the most important story. Through participatory planning, a negotiated implementation approach, the re-skilling of mid-level managers, and the work of emerging "street-level champions", I show how ZM planners and staff eventually began to restore public sector capacity. These findings contribute to the dearth of research on public sector implementation, particularly as it relates to developing countries and the growing initiatives aiming to effectively re-build national planning capacity. © 2016 Elsevier Ltd. All rights reserved.

*Key words* — policy implementation, decentralization, health planning, malnutrition, Latin America, Bolivia

## 1. INTRODUCTION

Thirty years after structural adjustment led to the widespread decentralization of developing country governments (Dobbin, Simmons, & Garrett, 2007), signs are emerging of a slow return to centralized state authority (Brenner, Peck, & Theodore, 2010; Grugel and Ruggirozzi, 2012). Latin America in particular, "the laboratory for neoliberal experiments par excellence" (2009, p. 171), has seen a surge of Leftist governments attempting to recentralize state authority (Escobar, 2010; Peck, Theodore, & Brenner, 2009; Stefanoni, 2013), as they aim to "reclaim the role of the protagonist that [they] lost as a result of decentralization" (Dickovick and Eaton, 2013, p. 1454). A return to country-led development is also supported by the 2005 Paris Declaration on Aid Effectiveness and follow-up Accra Agenda for Action in 2008, signed by 140 countries and over 40 international institutions (OECD, 2008). What is not apparent in these international agreements and state-led reforms is exactly how, and how well, national governments can *implement* actions after reclaiming the authority to plan.

The process of translating plans on paper to action on the ground is wrought with unexpected challenges in any context (Barrett, 2004; Pressman and Wildavsky, 1984; Pritchett, Woolcock, & Andrews, 2013). I argue that states attempting to re-establish central planning capacity after decades of public sector retrenchment and devolution face an even more daunting implementation context. I make the case that national planners may find it difficult to avoid replicating the fragmented administration model recentralization is often working against. On the other hand, I show how reversing or avoiding this tendency may be possible.

I build this argument through a case study of the Zero Malnutrition (ZM) Program, an example of broader recentralization processes unfolding in Bolivia, a country that was once a showpiece for structural adjustment (Crisp and Kelly, 1999) and decentralization (Kohl, 2003a). I explain my methods for studying ZM's implementation process after offering an overview of structural adjustment policies, how they played out in Bolivia (especially in the health sector) and the post-neoliberal responses being driven by Bolivia and other Latin American countries. My findings lay out the conditions that led ZM planners to rely heavily on flexible contracts to hire personnel, the implementation challenges this created during the program's first four years, and the approaches national and local ZM actors later applied to undo the obstacles they confronted.

Ultimately, this study contributes to the dearth of research on public sector implementation (Barrett, 2004; Saetren, 2005), especially as it relates to developing countries where

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knowledge about translating plans into action remains understudied (Blum, Manning, & Srivastava, 2012; Pritchett *et al.*, 2013). In particular, these findings offer instructive guidance to the growing initiatives aiming to re-build national planning capacity (Blum *et al.*, 2012; Pritchett, 2013).

## 2. STRUCTURAL ADJUSTMENT

Structural adjustment policies were first promoted by the International Monetary Foundation (IMF) and World Bank during the 1980s, as a condition for loans offered to countries with failing economies. These policy prescriptions were intended to encourage market-oriented development and to reform national government administration, seen as inefficient, corrupt, ineffective, and unresponsive (Babb, 2009; Helmsing, 2002; Khaleghian and Gupta, 2005; Murray and Overton, 2011). Borrowing countries were required to deregulate their economies, lower trade barriers, privatize state assets, and remove social support (Babb, 2009; Homedes and Ugalde, 2005; Lovell *et al.*, 2014). New Public Management theories also guided the use of strategies to infuse market discipline into government institutions, based on the idea that service delivery should become more competitive, efficient and flexible (Santiso, 2001). This included a shift from “government by control to government by contract” (Khaleghian and Gupta, 2005, p. 1084) via devolution of service provision to local governments, for-profit contractors, and non-governmental organizations (NGOs), as well as the use of temporary public sector staff (Osborne and Gaebler, 1992).

Most countries applying these neoliberal policies in the health sector lowered government investment (Bradshaw and Wahl, 1991), closed many public health care centers (Peet, 2003), increased privatization and user fees (Ewig and Palmucci, 2012; Grusky, 2001) and transitioned from tenured public employees to the use of temporary personnel (Homedes and Ugalde, 2005). Brazil, for instance, created 15 different types of contracts for public sector health staff under flexible contracts, just as many other countries in Latin America expanded the number of temporary workers, including Argentina, Colombia, Ecuador, El Salvador, Panama, and Peru (Homedes and Ugalde, 2005).

Some studies of health sector reforms in Latin America found that contracting sometimes improved access to services (Liu *et al.*'s, 2008). Noy (2011, 2013, 2015) also found higher—not lower—health care spending often correlated with greater involvement of the World Bank and IMF, that public sector spending continued to increase through 2009 even as private sector spending remained flat, and that the World Bank—the largest health sector lender at the time (Ruger, 2005)—had less influence on spending when governments had strong health agendas.

On the other hand, the World Bank admitted that its civil service reforms largely failed to produce more productive workforces and that the Bank's heavy reliance on long-term expatriate advisors was harmful to building institutional capacity (Dia, 1993). In Latin America, Homedes and Ugalde (2005, p. 13) argue that: “The promoters of health reforms failed to acknowledge that in a politically unstable region, civil service tenure was necessary to maintain an efficient, productive, and loyal labor force. Predictably, these threats triggered the opposition of professional associations and unions, led to strikes, and lowered productivity during the reform process.” Other evaluations found that only 17% of Bank projects strengthened local health institutions (Homedes, 2001). In some studies, worse health outcomes,

such as child mortality in Africa, were apparent in countries undergoing structural adjustment (Shandra, Shandra, & London, 2011). These revelations eventually led the Bank to roll out the Comprehensive Development Framework in 2000, with the intention of trying to actively build government capacity and support country-led agendas (Homedes, 2001).

## 3. STRUCTURAL ADJUSTMENT IN BOLIVIA

Bolivia was an “early adjuster”, one of the first of the heavily indebted countries where the IMF and World Bank initiated structural adjustment policies in 1985 (Heaton, Crookston, Forste, & Knowlton, 2014). The package of economic interventions initially reduced hyperinflation and supported moderate economic growth, but at the expense of increased poverty and inequality (Crisp and Kelly, 1999). Public spending on social services dropped from 8% of the GDP in 1981, to 1.8% in 1986 (Cuellar, Newbrander, & Price, 2000). Bolivia's decentralization process ten years later also produced mixed outcomes. Decentralization laws in the mid-1990s initiated elections for municipal representatives, created hundreds of new municipalities, legally recognized indigenous communities, mandated participatory budgeting, placed municipalities in charge of local infrastructure, and transferred 20% of national tax revenues to rural municipalities that had long been neglected (Fauget, 2014; Kohl, 2003b; Rowland, 2001). As a result, public sector spending became more equitable across social sectors (Fauget and Sanchez, 2008), but also increased regional inequities as recently formed local governments had little capacity to take on newfound responsibilities, or faced elite-capture (Batterbury and Fernando, 2006; Fauguet, 2014; Kohl, 2003b; Ribot, Agrawal, & Larson, 2006; Rowland, 2001). In the wake of these reforms, NGOs moved into fill governance gaps that emerged in health, education, and agriculture extension, growing from approximately 180 NGOs in 1981 to 1,600 in 2005 (Arellano-Lopez and Petras, 1994; Bebbington, 1997; Cordoba and Jansen, 2015; Kohl, 2003a).

Over this period, health care access in Bolivia improved for higher quintiles, but remained the worst in South America for the poorest populations (Silva *et al.*, 2011). Health outcomes were mixed, significantly improving in certain cases (e.g., Chagas, iodine deficiency), but worsening in others (e.g., anemia in pregnant women) (Silva *et al.*, 2011). The Pan American Health Organization and other scholars attributed these varied health outcomes to 20 years of neoliberal health policies that focused on “cost-effective” interventions, as opposed to primary and preventive care (PAHO, 2007; Silva *et al.*, 2011).

Neoliberal policies were also blamed for fragmenting Bolivia's health sector. Like many health systems in Latin America, Bolivia's was already segmented into services managed by the Ministry of Health (MOH) (which supplies free health-care to populations covered by state health insurance, largely poor women, and children), social security (which covers employees with company-sponsored health plans), private facilities, and traditional medicine providers (MOH, 1983). Under decentralization, however, the MOH system was further divided. Human resource management has largely remained centralized within the MOH. Nine departmental government offices (SEDES) manage salaries and technical support, along with Health Network Coordinators in charge of supervising groups of municipal health systems. Municipal governments manage physical infrastructure and some insurance packages of hospitals, health centers and rural health

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