A Women's Development Army: Narratives of community health worker investment and empowerment in rural Ethiopia*

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Abstract: Creating community health worker jobs in the public sector is a prominent goal in the global health-development industry. According to industry leaders, Ethiopia's government has created community health worker jobs at a scale and in a way that other countries can look to as a model. Based on extensive document review and interviews with district, national, and international health officials, we show that narratives about Saving Lives, Empowering Women, and Creating Model Citizens in a context of resource scarcity allow Ethiopia's ruling party to obtain international admiration for creating salaried community health worker jobs and to simultaneously avoid criticisms of its concurrent use of unpaid women's community health labor. Public sector community health worker investments in the 21st century are revealing of the layered narratives inherent in global development practices that entangle states, international donors, NGOs, and citizens.

Keywords: Ethiopia, women's empowerment, community health workers, citizenship, population health

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Introduction

Reducing unemployment is a contested approach to alleviating poverty and improving public health and wellbeing. In the public sector, the legacies of structural adjustment and neoliberal notions of cost-effectiveness and budgetary sustainability lead many officials to treat job creation for poor people as a poor use of money (Ferguson, 2010; Swidler & Watkins, 2009). But as the Millennium Development Goals (MDG) deadline has crept closer over the past few years, creating community health worker jobs in the public sector has become a prominent goal in the global health-development industry. Several global health leaders in public and private spheres have signed on, for instance, to the 1 Million Community Health Worker Campaign, sending a message that salaried community health worker jobs are unique, in that they offer not only livelihoods to the workers but also much-needed primary health care to wider communities. Conceptualized as important health technicians who wield multiple technologies (bikes, smartphones, forms, medicines, diagnostics) and who transmit information for population health monitoring and evaluation, community health workers are supposed to fill the gaps where doctors and other health professionals are absent or few. Even where there are other health professionals, community health workers are seen as useful, because they meet people "on their level." That is, they ideally come from the same socioeconomic backgrounds as the people they serve and provide them with relatively intimate care (Earth Institute, 2011: 6-10). Based on costing exercises, the 1 Million CHW campaign offers a simple equation:

6.86 USD per year per person served
+ 1 bicycle, 1 smart phone, 1 backpack = 1 paid, supervised, integrated CHW
+ political will

(McCord et al. 2013; Earth Institute, 2011; Singh and Sachs, 2013).

"Taken to scale" with sustained financing as well as best practices in recruitment, training, and supervision, this equation is supposed to translate into a health system-integrated, technology-equipped and data-driven community health workforce at the country level, which cost-effectively carries a country towards Millennium Development Goals and universal primary health care (Earth Institute, 2011; McCord et al. 2013: 250).

As the value of community health workers has been constructed and asserted in this way, sustaining the funding needed for large investments in community health workforces has come to be treated as imperative by industry leaders like the World Health Organization (2008). In contrast to those who see paying ground-level health staff as unsustainable, then, some global health leaders have criticized the common practice of relying on unpaid "volunteer" community health workers. Thus creating community health worker jobs has become an important terrain for debates over the role of public sector job creation in improving health and wellbeing in poor countries (Maes et al. 2010; Glenton et al. 2010; WHO, 2008; Drobac et al. 2013).

Backed by the Earth Institute's 1 Million Community Health Worker Campaign, the WHO's Global Health Workforce Alliance, and other industry leaders, high profile efforts at the country level have demonstrated the possibility of large-scale job creation for public sector community health workers in settings of "resource scarcity" and high unemployment (Earth Institute, 2011; Singh and Sachs, 2013; Farmer et al. 2013). Ethiopia's recent community health worker investments, namely its well known Health Extension Program, has been lauded by the 1

Million CHW Campaign and many other international health-development agencies, foundations, and NGOs (McCord et al. 2013; GHWA, 2010; Donnelly, 2010). According to these funding agencies, Ethiopia's government has created community health worker jobs at a scale and in a way that other countries can look to as a model. In this article, we look critically at the presentation of Ethiopia as a model for community health worker investment, describing the complex political and moral economy surrounding investments in CHWs.

In today's global health-development industry, the funds, energies, and affects of multiple players, including states, foundations, NGOs, and "local people", interact in complex ways (Ferguson, 2010; Cueto, 2013). Simplifying narratives and expressions of humanitarianism, however, often obscure these complex interactions of funds, energies, and affects (Fassin, 2013). Following historian Lorraine Daston (1995) and anthropologist Didier Fassin (2005), in this article we make use of the concept of moral economies, broadly conceived as involving the global and local "production, distribution, circulation, and utilization of moral sentiments, emotions and values, norms and obligations, in regards to specific social issues in particular historical contexts" (Fassin, 2013). The political and moral economies of community health workers include the production, distribution, and circulation of community health workers themselves, and the ideas, emotions and moral sentiments associated with them.

According to Fassin (2013), moral economies generally eclipse political economies: expressions of and narratives about empathy and concern for certain categories of people, often women and children, allow people to avoid "the necessary analysis of the structural determinants of their exposure to health risks and social hazards" (p. 129). When certain moral sentiments, emotions, and values become normative, Fassin asks, "what truth remains untold or even unspeakable?" (p. 111). As we show in this article, there are multiple narratives when it comes to community health worker job creation, which circulate among government and international NGO officials and donors, eclipsing underlying political-economic and historical complexities.

At the most simplifying and obscuring level are public statements by global health institutions such as the WHO and the 1 Million CHW Campaign, as well as by leaders of Ethiopia's Ministry of Health, which assert that Ethiopia's government has undertaken a bold investment in CHWs. As we explain below, such assertions obscure the complex political and budgetary processes that have accompanied this investment. Ethiopia's community health programs continue to rely on a massive amount of unpaid women's labor. Community health worker labor organization is nonexistent in Ethiopia, and contracts between labor and management are highly uncertain if not absent. In their place typically exist political dynamics in which government, donor, and NGO officials negotiate budgetary decisions in order to create (or not create) community health worker jobs and devise their job descriptions, while community health workers themselves are excluded from the policy-making process, are expected to do whatever it is that governments and NGOs would have them do, and in return receive below poverty-level wages or perhaps a mix of non-financial incentives (Maes et al. 2015).

Yet Ethiopian government officials and donor and NGO "partners" circulate powerful narratives that work to make unpaid community health worker labor and an overriding emphasis on worker/citizen discipline seem not only acceptable but desirable. Narratives about saving the lives of babies and mothers, empowering women, and creating model citizens in a context of resource scarcity are circulated by Ministry of Health officials and donors, as well as by district health officials who actually implement community health worker policies.

We explain these policies and the narratives circulated to legitimate them, by relating them to Ethiopia's high maternal and neonatal mortality rates, to Ethiopia's position in regional

and global political economies, and to the ruling party's history of mobilizing rural peasants and women in particular. These political dynamics shape attempts to improve population health at the district and village levels. These dynamics, however, are obscured by simplified narratives (of "saving lives" and "empowering women") inherent in global development practices that entangle states, international donors, NGOs, and citizens.

In this paper we focus on the discourses of government and international officials, and not on the perspectives and experiences of CHWs themselves (on the latter, see Maes et al. 2015). Our goal is to show how Ethiopia's national CHW program works *discursively* in policy documents and official narratives within government, NGO and donor circles, but not on the ground. Our analysis thus draws on interviews with national-level health officials and advisors in Addis Ababa (n=8), health officials in three districts in the West Gojjam zone of Amhara state (n=7), and Health Extension Workers in the same districts (n=11), as well as on an extensive review of documents produced by the Ethiopian government and donor partners, concerning primarily the Health Extension Program and the Women's Development Army. In our interviews, we asked about the Army—its structure and purpose. We asked about the economic calculations that inform decisions about employee pay and job creation. We also asked about their understandings of volunteer labor and livelihoods, and of the motivations of volunteers. We received IRB approval from Middlebury College and Addis Ababa University's Faculty of Medicine. We also pursued and received approval to carry out our research from the Federal Ministry of Health.

Ethiopia's Health Extension Program – A Pioneering Move "Away from Volunteerism"

Ethiopia's Health Extension Program, which centers on the creation of thousands of paid community health workers, is commonly identified by national and international health experts as the Ministry's "flagship" initiative and the "bedrock" of Ethiopia's attempts to expand primary health care. The Health Extension Program is frequently heralded as a model of community health worker investment for other countries to follow. Teklehaimanot and Teklehaimanot (2013), for instance, describe the Health Extension Program as a "model" for the 1 Million CHW Campaign. "The Ethiopian approach of revitalization of primary healthcare through innovative and locally appropriate and acceptable strategies," these authors explain, "can provide important lessons to other countries" (Teklehaimanot and Teklehaimanot, 2013: 10). In the *Bulletin of the World Health Organization*, McCord and colleagues (2013: 244) refer to Ethiopia, along with Rwanda and Malawi, as "pioneering countries" in community health worker investment. The Global Health Workforce Alliance, part of the WHO, calls the Health Extension Program an "innovative" program that reflects Ethiopia's "current momentum of international partnership, political commitment and leadership" (GHWA, 2010: 7). And in *The Lancet*, Donnelly (2010: 1907) claims that with the Health Extension Program, "Ethiopia had created a model to improve primary health care for others to follow."

What exactly is this program described as so pioneering, innovative, and successful? Starting in 2003, the Health Extension Program involved the construction of thousands of new health posts throughout the countryside, and the creation of full-time, salaried Health Extension Worker (HEW) jobs for roughly 34,000 young women who have completed 10 years of schooling. HEWs receive one year of health education before beginning work in a rural kebele, the lowest level unit of Ethiopia's federal government structure. There, they are responsible for a wide range of primary health care services, including preventive, promotive, and curative health

care, as well as data collection and reporting for monitoring and evaluation. According to both qualitative evaluations and government claims, Health Extension Workers are closely supervised by district health officials, local government officials, and health center staff. In return for their work, Health Extension Workers receive a monthly salary of about $100.

Accolades for the Health Extension Program like the ones described above illustrate that a government that rules over one of the poorest countries in the world can obtain significant international recognition for creating community health worker jobs. Community health worker reforms and "innovation" have become a key indicator of governmental commitment towards improved population health.[1]

An activist state

How did Ethiopia manage to create a salaried cadre of approximately 35,000 community health workers? The official narrative begins around the year 2000, when the Ethiopian Ministry of Health took stock of its progress in meeting the primary health care needs of the rural population and, disappointed, devised the Health Extension Program as part of a strategy to accelerate expansion of primary health care and to meet the Millennium Development Goals (FMOH, 2007). According to the official narrative, Ethiopia's government announced that it would fund the Health Extension Program with its own revenues, "demonstrating the commitment of the state" to meeting the MDGs and improving population health (GHWA, 2008: 4). After committing government funding, Dr. Tedros Adhanom, the Minister of Health of Ethiopia at the time, as well as Prime Minister Meles Zenawi, had an easier time lobbying international donors to provide additional support to the program (GHWA, 2008: 6).

Gaining donor support is complex. In the global health-development industry, there is a conventional conceptualization of "sustainability" that prefers funding projects that will continue to exist after a few years of donor funding end (Swidler and Watkins, 2009; Watkins and Swidler, 2012). In this approach, creating jobs and paying local labor with international donor funds is considered a bad idea, because these expenditures cannot be sustained by cash-strapped local organizations and governments when international funding pulls out. An unwillingness of some organizations to pay for local labor is also a result of the legacies of structural adjustment, which involved slashing government payrolls in order to balance government budgets (Pfeiffer and Chapman, 2010; Cometto et al. 2013; Goldsbrough, 2007). When the International Monetary Fund discourages governments from raising public sector payroll expenditures, paying for

[1] It is important to note, however, that experts do not really know just how successful the Health Extension Program has been, in terms of reducing maternal and child mortality in particular. The Global Health Workforce Alliance admits in a 2008 profile of the program that, "Some improvement has been observed in health indicators over the last five years, for example, infant mortality in 2005 was 77 per 1000, down from 97 in 2000. However, this cannot be attributed to the HEWs because the first graduates of the programme were only deployed in 2005. More time is needed before their impact can be fully evaluated" (GHWA, 2008: 2). Teklehaimanot and Teklehaimanot (2013: 9) also clarify that while observed changes in mortality and health indicators are "likely" due to the Health Extension Program, mediated by increased health service coverage and health-seeking behaviors, "formal systematic evaluation" is nonetheless required to know the real impact of the program.

essential labor becomes widely imagined as financially unsustainable (Dräger et al. 2006; Ooms et al. 2007).[2]

However, in creating the Health Extension Program, the Ethiopian government apparently used the rhetoric of sustainability in the service of creating paid jobs. Dr. Tedros Adhanom claimed that the success of the Program hinged upon "engaging health extension workers as full-time salaried civil servants" and thereby "moving away from volunteerism" (WHO, 2009). In Ethiopia's 4th National Health Accounts (FMOH, 2010), too, paid job creation is identified as the key to both the "HEP's early success and long-term sustainability." These statements echo the World Health Organization's 2008 recommendation that "essential health services cannot be provided by people working on a voluntary basis if they are to be sustainable" (WHO, 2008). These statements and recommendations are significant. They mobilize a specific, progressive conceptualization of sustainability that counters the more conventional conceptualization in the field of global health.[3]

Ethiopia was the first country to sign an International Health Partnership "compact" with its "development partners", which helped Ethiopia's leaders to pool donations that are not "ear-marked" for donor-driven projects and that thus can be more easily used for long-term expenditures like health worker salaries (FMOH, 2008). This approach is part of what makes the Health Extension Program "pioneering," "innovative," and "successful." According to this narrative, Ethiopia's head bureaucrats became participants, leaders even, in an activist movement away from volunteerism in primary health care delivery, through difficult negotiations with donors.

Aiding an ally

The narrative outlined above provides useful insight into competing notions of sustainability in global health. Yet with regards to Ethiopia, this narrative is decontextualized and ahistorical, conjuring a blank slate in which the world begins around the year 2000, with the announcement of the MDGs and Ethiopia's leadership realizing that it needed to greatly invest in primary health care (Easterly, 2014). Behind this narrative, there is a more complex set of processes involved in funding the Health Extension Program, including Ethiopia's role in the US/UK-led war on terror, its contentious human rights abuses, and the impacts these have on Ethiopia's relationship to international donors.

Ethiopia's previous regime, a military Marxist force known as the Derg, deposed of Emperor Haile Selassie in 1974 and ruled Ethiopia until 1991. In 1991, the Derg fell to a coalition headed by the Tigrayan Peoples Liberation Front (TPLF). The TPLF-led coalition, now

[2] In contrast, global donors have in recent history been more motivated to raise and spend the money to pay for high-level "expert" labor (i.e. NGO officers, consultants, and auditors) and medical technologies (i.e. the products sold by for-profit pharmaceutical and medical technology corporations). The sustainability doctrine has thus generated a salient inequality between the local, underpaid laborers and the salaried, transnational professionals involved in health programs in Africa.

[3] The WHO policy recommendation and the designers of Ethiopia's Health Extension Program implicitly argue that the widespread reliance on unpaid labor ironically creates programs that are unsustainable, in part because unpaid "volunteers" are usually poor and hopeful of receiving better opportunities, and that truly sustainable programs must create jobs backed up with a long-term commitment to funding by governments and global donors (Ooms et al. 2007).

known as the Ethiopian Peoples Revolutionary Democratic Front (EPRDF), still holds power.[4] The Derg signed on to the Declaration of Alma Ata in 1978 and created a community health worker program shortly thereafter (Kloos, 1998). Community Health Agents, as they were called, were supposed to be supported with donations or tributes of food and money from the community members they served. Partly because the Derg was stretched too thin by warfare, the regime did not invest much in the program. A few years before the Derg fell, the World Bank evaluated the program and concluded it required major investments (Kloos, 1998). When the EPRDF took power in 1991, however, it did not invest in the Community Health Agent program. More than a decade lapsed before the new regime began to re-invest in the newly designed Health Extension Worker program.

This decision to invest in primary health care, furthermore, occurred in the wake of not only the solidification of the MDGs but also Al-Qaeda's attack on the World Trade Center in New York City, which led the US and UK to ramp up its global war on terror. As Feyissa (2011) explains, the War on Terror had already included substantial investments in the Horn of Africa, targeting the rise of political Islam in the Sudan. The US' policy of "encircling" the Sudan involved establishing a category of what it called Frontline States, which included Ethiopia in the 1990s. In the 2000s, Ethiopia was categorized as an "anchor state" in the War on Terror and has remained a strategic ally to the United States (Feyissa, 2011: 793-4). As such, Ethiopia receives substantial US military aid (Feyissa, 2011).

It is rumored that the EPRDF made its initial investments in the Health Extension Program by dipping into its burgeoning military budget (personal communication, anonymous, 2014). If true, then the Health Extension Program is not a "totally government funded program." Instead, the Program was financed through US financial support for the EPRDF's military and the EPRDF's subsequent reallocation of funds from its military to its decrepit rural health system. The re-allocation of funds from Ethiopia's military budget to its health budget may sound progressive; however this is in a context of increasing—not decreasing—militarization in Ethiopia and the Horn. Even if the rumor is not true, its existence reflects contentious political and economic processes surrounding Ethiopia's overall development agenda, including its Health Extension Program.

In the first years of the new millennium, Ethiopia's ruling party likely perceived a double opportunity: to be a US/UK ally and receive military aid that could shore up the EPRDF against its internal and external enemies, and to seriously pursue the MDGs and thereby keep the international development aid money flowing (Feyissa, 2011). 2005, however, presented serious difficulties to the EPRDF. In May 2005, Prime Minister Meles Zenawi and the EPRDF were faced with apparently unexpected electoral defeats and election related protests in Addis Ababa. The party responded with state violence and repression, including the killing of protestors and jailing of many opposition leaders. In 2007 and 2008, Human Rights Watch released two reports documenting crimes against humanity perpetrated by the EPRDF military during its efforts to combat rebels in the Ogaden and Gambella regions. There was international backlash to the violence and repression. Members of the US Congress and other international donors threatened to defund the central government and to direct money instead to NGOs and to Ethiopia's district bureaucracies.

[4] For years, Dr. Tedros Adhanom, the previous Minister of Health who presided over the rollout of the Health Extension Program, has sat on the executive committee of the TPLF, the central core of political power in Ethiopia. Until his death in 2012, Prime Minister Meles Zenawi was the undisputed leader of the central committee of the TPLF. After his death, Dr. Tedros was re-assigned as Minister of Foreign Affairs.

The EPRDF in fact avoided a reduction in international aid channeled through the central government (Feyissa, 2011). As noted above, in 2007 the Ethiopian government's International Health Partnership "compact" with donors advanced Ethiopian leaders' efforts to direct development assistance for health into central government accounts. In 2009, the EPRDF-controlled legislature passed a law that greatly restricts the freedoms of NGOs and "civil society" (Feyissa, 2011). While the international and domestic NGO community expressed considerable dissent in regards to the 2009 law, ultimately they have had to follow suit.[5]

One way to explain Ethiopian leaders' apparent ability to pursue this agenda is to point to Ethiopia's role as a crucial ally in the war on terror. In 2006, the Union of Islamic Courts gained power in Somalia and appeared poised to take control of the country away from the internationally backed Transitional Federal Government of Somalia. Amid international criticism over Ethiopia's human rights abuses in the domestic sphere, the Ethiopian army, backed by the US, invaded Somalia to defeat the UIC (Barnes and Hassan, 2007). In this context, Prime Minister Meles Zenawi and Minister of Health Dr. Tedros Adhanom were able to not only avoid losing their grip on international aid, but also move towards a reform of development assistance for health that would channel more money through the central government.

Moving Away from Volunteerism?

So far, we have shown that the narrative that presents Ethiopia's leaders as pioneers in CHW investment obscures important political-economic processes that accompanied the financing of the Health Extension Program. Also softpedaled or absent in most international descriptions of the Health Extension Program is the fact that that from the beginning, Health Extension Workers relied heavily on a larger number of unpaid "volunteer community health workers" (CNHDE, 2011). These male unpaid community health workers were given a number of tasks including helping during immunization campaigns and relaying messages between households and HEWs (CNHDE, 2011; FMOH, 2007, 2010). The number of unpaid community health workers was never publicly tracked, but a conservative estimate is that there were five to ten volunteers for every Health Extension Worker.

In 2011, the Ethiopian government announced that it would replace the existing male volunteer community health workforce with a "Women's Development Army,"[6] which would include a huge proportion of the adult women living in Ethiopia's countryside. One woman out of every five households would become a Women's Development Army "leader," responsible for promoting the health of five neighboring households, under the supervision of the Health Extension Workers. These women are usually called "1-to-5 leaders." In addition, women called "1-to-30 leaders" are selected to liaise between a Health Extension Worker and five of the 1-to-5 leaders. All of these leaders are unpaid "volunteers", and tasked with activities similar to those performed by the previous volunteer CHWs. Thus much of the health care labor needed by the Ethiopian government's flagship program falls to unpaid workers.

Given the bold leadership offered by Ethiopia's government in "moving away from volunteerism," why did health officials continue to rely on so much unpaid labor? Part of the

[5] There is a great need for ethnographic work investigating exactly how domestic and international NGOs as well as bilateral, multilateral, and private donors have responded and adapted to this law.

[6] The Amharic translation is *yesetoch lemat serawit.* Sometimes the Army is called, in English, the "Health Development Army," and sometimes the "Health Transformation Army."

answer is that Ethiopia's population (at approximately 90 million) is one of the largest in Africa, and 85% of the population resides in rural areas. To reach the number of paid community health workers per capita that the 1 Million CHW Campaign recommends, there would need to be about four times as many Health Extension Workers (Earth Institute, 2011; McCord et al. 2013). Also, while the Health Extension Program was initiated during a time of burgeoning global health funding (Ravishankar et al. 2009), the global recession of 2008 constrained that funding (Benatar et al. 2011). In 2010, the Global Health Workforce Alliance thus reported that although the government had received a significant amount of pledges to its MDG Fund and pooled Multi-Donor Trust Fund, "it [was] still far from [the level of funding] needed based on the joint MDG costing" (2010: 26). Making a clean break from volunteerism may have seemed unaffordable.

Yet while the reliance on unpaid labor may have had a basis in budgetary constraints, it was supported through yet another layer of narratives, of Saving Lives, Empowering Women, and Creating Model Citizens. We describe each in turn below. Ultimately, these narratives help solidify a reliance on unpaid women's labor in the development industry, even in the face of an emerging global consensus on the importance of paying community health workers.

Saving Lives

Compared to other nations in Africa and around the world, maternal and child mortality rates in Ethiopia are high. A drop in the maternal mortality ratio (MMR) seen between 2000 and 2005 appears to have stalled in 2010 (Teklehaimanot and Teklehaimanot, 2013). According to Ethiopia's Demographic and Health Surveys (DHS), early neonatal death rates were also stagnant between 2005 and 2011 (Central Statistical Agency and ICF International, 2012).

The need to reach Millennium Development Goal targets by lowering these maternal and child mortality rates is routinely cited as the basis for major investments in Ethiopia's rural health care system, by both the government (FMOH, 2007, 2010, 2011) and major donors like the Gates Foundation. Health Extension Workers and volunteer community health workers, Ethiopia's Ministry of Health and its partners say, will hopefully do better in the coming years, particularly in promoting health facility births (i.e. not home births), as well as antenatal and post-natal care (FMOH, 2011; Teklehaimanot and Teklehaimanot, 2013). A post to the Gates Foundation web blog "Impatient Optimists" provides a typical example of the Saving Lives narrative:

> Ethiopia…is working diligently to save the lives of women and children; and it's doing it with the help of an army of thousands of women. The country is specifically aiming to reduce child mortality by two thirds and reduce by three quarters the maternal mortality ratio, all by 2015. Unfortunately some of these numbers are stubborn in their refusal to decline rapidly enough – or decline at all… It's why thousands of women are being trained as "frontline health workers" to spot diseases and get women and children treated as quickly as possible (James, 2012).

Reliance on unpaid community health workers in rural Ethiopia is thus partly driven by a construction of maternal and newborn mortality as urgent humanitarian problems by Ethiopian

and western health officials (see also USAID, 2012). When the focus is on immediately saving lives, questions of wages are eclipsed.

This process can be seen at work in the case of two multi-million-dollar Gates Foundation-funded projects, L10K and MaNHEP, aimed at reducing maternal and child mortality. Both of these projects were implemented through a partnership between John Snow International, the Ethiopian government, and other international NGO actors, and via the labor of government-salaried Health Extension Workers and unpaid community health workers. In their published newsletters and websites, L10K and MaNHEP construct Ethiopia's maternal and newborn mortality rates as major problems.

No efforts have been made to more fully move away from volunteerism in districts in which L10K or MaNHEP worked. We spoke with high-level staff at JSI and MaNHEP in Ethiopia, and they were well aware of the ethical and "sustainability" concerns involved in relying on unpaid labor, and questioned the Ethiopian government's policy of doing so. MaNHEP even produced a formative research report that provided evidence that volunteer community health workers were over-worked and often could not manage all of their farm work, housework, and community health work.[7] But high-level staff also felt strongly about reducing the number of maternal and newborn deaths in Ethiopia. If they wanted to carry out their respective projects successfully in "partnership" with the Ethiopian government, they had no choice but to rely on volunteer labor. It was a decision already made by Ethiopian government policymakers.

Instead, L10K commissioned a consultant to study volunteers' motivations and responses to various "nonfinancial incentives." Based on the study, L10K officials came up with recommendations for more and better festivals, trainings, visits by health officials, refreshments, prizes, credit schemes, and "community anchors," influential local people who can potentially motivate volunteers to work without a salary (L10K, 2010, 2012). Given the perceived urgency of reducing high mortality rates, these methods of encouraging or pushing Health Extension Workers and unpaid community health workers to reduce these rates seemed acceptable.

Creating Model Citizens

The creation of the Women's Development Army in 2011 was supported by another set of narratives supporting a reliance on unpaid community health labor (Fig. 1). One pervasive narrative is about creating model citizens. The Health Extension Program was originally conceived as a way to not only deliver primary health care, but to also create more and more "model households," households that adopt a full package of healthy beliefs, desires, and behaviors, and that assume "responsibility" or "ownership" for their own health, particularly with maintaining sanitation and hygiene, seeking antenatal checkups, and giving birth within health posts or health centers. As the name implies, model households are expected to get other households on board, and thus diffuse desirable beliefs and behaviors throughout the population (FMOH, 2007; CNHDE, 2011).

[7] See http://www.nursing.emory.edu/_includes/docs/sections/manhep/Formative_Research_Report.pdf [accessed May 7 2015].

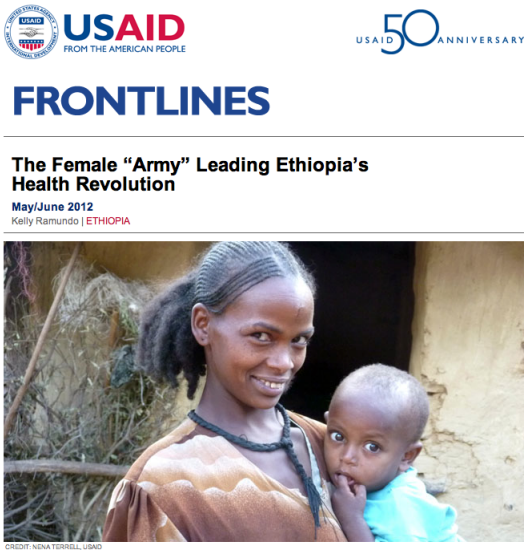

Fig. 1: The USAID web publication that profiled the new "army" reform (Ramundo, 2012).

A dose of healthy discipline

Government documents state that the diffusion of model beliefs and practices was happening too slowly during the first several years of the Health Extension Program. Ethiopia's 2011 Ministry of Health Annual Performance Report (FMOH, 2011) notes that there were many communities and families "lagging behind" in terms of adopting a "healthy lifestyle," a major impetus for organizing the Women's Development Army (CNHDE, 2011; FMOH, 2010, 2011; James, 2012; Teklehaimanot and Teklehaimanot, 2013). The Annual Performance Report portrays the new Army as a means of strengthening and improving the Health Extension Program, and extending it "deeper into communities and families" (FMOH, 2011). In the Army, one woman who comes from a "model household"—an Army "leader"—is to lead the women of five other nearby households towards a healthier lifestyle.

Connected to the goal of creating model households is an emphasis on discipline. In a January 2014 article in the UK newspaper *The Guardian*, Ethiopia's current Minister of Health, Dr. Kesetebirhan Admassu, made clear that military-like discipline was an ideal underlying the Women's Development Army: "Such a movement would not be successful without the discipline of the army… We said this is the way we really want to mobilise the community…they work with the discipline of an army" (Provost, 2014; cf. Admassu 2013). This rhetoric has resonances to the TPLF's guerrilla struggle against the Derg in the 1980s, when rural women were mobilized as fighters and lieutenants.[8]

[8] During the guerilla movement, the TPLF (the precursor of the EPRDF) also organized women's associations in Tigray and denounced women's oppression under feudal and capitalist regimes (Hammond, 1999). However, as recounted by Yewubmar Asfaw, one woman who fought in the struggle and served as a TPLF cadre member for several years, the TPLF ultimately sought to subordinate women to the cause of gaining political control over the

"The principal thing is unity in understanding"

The emphasis on discipline and the intention to create more and more model households through a pervasive one-to-five network point to a core belief of the Ethiopian government: that unified thinking and behavior across its population is key to achieving economic growth and the reduction of poverty. This philosophy is further elaborated within a non-public Amharic language document apparently created by a high level government official, a long series of PowerPoint slides titled "Developing a Change Army":[9]

> Like a regular army that is arranged for war, all the bodies—from the lower soldier to the higher leading powers—unite and form the army. [The Development Army] starts from the top leading power of the country all the way to the lower army fighter, for example to the rural farm owner…. The principal thing is unity in understanding and implementation…. It is not possible to say that a Change Army is established if there is variation in ideas….
>
> During formation of this Change Army, there will be struggle between development and rent-seeking. We must make the developmental front prevail... By [organizing the Army], we can have an unbreakable impact on rent-seeking and shift the power to the side of development once and for all, in an undisputable way.

The construction of "rent-seekers" as enemies who must be indoctrinated is a particularly important one. The government aims for a citizenry that will not seek to support themselves through patronage from the state, but instead will be productive farmers and entrepreneurs, creating wealth and "development" not only for themselves but also for the entire country (Little, 2013; Segers et al. 2008; Brown and Teshome, 2007; de Waal, 2012).

Accordingly, the Women's Development Army is expected to work without seeking "rent," that is, without expecting any sort of payment. In fact, the government has stipulated that Army leaders not be given *any* incentives by international NGOs or bilaterals. One national level NGO staff told us that the government had recently prohibited providing nonfinancial incentives for volunteer community health workers, and that NGOs were now prohibited from giving Army leaders so much as a T-shirt or an umbrella. One NGO official said he had been told regarding Army leaders, "don't touch them."[10]

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country. Some TPLF women sought to pursue a feminist agenda only to face intimidation and disempowerment from men within the TPLF leadership (http://www.ipsnews.net/2008/11/politics-ethiopia-disappointed-but-not-defeated/ [accessed May 29, 2015]). More recently, Azeb Mesfin, the wife of former PM Meles Zenawi and a former woman fighter during the guerrilla struggle, has been the sole woman on the TPLF central committee (International Crisis Group, 2012).

[9] The document was apparently written circa 2011 by someone near the top of Ethiopia's ruling party.

[10] He added, "the government doesn't want us to go below the Health Extension Workers." His NGO had also been clearly directed to do "no training whatever" of Army leaders and members. When asked why this restriction on training was in place, the official responded that the government wants to show its people that health-development "is a government effort, without any external input." Other NGO officials also speculated that restrictions on training and remuneration were to ensure that the government had control over motivations and incentives, thus increasing their influence vis-à-vis NGOs.

Through a focus on discipline and "development mindedness" as opposed to "rent-seeking," high-level government officials foreclose discussion of payment and instead focus on the special kind of goal that Army leaders will pursue: turning people into model families, systematically and quickly. Creating compliant patients is of course a goal of many health systems and global health interventions (Nguyen, 2010). But the EPRDF's conception of "model households" goes beyond the domain of behaviors like using bednets and getting prenatal checkups. Creating "model households" may also mean encouraging the population to support the EPRDF's medium-term hold on power and to be satisfied with contributing unpaid labor to state-led programs (Bach, 2011; Emmenegger, 2011; Little, 2013).

The EPRDF maintains a philosophy and style of government that encourages strong state power over the economy, promoted by the party as *abyotawi* (revolutionary) democracy (Bach, 2012; Data Dea Barata, 2012; de Waal, 2012; Feyissa, 2011). Mega-dam construction, large agrarian land leases to foreign investors, and achieving Millennium Development Goals are crucial elements in the ruling party's development dream of becoming a middle-income nation and a regional power in east Africa in the next couple decades (Feyissa, 2011; Teferi Abate Adem, 2012; Little, 2013; Abbink, 2012; Verhoeven 2013, 2015; Jones et al. 2013; de Waal, 2012). Yet they are still highly dependent on international donors, and beset with governing a massive rural population they see as having "backward" beliefs and behaviors. With its ideology of *abyotawi* democracy, the ruling party has thus aimed to maintain state power over not only the macro economy, but also over social organization and peoples' basic beliefs and desires.

Many farmers in agrarian Ethiopia say they feel the government treats them as people in need of indoctrination and micro-management from the top-down (Little, 2013; cf. Abbink, 2012 regarding southern agro-pastoralists). Recent ethnographers of agrarian Ethiopia describe a reality in which peasants do not simply "volunteer" their labor to agricultural and other "development" projects led by the state. Rather, peasants participate and donate labor in order to demonstrate their support for (or their lack of open opposition to) the ruling party. If peasants choose not to participate, they risk fines, confiscation of farmland, lack of access to key resources doled out by the government, and imprisonment (Harrison, 2002; Lefort, 2007; Little, 2013; Teferi Abate Adem, 2012; Abbink, 2012). A Women's Development Army with "unity in understanding" fits this pattern of government mobilization against rural people's putative backwardness, tendency towards "rent-seeking," and thus lack of development (Little, 2013).

"They work for themselves"

When asked why Women's Development Army leaders should not be paid, district level officials—in contrast to national level documents—did not engage in ideological talk about rent-seeking. Instead, they said that leaders in the Women's Development Army are not working for the government, but are working for themselves, simply engaging in household and social activities that are expected of any decent woman-citizen.

Some district health officials claimed that the women's army leaders are simply expected to tend to their routine "house work" with more hygiene in mind; to take care of their *own* health; and socialize with other women like they usually do, but now with a goal to spread and reinforce healthy household behaviors. Other officials asserted that Army leaders were fulfilling their own personal interests through their work and thus did not deserve pay from the government. One said, "They work for their own children, for their own families… So, the idea is, for the

development of their own community, they should work by being committed without any payment." Another explained, "They are not working for somebody else but for themselves. Once they are made clear and aware of this, they work with the understanding that their work is totally for themselves."

But army leaders are expected to do more than their own housework and neighborhood socializing. A mid-level Ministry of Health official noted that the Ministry intended that Army leaders would "take over" the promotive and preventive health care aspects of the Health Extension Program. Army leaders are also supposed to help compile health data and report it to the government.[11] Several district level health officials said that the introduction of the Women's Development Army had already successfully eased the workload of Health Extension Workers. One explained:

> In previous times, before the development army was established, the HEW had to go to each house for her work, but now the HEW supports the development army leader… So, the person that the HEW now directly interacts with, which was previously with each household, has become closer: it is the development army leader.

Thus the claim that Army leaders are working "totally for themselves" sidesteps the fact that their jobs are supposed to take over some of the workload of Health Extension Workers—that creating model citizens and monitoring this process is in fact work.

Taken as a whole, the Creating Model Citizens narrative is a powerful example of a health initiative involving an attempt to increase state power: both through the creation of a "disciplined" population, one that follows government mandates rather than rent-seeking, and also perhaps by putting greater pressure on rural populations to support the ruling party (Foucault, 1977, 2008; Ferguson, 1990). The program is, of course, unlikely to work so neatly in practice; this narrative reveals only the state's *intentions*, not what is actually happening in rural districts. On one level, in good neoliberal fashion, improvements in health in this conception will come not from additional state services, but from changes in the behavior of the poor (Goldstein, 2001). This narrative promotes claims that by engaging in healthy behaviors exemplified by "model families"—and by engaging in behavior change work for free, without engaging in "rent-seeking"—health will improve independent of state provision of higher quality health services.

This is not to say that the Ethiopian government, through the Health Extension Program, has not made significant efforts to improve health care in rural areas. Government legitimacy in the eyes of both peasants and of international partners appears to depend in part on genuine attempts at delivery of better health care. Still, the Creating Model Citizens narrative may function to relieve some of the pressure state leaders feel to both provide more services for citizens and pay citizens for their labor. Providing health care infrastructure and strengthening control over the behaviors/lifestyles of citizens are attempts both to improve population health and expand state power.

[11] One district level official hoped that the "hard" work—physical labor and extensive recordkeeping—would soon become the responsibility of the Women's Development Army once the Army was "strengthened." Noting their responsibilities, one high-level NGO official commented, "Of course [what the army does is] work."

Empowering Women

One of the most pervasive claims made by Ethiopia's Ministry of Health is that women are being empowered by the Health Extension Program and Women's Development Army (e.g. FMOH, 2007). "These development [army] teams," says Ethiopia's Health Sector Development Plan, "are being empowered to monitor health and well-being" (FMOH, 2010). These claims reflect the fact that "gender mainstreaming" is an official "focus area" within the government's development plans (FMOH, 2010).

These narratives do not, of course, exist in a vaccum. The narrative that women's empowerment will lead to development is currently a powerful one globally. "Promote gender equality and empower women" is a Millennium Development Goal. Nicholas Kristof and Sheryl WuDunn (2009) write that the goal of their bestselling book Half the Sky (which uses a photo of a starving Ethiopian girl to draw readers into the Introduction) is to "recruit you to join an incipient movement to emancipate women and fight global poverty by unlocking women's power as economic catalysts" (p. xxii). Melinda Gates (2014) was recently given space in the journal *Science* to argue that "there are strong associations between women's empowerment and specific health and development outcomes" (p. 1274).

"They are all happy"

This narrative had powerful reach within the Ethiopian government system; its rhetoric was pervasive among district health officials.[12] To "empower" women to participate more fully in Ethiopia's development, district health officials said they needed to convince men, and husbands in particular, to support the greater participation and autonomy of women. Men, they said, typically influenced every aspect of women's lives, "taking every power for themselves," and expected women to stay in the house and refrain from "meeting and discussing things together out of the house," except perhaps at church. Through the Women's Development Army, a district official claimed proudly, women "now have the freedom to communicate with their husbands," and to converse with women and even other men outside of the home. "Being able to talk freely like men is a big change," he said.

Empowering women and increasing their autonomy vis-à-vis husbands through the Army reform, district officials further claimed, improved women's lives. District officials said that by helping women to increase their knowledge, expand their social networks, and "develop their leading ability" through new social interactions, the Development Army was "making their lives better." District officials also argued that such empowerment provided emotional benefits to women—happiness—"even without payment":

> Starting from the leaders, they are all happy. I am not exaggerating when I say that women, in the past, used to be in the forest and knew nothing about leaving the village. Even leaving the home for health services was difficult due to the men's customs. Now, women are happy, even without payment, because being a WDA member means being able to talk freely and move outside the home like men.

[12] The extent to which they believed it is not knowable given our methods, but they incorporated the narrative fully into their rhetoric.

Talk of empowerment primarily arose when officials were discussing *unpaid* community health workers, and women among the peasantry more generally. District officials did not explicitly connect the job responsibilities of paid Health Extension Workers to the idea of empowering them.[13]

Alma Ata, Participation, and Empowerment

When talking about female community health workers, the empowerment narrative draws not only on global narratives of *women*'s empowerment but also on global narratives of CHW work as *community* empowerment. Historically, community health workers have been closely connected to the idea of local community participation in health systems. Early models of local participation included China's barefoot doctors as well as village health teams organized by Christian missionaries in Africa and elsewhere (Cueto, 2004; Lehmann and Sanders, 2007; Basilico et al. 2013). In 1978, the well-known Declaration of Alma Ata affirmed community participation as central to its goal of "health for all." It advocated the "full participation" of communities in health provision and emphasized that primary health care "requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care." The language in the Alma-Ata Declaration clearly connects local participation in primary health care to a pursuit of social justice (Muller, 1983; Cueto, 2004), the ability of socially and politically marginalized people to *control* their health care system and hold states, donors, and health-development foundations accountable.

Following Alma Ata, community health worker programs were frequently conceptualized as being central to such community participation. However, many CHW programs were actually statist and top-down, rather than autonomous movements seeking health equity and social justice (Basilico et al. 2013; Maupin, 2011). Such outcomes illustrate the durability and resistance to change of health care bureaucracies controlled by elites including doctors, government officials, and international donors (Nichter, 1999).

When it comes to the recent resurgence of interest in community health workers in poorer countries, it is important to investigate whether a social justice orientation remains at the margins (Arvey and Ferndanez, 2012). In language, today's CHW programs are much less likely to refer to goals of social justice than in previous decades (Lehmann and Sanders, 2007). Based on his work with community health workers in Mozambique, anthropologist Ippolytos Kalofonos (2014) explains that the role of CHWs "has shifted from 'change agent' to 'extension worker,' oriented towards technical and community management functions" rather than towards social justice.

Global narratives construct female community health workers as improving health and empowering themselves simultaneously as a result of their participation in health work (Ramirez-Valles, 1998). Because community health workers ideally meet people on their level and provide them with intimate, quality care, their roles are often said to provide them with experiences of emotional and spiritual satisfaction (Maes et al. 2010; Maes, 2012). These

[13] This is not to say that the empowerment narrative does not exist within discourse about HEWs. Dr. Tedros Adhanom, other Ministry leaders, and their development partners make much of providing Health Extension Workers with not only a salary, but also opportunities for some to continue their education and careers (USAID, 2012).

narratives of intrinsic satisfaction and empowerment form a powerful moral economy around community health workers.

Critiques of the Women's Empowerment Narrative

Jesus Ramirez-Valles explains that the women's empowerment narrative typically represents "third world and non-white" women as children who are "transformed, enlightened, and admired for their efforts despite adversity" (Ramirez-Valles, 1998). Laila Kabeer (1999) argues compellingly that descriptions of the "average disempowered third world woman" flatten significant social differences between women and create an analytical frame of an oppressed woman that lacks any social context and fails to acknowledge the power that many women do wield (see also Malhotra and Mather, 1997).

When women's participation in development programs is based squarely on women as central to domestic life and the domain of health, gendered power structures may actually be reinforced (Molyneux, 2006). While poor women are frequently conceptualized as having time to give (Budlender, 2004), women are often "an over-utilized not an under-utilized resource" (Elson, 1999). The inherent contrast between using women to make health development interventions more cost-effective, and simultaneously describing them as "empowering," lead Katherine Brickell and Sylvia Chant to describe the idea that women are naturally accustomed to and happy to engage in unpaid "altruistic" work as "one of the deepest bastions of gender inequality" (Brickell and Chant, 2010; Chant 2008).

Detailed ethnographic research on other CHW programs show that women's relationship with their work is complicated—that it empowers them in certain ways and deeply limits them in others. In some contexts, the ability to travel outside the home is important, and women find the health work that they do interesting and meaningful. Yet their position at the bottom of the health system hierarchy is one in which they have very little power, and is a position that many find oppressive (Closser and Jooma, 2013; Khan, 2008; Maes and Kalofonos, 2013; Mumtaz et al. 2003; Scott and Shanker, 2010).

The Value of Women

The decision to create the Women's Development Army represents an explicit shift in the gender makeup of unpaid community health workers—from men to women (CNHDE, 2011). In the past, both men and women have been compelled by the ruling party's district and local level arms to participate in building roads, digging rainwater harvesting pans, terracing farmland, and promoting the Health Extension Program, among other tasks. The Women's Development Army is another installment in a series of "mass mobilization campaigns," this one focused intently on women's beliefs and behaviors.

Why has the Ethiopian state decided to focus on women in this way? District officials told us that women are "naturally" suited to housework, family health and hygiene—and thus to meeting the health-related Millennium Development Goals. District officials also said it was easier for women, as opposed to men, "to accomplish the work of health at home." In addition, district officials felt women were ideally suited to convincing other women to adopt preferred behaviors:

> We are now observing big changes since the transition [from male to female community health workers]. In previous times, approximately 30 women per year in each district would deliver in health facilities. In this past year since the transition, approximately 2000 women delivered in health facilities, assisted by trained health professionals.

Another district level official said, "If we have women with us, it means that we have the family with us, the community with us, and hence the whole country with us… So, everything will be tied together by them, the women." As community health workers, then, women are framed as being more effective and thus more valuable than men.

District officials also valued women because they perceived them as less likely to expect pay. A Health Extension Worker agreed that the Women's Development Army reform represented an opportunity to engage a naïve workforce not "habituated" to payment:

> It will not be good if they habituate to money. Men got used to money because they got paid for training and vaccination campaign work. It was a problem that they got habituated to money.

One district health official also compared male volunteer community health workers to the Women's Army leaders:

> In previous times, it was the men who were attaching this work to incentives and needing incentives… But the women do not know such kind of incentives from the very beginning… The women do not expect money.

Thus, even as officials say they are empowering rural Ethiopian women to be more equal to men, officials at the district level value their female workers specifically for the ways in which, unlike men, they are associated with housework and less likely to demand payment.

There are still other perspectives on why women are particularly valuable to Ethiopia's government. An expert on Ethiopia's agricultural development sector told us that the ruling party has identified women as an important constituency that had not yet been sufficiently organized and pushed to adopt its philosophy and goals. Many of our interlocutors in Ethiopia—but not district level health officials—told us that they perceive that the ruling party created the Women's Development Army partly to solidify a countrywide, grassroots network of women who will conduct surveillance over their neighbors.

In Ethiopia, Health Extension Workers are supposed to sit on local government (*kebele*) councils or cabinets, which officially gives them a way to advocate for themselves and for the people they serve (FMOH, 2010). The Global Health Workforce Alliance argues that in Ethiopia, this arrangement leads to HEWs having "good relationships with decision-makers at [the] grass-roots level" (GHWA, 2010: 16). But being a member of a local governing council in the EPRDF's Ethiopia does not necessarily empower Health Extension Workers or Women's Development Army leaders to, for example, negotiate over their remuneration and job conditions, or to hold the government accountable for the injustices that they and their fellow villagers see and live every day. Instead, these councils may primarily serve as a venue to take

orders and report back on their activities (cf. Abbink, 2012). The actual consequences of the Women's Development Army and Health Extension Program on peoples' lives, and the ways that people are making their own attempts to reinforce, shape, and/or resist these programmatic reforms and their associated discourses, demand in-depth and sustained ethnographic investigation.[14]

Conclusion: Unpacking the Rationales for Unpaid Work

The creation of the Women's Development Army is tied up in complex political and moral economies, and serves a constellation of interests beyond simply the provision of health services. The political economy of aid and government revenue generation largely dictates how much international funding is available to pay community health workers, particularly over the long term. Further, the political economy within Ethiopia reflects governmental desires for "model," compliant citizens that support the EPRDF and carry out specific behaviors like limiting their fertility and giving birth in government facilities. Ethiopian officials can take advantage of the reemerging interest in community health workers and the push to create CHW jobs to advance their goals of legitimizing the government and strengthening its rural presence (cf. Ferguson, 1990; Abbink, 2012). In tandem with these political economies are extremely powerful moral economies that tout the importance of saving lives—especially the lives of mothers and children (Fassin, 2013)—and the importance of "empowering" women vis-à-vis their husbands.

The political objectives of the Women's Development Army are clear to NGO and donor officials in the capital. Interviewees repeatedly speculated that the Women's Development Army was in a sense a surveillance arm of the EPRDF. However, their awareness of these factors had little effect on their public support of the program.

Discourses promoting empowering women and saving lives have the effect of foreclosing discussions about giving CHWs rights to organize and take a seat at the policy table. The emergent moral economy of community health work thus prevents the potential needs and desires of the workers themselves from being seriously examined, and is likely to create new inequities and reshape existing ones.

These political and moral economies overshadow goals to "move away from volunteerism" and to champion a new approach to CHW payroll "sustainability" in global health, goals that both the Ethiopian government and international donors have espoused. Narratives about empowerment, resource scarcity, and saving the lives of children and mothers are empirically questionable but extremely powerful.

[14] From our preliminary observations in three districts of rural Amhara, the intended empowerment of Women's Development Army leaders appears to reference only potential empowerment within the family, and not empowerment within the health bureaucracy. Neither Health Extension Workers nor Army leaders appear to be more "empowered" by these programs in the sense of holding higher-level officials accountable, openly questioning policy and practice, and advocating for social and political changes (Maes et al. 2015). Recent qualitative work conducted in another part of Amhara regional state by Banteyerga (2014) suggests that through these same programs, Ethiopia's government is in some cases genuinely encouraging more women to make open requests and demands of government, pertaining to their desires for more easily accessible health centers (not just the smaller and less comprehensive health posts), better selection and stock of medicines at government pharmacies, and warmer, better quality health care within health centers and hospitals. Future work in various parts of Ethiopia is needed to understand this variation.

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