

Democracy, Primary Healthcare Institutions, and People with Multiple Health Burdens in the Developmental State of Ethiopia

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Abstract

Ethiopia's economy has shown rapid increase during the past decade, and the ruling party of the country has been engrossed itself in the idea of establishing a developmental state in which the party plays dominant role in guiding and managing the overall socio-economic development of the country. Some of recent development indicators indicate that Ethiopia is one of the sub-Saharan countries that have been most successful in translating recent economic growth into the well-being of its population. Global health experts commend newly introduced primary healthcare institutions of Ethiopia as the effort to deliver equitable health service to its population at the affordable cost. However, health interventions may result in wider welfare disparities, particularly when the government fails to address the diverse health needs of different groups of people. The question is whether the government of Ethiopia can effectively address these diverse health needs despite of the limited political diversity in the country. In this paper I focus on a group of people with multiple health burdens based on my field research in a provincial town in southern Ethiopia. I argue that the country's primary health care system fall short in addressing the needs of this certain group of people. I also argue that the country's legislation to confine civil society activities deprive the people of their access to necessary care and of the channels to advocate for recognition.

Introduction

Equitable access to primary healthcare services is an important determinant of the health of a population. India's population suffers from poor health outcomes despite the fact that the healthcare sector of the country has many advantages, including abundant human resources, robust private sector institutions, and flourishing alternative medical practices. Failure of public healthcare systems to provide universal coverage, coupled with high out-of-pocket health spending in society, has resulted in great disparities in health and welfare status within the population (Selvaraj and Karan 2009; La Forgia and Nagpal 2012; NIMS, ICMR, and UNICEF 2012; Purohit 2004). India's under-five infant mortality rate is markedly higher than the corresponding rates in Sri Lanka and Japan, where central governments play a leading role in providing universal healthcare services (Figure 1).

The healthcare development in Ethiopia presents a unique antithesis to the situation in India. When the current ruling party, the Ethiopian People's Revolutionary Democratic Front (EPRDF), seized power in 1991, public health institutions in urban areas were devastated, and were almost non-existent

in rural areas. Human resources for healthcare were extremely scarce. After two decades, the under-five mortality rate in the country fell by two-thirds, narrowing the gap with India (Figure 1). Although the country's health sector still suffers from insufficient human resources, the government has deployed more than 30,000 health extension workers (HEWs) in rural areas. Global health experts now consider Ethiopia's health policy as a contemporary model for achieving good health at low cost (Balabanova et al. 2013).

On the other hand, the government of Ethiopia has imposed severe restrictions on the activities of non-government organizations (NGOs) and civil society organizations (CSOs) that have played a significant role in socio-economic development in the country. Ethiopia has recently emerged as a "developmental state" poised to mobilize development resources under the command of the ruling party to bring about a rapid socio-economic transformation. Primary health is the area in which the "developmentalist" intervention of the EPRDF seems to have worked well. Indeed, primary health is a development sector in which top-down uniform interventions succeed. Admittedly, authoritarian governments are in a better position to take on such initiatives. In post-war Japan, the national health insurance (NHI) scheme and public health nurse (PHN) system have been key institutions that improved the health of the populations (Ikegami et al. 2011, Murashima et al. 1999). It was when the country was at war with China (1937–45) and with the United States (1941–45) that both of these systems were introduced and rapidly expanded in both urban and rural areas.¹ Ironically, the militarist government of pre-war Japan, which led the nation to unprecedented losses, laid the foundation for the current status of Japan's population as one of the healthiest in the world.² Though the political system of post-war Japan has been a more democratic one, it is often pointed out that the "developmentalist" nature of state governance under the one-party-dominant system (in which one party wins successive elections and its defeat cannot be envisaged in the near future)³ contributed to

¹ In pre-war Japan, the driving force to expand NHI coverage was the military, which was concerned about the physical condition of draftees and of women in their childbearing years. The government's efforts to expand coverage succeeded to the extent that 70% of the Japanese population was insured in 1943 (Ikegami et al. 2011,1107-1108). Deployment of PHNs was promoted under the Health Center Act of 1937. Formulation of the National Health Insurance Act in 1938 prompted a sharp rise in the number of PHNs employed under the NHI schemes and deployed to rural districts. The number of registered PHNs employed under the NHI schemes rose from 334 in 1941 to 9,641 in 1945 (Oguri 1991).

² How and when Japan's health transition happened, and what the primary factors for it were, is subject to further discussion. For instance, the infant mortality rate in rural Japan started to fall from 1920 in spite of stagnant public healthcare investment and growing economic disparities (Saito 2008). Ito attributes this to the growing number of public birth attendants who received training at modern schools and training facilities. The number of schools and training institutes training modern birth attendants in Japan grew from 267 in 1917 to 4,955 in 1935. The number of licensed birth attendants grew from 21,274 to 51,157 during the same period (Ito 1998). On the other hand, the tuberculosis mortality rate remained high throughout the first half of the 20th century in spite of the significant attention society gave to the disease. Oppressive working conditions in the industrial sector and expanding recruitment by the army (in which the incidence of tuberculosis was high) are believed to be the major factors that impede the government's efforts to control the disease (Aoki 2004).

³ See Suttner (2006) for definitions of one-party-dominant system and dominant-party system. In post-war Japan, the Liberal Democratic Party (LDP) has been in power since 1955, except for an 11 month period between 1993 and 1994 and a period from 2009 to 2012.

the rapid socio-economic reconstruction during the post-war period (Johnson 1995).

Thus, the question remains: Do we need an authoritarian government to achieve equitable health? In this paper I consider the relationship between political systems and primary healthcare development by examining health interventions in Ethiopia under the EPRDF. The top-down uniform nature of health interventions in Ethiopia seems to have contributed to recent rapid improvement in general health indicators. However, I argue that the top-down uniform nature of Ethiopia's health interventions has specific limitations in bringing about equitable health outcomes. While uniform interventions can actually bring about significant improvements in general health indicators, health outcomes in certain groups of people may remain stagnant, resulting in a widening health gap compared with the general population. This appears to be the case with people with multiple health burdens in Ethiopia, since the government's interventions are not designed to meet their diverse health needs. I also argue that such limitations may be reinforced by the government's policy of restricting the activities of NGOs and CSOs by depriving them of the ability to address the diverse health needs of the Ethiopian population.

The latter portion of the paper starts by examining two features of Ethiopia's political system: the dual governance of administrative and party structures, and party control of development resources and alienation of civil society. Both are important preconditions for formulation and implementation of health interventions in the country. Next, I explain the top-down uniform nature of government health interventions by focusing on the Health Extension Program, under which HEWs are deployed to convey key health messages to the rural areas in the country. Then I describe the living conditions of HIV-positive individuals with multiple health burdens in a provincial town of southern Ethiopia. Even with the support and care provided by the dedicated staff from a local association of HIV-positive people, it is very difficult to improve the living conditions of those individuals. Finally, I discuss how lack of political diversity may make it difficult for the government to recognize and address the diverse problems of its population. I compare Ethiopia's polity under the EPRDF with that of post-war Japan, where robust civic activities contributed to addressing the needs of people who were often neglected by mainstream society.

Key features of the developmental state of Ethiopia

During the 20th century, Ethiopia was regarded as among the most "starved" and "conflict-prone" countries in the world. However, the country's food security improved, and relative political stability was maintained during the two decades of rule by the late Prime Minister Meles Zenawi, who died in August 2012. Ethiopia's economy has increased by about 10% every year since 2004, and the

government has set the ambitious goal of achieving middle-income status by 2023 (MoFED 2010). It was in this context that Meles presented his aspiration for establishment of a “developmental state” as the only pathway for bringing about genuine transformation of the country’s economy and society (Meles 2006; 2012). The Growth and Transformation Plan, which serves as the strategic framework for the country’s development from 2010 to 2015, emphasizes the government’s role to guide and manage the overall development of the country and to mobilize domestic financial and human resources to achieve fundamental change in the economy and society (MoFED 2010,1).

Below, I explain two features of Ethiopia’s political system: the dual governance of administrative and party structures, and party control of development resources and alienation of civil society. Both are important preconditions for formulation and implementation of health interventions in the country.

Dual governance of administrative and party structures

Although the EPRDF is known for its centralized and top-down style of decision making, the way the ruling party of Ethiopia exercises its leadership over the country is not straightforward. A key feature of the EPRDF’s polity that affects the implementation of development interventions is what I call here the “dual governance” of administrative and party structures. When the EPRDF seized power after decades of civil war, it was urgent to contain intractable tensions among ethnic groups. The key tenet of the EPRDF was that the political stability and integrity of the state of Ethiopia could be achieved only through ensuring political and economic rights for many ethnic groups (or “nations, nationalities and peoples” according to the terminology of the EPRDF), which had been marginalized in previous regimes (Adhana 1994). The country was divided along supposed ethnic lines (which turned out to be highly controversial), and each regional state was endowed with significant administrative autonomy under the constitution of 1995.⁴

The World Bank reported in 2010 that the country’s decentralization initiative involving legal, regulatory, administrative, civil service, and public financial management reforms had made significant progress, including improving the equality with which basic services are delivered across the country (World Bank 2010). However, this report explains only one side of the coin. Whereas administrative authority is highly decentralized and resides at the regional and district levels, agreement with key political goals and important programs is strictly maintained through the party line. This dual governance operates under the *de facto* one-party system, where opposition parties are

⁴ See the “Proclamation to Pronounce the Coming into Effect of the Constitution of the Federal Democratic Republic of Ethiopia” No. 1/1995, *Federal Negarit Gazeta* 1/1, August 21, 1995.

effectively prevented from participating in state politics.⁵ All regional and federal parliaments are controlled by member organizations and allies of the EPRDF,⁶ and key positions down to the lowest level of the administrative structure are occupied by party members.⁷

Dual governance in Ethiopia has a profound impact on implementation of development policies in the country. The centralized uniform intervention in the primary health sector in Ethiopia (which I describe later in this paper), in spite of the highly decentralized administrative structure, was largely enabled by the uniformity of the party line. However, it must be noted that not every sector of development is provided with such a “privileged” status. In principle, Ethiopia’s federal bodies are expected to be engaged in general policy making. Policies will not be enforced unless regional states formulate matching state laws to implement specific interventions. Such division of administrative power is reflected in federal legislation concerning persons with disabilities. Federal legislation stipulates that the Ministry of Labour and Social Affairs has the power and duty to “undertake and facilitate the implementation of studies” on “the creation of enabling conditions for persons with disabilities to benefit from equal opportunities and full participation”.⁸ As a result, disability policy in Ethiopia lacks centralized leadership. It also lacks a country-wide program for policy implementation that is comparable with the Health Extension Program.

State control of development resources and alienation of civil society

The country’s master development plan for 2005–2010 stated that “a massive push” to accelerate growth was necessary to eradicate poverty and improve people’s livelihoods (MoFED 2006,46). The government of Ethiopia launched a number of development programs that provided substantial new employment opportunities to the people. It deployed more than 30,000 HEWs in the 5 years between 2005 and 2009 (Koblinsky et al. 2010) to implement the Health Extension Program included in its health sector development plan (MoH 2005). In addition to a program deploying more than 55,000 agricultural development agents (MoFED 2006,88), the government provided new opportunities for

⁵ The federal parliaments have been dominated by the EPRDF and no substantial opposition party was allowed to secure legislative seats, except for after the May 2005 election when opposition parties won one-third of the 547 seats in the House of Peoples’ Representatives (the lower house). The opposition parties were wiped away again in the subsequent May 2010 election when the EPRDF won all but two seats in the House of Peoples’ Representatives.

⁶ The Oromiya, Amhara, Southern, and Tigray regional states are ruled by member organizations of the EPRDF: the Oromo Peoples’ Democratic Organization, the Amhara National Democratic Movement, the South Ethiopian Peoples’ Democratic Front, and the Tigrayan Peoples’ Liberation Front, respectively. Another five regions (Afar, Somali, Harari, Benishangul-Gumuz, and Gambella) are governed by allies of the EPRDF.

⁷ Harbeson rejected Henze’s claim that the EPRDF brought about a successful democratic transition to Ethiopia’s polity, and argued that EPRDF rule led to the creation of a bureaucratic authoritarian regime in Ethiopia (Harbeson 1998; Henze 1998).

⁸ See Article 30-7 of the “Proclamation to provide for the definition of powers and duties of the executive organs of the Federal Democratic Republic of Ethiopia”, *Federal Negarit Gazeta* 17/1, Proclamation No. 691/2010.

employment in rural Ethiopia. In urban areas, the government implemented the Integrated Housing Development Program, which aimed to construct 400,000 housing units and create 200,000 jobs in Addis Ababa and in provincial towns by 2010. Although these targets were not met, 171,000 units were constructed and 176,000 new jobs were created in 5 years (UN-HABITAT 2010),⁹ which is an impressive achievement. In tandem with the government's efforts to provide employment and housing for the people, the EPRDF expanded its mass base of support. In 2011, the party reported that it had a membership of 5.9 million individuals.¹⁰

At the same time as the government increased its public investment, it also imposed severe restrictions on the activities of NGOs and CSOs. The "Charities and Societies Proclamation" issued in 2009 prohibited NGOs and CSOs from allocating more than 30% of their budgets to administrative activities (the 70/30 rule).¹¹ It also stipulated that NGOs and CSOs could not engage in most advocacy activities if they received more than 10% of their revenues from foreign sources (the 10% rule).¹² Though the 70/30 rule seems reasonable, a report commissioned by donor agencies operating in Ethiopia pointed out that the government guideline classified a number of actual program costs as administrative costs (DAG Ethiopia 2012). Considering that the NGOs in Ethiopia are already heavily burdened with reporting and auditing obligations, such a rule may have a negative effect on implementation of NGO activities. The 70/30 rule may also have a negative impact on the efforts of international NGOs to assist with the activities of local NGOs and CSOs, since the guideline treats any financial transfer to a downstream partner as an administrative cost (DAG Ethiopia 2013a).

That gross disbursements of official development assistance to Ethiopia through NGOs and civil society continued to grow in 2010 and 2011¹³ demonstrates that the NGO sector in Ethiopia survived the controversial Proclamation. Nevertheless, the new rules imposed under the Proclamation had a grave impact on the activities of NGOs and CSOs in the country. The number of federally registered local and international NGOs dropped by 45%, from 3,800 in 2009 to 2,059 in 2011 (Dupuy, Ron, and Prakash 2014). Research revealed that the Proclamation not only resulted in the closure of so-called "briefcase" NGOs, but also obliged many local human rights NGOs, especially those of the single-issue type, to shut down because they could not comply with the 10% rule. The research also

⁹ Additionally, programs for paving community roads with cobblestones are operating in more than 120 cities and towns in Ethiopia. A local business paper reported that 130,000 people (45% of whom are women) were estimated to be employed in the sector in 2011 ("Ethiopia: Cobblestone's Rocky Road," *Addis Fortune*, April 28, 2013).

¹⁰ "Some Facts about EPRDF", Public and Foreign Relations Department, EPRDF. (Retrieved September 24, 2013, from <http://www.eprdf.org.et/web/guest/aboutus>).

¹¹ See Article 88, "Proclamation to Provide for the Registration and Regulation of Charities and Societies", No. 621/2009, *Federal Negarit Gazeta* 15/25, February 13, 2009.

¹² See Articles 2-2, 15-2, and 15-5, "Proclamation to Provide for the Registration and Regulation of Charities and Societies", No. 621/2009, *Federal Negarit Gazeta* 15/25, February 13, 2009.

¹³ The figure rose from 516 million US dollars in 2008 to 539 million in 2009, 574 million in 2010, and 710 million in 2011, before decreasing to 622 million in 2011. (Data extracted on July 14, 2014 from the OECD Creditor Reporting System [<http://stats.oecd.org/Index.aspx?datasetcode=CRS1>]).

found that a number of NGOs had to reduce staff levels, scale down activities, or restructure in order to survive. Many surviving NGOs had to shift their activities from “rights based” ones to an older “needs-based” development approach, emphasizing service provision and gap filling (Dupuy, Ron, and Prakash 2014).

The Charities and Societies Proclamation imposed challenges on the activities of NGOs and CSOs operating in the health sector too. Considerable numbers of NGOs and CSOs in Ethiopia are involved in activities in the health sector. Of the 5,706 NGO and CSO projects conducted in the country in 2011, as many as 1,626 were health projects (986 were projects in child affairs and 754 were education projects) (DAG Ethiopia 2013b). Given that that some project-related costs, such as clinical mentorship, training for healthcare professionals, and outreach services are classified as “administrative costs”, it may be difficult for NGOs and CSOs to cope with the 70/30 rule. Additionally, the 10% rule may make it difficult for NGOs and CSOs to plan and implement advocacy programs on health issues (DAG Ethiopia 2013c). Severe restrictions on the activities of NGOs and CSOs, coupled with the aggressive expansion of the government’s primary healthcare services, which I describe in the next section, show the EPRDF’s intention to gain greater control over primary health interventions in the country.

Health sector development in Ethiopia

Since it seized power, the EPRDF has shown a strong commitment to improving the health of its people. Per capita government expenditure on health increased more than sevenfold in 16 years, from 4.1 USD in 1995 to 30.0 USD in 2011 (figures expressed in PPP international dollars). The government share of per capita total expenditure on health also rose from 39% to 70% during the same period.¹⁴ The number of health centers grew from 247 in 1997 to 3,245 in 2012 (MoH 2005; 2013). The health outcomes in the country have also improved considerably. In addition to the considerable improvement in child health described above, the burdens of some diseases on the population decreased significantly. Numbers of new HIV infections, which peaked at 170,000 in 1996, fell to 20,000 in 2012.¹⁵ The prevalence of tuberculosis decreased from 480 (per 100,000 population) in 1995 to 224 in 2012.¹⁶

A report commissioned by the Tony Blair Africa Governance Initiative (AGI), written by the

¹⁴ Data extracted on July 8, 2014 from the WHO Global Health Observatory Data Repository (<http://apps.who.int/gho/data/node.main>).

¹⁵ Data extracted on July 8, 2014 from UNAIDS AIDSinfo (<http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>).

¹⁶ Data extracted on July 8, 2014 from the WHO Global Health Observatory Data Repository (<http://apps.who.int/gho/data/node.main>).

staff of the Boston Consulting Group (BCG), lauded Ethiopia as one of the sub-Saharan countries that has been most successful in translating recent economic growth into programs that enhance the well-being of its population. The report noted that those gains were, in large part, driven by improvements in healthcare and that the country has successfully instituted a primary healthcare program that is transforming the health of its citizens (Baker et al. 2013). The BCG report noted a 3.5-year improvement in life expectancy at birth and a 23% reduction in the mortality rate of children under age 5 between 2005 and 2010, and identified HEWs as the major force behind these changes (Baker et al. 2013).

There is increasing recognition among international health experts that community health workers should play key roles within the formal healthcare system of each country. A task force of experts agreed that roughly 1 million community health workers should be trained and deployed in sub-Saharan Africa by 2015 (Singh and Sachs 2013). Ethiopia is considered one of the “model” countries in this regard. A review article in the *Lancet* indicated that Ethiopia’s health extension program is a novel way to affordably deliver healthcare services. The authors of the article noted that the effective leadership of Meles and health minister Tewdros Adhanom (2005–2012) had underpinned this success story (Balabanova et al. 2013). The government of Ethiopia deployed more than 30,000 HEWs in the 5 years between 2005 and 2009 (Koblinsky et al. 2010) as part of its national Health Service Extension Program (MoH 2005). Rapid deployment was made possible by the rapid expansion of the national technical and vocational education and training (TVET) program prior to the launch of the health extension program. Between 1996 and 2004, the number of TVET institutions providing formal non-agricultural TVET in the country increased from 17 to 199, and the number of students enrolled in these programs increased from 3,000 to 106,305 (MoE 2008,10). In 2005, more than 7,700 students, all female, were enrolled in a 1-year course devoted to TVET, related to health extension in four regions (Tigray, Amhara, Oromiya, and SNNP) of the country (MoE 2007). It is worth noting that the program also contributed to the creation of jobs for young educated women.

However, some researchers have offered sharply contrasting assessments of the quality of the program. Medhanyie et al. conducted interviews with 50 HEWs to assess their knowledge about antenatal and delivery care. They concluded that it was difficult for HEWs to play a key role in improving deliveries at health facilities, in participating as skilled birth attendants, and in providing on-time referral through early identification of danger signs given their impoverished knowledge base, the poorly equipped health posts, and the poor referral systems (Medhanyie et al. 2012).

Further studies are needed to determine whether HEWs have played (or will play) a key role in improving the health situation in rural Ethiopia. The decline in the infant mortality rate in Ethiopia started well before the introduction of the health extension program. It is difficult to verify the extent of the contribution of HEWs to the recent trend, and it must be noted that the decline in child mortality is related to many factors, including access to clean water (Cheng et al. 2012) and the

educational attainment of mothers (Gakidou et al. 2010). During the past two decades, significant improvements have been made in both the water and education sectors in rural Ethiopia.

Singh and Sachs noted that the key to a functioning community health worker system involves viewing workers as integral and formal parts of the healthcare system, with reporting lines, training, supervision, and feedback (Singh and Sachs 2013). Studies conducted during the early stage of the Ethiopian health extension program pointed out the lack of proper guidelines for, and meaningful supervision of HEWs (Kitaw et al. 2007; Teklehaimanot et al. 2007).

The Federal Ministry of Health is currently working hard to create a coherent system for its health extension program. The key strategy is the organization of the Health Development Army (HDA), a system for delivering key health messages to communities. According to Kesetebirhan, Ethiopia's Health Minister since November 2012, the HDA is a community-level woman-centred movement that functions through participatory learning and action meetings. Organizing a functional HDA requires the establishment of health development teams comprising up to 30 households residing in the same neighborhood. The health development team is further divided into smaller groups, each of which consists of a leader and five members. Such a group is commonly referred to as one-to-five (or *and-le-ammist* in Amharic). The formation of the health development teams and the one-to-five networks is facilitated by HEWs and the local administration. Furthermore, coordinating bodies have been established at each level of the government to monitor the implementation of the HDA. Members of the coordinating body are drawn from relevant sectors, such as agriculture, education, water, women's affairs, and social services (Kesetebirhan 2013).

People with multiple health burdens

Ethiopia's inclination to provide top-down uniform primary healthcare services, which I described in the previous section, is justifiable on the assumption that the population suffers equally from a lack of basic health services and therefore benefits equally from provision of such services. Although the great majority of the Ethiopian population has unquestionably benefited from current health interventions, some groups of people benefit less than the others. According to demographic and health surveys in Ethiopia, which show data disaggregated by household wealth quintile, the under-five mortality rate in the lowest wealth quintile (poorest households) increased from 130 per 1,000 live births in 2005 to 136 in 2011; the figures for the wealthier quintiles (or households) decreased (CSA 2006; 2012).

Although the Ethiopian population is often construed as equally poor and suffering from a lack of access to health services, it is important to recognize disparities in well-being among households, since poorly endowed households may require extra (medical and non-medical) support to achieve the same level of health as the general population. Sharp and Devereux distinguished "sustainable",

“viable”, “vulnerable”, and “destitute” households to analyze the livelihoods of rural households in northern Ethiopia (Sharp and Devereux 2004,235). Whereas a “sustainable” household is able to meet the livelihood needs by its own efforts and to establish savings and investments, a “destitute” household is defined as lacking access to the key productive assets needed to escape from poverty, and is therefore dependent on support from the community or government (Sharp and Devereux 2004,231-232).

Disparity in health status among individuals should also be considered. Individuals with chronic diseases, long-term illness, and physical and mental disabilities often need personalized care and support to achieve an improved health outcome. Below, I provide a brief account of a group of HIV-positive individuals with multiple health burdens in a provincial town in southern Ethiopia. I also explain the activities of an association of HIV-positive people that provides care and support to them. Herein, health burdens are broadly defined as physical and mental disease/illness (chronic or recurrent diseases and long-term illness in particular), disabilities, social isolation, and economic deprivation.

Care and support for HIV-positive individuals with multiple health burdens

HIV treatment is the intervention area in which the government of Ethiopia has demonstrated significant progress since 2005, when the government started to provide anti-retroviral treatment (ART) free of charge. The number of health centres and other health facilities providing ART increased from 168 in 2005 to 880 in 2012 (MoH 2013). The number of people on ART also increased, from 20,000 thousand to 290,000 during the same period, and estimated ART coverage reached 68% in 2012.¹⁷ There is little doubt that the overall health of the HIV-positive population in Ethiopia will continue to improve as the government expands its ART program. However, at the same time, it is possible that differential health outcomes develop among HIV-positive individuals with different social, economic, and health statuses. In sub-Saharan Africa, where institutional health resources are limited, social capital is an important determinant of adherence to ART (Binagwaho and Ratnayake 2009; Ware et al. 2009). In other words, HIV-positive individuals who have better access to financial and moral support from their family members and neighbours are less likely to give up taking medicines. In a case study in a rural village in southern Ethiopia, I observed significant differences in living conditions between two HIV-positive women with and without support from neighbours (Nishi 2014,38-43).

One might assume that the health conditions of HIV-positive people in Ethiopia are better if they live in urban centres since they have better access to health facilities than in villages. However, for those who suffer from multiple health burdens, including social isolation and economic distress, achieving a healthy life is extremely difficult, even when access to ART is secured. Currently, I am

¹⁷ Data extracted on July 15, 2014 from UNAIDS AIDSinfo (<http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/>).

engaged in research with members of an association of HIV-positive people in a provincial town in southern Ethiopia. Between August 2013 and March 2014, I conducted a preliminary questionnaire survey of 50 members who were identified by the association as having multiple health burdens. The survey revealed that almost all the respondents are on ART, and the majority of them report good adherence to the treatment. Still, the association finds it extremely difficult to maintain the living conditions of the members. Many of the respondents reported that their monthly income did not exceed 300 birr (15 US dollars), which barely covers the rent for a room in a local tenement. Some others responded that they were unaware of their income. Their income is actually quite unstable since the majority of them are either unemployed or day labourers. Various health burdens including gynaecological diseases, recurrent tuberculosis, physical disabilities, and mental illness were reported, though the respondents were relatively young (mean age 35 years). Social isolation seems to be another factor contributing to their poor life situation. A typical profile of a female respondent is something like this: she is living with one or more children, is divorced or widowed, and has little contact with her family members for (often complicated) reasons including her HIV-positive status.

The association provides home-based care (HBC) services to its members. All 17 HBC workers who work for the association are unpaid volunteers. Each HBC worker is assigned up to 10 clients. They visit each client once a week to make sure that they follow ART and to give necessary health and sanitation advice. When required they also provide basic care and household services such as bed bathing, cleaning, clothes washing, and shopping for the clients. If the HBC notices non-adherence to ART or salient changes in the client's health and living conditions they report this to the association. In response, the association takes necessary measures, such as referring the case to local health professionals. It solicits contributions from its members and from town dwellers to raise funds for medical treatment if necessary. In addition, it organizes income-generating activities and looks for personal sponsors (who provide regular support in cash or in kind) to secure income sources for destitute clients.

The association staff faces great difficulties in meeting the needs of its members because of shortages in human and financial resources. The chair of the organization explained to me that the lack of expert knowledge often makes it difficult for them to figure out the relevant response. For instance, one of the female members of the association has hearing impairment. Also, she cannot read and write since she never attended school (which is not uncommon among Ethiopian women). As a result, it is very difficult for the staff to communicate important health messages to her. It is also difficult for them to elicit her illness experiences, her problems, and her needs.

The chair also indicated that the living conditions of some destitute members were further deteriorating because of price hikes.¹⁸ Particularly damaging was the surge in room rents triggered by

¹⁸ Annual consumer price inflation in Ethiopia was 33.2% in 2011, 22.8% in 2012, and 8.1% in 2013. (Data

the expansion of a government university located in the town.¹⁹ The low-income population in the town, including the association members, were forced out of accommodation located in the town centre and forced to migrate to the suburban outskirts. This not only affected the access to work of the association members, who rely on day labour, but also made it difficult for the association's HBC workers to make weekly visit to their clients. While expansion of the university meant increased economic and educational opportunities for the better-endowed population of the town, it could mean further marginalisation for the most disadvantaged group of people.

Discussion

Ethiopia's late Prime Minister Meles Zenawi argued that the establishment of a dominant-party system that guarantees the stability and continuity of development policy is essential for a successful developmental state in Africa (Meles 2006). He focused on the fact that some welfare regimes emerged under the rule of a dominant party that had maintained power for several decades after World War II. According to Meles, the best examples of democracy under a dominant-party system were seen in some Scandinavian countries under social democratic regimes and in post-war Japan under the Liberal Democratic Party (LDP) (Meles 2006). Indeed, post-war Japan has been characterized as a developmental state in which the government played a significant role in improving the welfare of the population under a dominant-party system. With the exception of brief interruptions in 1993–94 and 2009–12, the LDP has essentially remained Japan's ruling party since its formation in 1955. Under LDP rule, Japan experienced the so-called post-war miracle in which its GNP grew fivefold in the two decades preceding 1973. Policies to deliver equitable welfare to the population were also promoted under the LDP, resulting in the establishment of an East Asian welfare regime (Goodman and Peng 1996; Lee and Ku 2007).

Post-war Japan's most notable achievement as a welfare state has been its delivery of good healthcare at a low cost with minimal disparities among different groups (Shibuya et al. 2011). One of the key policies contributing to this achievement has been universal health coverage promoted by the central government: since 1961 almost all Japanese citizens have been insured by either employee-based or community-based health insurance schemes (Ikegami et al. 2011). Additionally, Japan's public health nursing system (which is comparable to Ethiopia's health extension program) has contributed to the promotion of health at the household level (Murashima et al. 1999), particularly in the areas of mother–child health (Yamagishi, Yamazaki, and Ota 2003) and tuberculosis prevention (Kobayashi 2013).

extracted on July 24, 2014 from World Bank Open Data [<http://data.worldbank.org/country/ethiopia>].

¹⁹ Between 2008 and 2012, enrolment in undergraduate programs in government universities in Ethiopia increased by 86%.

It must be noted, however, that political diversity and robust civic activities have also been important driving forces behind equitable healthcare in post-war Japan. Achievement of universal health coverage in Japan was facilitated by the relatively strong presence of opposition parties, such as the Japan Socialist Party²⁰ (Sugita 2007). Civil society campaigns against the widespread pollution caused by rapid industrialization also played a decisive role in protecting the health of the affected populations.²¹ Rights-based movements contributed to the promotion of the social rights and welfare of people with disabilities, who had been largely neglected by society in the past.²² In 1970s Japan, some public health nurses were actively engaged in civic movements to address the needs of mentally ill people, another neglected group (Nakazawa and Utsuno 1985). More recently, NGOs have been active in providing housing, mitigating disease burdens, and addressing the care needs of elderly and socially isolated ex-day labourers in the city of Osaka.²³ Actions to establish social support and healthcare access for otherwise neglected groups of people are an important part of post-war Japan's aspiration for equitable health and the right to life.

Conclusion

In Ethiopia, the lack of political diversity may make it difficult for the government to recognize and address the diverse problems of its population. Current legislation regarding civil society activities in Ethiopia makes it difficult for people with disabilities and other groups with unaddressed needs to advocate for the recognition of these needs. Thus, it is largely up to the government healthcare institutions to identify unrecognized health needs and deliver appropriate interventions. However, it is questionable whether Ethiopia's HEW and HDA systems actually accomplish this goal given their top-down organization. While uniform interventions can bring about significant improvements in general health indicators, health outcomes in certain groups of people may remain stagnant, resulting in a widening health gap compared with the general population. The HIV-positive

²⁰ The Japan Socialist Party held one-fifth to one-third of the seats in the House of Representatives (the lower house of the National Diet of Japan) during the period from 1955 until 1996. The party lost its political significance after 1996, when many of its MPs left the party to join the newly formed Democratic Party of Japan.

²¹ The significance of anti-pollution movements as a form of protest against the Japanese government's growth-oriented policy was described by Broadbent (1999). The movement's significance in the context of post-war Japan's party politics was described briefly by Masumi (1988,296–298).

²² Most notable is the *Aoishibanokai* movement, the association of people with cerebral palsy in Japan. The association was formed in 1957 as a small group in a neighbourhood in the city of Ota, Tokyo. The group later emerged as a nationwide advocacy movement for people with disabilities.

²³ Supported housing services have been provided by several local institutions since 2000 in Kamagasaki, a neighborhood in Osaka with a highly concentrated population of ex-day labourers. Health Support Osaka, which was established in 2006 to facilitate tuberculosis treatment and prevention, is another notable and active NGO in this neighborhood. The prevalence of tuberculosis in Kamagasaki exceeded 500 per 100,000 population in 2009. This was much higher than the figure of 19 for the general population of Japan.

individuals with multiple health burdens whom I describe in this paper are an example. Although they have access to HIV treatment provided by government health institutions, health burdens such as chronic diseases, recurrent illness, social isolation, and economic deprivation prevent them from achieving better living conditions. Even with support and care provided by the dedicated staff of a local association of HIV-positive people, it is a very difficult task to stop further marginalization of individuals with multiple health burdens given the limited financial and human capacity of the association.

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