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Does volunteer community health work empower women? Evidence from Ethiopia's Women's Development Army

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Key Messages:

- The Women's Development Army offered women new roles, and in a few cases new opportunities.
- Work for the Women's Development Army also reinforced gender hierarchies in new ways, requiring women to work without compensation on pre-determined tasks directed by top-down government structures.
- Rhetoric about the empowering aspects of CHW programs should not be taken at face value; ethnographic work should be more widely used to reveal the full complexity of program impacts on womens' lives.

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Abstract

Of the millions of Community Health Workers (CHWs) serving their communities across the world, there are approximately twice as many female CHWs as there are male. Hiring women has in many cases become an ethical expectation, in part because working as a CHW is often seen as empowering the CHW herself to enact positive change in her community. This paper draws on interviews, participant observation, document review, and a survey carried out in rural Amhara, Ethiopia from 2013-2016 to explore discourses and experiences of empowerment among unpaid female CHWs in Ethiopia's Women's Development Army (WDA). This program was designed to encourage women to leave the house and gain decision making power vis-à-vis their husbands—and to use this power to achieve specific, state-mandated, domestically-centered goals. Some women discovered new opportunities for mobility and self-actualization through this work, and some made positive contributions to the health system. At the same time, by design, women in the WDA had limited ability to exercise political power or gain authority within the structures that employed them, and they were taken away from tending to their individual work demands without compensation. The official rhetoric of the WDA—that women's empowerment can happen by rearranging village-level social relations, without offering poor women opportunities like paid employment, job advancement, or the ability to shape government policy—allowed the Ethiopian government and its donors to pursue "empowerment" without investments in pay for lower-level health workers, or fundamental freedoms introduced into state-society relations.

As she did every Wednesday in her small town in rural Amhara, Ethiopia, Eleni was running a meeting. After a delay caused by a spontaneous downpour, 30 women gathered under a straw roof supported by large sticks. Eleni started by managing a lending circle; she collected small sums of money from each woman, recording every transaction in a notebook.

Eleni was a leader in the Women's Development Army (WDA), a government-sponsored organization of unpaid female Community Health Workers (CHWs). The Ethiopian government created the WDA in 2011 to supplement its Health Extension Program (HEP), which provides Primary Health Care to rural communities. The WDA aims to incorporate the vast majority of the adult women in rural Ethiopia into an enormous network. One woman out of every five households is to become a 1-5 WDA leader, ideally chosen for her status as a "model woman," meaning she has adopted practices deemed healthy and development-minded by Ethiopia's government. In turn, a group of five or six 1-5 leaders is led by a 1-30 leader like Eleni, tasked with holding weekly meetings to discuss issues identified as important by the government, such as giving birth in health facilities and building latrines. The government promotes the program as contributing to women's empowerment.

In Eleni's group, there were steep penalty fees for missing a meeting (10 birr or around 50 cents, unaffordable for most women). So, nearly everyone was in attendance, many with their children. Most children were playing quietly, but Eleni's 3-year-old son stormed in and out of the room with a series of tantrums.

One woman's sharp voice rose: "There should be a penalty fee for women whose children are interrupting the meeting." The intent was clear: this was a complaint about Eleni, whose status in the community was tenuous. Eleni had no land; she distilled a little *areke* (liquor) to sell at the weekly market, but mostly, she and her two children relied on the charity of relatives who themselves did not have enough. Despite her warm and outgoing personality, as a young, divorced, impoverished woman, Eleni sometimes had trouble maintaining authority in WDA meetings.

Eleni, a Model Leader

Ethiopia's HEP, launched in 2004 and hailed as a global exemplar, trains and employs female secondary-school graduates as CHWs. Two Health Extension Workers (HEWs) are linked to each health post, serving between 5,000 and 15,000 people. HEWs in our

study area provided vaccinations and family planning, and were the frontline providers for malaria, diarrhea and other common illnesses.[1]

The WDA was designed to task-shift some community-based activities, particularly the promotion of healthy behaviors, from HEWs to a huge cadre of unpaid female workers. WDA leaders, supervised by HEWs, ideally help during immunization campaigns, keep track of pregnancies and illnesses, and relay messages and data between households and HEWs. They receive no pay, and government policy has been that they receive no incentives of any kind from donors, NGOs, or other partners.

Eleni's path to being a WDA leader came from a difficult personal history. As she told it, in high school, she was at the top of her class, and looked forward to attending university and finding employment. But in 9th grade, Eleni was raped while coming home from the grain market, and she became pregnant. The rapist came forward to claim the baby; under pressure from her family, Eleni married him. She struggled to keep up with her schoolwork, housework, and child care; eventually, she dropped out of school. After the birth of their second child, when Eleni's husband started drinking heavily, Eleni got a divorce and a restraining order with the help of the government's Women's Affairs Office. The relief was enormous, and Eleni wanted to help others in similarly difficult situations, so she became a WDA leader.

Because Eleni was an exemplary 1-30 leader, energetically carrying out her tasks, she was occasionally selected for paid government activities. For a while, she earned $20 a month to teach an adult literacy course for women. Eleni enthusiastically shared the course's curriculum with us: it included topics ranging from basic arithmetic, to the importance of handwashing, to the evils of child marriage (see Figure 1), to "modern" practices like eating from a table.

Eleni's own home, a tiny rented stick-and-mud room, did not have room for a table; it was furnished with a bed, a small coal cookstove, and two wooden benches. The other half of the small building was rented by three men who sometimes drunkenly yelled questions at her through the thin walls.

Eleni said she was glad to work for the WDA: she would rather "help my community, instead of sit around all day." While she ultimately wanted to start her own business instead of engaging in government work, she had no money to do this, and no way to get it. In the WDA savings circles, the women were only able to scrape together 5 birr (25 cents) per week. One of Eleni's groups dreamed of purchasing a motorcycle

[1] There is a program of career advancement for HEWs. However, HEWs in our study told us that despite getting additional training and an advanced designation, they had yet to receive any additional pay or responsibilities.

rickshaw, but at this rate, saving up the money to buy one could take them nearly seventy years.

In this paper, we critically evaluate women's empowerment in the WDA. Because this workforce was living in precarity and prone to exploitation, using female volunteer CHWs had limitations. Some women discovered new opportunities for mobility and self-actualization through this work, and some made positive contributions to the health system. Yet their empowerment was limited because, by design, women in the WDA had limited ability to exercise political power or gain authority within the structures that employed them.

Community Health Workers: A Female Volunteer Workforce

Globally, most CHWs are women. Many of the most lauded and copied CHW programs – from the Comprehensive Rural Health Project in Jamkhed, India, to BRAC in Bangladesh, to Ethiopia's HEP – have engaged female-only workforces. There are perhaps twice as many female as male CHWs in Sub-Saharan Africa (One Million Community Health Workers Campaign, 2018).

There are several reasons for this. First, women are often socially well positioned for maternal and child health work. In Ethiopia, the government says that female CHWs are "culturally acceptable" because of "women's traditional role as care providers and as health care seekers" (Ethiopia Ministry of Health, 2013, p. 27).

Also, women are frequently idealized as caring and virtuous, natural change-makers ripe and ready to deploy for development (Akintola, 2008; Chant, 2016, 2008; Friedemann-Sánchez and Griffin, 2011; Molyneux, 2006; Ramirez-Valles, 1998). A recent One Million CHW Campaign report says that women "often are superior CHWs" compared to men, due, in part, to "their attachment to the community, and their less common use of alcohol in evenings" (*One Million Community Health Workers: Technical Task Force Report*, 2013).

Less explicitly stated, but nonetheless important, is the fact that female labor is often cheap. Women have fewer employment opportunities in many social contexts, and may be more willing (or seen as more willing) to accept a very low wage (Closser et al., 2017). The report quoted above hints at this, saying that women "are less likely to abandon their posts as CHWs for better opportunities" (*One Million Community Health Workers: Technical Task Force Report*, 2013). Many countries, including India, Nepal, and

Ethiopia, transitioned their volunteer CHW programs from male to female workers in the last 50 years, in part because of demands by male CHWs for more payment.[2]

CHW programs have long been pitched as cost-saving strategies, and many CHWs across the word are described as volunteers (Bowser et al., 2015; Haines et al., 2007; Vaughan et al., 2015). But, the term volunteer is slippery and often misleading: many volunteer CHWs get per diems or incentives of some type that they consider pay—albeit very low pay (Brown and Prince, 2015; Closser et al., 2017; Prince and Brown, 2016; Scott and Shanker, 2010).

The choice to employ a volunteer CHW labor force may also be ideological. Many policymakers believe that if she is to be a true community activist, a CHW cannot simultaneously be a paid employee at the lowest level of a government health system (Schaaf et al., 2018). Others argue that CHWs should be driven by "intrinsic motivation," framed as leading to a more committed workforce (Glenton et al., 2010).

But the lofty vision of CHWs as intrinsically motivated, empowered community activists often masks a starker reality. Scholars have argued that volunteering in sub-Saharan Africa is a neoliberal practice in that shifts responsibility for key state tasks onto individuals (Prince and Brown, 2016; Swidler and Watkins, 2009). CHWs are frequently disempowered staff at the bottom of health bureaucracies, facing severe restrictions on their ability to advocate for themselves or for the needs of their communities (Campbell and Scott, 2011; Colvin and Swartz, 2015; Maes, 2015; Walt and Gilson, 1990). Unpaid work for health programs in low-income contexts is often taken up by people who greatly need paid work but who cannot obtain it, and who hope that volunteering will eventually lead to a paid position (Closser, 2018; Colvin, 2016; Maes and Kalofonos, 2013; Rosenthal, 2017).

The discourse surrounding volunteer CHW work has thus been steeped in a complex empowerment-exploitation dynamic (Smith et al., 2012; Stark, 1985; Werner, 1981). Some CHWs may in fact experience forms of disempowerment through their work, if they are treated as disposable labor to be disciplined, rather than as agents who engage in processes of problem identification, policy solutions, and political advocacy (Justice, 1984; Morgan, 1993; Nichter, 1996). This dynamic has animated passionate debates (Schaaf et al., 2018). As David Werner put it in 1981, are CHWs lackeys or liberators?

[2] This statement is based on conversations with policymakers with historical knowledge of these policy shifts.

The Empowerment Question

Across the world, women have been repositioned – often willingly, but rarely on their own terms – to provide low-cost labor for health programs. Female volunteer CHW programs are frequently promoted as "empowering" the women they deploy (e.g. USAID Nepal, 2013; Maes et al., 2015a). Empowerment rhetoric both provides a moral compass for health interventions, and lends them legitimacy (Cornwall and Brock, 2005).

Some CHW programs have managed to thrive in environments of scarcity, while simultaneously giving poor women a voice (Arole and Arole, 1994; Nandi and Schneider, 2014). These programs set a complex and debatably unrealistic model for programs that followed, particularly in the absence of careful evaluation of why and how these efforts "worked." Empowerment is often assumed rather than demonstrated in CHW programs. The exceptions are anecdotes framed to appeal to donors, where empowerment is often conflated with carrying out top-down directives, as in the case of a report about the WDA saying that its members are "empowered to learn about the HEP" (L10K, 2013).

Despite the pervasive rhetoric, we know very little about how community health work actually empowers women, and even less about women's own perspectives of their empowerment (Sabo et al., 2013). Previous research in other regions of Ethiopia showed that work as an HEW provided new opportunities for paid employment, mobility, and impact on community health, but also required women to work on pre-determined tasks under often poor working conditions for low pay (Jackson et al., 2019). The gender norms and power relations that a given CHW navigates are context-specific, shaped deeply by local culture and politics (Steege et al., 2018). This article aims to speak to global debates about CHW empowerment by examining a specific case.

We are anthropologists, and we define empowerment in solidly social terms. Empowerment is a dynamic "social-action process" (Wallerstein and Bernstein, 1994, p. 142) in which an individual or group identifies and pursues, with increased self-efficacy, changes to their social and political environment that secure better living conditions for them. This could result from more fully embodying traditional roles (Mulema, 2018), by changing them, or by forging new paths. This process is complex—it involves individuals and groups with unequal levels of power and often divergent values and priorities. Empowerment is distinct from participation; changes in power and control of resources are necessary for empowerment (Laverack and Wallerstein, 2001; Rifkin, 2003).

This social and political definition of empowerment is different from some common conceptualizations. For example, a recent excellent assessment of empowerment in

CHW programs defines empowerment psychologically, focusing on CHWs' own perceptions of self-efficacy and impact (Kane et al., 2016). The findings of that study resonate with our own data. However, from an anthropological perspective, ideas of personal efficacy can only be labeled "empowerment" insofar as they lead to changes in power and social status. Ethnographic work can show whether psychological empowerment leads to other groups' accepting CHWs' demands and allowing them to influence policy.

Without this focus, female CHW programs can veer easily into "empowerment-lite" (Cornwall et al., 2008; Farmer, 1996), feeding into technocratic, top-down efforts to change low-level women's and men's beliefs and behaviors, and neglecting active engagement of poor and rural women in processes of social and policy change. In doing so, these programs may in fact strengthen power structures that limit women's agency.

Methods

Our research team carried out mixed-method research on the WDA in the West Gojjam Zone of Amhara State between 2013-2016. Researchers on this project shared a commitment to anthropological method and theory. Our backgrounds were otherwise diverse, including Ethiopians and Americans with a range of experience with CHW programs and Ethiopian health systems. The material in this paper is drawn from semi-structured interviews, participant observation, document review, and a survey.

We interviewed 16 NGO, academic, and government officials in Addis Ababa and in Bahir Dar, the capital of Amhara state. These interviews were conducted in English. Obtaining valid interview data in the political context of Ethiopia is challenging: respondents tend to echo the party line (Østebø et al., 2018). NGO and academic respondents were often quite open and critical in discussions of WDA policy, while government officials hewed closely to official rhetoric.

We also interviewed 17 government officials at the *woreda* (district) level in West Gojjam Zone. In these interviews, conducted in Amharic, most respondents confined their remarks to describing and commenting positively on government policy. These interviews were nonetheless very useful in understanding how WDA policy was framed and implemented in our study area.

Finally, we interviewed 69 HEWs and WDA members in six *kebeles* (local administrative units) in West Gojjam. In our first round of interviews, most respondents repeated the same positive things about the WDA. We conducted multiple interviews with many respondents, for a total of 106 interviews; over time, a more complex picture of our respondents' relationship with the WDA emerged.

We conducted participant observation in health posts and in the homes of HEWs and WDA leaders, taking detailed fieldnotes. In seven homes, including those of the women called Eleni and Yezena in this paper, we carried out more intensive participant observation; our relationships with these families deepened with repeat visits over the course of years.

Our document review included WDA policy documents and public media in English and Amharic. We transcribed interviews and translated Amharic-language documents and interviews into English.

Our survey included WDA participants in four study *kebeles*, diverse in terms of accessibility and level of activity of the WDA. After randomly selecting and surveying 1-30 leaders from lists provided by HEWs, we randomly selected and surveyed 1-5 leaders and members affiliated with these 1-30 leaders. In total, we surveyed 73 1-30 leaders, 142 1-5 leaders, and 207 1-5 members. We pooled data from all four *kebeles*, and analyzed survey data in SPSS.

We coded interview transcripts, fieldnotes, and documents using MAXQDA. For this paper, we focused on material coded as relating to women's empowerment, and to experiences within government hierarchies. Our team discussed the interview data and, relying both on understandings of cultural context and on the positionality of individual interviewees, established consensus on interpretations of that data.

The IRBs of Anonymous College and Addis Ababa University's Faculty of Medicine reviewed and approved this research. We also received political approval from the Federal Ministry of Health and the Amhara Health Ministry.

In the discussion that follows, we focus on 1-30 leaders within the WDA, who have more CHW responsibilities than 1-5 leaders.

The Women's Development Army: Designed to Empower

Ethiopia's ruling coalition of parties, the Ethiopian Peoples Revolutionary Democratic Front (EPRDF), holds a high-modernist ideology and aims to run a strong, stable, authoritarian state. It bases much of its legitimacy on its delivery of "development," and considers its rural population a "traditional" and dependency-prone people in need of discipline, mobilization, self-reliance, and modern mentalities (Abbink, 2012; Adem, 2012; Little, 2014). The EPRDF has long linked gender equality with modernization and economic development (Østebø and Haukanes, 2016).

Content analysis of policy documents and high-level interviews revealed a pattern in which poor rural women were described as virtuous, modern, and inherently development-minded (Figure 2), while poor rural men were often portrayed as barriers to development. In the health sector, federal-level plans asserted that "empowering women is the principal means to ensure the health of all family members in the household" (Ethiopia Ministry of Health, 2015, p. 61). The WDA, a program shared between the Ministry of Health and the Ministry of Women's Affairs, was focused on achieving this empowerment. A national level minister explained that the WDA was helping women build "social capital" that they could use to rise above "harmful traditional practices." An Amharic-language government document on the WDA in our study area said that a primary challenge was "the harmful traditional practice of women to kitchen and men to forum"—that is, women's inability to participate in decisionmaking was seen as a barrier to development.

In interviews with district government officials (the vast majority of whom were men), male obstruction of female initiative was repeatedly mentioned as a problem. Men were presented as symbolic of the "old way" (or the "cultural" way), and blamed for slow health and development progress. One official commented,

> The first [problem] is men's dominance or control of women. There are husbands who would tell their wives not to go to health facilities to get treatment for their sick children. It is easy to convince women [to adopt health behaviors], but it is tough to work with men.

In addition to reflecting EPRDF ideology, such framings resonated heavily with constructions of women in global health and development discourse (Parpart, 2014). Melinda Gates, for example, told Fortune magazine about women's groups like the WDA, "women tell me that when they spend time together in these groups, they see that they have a lot more power over their lives and their futures than they ever imagined" (Fairchild, 2014). And, these framings of women were tied to global funding streams. The "Leave No Woman Behind" program featured in Figure 2, which implemented Eleni's adult literacy course, was largely financed by the Government of Spain's Millennium Development Goals Achievement Fund (UN Women and Cooperacion Espanola, 2013).

The vision of women as more development- and health-minded than men was tied to ideas of their domesticity. Comparing the WDA, with its model women, to Ethiopia's model farmer program, made up predominantly of men, is instructive here. Both Ethiopia's model farmers and its model women were subject to top-down directives, but while model women were expected to transform domestic life, the government's goals for its cadre of largely male model farmers was economic, focused on increasing crop yields (Berhanu and Amdework, 2011; Lefort, 2012). Thus even as government

officials argued for moving beyond a "women to kitchen" ideology, the tasks allocated to women reinforced their domesticity.

Government officials repeatedly framed women's ties to the home as the reason they were ideal for health work, and as the reason that WDA leaders did not need to be paid. A woreda-level official explained that WDA work "does not take that much time. The work is mainly what they would be doing anyway in their village through their social interactions." Another official noted that WDA leaders would benefit from the program because "they will be empowered."

Thus the wicked problems of rural poverty were framed in a way that shifted attention away from the EPRDF, elites in Ethiopia, or the global neoliberal economic system. In this representation of the problem (Bacchi, 2009), local cultural norms and local impoverished men, not larger structures, were to blame for poverty and poor health outcomes. The solution was framed as resting within the control of poor rural women empowered by meeting in groups and following government directives. The Ministry of Health asserted that the WDA "empowers communities to manage health programs specific to their communities, thus enabling them to produce their own health" (Ethiopia Ministry of Health, 2015, p. 22). This framing served the EPRDF well. Although freedoms of speech and political freedoms may be emerging under the current government, the EPRDF has historically had a weak record on free speech and human rights (Maes et al., 2015a, 2015b; Østebø et al., 2018).

The EPRDF drew on a vision of an inherently health- and development-minded female populace leaving the house and gaining decision making power vis-à-vis their husbands—and using this power to achieve specific, state-mandated goals, from the feeding of specified foods to infants, to the construction of a certain type of storage shelf for household goods. "Women" were constructed as a homogeneous, meek population, ready to embrace empowerment and yet also relatively easy to control. The goal of the WDA was to take control over rural women's activities away from "men" (meaning these women's husbands), and to replace it with government control.

Freedom of Speech and Movement

Some WDA leaders asserted that the WDA was empowering, their language echoing government officials and documents. For example, one said:

> We used to be left at home, but now we are free to come out of the home and express our ideas… Now this government has come for us and enabled us to speak our ideas freely, our problems, and get solutions.

Another noted:

> We the women have become able to get together and to be part of the solution for different community problems. In the past it was only the men who sat for leadership always.

Since such statements are so close to government rhetoric in an area where the party line is well known, they may not exactly reflect these women's experiences (Østebø et al., 2018). Still, this widely repeated discourse is likely to have some impact on social norms.

Our survey found that married 1-30 and 1-5 leaders were more likely to have decision making power within their households than other women (Table 1). Our interviews suggest that this was largely a result of the selection process. One HEW, for example, told us that some women could not become 1-30 leaders because they were "under the control of their husbands," who would not "allow them to go out of the house and do the work." Selection processes may also explain why 1-30 leaders were more likely to be divorced or separated (Table 2). One woman explained that a local 1-30 leader was selected because "she is not married and is living alone and is free to work. She can leave her home and come back when she wants."

The WDA leaders whose households we stayed in moved about a great deal, in part because, like Eleni, many WDA leaders were not only managing domestic tasks but also struggling to provide for their families economically. They procured water; visited markets; sold goods like *areke* (homemade liquor); and visited neighbors and stores. Women's mobility for WDA activities was not unusual against this backdrop.

Yezena, a Disillusioned Leader

Yezena lived in a rural town, a strip of dusty stores over an hour from the main road. Her two-room house was a slice of a larger building, and the corrugated metal door was left open for light; there were no windows. The main room doubled as her café, and benches for customers lined each mud-straw-and-dung wall. On one wall, decorated with woven plastic sheeting, Yezena's high school graduation photo had pride of place.

There was a steady stream of customers; most ordered *tella*, a home-brewed alcoholic soft drink, for 1 birr (4 cents) a glass. Yezena made multiple varieties of *tella*, and when she poured any given version, she bragged in a booming voice that it was a local favorite. Often she worked on embroidery while serving customers, deftly creating a neon green pattern and cajoling people to buy it from her. Yezena knew all of the

gossip, and delighted in repeating it, usually with dramatic embellishment delivered with a knowing wink.

Yezena was loud and lighthearted, but she could be serious. When a teenaged girl came to her for advice on how to leave an abusive boyfriend and mend relations with her estranged parents, Yezena urged the girl to go back to school. She told the girl in a caring but forceful tone to get herself in a position where she could support herself. If the girl did this, Yezena promised, she would talk to the girl's family and help to make amends.

Yezena's own marriage had ended in divorce, and the past few years had been hard. Opening her café had helped financially, but eking out a profit there was difficult. The profit margin on *tella* was razor thin; when the price of sugar increased, Yezena was forced to close. She had taken out a loan to buy a small fridge so that she could sell bottled soda and beer, which had a higher profit margin, but her customers could not afford these luxuries, and eventually Yezena gave up and unplugged the fridge.

Water was also a challenge. Yezena's 5-year-old son hauled jerrycans of water on a plastic sled from the spring a kilometer away, where lines were long and access was contested. Yezena and her children rarely washed their bodies, and they almost never washed their much-mended clothes.

Yezena had once been an enthusiastic 1-30 leader, but over the years we knew her, she ceased to hold meetings at all. A turning point was when Yezena worked on a disease control project carried out by an international NGO. This NGO had given HEWs a small per diem for their work, but had given nothing to 1-30 leaders. (Officials at this NGO told us they would much prefer to pay everyone, since volunteer labor was unreliable, but the government would not allow it.) "They paid the HEWs and the head of the health center," Yezena commented bitterly, but "they gave us nothing: not so much as a gift of soap. Why are NGOs paying HEWs and not us?! They have money!" To top it off, she continued, "community members think and act as if we are being paid for our work."

Yezena decided that without pay, she wouldn't hold WDA meetings. "Why should I waste my time trying to collect all those women when I have work to do?" she commented. Yezena's resistance was effective: other WDA leaders had followed her lead, and the local HEW complained that she couldn't get them to do anything.

Controversies over Financial Support

Yezena and Eleni were not alone in struggling with poverty; in fact, they were better off than most WDA leaders. Our survey showed that 1-30 leaders had few assets and services (only about 7% had electricity, for example), had heavy workloads, and commonly experienced both food and water insecurity (Anonymous 2018).

Leaders repeatedly described WDA meetings as venues to "solve our own problems," or to "help each other." When it came to requesting support from the government, they said things like "I have never asked a question" (see Table 3). Yezena explained that there was little point. "If the administration is going to give us something," she explained, "*then* we will ask them about it."

Officially, the WDA was designed to provide an avenue for women to make their collective voices heard. At the same time, asking for material assistance was seen as dependency by the government, and regarded as a disruption to the process of empowerment. Some of our respondents noted that upward communication could be difficult. One HEW commented on the "lack of attention given to WDA leaders by *kebele* leaders." One 1-30 leader, commenting on a negative experience being "insulted" at a *kebele* meeting, said that attending such meetings had been a "mistake."

A savings circle for chickens was the cause of particular bitterness in one town. A group of WDA women started the circle, which grew to more than 100 women when the local government said it would provide chickens if the group raised 60 birr ($3) per person. The women slowly saved up the required amount, only to see the government raise the required per person investment to 300 birr, and then to 400 birr. The women pressed on, raising 400 birr each, but the third time the government tried to raise the women's contribution, the women lost their patience. The investment fell apart, and the WDA leader who had organized the venture felt blowback from other women. She explained that they told her "not to call us together for any WDA work like this again," because "the government doesn't want to help us, they only want us for our money."

Other WDA groups also banded together for government-promoted income-generating activities only to find that they were expected to provide the necessary capital investments themselves. Many echoed the WDA leader who asked, "Why should I work with different people, with different behavior, with my own money? That is not profitable for me."

As Eleni's challenges maintaining authority demonstrate, these dynamics could lead to social stress. Another leader commented, "There are even times when we are insulted and disrespected for the work we do… Women want to know why we are only telling them what to do without doing something useful to help them."

Questions of Political Benefit

Such dissatisfaction might have stemmed in part from perceptions that WDA leaders were well connected politically. Academics and NGO officials in Addis Ababa, for example, speculated that the WDA was made up of party supporters. There was precedent for this view: the model farmer program mentioned earlier in the paper was a political as well as an agricultural operation. In return for party support, or at least political neutrality, farmers hoped to receive material support from the government (Lefort, 2012).

Model women, like model farmers, occupied an unpaid position. Yet, like Yezena, many complained that they were asked to take on substantial work, for which they received little or no benefit. The small per diems that model farmers received for attending meetings were not available to them—something that one district official commented was unfair.

Across our study sites, there were some active WDA groups, like Eleni's, but others where the women did not meet at all, or only came reluctantly when called by government officials. Women who became WDA leaders in hopes of getting government benefits became disillusioned when those benefits did not appear. Hardworking women living in great precarity made cost-benefit calculations about where to spend their time, and WDA activities did not seem worth it to many.

Empowerment in CHW Programs

The WDA had complex impacts on the lives of its leaders. Along with other government programs, it shifted discourse on women's place in society, offered women new roles and access to resources, and provided self-actualization to some leaders like Eleni.

WDA work also took leaders away from other tasks without compensation. Under what at the time was an increasingly authoritarian regime, the WDA intended to expand the reach of government hegemony into domestic practices ranging from childbirth to methods of consuming food (cf. Ferguson, 1994). Such extension of state power, insofar as it narrows the range of acceptable choices for any given woman, may in fact function to limit her agency (Biseswar, 2008).

The global donor community has given Ethiopia's HEP and WDA positive press and encouragement. The ideology of the WDA—that women's empowerment can happen

by rearranging village-level social relations, without offering poor women opportunities like paid employment, job advancement, or the ability to shape government policy—serves both the EPRDF and its donors. Rather than confronting larger social systems, this ideology frames rural women as the solution to problems caused largely by rural men, and aims to shift domination and discipline of women from their husbands to their government. It allows policymakers to pursue "empowerment" without investments in pay for lower-level health workers, or fundamental freedoms introduced into state-society relations.

Empowerment, defined as significant changes in social power and economic status, did not accrue to WDA leaders through the program. Neither Eleni nor Yezena, for example, were able to advance themselves economically through WDA work. We did not find compelling evidence that the WDA increased women's mobility, or that their social power was enhanced. WDA leaders' ability to speak up was limited to certain demands, truncating their potential to serve as an effective advocate for local women, and they sometimes faced censure from other community members who did not appreciate being told what to do. We found no examples of a WDA group successfully bringing attention to self-identified needs not already part of the government's agenda.

Despite its particularly, the authoritarian and community-mobilizing-focused Ethiopian context offers lessons for CHW programs around the world. The issues of poor remuneration, limited voice, and lack of opportunities for advancement are themes across female CHW programs globally (Closser and Jooma, 2013; Jackson et al., 2019; Mumtaz et al., 2003; Scott and Shanker, 2010), as are constructions of poor rural women as an unthreatening and altruistic CHW workforce (Ramirez-Valles, 1998). As health equity and poverty alleviation agendas globally become increasingly gendered, women's empowerment has become a standard part of a "good" CHW program. Yet empowerment that enables CHWs to make whatever demands they like, and to critique policies, is likely to highlight gaps and inadequacies in the very institution running the CHW program.

Also, empowerment in the sense of ensuring that female CHWs can earn money and advance in their careers may lead to problems of cost and retention. In the face of unreliable donor funding, pressure to design "sustainable" health systems has promoted institutions designed to be, to the extent possible, static. Empowerment, which involves movement of individuals across social spaces, conflicts with this conception of sustainability.

Many governments and agencies probably do not desire the empowerment of poor women in the way we are conceptualizing it. The potential threats that politically empowered rural women would pose to those in power may lead program managers to design programs in which empowerment, although an explicit goal, is defined in

strategic and limited ways. By skating over—whether through cunning or naiveté—the conditions for true empowerment, implementers can invoke the label without true empowerment's financial and political risks.

Towards Truly Empowering Health Systems

We propose that empowering CHWs can begin within the health system that employs them. A few successful programs have documented processes ensuring CHW empowerment within the workplace (Garg and Pande, 2018; Nandi and Schneider, 2014; Smillie, 2009). We call on policy makers to acknowledge the extent of CHWs' contributions towards health objectives, and to reward them for it.

Providing CHWs with just pay, opportunities for advancement, and representation in high-level policy decisions for would both motivate and truly empower them (Ballard et al., 2018; World Health Organization, 2018). A recent article on gender in health systems research (Morgan et al., 2016) provides a helpful framework for building truly empowering programs, focusing on structures that can keep CHWs in poverty with a limited voice (a few useful questions for use in planning are listed in Table 4).

Empowerment is a process that is integrally related to the system within which it is deployed. If programs fail to provide decent pay, real voice for CHWs in policy decisions, and the advancement of fundamental freedoms, policymakers and donors should be honest that their programs might not be empowering. If empowerment is a notion explicit within the health agenda, it should be reflected within the structures of the health systems that policymakers navigate—and, in many cases, create.

Abbreviations

CHW: Community Health Worker; WDA: Women's Development Army; HEW: Health Extension Worker; HEP: Health Extension Program; EPRDF: Ethiopian People's Revolutionary Democratic Front

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Figure 1. Government billboard erected at one of our study sites, encouraging women's education, discussion groups to facilitate change, improvement in women's quality of life, and use of reproductive health services.

Figure 2. An illustration from Eleni’s textbook arguing against forced and child marriage.

	1-30 Leaders	1-5 Leaders	Members	P-value
Decision-empowered, %	68.9%	66.7%	56.1%	p=.037

Table 1. WDA leaders' decision making power within their families. Following the format of the DHS survey, we asked married women (but not divorced or unmarried women) whether decisions were mostly made by them, mostly made by their husband, or shared between them in each of three domains: decisions about the woman's health care; decisions about large household purchases; and decisions about the woman's visiting friends and family outside the home. Following the analysis methods of the Ethiopia 2016 DHS survey (Central Statistical Agency (CSA) [Ethiopia] and ICF, 2016), we considered women "decision-empowered" if they made decisions alone or jointly with their husbands in all three of these domains. P-Value is from a Chi-square test comparing 1-30 and 1-5 leaders with members.

	1-30 Leaders	1-5 Leaders	Members	P-value
Married, %	61.6	80.3	82.6	0.000
Divorced or separated, %	21.9	7.7	7.7	0.000
Widowed, %	15.1	11.3	8.7	0.180

Table 2. Marital status of WDA leaders. P-values are t-tests comparing 1-30 leaders to other women.

What is one thing the government should do to improve the lives of women in the community?, %	1-30 Leader
Give land	9.6
Give money	30.1
Give jobs	15.1
Give food aid	1.4
Improve water access	6.8
Improve health care	8.2
Nothing	2.7
Other	24.7
Don't know	1.4
Has asked the government for this action (yes), %	17.8

Table 3. Survey responses from 1-30 leaders regarding services they desired from the government. Responses from 1-5 leaders and WDA members were similar.

- To what extent do women and men have the same access to educational and training opportunities?
- Are there sex differences in relation to remuneration, job promotion, job security, working hours and benefits across and within all types of health workers?
- To what extent are women more or less likely to work in frontline service delivery in poorly compensated (including volunteer) or less supported positions than men?
- To what extent are women more or less likely to work in management positions than men?
- To what extent are female providers less likely to ask for promotions and less likely to complain about poor working conditions than male providers?
- To what extent are there differences by sex and other social markers in participation, decision-making and planning of interventions?
- Which cadres are authorized to prescribe and distribute certain drugs or commodities, and is there a gender difference?

Table 4. Questions suggested by Morgan et al (2016) for health systems research. These questions would also be useful in designing and identifying CHW programs that truly empower women.