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MEDREK

The Newsletter of the Forum for Social Studies

A Centre for Research and Debate on Development and Public Policy

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To Our Readers

MEDREK is happy to bring to its readers the continuing debate on poverty organized by FSS. In response to public demand, FSS has reprinted and distributed the full text of the Government's *Interim Poverty Reduction Strategy Paper* (IPRSP) in order to stimulate a more informed debate on the complex issues of poverty. The Poverty Dialogue Forum, which is one of the focal points of FSS' program on poverty for this year, has generated keen interest among a wide spectrum of civil society. The debates we have been holding have gone beyond the IPRSP and have raised fundamental issues relating to the dynamics of poverty and underdevelop-

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Poverty Dialogue Forum

Civil Society Groups and Poverty Reduction

Brief Report of the Workshop

The **third** workshop of FSS' **Poverty Dialogue Forum** was held on Friday, 8 June 2001 at Global Hotel located on the Debre Zeit road. This is a new venue for FSS, and the decision to change the venue was made in order to improve the discussion forum and to have access to better acoustic and audio facilities. The turnout was quite satisfactory given the fact that there was heavy rain right before the program, and some of the invited guests were not familiar with the new venue. The workshop, which was originally scheduled for April 27, had to be postponed due to the student protests in April and the subsequent events that occurred the following month. FSS felt that under the circumstances it was not possible to conduct a public discussion of poverty issues at the time. Some of the speakers who were scheduled to speak in April were unable to participate and had to be replaced by others. The new panelists consisted of Dr. Abonesh H. Mariam, member of the Ethiopian Public

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Structure of Governance

FSS is democratically governed, with decision-making shared by the General Assembly, the Board of Advisors, and the Management Committee. The General Assembly meets once a year to review and approve the broad policies of the organization. The Board, which meets more frequently, is responsible for drawing up the policies and strategies of FSS, monitoring the work of the executive, and reviewing and approving the finances. Of the nine members in the Board four are women. The Management Committee is the executive body of FSS. It is responsible for implementing the decisions of the Board and managing the activities of the organization.

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To Our...

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ment in this country. The interest the program has aroused will, we hope, be sustained beyond the poverty reduction strategy initiative because we believe that poverty in this country will not disappear for a long time to come and that there is a need for strong public concern about the problem.

MEDREK also likes to inform its readers that FSS, in cooperation with WAAG Communications, a seasoned media company based in Addis Ababa, and with support from the Friedrich Ebert Stiftung, has been broadcasting a series of public awareness programs on social and community issues on FM Radio. The program, which started in March of this year, is broadcast twice a week, and a good deal of it has focused on poverty issues. Some of the discussions in our Poverty Dialogue Forum have been featured in the FM program. We have not yet carried out an audience survey to assess the impact of the broadcasts, but we have been encouraged by the response we have obtained from some of the listening public.

In this issue of *MEDREK* we present a short report on the third workshop of the Poverty Dialogue Forum, which brought together panelists from three important civil society groups, namely, the Ethiopian Public Health Association, the youth organization of the Ethiopian Orthodox Church, and the Confederation of Ethiopian Trade Unions. In the 'DEBATES' section of the newsletter, we present two short pieces on the Health component of the IPRSP and on Population. Finally we have reprinted an article on the IMF and World Bank's push for water privatization in poor and debt-ridden countries, which may be of interest to our readers. It is ironic, if not perverse to find these two institutions forcing highly vulnerable client countries to prepare poverty reduction programs on the one hand, while on the other pushing them to undertake the privatization of water which will benefit multinational companies and hurt millions of poor people who will be unable to afford the high price of clean water.

FSS would like to thank the FRIEDRICH EBERT STIFTUNG for its financial support for the workshop.

Civil Society...

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Health Association, *Deacon* Zena Berhanu, official at *Mahbere Kidusan*, the youth and community development arm of the Ethiopian Orthodox Church, and Ato Zewdie Shitie, an official from the Confederation of Ethiopian Trade Unions (CETU).

The panel was chaired by Dr. Kassahun Berhane of the Political Science Department of Addis Ababa University. Dr. Meheret Ayenew, the Coordinator of the Poverty Dialogue Forum, welcomed the guests and introduced the theme of the workshop. This, he said, was the second opportunity provided to civil society groups to share their insights into poverty

in Ethiopia and their thoughts about the possibilities of poverty reduction. The previous workshop brought together panelists from some of the important NGOs working with the poor in the urban and rural sectors of the country.

Dr. Abonesh said that about half a million women die every year due to reproductive health problems and the great majority of these are poor women. Mental health problems were also common among poor women due to marital violence, stress and the heavy burden of household responsibility

Dr. Abonesh spoke on Poverty, Women and Health Care in Ethiopia. This, she said was an important subject because the three elements were closely linked. She argued that poor women suffer from a wide variety of health problems because of their poverty and their lack of access to proper health care. Among the main factors contributing to serious health hazards for poor women were the lack of access to adequate food, shelter and clean water. Poor women suffer more reproductive health problems than women in higher income brackets. Malnutrition is endemic especially among children of poor families. Maternal mortality is also high among poor women. Dr. Abonesh said that about half a million women die every year due to reproductive health problems and the great majority of these are poor women. Mental health problems were also common among poor women due to marital violence, stress and the heavy burden of household responsibility. Dr Abonesh noted that there were gaps and inadequacies in the Government's IPRSP. She singled out the fact that the issue of reproductive health was not addressed, and that HIV and its impact on women was not adequately considered in the document.

Deacon Zena Berhanu's topic was entitled Poverty Reduction and the Orthodox Church. *Deacon* Zena talked a good deal about the Church and poverty, arguing that the Church believes poverty is a social problem and must be solved by society. He noted that there was large-scale poverty and food insecurity in the country. He stressed that there was a long tradition in the Church of dealing with poverty based on moral values and the ethic of sharing. Sharing of goods and resources should be encouraged as a means of poverty reduction and development. His organization, *Mahbere Kidusan*, works with the young and Church students. The organization is also involved in community development efforts, and it combines moral teachings with development programs at the grassroots level. It was his opinion that the Government's IPRSP has not given adequate consideration to moral values as a force of development and poverty reduction.

Ato Zewdie argued that the Government's IPRS does not address the issue of employment and employment generation schemes as a means of poverty reduction, and for this reason he thought the document was seriously deficient. He stressed that a poverty reduction policy cannot succeed unless it places special emphasis on employment generation.

The third panelist, Ato Zewdie Shitie from CETU, spoke on Trade Unions and Poverty Reduction. He noted that CETU consists of 500 indi-

vidual trade unions with a combined membership of over 350,000 workers. His paper was concerned about poverty reduction from a worker's perspective. He stressed that employment should be the focus of a sound poverty reduction policy. While temporary respite may be achieved through safety net schemes, poverty reduction on a sustained basis can only be achieve through employment generation schemes. On the subject of safety nets, he stressed that to promote economic efficiency employment-based safety nets must be chosen over other forms of safety net programs. Another issue he dwelt upon was privatization of state enterprises. It was his opinion that privatization jeopardized workers' and unions' rights. Privatization will often lead to workers losing their jobs and unemployment is the cause of poverty. Ato Zewdie argued that the Government's IPRS does not address the issue of employment and employment

generation schemes as a means of poverty reduction, and for this reason he thought the document was seriously deficient. He stressed that a poverty reduction policy cannot succeed unless it places special emphasis on employment generation.

There was a good deal of discussion after the panelists had completed their presentations. Many of the questions from the audience were directed at *Deacon* Zena and his discussion of moral and social issues in poverty reduction. The full text of the papers and the discussion from the floor will appear in our *Consultation Papers on Poverty No. 3* to be published soon. The first issue of this series containing the papers on the *Social Dimension of Poverty* was distributed at the workshop. The second number in the series is now out and ready for distribution.

New Distribution Arrangement for FSS Publications

FSS has finalized an institutional arrangement with Image International, a local book agent, for the distribution of its publications. From now on, all FSS publications (except *MEDREK)* will be distributed by Image International, which has a chain of bookstores in Addis Ababa and several parts of the country as well as outlets overseas. In Addis, Image's bookstores are located in Kazalnches (tel.: 51 09 54). Its other bookstores are in Nazret (tel.: 02-11 37 48), Bahr Dar (no telephone yet), and Gonder (tel.: 08-11 12 92). Image will soon have a website where a list of FSS publications will be posted for interested clients abroad. FSS will only be responsible for distributing complementary copies to important officials, and to libraries, donors and government institutions. We believe this arrangement will make FSS publications accessible to a wider readership and will relieve the organization of the paper work and storage.

Poverty Profile of Ethiopia

Compiled by *MEDREK* Staff

The extent of poverty in Ethiopia may be gauged from the following basic figures. This is only a snapshot and does not provide a full picture. It does not, for example, include data on health, education, employment, and access to social services.

- If the current annual population growth rate of about 3 percent continues, the population of the country (now 63 million) will double in 23 years. This will immensely exacerbate the poverty problem.
- Ethiopia's urban population is 17 percent of the total while for Sub-Saharan African countries the figure is 34 percent. Limited urbanization means limited opportunities for economic improvement, hence greater poverty.
- If poverty is defined as income below one or two US dollars per day, 31.3 and 76.4 percent respectively of the Ethiopian population will fall below the poverty line.
- At GNP per capita of 100 US dollars, Ethiopia is ranked 206th out of 206 countries; thus, on this measure, it is the poorest country in the world. GNP per capita for Sub-Saharan Africa is 500 USD.
- According to CSO/CSA data, per capita food output has been declining since at least the 1970s. This means that the ability of the country to feed its population has continued to deteriorate. In 1980/81, output per capita was 174 kg.; in 1989/90, it was 142 kg., and in 1993/94, 97 kg.
- DPPC sources show that since the 1980s, there is, annually, a sizable population that is unable to feed itself. In 1992, for example, 6.1 million people were affected by food shortages. In 1995, the figure was 4 million, and in 1998, 5.8 million.
- The 1998 child and infant mortality rates for Ethiopia were 173 and 107 per thousand respectively, while the average for Sub-Saharan African countries was 151 and 92 per thousand.
- The prevalence of malnutrition among children under five was 48 percent, while the figure for Sub-Saharan Africa was 33 percent. The consequences of malnutrition are revealed by the fact that in 1995/96, 44 percent of Ethiopian children under five were found to be **severely** stunted while 67 percent were stunted.
- Adult literacy rates in 1998 were 42 percent for males and 30 percent for females; the comparative figures for Sub-Saharan Africa were 68 and 61 percent respectively.
- Life expectancy at birth in 1998 was among the lowest in the world: 42 years for males and 44 years for females; for Sub-Saharan African countries, the figures are 49 and 52 respectively.
- In 1995, only 8 percent of the population had access to sanitation, and 26 percent to safe water. The comparable figures for Sub-Saharan Africa are 48 percent and 47 percent respectively.
- According to the UNDP, Ethiopia's Human Development Index ranking has deteriorated over the years. It was 138 in 1992 and 171 in 1998.

These and related information are available in the current issue of the World Bank's *World Development Report* and UNDP's *Human Development Report*. See also *Annual Report on the Ethiopian Economy*, 1999, edited by Befekadu Degefe and Berhanu Nega and published by the Ethiopian Economic Association.

We would like to invite readers to participate in an on-going debate on issues related to development and public policy in Ethiopia in Medrek. Send us think pieces, comments and letters (not more than 2000 words for publication in these columns.

Some Comments on the Health Sector Coverage in the Interim Poverty Reduction Strategy Paper (IPRSP)

Yasmin Yusuf
Essential Services for Health in Ethiopia (ESHE)

Introduction

Poverty is widespread in Ethiopia and is characterized by lack of purchasing power, exposure to risk, insufficient access to basic necessities, and limited opportunities for productive employment. The country's health care system is not well developed. It is under-financed and dominated by public providers, with utilization of available resources often inefficient. Moreover, shortage of skilled manpower, low quality care, and inadequate access to health services are among the problems evidenced in the sector. Currently one hospital serves 611,000 people, one health center 177,000 people, and one health station 10,000 people. The ratio of hospital bed per population is one to 5390. This is well below the Ministry of Health (MOH)/ WHO standard of one health center for 100,000 people, and one health station for 10,000 people. In the public health system there are only 1263 physicians, 6713 nurses, and 86 pharmacists.[1] Consequently, health outcomes are low.

The other serious problem that the country faces at present is the HIV/AIDS epidemic. Globally, Ethiopia ranks third, next to South Africa and India, in terms of the number of people living with HIV/ AIDS which is about 2.6 million, 10% of which are children under five. What is worse is that the pandemic is gaining momentum.

The findings from the recently released demographic and health survey[2] reveal that average number of children per woman is 5.9. Though it has declined in the past decade, this is still high if one compares it with 4.7 children per woman in Kenya or 3.5 in Egypt. The infant mortality rate is 97 per 1000 births while the mortality rate for under-fives is 167 per 1000. Ethiopia also has a high rate of maternal mortality which is 871 deaths per 100,000 live births. On top of that, chronic and acute child malnutrition is one of the highest in Africa with 52% of children under 5 stunted, 11% wasted and 47% underweight.[3] The other serious problem that the country faces at present is the HIV/AIDS epidemic. Globally, Ethiopia ranks third, next to South Africa and India, in terms of the number of people living with HIV/AIDS which is about 2.6 million, 10% of which are children under five[4]. What is worse is that the pandemic is gaining momentum.

On top of all this, the economy is sustaining a huge external debt, which is close to USD 10.1 billion. Of this amount, 27% is multilateral, 71.7% bilateral and the remaining 1.3% commercial. This debt burden is more than 150% of GDP and 940% of export in net present value terms at the end of 1998 Ethiopian fiscal year.[5] It is well over the sustainable debt level of 80% of GDP and 200-250% of export earnings. With the nation placed in the IDA/World Bank low-income country category, Ethiopia has qualified for the Highly Indebted Poor Countries (HIPC) Initiative.

The Poverty Reduction Strategy Program (PRSP) is a national program for poverty reduction that is the basis for

IMF and World Bank lending. Also, for a country to qualify for multilateral debt relief, it must put in place a PRSP, which indicates how the country plans to use the resources freed by debt relief. Thus, the Ethiopian government has drafted its own interim poverty reduction paper and has submitted it to the joint World Bank/ IMF board. The draft document is based on the second five-year development plan of the government (SFYDP). This short article is prepared to comment on the treatment of the health sector in the IPRSP and to point out weaknesses in it. In doing so, it aims to contribute to the policy debate pertaining to the PRSP process.

Health Sector and the IPRSP

Apart from the overall strategy outlined, the IPRSP has sectoral strategies that focus on infrastructure development, education, health, and energy in addition to programs in agriculture, rural development, food security and nutrition. With regard to the health sector, the *Paper* prioritizes improving the health status of the Ethiopian people by establishing a firm institutional base. The coverage of the health sector in the IPRSP is, in essence, *a restatement of the Health Sector Development Program (HSDP).*

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The HSDP is a government program that is designed to address the poor health status in the country based on a 20-year sector development strategy divided into four five-year investment programs, the first of which covers the period 1997/98 – 2001/2002. This program acknowledges the fact that current public health service utilization is low and has limited financing. Its objective is thus to increase coverage, utilization, and the quality of public care. Accordingly, the HSDP sets out to design a package that *(a) responds to the identified burden of diseases (b) can be delivered by primary health care units located within a reasonable distance of the population served, and (c) are cost effective thereby making the service financially accessible.*[6] Consequently, the government is reorganizing the current six tier system of health care delivery into a four tier system: primary health care units with satellite health posts focusing on primary and preventive care, district hospitals, regional or zonal hospitals and specialized hospitals each with its own capacity and distinction.

Table 1. Monitorable Impact and Outcome Indicators of the HSDP

Indicator	Baseline 1997	By 2002	By 2007
Impact			
Life expectancy at birth (years)	52	55-60	64
Population growth rate (percentage)	2.9	2.5-2.7	2.0
Maternal mortality rate per 100,000 live births	500-700 (871)*	450-500	300
Infant mortality rate per 1000 live births	110-128	90-95	50
Outcomes			
PHC service coverage (percentage)	45	55-60	90
Contraceptive coverage (percentage)	8	15-20	40
Immunization coverage (percentage)**	67 (20.7)*	70-80	90

Source: MOH, Program action plan for the HSDP, 1998

Health facility construction and rehabilitation, human resource development, adequate supply of drugs, promotion of IEC (information, education

and communication), development of financing mechanisms and improved health management systems are emphasized in support of this basic approach. Three core strategies have been identified concerning financing mechanisms. One is shifting the emphasis from curative, urban-based hospital treatment to preventive and rural focused care. The second is increasing efficiency by focusing public health care on specific target groups like mothers and children, restructuring the target base towards specified diseases and focusing service supply on areas with the largest public impact, namely safe drinking water or sanitation. The third is additional resource mobilization, i.e. from government sources, through proceeds from user fees and external assistance. By targeting government financing of health care to preventive services, and increasing access to the rural poor and vulnerable groups, the HSDP is expected to contribute to poverty reduction. Monitorable indicators of impact and outcomes have been highlighted in the HSDP action plan.

While the HSDP introduced policy reforms in the health sector, it did not yet sufficiently work out the way to implement these reforms. For example, provision for transition from six-tier system to a four-tier system was not provided. Another example is that implementation arrangements for the Health Care Financing Strategy were not initially put in place.

Problems of the HSDP

1. While the HSDP introduced policy reforms. It did not yet sufficiently work out the way to implement these reforms. For example, provisions for transition from a six-tier system to a four-tier system were not provided. Another example is that implementation arrangements for the Health Care Financing Strategy were not initially put in place.

2. The HSDP was developed without full consideration of resource availability and the government's normal planning and budgeting process.

3. Special concerns of pastoral and urban areas do not appear to have been taken into account.

4. Given the low coverage of health care, the HSDP has emphasized sectoral expansion. There was, however, an imbalance between expansion and quality considerations, which will need resources to rectify.

5. As a result of decentralization policy, management of HSDP has been delegated to the regions. According to the Program Action Plan, there have been difficulties in redefining roles and relationships between central and regional levels as well as limited capacity for implementation at regional, zonal and woreda levels.

6. HSDP implementation has focused on service delivery. However, if the reforms incorporated in the program are to be achieved, this must be complemented by system strengthening which has not received much financial resources.

Table 2. Health Sector Targets in the IPRSP

Current Status in Ethiopia (2000)	Target
IMR = 97/1000	95/1000 by 2002 50/1000 by 2017
MMR = 705/100,000 (871)*	500/100,000 by 2002 300/100,000 by 2017
CMR = 167/1000 (76.7)	160/1000 by 2005
Access to health services = 51%	55% by 2002 90% by 2017
Immunization of children = 60% (20.7%)**	70% by 2002 90% by 2017

Source: Ethiopia IPRSP, 2000[7***]

A mid-term review of the

HSDP has been undertaken recently and the above problems are recognized. Moreover, steps are being taken at various levels to address many of the issues. The IPRSP has also pointed out the targets that the poverty reduction strategy aims to attain with regard to the health sector. These are more or less the same as the HSDP targets albeit the latter being over a longer time-frame.

The three-year policy matrix also outlined the poverty reduction strategy's aim to increase public expenditure and strengthen expenditure management by giving priority to health, in addition to education, agriculture and natural resources, and roads in the coming three years up to 2003. Accordingly, the Government plans to raise the share of health in the national budget to 7% by the end of the period.

Conclusions

Increasing the quality of health service and utilization by investing in the health sector facilitates economic growth and poverty reduction by cutting down on productivity loss due to morbidity and mortality. Emphasis should be given to producing a sound poverty reduction strategy paper and monitoring its implementation, which is the basis for resource mobilization from debt relief in the HIPC initiative that could be employed to develop the health sector. Of the USD 10.1 billion external debt that Ethiopia is burdened with, about USD 2.7 billion (27%) is multilateral. This, in principle, is the potential sum of money that Ethiopia is entitled to because of the HIPC initiative, leaving out relief from bilateral sources.

The policy matrix would be more complete if issues regarding the private sector in health care were included. For example, promotion of private-public partnership in health service delivery could be added as one means of improving health care delivery.

Finally, following are general comments on the IPRSP in relation to the health sector:

1. The policy matrix would be more complete if issues regarding the private sector in health care were included. For example, promotion of private-public partnership in health service delivery could be added as one means of improving health care delivery.

2. Reallocating debt-servicing resources to health should result in more than a minor increase in budget allocation to the sector. Already, the health sector's share in the budget is very low compared to other Sub-Saharan countries. In 1995, the percentage of total expenditure spent on the social services was close to 19% in Ethiopia, which is far below the 35-60% range in many Sub Saharan nations[8]. Moreover, an increased system support for the health sector, improving budget development, utilization, and disbursement would give high returns on investment.

3. Even though donors have often expressed interest to provide resources for budget support, they have not been able to do so due to weaknesses in the government's financial system. Hence, resources freed from debt relief could be utilized in system strengthening, which would lead to increased donor support.

4. The IPRSP focuses on long-term health outcomes as its indicators and targets. It would, however, be more meaningful if variables such as performance on reforms and systems-strengthening could be used as measures of progress given that this critical weakness in the HSDP does not get adequate finance from other sources.

To be eligible for debt relief under the HIPC initiative, a country has to pass through various stages in a six-year period. In the first stage, a country has to register a track record of good policy implementation with IMF/World Bank supported adjustment programs. It then passes to eligibility, the second stage and completion point. These steps are complicated and it takes time for a country to qualify for debt relief; this has to be adjusted. When evaluating the implementation of health policy reform, the PRSP should focus on system strengthening and policy focused reforms within the HSDP, rather than concentrating on health outcomes.

Notes

- * There is discrepancy between the MOH and DHS 2000 findings, figures in bracket show the relative DHS estimate

- ** The MOH immunization coverage estimate of 67% is based on DPT_3 coverage only but even at that, the relative DHS value is 20.7% indicating wide gap.

- *** Here again the health and demographic indicators lack comprehensiveness and consistency. The IPRSP has solely depended on MOH estimates (Health and Health Related Indicators). The implications of these inconsistencies would be that the IPRSP would not attain its targets because of a problem in its baseline data.

Reference

[1] MOH, *Health and Health Related Indicators*, Addis Ababa, 1992 E.C.

[2] Central Statistical Authority, *Ethiopia Demographic and Health Survey 2000*, Addis Ababa, May 2001.

[3] A child is **stunted** when it has low height for age, **wasted** when it has low weight for height and **underweight** when it has low weight for age.

[4] Ministry of Health, *AIDS in Ethiopia*, third edition, November 2000.

[5] Teklu Tefera and Kifle Asfaw, *External Resource Mobilization and External Debt Situation*, a paper presented at the Symposium for Reviewing Ethiopia's Socio-economic Performance 1991-1999 organized by the InterAfrica Group, Addis Ababa, April 26-29, 2000.

[6] Federal Democratic Republic of Ethiopia, *Program Action Plan for the Health Sector Development Program*, Addis Ababa: Ministry of Health, October 1998.

[7] Government of Ethiopia, *Interim Poverty Reduction Strategy Paper 2000/01 – 2002/03*, Addis Ababa, November 2000.

[8] World Bank, *World Development Report 1997: The State in a Changing World*, Washington DC: Oxford University Press, 1997.

FSS's **fourth** Poverty Dialogue workshop, entitled *Listening to the Poor*, will be held on Thursday, July 12. The panelists will consist of poor people who will talk about **their** experience (what it means to live in poverty), and who will discuss what **they** consider to be sound programs and policies that will help improve the conditions of the poor. The program will also invite others from the poor community to serve as discussants and to participate in the debate.

Population and Poverty Issues in Ethiopia

By Aklilu Kidanu
Miz-Hasab Research Center

The government has issued an Interim Poverty Reduction Strategy Paper (IPRSP), which gives priority to agricultural development led industrialization (ADLI). This presupposes adequate land for the production of raw materials for agro-industry and for the earning of foreign exchange through the export of agricultural products. In a country where population growth is unprecedented and where agricultural land is dwindling as a result of population pressure, the realization of ADLI becomes doubtful. In this article I will attempt to give a general description of poverty in the country. I will also try to suggest what steps need to be taken to introduce an effective family planning program as a basic step in poverty alleviation endeavors. It is worth noting that the IPRSP makes no mention of the population issue and its impact on the poverty situation in the country.

Population and poverty

Ethiopia is one of the most populous countries in Africa, with a population of 63 million. Population density is 63 persons per sq. km, which is much higher than the average for Sub-Saharan Africa (27 per sq. km). Most of the population lives in the highlands. The lowland areas of the country, which have limited rainfall and are a health hazard, are sparsely populated.

Poverty is widespread in both the rural and urban areas of the country. The rate of poverty in the rural areas, however, is higher. Significant problems for rural communities include access to adequate farmland and drought. The land issue has been aggravated by the rapidly increasing number of landless peasants, and the decreasing availability of land. Land resources have lost their productivity due to deforestation, high rates of soil erosion and fragmentation of plots. The rural economy is a subsistence economy, and most farming households produce to satisfy the basic needs of the family. In the urban areas the main factors which have aggravated the poverty situation are chronic unemployment and lack of access to basic services such as health and housing.

Rapid population growth is one of the major causes of poverty in Ethiopia. Ethiopia's total population grew from 38 million in 1980 to 63 million in 1999.

Rapid population growth is one of the major causes of poverty in Ethiopia. Ethiopia's total population grew from 38 million in 1980 to 63 million in 1999. At this rate of growth, the country's population is estimated to double every 23 years reaching about 130 million by 2030. The average Ethiopian woman has 7 children; about half of the population of the country is below age 16, severely crippling the saving and investment capacity of the working people.

Living standards are distinctly lower in rural Ethiopia. Food consumption represents just over 60 percent of total consumption in rural areas, yet on average, calorie intake is less than 2,000 per adult per day. More than two thirds of children were stunted in 1995/96, and almost one in ten showed signs of wasting. Moreover, about a quarter of the rural adult population is malnourished, with little difference between women and men.

Population growth and quality of life

The quality of life indicators show depressing facts. In 1997, there were 195 radios, 5 television sets, and 3 telephone mainlines per 1,000 people. Other non-income poverty indicators such as literacy rate, stunting of children, access to sanitation facilities, etc., show that Ethiopia is one of the most disadvantaged countries in Sub-Saharan Africa and the UNDP Human Development Report of 1998 confirms this. Let us just take two examples, education and health. The quality of education offered is abysmally low. There are high rates of repeaters and dropouts; there is serious shortage of books and facilities, inadequate teacher

training, poor curricula and procedures for assessing learning. Only half of those who enroll complete primary education. According to the World Bank Report (200), Ethiopia's education sector is woefully deficient in almost all respects.

The health sector is one of the major areas where the level of poverty of the country is reflected. Health delivery services remain poor in quality and inadequate in quantity. Public expenditure for health between 1990 and 1998 was only 1.7 % of GDP. The bulk of the population has serious health problems, which contribute to low levels of development. Different types of diseases are prevalent at high rates throughout the country. The HIV/AIDS prevalence in Ethiopia is among the highest in the world, estimated as high as 11 percent of the adult population in 1999. The most important group of people in terms of labor and productivity account for about 90 percent of the AIDS cases.

Contraceptive prevalence rate of married women aged 15-49 for the years1990-1998 averaged only 4%. Life expectancy at birth for males for 1990 was 45.5 years and for females 47.1; for the year 1998 the figures were 42.5 for males, 44.5 for females and 43.4 for both sexes in aggregate. The averages within the same category of HDI are 51.0 and 48.9 for the years 1990 and 1998 respectively, and 52.0 and 50.3 for females for the same years respectively. There is a declining trend in both life expectancy and averages within the same category of HDI.

Food security

The main source of food security is the agricultural sector. Agriculture is very much dependent on traditional practices and consequently productivity remains one of the lowest in the world. Per capita food production has markedly declined from the 1960s through the 1990s. Similarly, per capita land holdings have also declined in these decades. At present, the average size of farmland per household in most of the cereal growing parts of the country measures less than one hectare while in the *enset* growing areas the average size is less than half a hectare. Productivity of farm work measured in cereal yield per hectare for the decades since the 1980s has not shown any significant improvements. All this is a good indication that the capacity of the rural population to feed itself has been deteriorating for quite some time.

Deforestation, which occurs at an annual rate of 624 sq. km of land, is threatening the ecology of the country. Only 55.2 thousand sq. km. of land (or 5.5% of the total land area) was naturally protected in 1996. Famine and chronic food insecurity are major problems facing the farming population. There have been more than four serious food crises in the last four decades, some of which were responsible for the death of thousands of lives and the loss of innumerable livestock. 52 % of the rural population suffers from *food poverty*, which means that some 28 million people are not able to meet their daily nutritional requirements on a regular basis. Nearly half the farm households can feed themselves only between 6 to 8 months in the year; they go hungry for the remaining months. As a result, there are high rates of malnutrition among the farm population.

Unemployment

Unemployment is becoming an obstacle to the national development endeavor. In 1984, of the total 14.7 million economically active population, 170,000 (or 1.2 %) were unemployed. In 1994, of the 26.5 million economically active population, 770,000 (or 2.9 %) were unemployed. This shows that the number of unemployed people nation-wide increased by 600,000 people, representing a 35.2 % increase during the ten-year period.

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The age group with the highest rate of unemployment in 1984 was 15-19 with a 2.5 percent rate; in 1994 the highest unemployment rate, 6.6 %, was

observed for the 20-24 age group. In both cases, the proportion of female unemployed was higher than the males. In the urban areas of the country, among the 1.5 million economically active people in 1984, almost 8 percent were unemployed. In 1994, the unemployment rate increased to almost 22 percent among the 2.7 million economically active people. The proportion of female unemployed was higher than the male both in 1984 and 1994.

In 1984, in urban areas, the 15-19 age group had the highest unemployment rate (19.2 %) followed by the 20-24 age group (14.6 %). In 1994, the highest unemployment rate in urban areas was among the 20-24 age group (38.5 %), followed by the 15-19 age group (37.5 %). In the younger age groups, there were higher proportions of unemployed females than there were males. The proportion of unemployed males was much higher ámong the older group.

Poverty Reduction Strategies

The government's IPRSP outlines a strategy based on four major building blocks: (i) ADLI, (ii) judiciary and civil service reform, (iii) decentralization and empowerment, and (iv) capacity building. If all these were successfully implemented, I would be in no doubt that there that there would be a significant improvement in poverty reduction. Be that as it may, I believe special attention needs to be given to the population policy of 1993 and there should be a strong family planning program that should be implemented across the nation. The problems of food security, unemployment and poor social services described above cannot be alleviated unless Ethiopia implements a strong family planning program. In the absence of mechanized agriculture, which requires offering vast tracts of land to private investors, ADLI cannot be fully realized. In the face of population pressure, the protection of the environment and growth in agricultural productivity cannot be realized; neither can quality social services and improved living standards be achieved.

The problems of food security, unemployment and poor social services described above cannot be alleviated unless Ethiopia implements a strong family planning program. In the face of population pressure, the protection of the environment and growth in agricultural productivity cannot be realized; neither can quality social services and improved living standards be achieved.

Improving the Quality of Life through Family Planning

In countries like Ethiopia where population growth is high and poverty affects half of the population, a Family Planning Program is a priority measure to take for a sensible government. In essence it should be a national program. The government must sponsor, support, facilitate and staff it with competent personnel. Moreover, other private efforts such as family planning associations, NGOs and commercial firms should be encouraged to operate within the national program if it is to be effective. An effective family planning program has a number of advantages. It reduces fertility, improves maternal/child health status, enhances the reproductive freedom of women by providing them with the means to control their family, and improves the quality of life of the users in particular and the community at large. Reduction of fertility is the major target in any Family Planning Program.

Ethiopia has a population policy, which is conducive for the use of family planning methods. However, the government's commitment to the implementation of the policy looks tentative. The service delivery operations remain practically poor and limited in scope. Consequently, the service output is low: only 4% in the reproductive age group use contraceptives. In the health facilities where family planning services are offered, the quality of service, availability of commodity, consultation, education and the clients' awareness and use of service utilization remain poor.

Although there are complex issues that contribute to the determination of family size in a given society, it is believed that the supply environment has a major influence in family planning. Many argue that by making family planning services more readily available, one can not only fulfill a latent demand for spacing or limiting

that may exist in a given society, but also create a demand for these services by providing couples with alternatives to continued childbearing and the means of achieving pregnancy prevention. Thus, if a family planning program is to be effective the following factors need to be considered:

- The political and administrative system within which the program will operate must be supportive and committed to the implementation of the program.
- Adequate resources must be allocated: the use of provider and acceptor incentives, and cost recovery will determine adequacy of the facilities, staff, equipment, commodities and other materials needed for a viable program.
- Legal codes and regulations must be conducive, for they affect the flow of contraceptives into the country, the number of methods that are legal, the characteristics of persons eligible to receive them, and related issues that influence access to contraception.

The policy environment influences how a family planning program is organized. This includes the infrastructure available for service delivery, the extent of integration of family planning with other sectors of the government, the types of service delivery strategies used (clinic-based, community based distribution and contraceptive social marketing) and the relative contribution of the public and private sector. A comprehensive family planning service delivery program consists of a number of operations. These operations correspond closely to the divisions found in most governmental or private family planning programs: management, supervision, training, commodities and logistics, information-education-communication (I-E-C), and research and evaluation.

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The family planning program at the government level is poorly organized in Ethiopia. The support given is minimal. In fact, it is left to NGOs and interested associations. Consequently, the services available including methods, commodities, and education are inadequate. The providers are either not well trained or inadequate in number.

Ethiopia has to include family planning as a way to fight poverty and improve the quality of life of its people. The current issues in the Family Planning Program in Ethiopia are:

- Family planning (FP) is very much dependent on external assistance. Therefore, the government needs to allocate a sufficient budget.
- FP is currently undertaken by NGOs and donors and the Government seems to be tentative in its commitment to the program. The population policy issued in 1993 is still on paper. Government officials need to show in practical terms that they are committed to the development and implementation of the Family Planning Program
- The FP service infrastructure is not developed to implement and sustain FP services. Therefore, measures need to be taken to ensure that the service infrastructure is conducive for FP services.
- The delivery strategies used are not systematic enough to make an impact. Measures need to be taken to improve the delivery strategies so those users can have easy access to FP services.
- I-E-C use is quite limited, counseling services are not adequately given even to those who come for FP methods. Providers need to be trained in adequate numbers to improve service delivery.
- FP commodities are not available according to the needs of users. Enough budget should be allocated to make commodities available in adequate stock.
- Monitoring and evaluation of FP activities need be strengthened. Follow up of clients' behavior and their use of FP methods and their reactions to methods hardly exist.
- Participation in FP/RH (reproductive health) is limited to MCH (mother and child health) clinics and

NGOs involved in the service. The private sector is excluded. Attempts should be made to mobilize all available capacity for offering FP services including the private sector.

- There is no positive understanding between government health authorities and professionals and NGOs working on FP/RH. Therefore, the FP environment is not encouraging. This suggests the need to have an open policy on FP defining the roles of public and private agencies, NGOs and other civic organizations and individuals.

Programs by Civil Society Groups on the PRSP

A number of civil society groups are undertaking a variety of programs in connection with the PRSP initiative. Workshops, debates and papers have been prepared by the Pastoralist Forum, CRDA, and some NGOs. CRDA is establishing a Task Force to ensure that civil society's concern in general and that of NGOs in particular is addressed in the final PRSP. The Ethiopian Economic Policy Research Institute is planning a diverse set of programs, including monitoring and evaluation of the PRSP implementation. FSS is happy to acknowledge that other civil society groups are keen to have an input in the PRSP process. We have now been informed that the Government has set up a number of technical committees to begin work on the final PRSP, which is scheduled to be completed in March 2002.

Just Off the Press ... Just Off the Press ...

FSS Conference Proceedings

Food Security and Sustainable Livelihoods in Ethiopia. Edited by Yared Amare, 2001

Consultations Papers on Poverty

No. 1. *The Social Dimensions of Poverty*. Papers by Minas Hiruy, Abebe Kebede, and Zenebework Tadesse. Edited by Meheret Ayenew, June 2001

No. 2. *NGOs and Poverty Reduction*. Papers by Fassil W. Mariam, Abowork Haile, Berhanu Geleto, and Jamal Ahmed. Edited by Meheret Ayenew, July 2001

IMF and World Bank Push Water Privatization on Poor Countries

(Taken from *News & Notices for IMF and World Bank Watchers,* Vol. 2, No. 4, Spring 2001)

A random review of IMF loan policies in forty countries reveals that, during 2000, IMF loan agreements with 12 borrowing countries included conditions imposing water privatization or cost recovery requirements. In general, it is African countries and the smallest, poorest and most debt-ridden countries where loan documents reveal IMF conditions on water privatization and cost recovery. Cost recovery, from the perspective of the IMF and the World Bank, entails ending deficit-inducing state subsidies. User fees paid by water consumers must cover water system costs, which include the cost of operation, maintenance and capital expenditures. In contrast, wealthy countries such as the U.S., continue to provide a range of government subsidies for water and sanitation services in accordance with statutory requirements including the federal Clean Water Act and the Safe Drinking Water Act.

Wealthy countries such as the U.S., continue to provide a range of government subsidies for water and sanitation services in accordance with statutory requirements

In the division of labor between the IMF and the World Bank, it is the World Bank that has primary responsibility for "structural" issues such as the privatization of state- owned companies. Therefore, it can be presumed that in countries where IMF loan conditions include water privatization or cost recovery requirements, there are corresponding World Bank loan conditions and water projects that are implementing the financial, managerial, and engineering details required for "restructuring" the water sector.

More than five million people, most of them children, die every year from illnesses caused from drinking unsafe water. As water becomes more costly and less accessible, women and children who bear most of the burden of daily household chores must travel farther and work harder to collect water.

The IMF and the World Bank argue that many developing country governments are too poor to provide subsidies for water and sanitation services. Hence, full cost recovery from water consumers is necessary. The institutions also argue that privatization and cost recovery will provide the resources necessary to extend the coverage of water and sanitation services to those outside the system. However, there is little empirical evidence that this has happened.

The IMF's and World Bank's drive to privatize and extract full cost recovery from water systems is generating concerns worldwide about the potential for such policies to compromise public health and rob low-income communities (which make up the majority of developing country populations) of access to affordable water. The most immediate impact of reducing the access to safe and affordable water will fall on women and children. More than five million people, most of them children, die every year from illnesses caused from drinking unsafe water. As water becomes more costly and less accessible, women and children who bear most of the burden of daily household chores must travel farther and work harder to collect water - often resorting to water from polluted streams and rivers. Families are forced to make trade-offs between water, food, schooling, and health care.

Who should decide?

Citizen and community involvement in water management decisions is essential. But, in the countries in Sub-Saharan Africa crucial decisions about water privatization and cost recovery were made by IMF officials negotiating with key government leaders behind closed

doors and without the knowledge or consent of citizens. Neither the IMF and the World Bank nor borrowing governments are obliged to publicly disclose information about loan negotiations. Eager, and sometimes desperate, government leaders will often adopt IMF policy prescriptions in order to secure necessary resources. In some respects governments, especially highly indebted governments, can become more accountable to international lenders than to their own citizens.

International concern about IMF and World Bank water privatization policies

There are four basic reasons why the role of the IMF and World Bank in promoting the privatization of water services is causing widespread concern:

1. *Water is a resource essential to human survival - some have argued that water is a human right.* Decisions regarding the allocation of water should not be driven primarily by economic considerations. Decisions related to water provision touch upon critical issues related to public health, social equity, the environmental, gender roles and responsibilities and sustainable resource management.

2. *Water is often viewed as common property or a "commonpool" good rather than a market commodity.* The fact that many governments have failed to provide safe and affordable water to large segments of the population does not automatically justify initiatives to treat water as a commodity or a strictly commercial or economic good. Because the private corporation exists to generate profit for its shareholders, it may not be the appropriate institution to manage the myriad of interests related to the provision of an important public resource.

3. *Democratic and community involvement in water management decisions is essential.* The IMF and the World Bank should not be making decisions about water management in countries around the world. Governments should be accountable primarily to their own citizens for such decisions, not to the international financial institutions.

4. *Public sector ownership provides a legal and sometimes constitutional basis for accountability to the broader public interest.* Private corporations are not legally or constitutionally bound to serve the public interest in the countries where they operate. Many corporations have minimal information disclosure requirements which makes it difficult for citizen's groups or even governments to provide oversight and encourage accountability. Corporate interest may exercise undue influence over a government, compromising its ability to govern based on the interests of the public.

What is privatization?

There are many different types of privatization. The least controversial form of water privatization involves providing incentives for small, local businesses to subcontract with publicly-owned water facilities to perform specific water services such as drilling bore holes, digging wells, expanding or improving connections, etc. However, most of the IMF loan conditions are promoting a more controversial type of privatization that involves the transfer of significant rights and obligations from the public sector to private sector companies through management contracts, leases, or concessions. Usually, contracts, leases or concessions are granted to foreign multinationals or their subsidiaries. There are some important differences between the three common types of water privatization. The most common legal arrangement is the concession.

Why do the IMF and World Bank promote water privatization and full cost recovery?

The IMF and World Bank promote macroeconomic and fiscal stability for all borrowers, especially those which are debt and deficit-ridden. When state-owned water companies contribute to the overall government deficit, as often they do, the institutions will encourage an end to state subsidies, full cost recovery, and better management and administration of the accounting and fee collection procedures. The IMF and the World Bank, generally believe that abandoning state-owned enterprises for privately-owned and managed firms will

improve the economic efficiency of water mater management with positive downstream benefits such as a reduced public debt and improved management of the national budget. In general, the two institutions believe that the private sector is more efficient and cost-effective as the provider of basic goods and services in many sectors, including water.

However, there is little evidence that privatization improves the access to, or affordability, of water especially for the poorest sectors of the population. Too often water price hikes and water quality problems follow in the wake of privatization.

Governments may expect that privatization will reduce their debt. The willingness of private sector companies to invest will depend upon the profit stream the company can expect. This, in turn, will depend on the level of fees charged to water consumers and agreements between the government and the private company about how the costs of infrastructure maintenance and expansion should be borne and who owns the company assets. In the end, the reduction of developing country debt and a guaranteed profit stream to the new private company, will likely be borne by increased costs to water consumers. Should water consumers be saddled with the responsibility for ensuring debt reduction and corporate profitability? This seems inappropriate, especially in developing countries where the majority of water consumers are low income or poor. Consumers who are unable to afford safe water may be forced to use untreated and unsafe sources of water. Or, consumers may be faced with trade-offs between purchasing food, water and essential medicine and paying school fees.

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World Bank Policies on Subsidy and Cost Recovery in the Water Sector

While the World Bank encourages full cost recovery in the water sector, there appears to be some debate within the Bank about the exact definition of the term. The basic definition of full cost recovery implies that water consumers should cover the cost of operating, maintaining, and expanding the water utility as needed. There is some sensitivity on the question of whether full cost recovery should entail the provision of a "a reasonable rate of return on investment." However, in the case of a private company, full cost recovery includes a "reasonable" profit margin.

There is greater unanimity on the issue of government subsidies. In general, the World Bank will not finance water projects where a government has defaulted on subsidy payments. The general practice of the World Bank is to discourage debt and deficit-ridden governments from subsidizing water and to push for full cost recovery from water consumers.

The IMF and World Bank position on subsidies and cost recovery should be viewed in the broader context of the financing practices for water and sanitation services in the G-7 countries. In the U.S., for example, there are substantial public subsidies of water and sanitation services. The federal Clean Water Act and the Safe Drinking Water Act, along with state and local resources, subsidize about ten (10) percent of U.S. water and sanitation needs. The American Water Works Association estimates that this public subsidy will need to increase by approximately $23 billion a year over the next 20 years due to the aging nature of the U.S. infrastructure. According to the April 2000 report, *"Financing the full $23 billion a year with utility rate increases would result in doubling of rates, on average, across the nation. If this were to happen, at least a third of the U.S. population would face economic hardship.* Yet, the World Bank and the IMF insist that full cost recovery is appropriate public policy for the poorest countries in the world!

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FSS Newsletter

Medrek (Quarterly since 1998. English and Amharic)

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No. 1. *Water Resource Development in Ethiopia: Issues of Sustainability and Participation.* Dessalegn Rahmato. June 1999

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No. 2. *NGOs and Poverty Reduction.* Papers by Fassil W. Mariam, Abowork Haile, Berhanu Geleto, and Jemal Ahmed. Edited by Meheret Ayenew. July 2001

No. 3. *Civil Society Groups and Poverty Reduction.* Papers by Abonesh H. Mariam, Zena Berhanu, and Zewdie Shitie. Edited by Meheret Ayenew. Forthcoming 2001

Books

1. *The View from Below: Democratization and Governance in Ethiopia.* Edited by Bahru Zewde and Siegfried Pausewang. Forthcoming (Co-published by FSS)

Special Publications

Thematic Briefings on Natural Resource Management. Edited by Alula Pankhurst. Published jointly by the Forum for Social Studies and the University of Sussex. January 2001

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