Politics, State Capacity, and Development under Authoritarian Rule:

Explaining Divergent Infant Mortality Outcomes in Ethiopia's Amhara and Tigrai Regions

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Abstract

Why do regions governed by the same authoritarian coalition experience divergent health outcomes? This thesis examines differences in infant mortality between Ethiopia's Amhara and Tigrai regions under the Ethiopian People's Revolutionary Democratic Front (EPRDF). Using a mixed-methods design, it combines regional infant mortality estimates from Demographic and Health Surveys for 1995–2015 with an index of infrastructural and healthcare-access capacity, regression analysis, and qualitative evidence from archival documents, party histories, interviews, and health-sector reports. The quantitative analysis finds that infant mortality declined significantly faster in Tigrai before 2004; afterward, the estimated difference in regional decline rates became small and statistically insignificant. Associations between measured state capacity and infant mortality vary across model specifications, providing limited support for a straightforward capacity-based explanation. The qualitative analysis suggests that differences in regional political incentives help explain these trajectories. The Tigrayan People's Liberation Front's historically embedded relationship with rural communities encouraged early initiative and coordination in primary healthcare. By contrast, the Amhara National Democratic Movement's dependence on central political backing made federal direction more consequential for regional policy priorities. The national expansion of the Health Extension Program coincided with improvements in Amhara's primary healthcare provision and greater comparability between the regions on selected service-capacity indicators. Although the study does not isolate causal effects or directly establish differences in health-policy uptake, its findings suggest that political legitimacy and relationships of accountability shape how service-delivery capacity is developed and used under authoritarian rule.

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List of Abbreviations

ADCS	Adigrat Diocesan Catholic Secretariat
ANDM	Amhara National Democratic Movement
CBHI	Community-based health insurance
CHW	Community health worker
CUD	Coalition for Unity and Democracy
DHS	Demographic and Health Survey
E.C.	Ethiopian calendar
EDU	Ethiopian Democratic Union
EPDM	Ethiopian People's Democratic Movement
EPLF	Eritrean People's Liberation Front
EPRA	Ethiopian People's Revolutionary Army
EPRDF	Ethiopian People's Revolutionary Democratic Front
EPRP	Ethiopian People's Revolutionary Party
HEP	Health Extension Program
HEW	Health extension worker
IES	Institute of Ethiopian Studies
IMF	International Monetary Fund
IMR	Infant mortality rate
MEISON	All-Ethiopia Socialist Movement
MLLT	Marxist-Leninist League of Tigrai
NGO	Nongovernmental organization
OLF	Oromo Liberation Front
OLS	Ordinary least squares
ONLF	Ogaden National Liberation Front
OPDO	Oromo People's Democratic Organization
REST	Relief Society of Tigray
RSDP	Road Sector Development Program
SARDP	Swedish-Amhara Rural Development Programme
SNV	SNV Netherlands Development Organisation
TPLF	Tigrayan People's Liberation Front
TUSA	Tigrayan University Students' Association
WHO	World Health Organization

Glossary

Abiyotawi Democracy	Revolutionary democracy; the EPRDF's political doctrine.
Ato	A male honorific equivalent to "Mr."
Baito	Council or assembly.
Birr	Ethiopian currency.
Derg (Dergue)	Committee or council; Ethiopia's military regime, 1974–1991.
Gimgema (Gim-gema)	Evaluation through criticism and self-criticism.
Hidar	The third month of the Ethiopian calendar.
Kebele	A local administrative unit below the woreda.
Kinijit	The Amharic name of the Coalition for Unity and Democracy.
Neftegna	Rifle bearer.
Ras	An Ethiopian noble title.
Tabia	A local administrative unit in Tigrai, equivalent to a kebele.
Woreda	A district-level administrative unit.

Introduction

At first glance it may not seem intuitive but authoritarian regimes often must build levels of legitimacy with key stakeholders to stay in power. In many cases, they build this legitimacy for self-serving reasons, but they do so in ways that have positive spillover effects for the population, such as pursuing policies for health and child survival (Patterson, 2017).

The efforts of authoritarian governments (frequently classified across spectrums from competitive authoritarian to autocratic) to win legitimacy is of particular importance to basic research on development because around 72% to 75% of the world's population lives under these political conditions. Although substantial research has been done on why these governments choose certain areas like health as a means to build legitimacy and how they do it (Gerschewski, 2013; McGuire, 2010), little has been done on if there is internal variation to these effects and what causes them. Understanding the causes of subnational divergence can help policy experts work on policies to better people's lives and ensure as little variation as possible, even under undesirable political conditions.

Ethiopia during the EPRDF era provides a particularly interesting case study for this dynamic. From 1991 to 2020, the EPRDF ruled Ethiopia under a dominant-party, moderately authoritarian system. During this period, the government focused a massive share of its efforts on bettering primary health outcomes. One of these critical outcomes was infant mortality. This is important to study for development because a life not lived is one that cannot be developed, and the infant mortality rate speaks directly to the health quality of a nation overall (Dawson, 2010).

Infant mortality is also responsive to policy intervention: expanding access to basic healthcare and other inexpensive social services can improve survival even where economic resources remain limited (McGuire, 2010). Studying IMR therefore connects the performance of public institutions to whether children survive their first year of life. Well, in Ethiopia's case, they were able to reduce the infant mortality rate from 101 to 55 deaths per 1,000 live births (Central Statistical Authority & ORC Macro, 2001; CSA & ICF, 2016).

However, if you dig under the surface you find an interesting story, with two regions in particular: Amhara and Tigrai. They started the period with relatively close infant mortality rates according to the 1995 DHS wave, with Amhara at 10.9% and Tigrai at 9.24% (Central Statistical Authority & ORC Macro, 2001). A two-sample proportion z-test shows this baseline difference is not statistically significant ($p = 0.274$), meaning they started next to each other with the same basic conditions. However, these numbers would gradually diverge over time. So, how did these regions who started the same, are right next to each other, and have similar baselines, diverge under the same national policy?

Although you could argue that Ethiopia was a federal state during this period and regions had policy autonomy, this ignores the internal dynamics. In fact, the regions were all controlled by the regional parties of the EPRDF and in practice had little functional autonomy, pointing to different causes (Heyi, 2025; Lavers, 2023). One theory could be that in relation to state capacity, given the fact that the Tigrayan People’s Liberation Front was the central party in the EPRDF, this allowed Tigrai to build up state capacity faster, impacting infant mortality (Perra, 2026). Or was it because many Amharas did not trust the Amhara National Democratic Movement, seeing it as a TPLF shell, and did not comply with policy, a case of poor legitimacy (Lavers, 2021)?

These questions lead to 2 hypotheses that can be tested:

- **Hypothesis 1 (H1):** Subnational variations in grassroots party legitimacy hindered policy implementation in Amhara while boosting compliance and health policy uptake in Tigrai.
- **Hypothesis 2 (H2):** Divergent growth in regional administrative state capacity directly accounted for the variations in infant mortality trends between the two regions.

To answer these hypotheses, we will use a mixed methods approach. We will use quantitative analyses in the form of regression models, z-tests, and other statistical methods to analyze H2. To answer Hypothesis 1, we will use qualitative analysis of primary and secondary sources.

The remainder of this thesis proceeds as follows. Part 2 provides a literature review to analyze what has already been written on this matter. Part 3 outlines our methodology, exploring our data choices and variable measurements. Part 4 presents the quantitative and qualitative results, and Part 4 offers a conclusion along with the limitations of the study.

Literature Review

This study engages with several strands of literature at the intersection of political institutions, state capacity, and development outcomes. First, a growing body of research examines how authoritarian regimes utilize public policy, particularly in the health sector, to build political legitimacy and maintain control. Second, scholarship on Ethiopia's post-1991 political system highlights the tension between formal federal institutions and the centralized dominance of the Ethiopian People's Revolutionary Democratic Front (EPRDF). Finally, literature on state capacity and public goods provision emphasizes the role of administrative reach and political organization in shaping policy outcomes. While this literature provides

important insights into the relationship between political structures and development, they do not fully explain why regions operating under the same national framework experience divergent outcomes. This review synthesizes these strands to motivate an analysis of regional variation in infant mortality across Ethiopia.

I. Authoritarian States and Advancements in the Health Sector

Despite the general association of authoritarianism with poor governance and quality of life, many authoritarian regimes have made significant strides in spurring development, especially in the health sector. Although the motivation for these actions tended to be self-interest, the results still tangibly help the broader population. In fact, there are many notable examples of autocratic regimes not only improving their nation's health metrics but doing so in a substantial way.

Although Zweifel and Navia (2000) argue that democracies overall outperform authoritarian regimes in reducing infant mortality, authoritarian regimes can and have reallocated resources to also effectively combat infant mortality. In fact, Patterson (2017) finds that the type of democracy and autocracy matters in determining effectiveness in combating infant mortality. Competitive authoritarian states, which have institutions like elections, were found to be equally effective at reducing infant mortality as majoritarian democracies (Patterson, 2017, p. 94). The ability of competitive authoritarian states to perform so well in combating infant mortality stems from a desire to build legitimacy and quell unrest or legitimate election loss (Patterson, 2017, p. 97).

This logic motivated both Chile and Taiwan to investing in policies that helped combat issues such as infant mortality. In the case of Chile, the Pinochet regime, although not a

competitive authoritarian state, invested in policies that would broadly improve health metrics (McGuire, 2010). The reason the Chilean government implemented these low-cost policies was that it hoped to find a cheap way to win public support. This support was necessary as they realized the authoritarian regime would eventually have to face the population, and they wanted to build support for this eventuality (McGuire, 2010, pp. 94-119). Similarly, the Kuomintang also pursued policies to reduce infant mortality as a means to build legitimacy, and as the advent of elections caused them to have to compete for power (McGuire, 2010, pp. 181-202).

The literature demonstrates that semi-competitive authoritarian regimes can effectively fight and reduce infant mortality to build their legitimacy. Although certain types of democracies still outperform authoritarian regimes, there are notable examples of significant reductions in infant mortality in authoritarian states where the right policies are pursued. As described above, Taiwan and Chile provide compelling cases from the 1960s through the 1980s; however, a more recent example is Ethiopia under the EPRDF.

II. Ethiopian Political and Administrative Context Post-1994

The collapse of the Dergue in 1991 heralded a new era in Ethiopian politics, spearheaded by the Ethiopian People's Revolutionary Democratic Front (EPRDF). The EPRDF was a coalition of parties based on ethnicity that was led by the Tigrayan People's Liberation Front (TPLF) (Lavers, 2023, p. 13). The EPRDF and its constituent parties sought to reshape the political system from a unitary to an ethno-federal state that emphasized the autonomy of Ethiopia's many ethnic groups. To achieve this aim, the EPRDF promulgated a new Constitution in 1995 that reorganized sub-national administration by creating ethno-regions and enshrining the autonomy of these regions in the Constitution (Constitution of the FDRE, 1995).

Despite the EPRDF's overtures regarding democratic reform and devolution, the new political system lacked both. Even in the midst of the constitutional drafting process, the EPRDF was already cracking down on opposition groups such as the Oromo Liberation Front (OLF) and the Ogaden National Liberation Front (ONLF) (Lavers, 2023, p. 86). These early crackdowns led opposition parties to boycott the 1995 and 2000 elections, allowing the EPRDF to win almost every seat at the federal level, and giving their constituent parties control of all regional governments (Arriola, 2008, p. 118). The EPRDF's almost total control of the political system would be emblematic of this period of Ethiopian politics.

Despite their political dominance, the party experienced a few political scares that would force them to reshape their governance model, notable among these scares being the 2005 election. The 2005 election saw the consolidation of many of the opposition parties into the Coalition for Unity and Democracy, more popularly known as Kinijit and the United Ethiopian Democratic Forces (Arriola, 2008, pp. 119-120). As Arriola notes, the EPRDF's underestimation of the opposition led to a political bloodbath in urban areas, such as Addis Abeba, where they lost every seat, and in two of the country's largest regions (Arriola, 2008, pp. 121-123). Although the results of the election remained hotly contested, with both sides claiming victory and the EPRDF cracking down on opposition protestors, this drubbing caused the party to reflect and refocus its political objectives.

As Gerschewski (2013, p. 20) notes, authoritarian governments often use policy to build political legitimacy, and the EPRDF was no different. In the aftermath of the 2005 election, the EPRDF chose a two-pronged approach to maintain its control: more restrictions on opposition groups and a doubling down on their political agenda of Abiyotawi Democracy (Lavers, 2023, p. 97). The driving force of the EPRDFs agenda, Abiyotawi Democracy sought to create a political

vanguard among the peasantry that made up more than 70% of Ethiopia's population (Bach, 2011, pp. 646-648). The impetus for this program, as Lavers notes, was the TPLF and EPRDF's lack of a base outside of Tigrai (Lavers, 2023, pp. 13-15). Although this policy had guided the EPRDF's policies prior to 2005, Bach (2011, pp. 643-650) claims that the election demonstrated the party needed to double down on the economic development side of this program, along with building a large base of cadres and some legitimate support.

Beyond its ideological foundations, Abiyotawi Democracy functioned as a mechanism for extending party control into local administrative structures. As Lavers (2021) and Bach (2011) note, the EPRDF sought to embed party cadres within rural communities, particularly through kebele-level institutions, allowing for direct interaction between the state and the peasantry. This system enabled the party to mobilize citizens, monitor compliance, and facilitate the implementation of development programs (Lavers 2021; Labzaé 2021). As a result, the effectiveness of policy delivery depended not only on formal administrative capacity but also on the depth of party penetration within local communities.

The emphasis on party penetration into local communities suggests that governance outcomes under the EPRDF were not solely determined by formal administrative structures, but by the extent to which party institutions were embedded within society. As Lavers (2021, pp. 84–97) and Clapham (2018) argue, the effectiveness of the Ethiopian developmental state depended heavily on its ability to extend political control and administrative reach into rural areas. In regions where party organizations were deeply integrated into local communities, the state was better able to mobilize citizens, monitor behavior, and implement development programs (Lavers 2021, pp. 90–100; Labzaé 2021, pp. 551–559). Conversely, in regions where party structures

were weaker or less embedded, the state's ability to translate policy into outcomes may have been more limited.

With their dominance of regional and federal administration, the EPRDF utilized their constituent parties to implement policies that promoted Abiyotawi Democracy. In fact, Heyi (2025) demonstrates that EPRDF's dominance of the political system effectively nullified the federal nature of the government. His study finds that although the Constitution grants regions equal policy autonomy comparable to the autonomy exercised by Swiss cantons, in reality regional autonomy varies and is much less than constitutionally mandated (Heyi, 2025, p. 18). This was furthered by the top-down structure of the EPRDF, which forced party members to comply with directives and policies from the top (Lavers, 2023, p. 84).

To ensure that party cadres followed directives, the EPRDF instituted the Gim-gema (evaluation in Amharic) process for all government employees. The practice found its impetus in Maoist teachings of criticism and self-criticism. The TPLF adopted this practice while in the bush and nationalized it when they achieved power (Labzaé, 2021, p. 559). As Labzaé (2021) demonstrates, the process became crucial to the Ethiopian state by the early 2000s, with every civil servant and government bureaucrat subject to an annual Gim-gema. These sessions saw party cadres and officials as the evaluators in the process and created an inextricable link between the party and state apparatus by giving the EPRDF a means to keep civil servants in line with party doctrine (Labzaé, 2021, p. 551-555).

Taken together, these features of the EPRDF system suggest that governance outcomes were shaped less by formal institutional design and more by the strength of party organization and its integration into local communities. While these mechanisms were present across regions,

their effectiveness likely varied depending on the historical development and cohesion of regional party structures. This raises the possibility that differences in political organization contributed to variation in policy implementation and development outcomes across regions.

III. Development and Health Policy under the EPRDF

The EPRDF's ability to maintain discipline among party cadres and embed its organizational structures within local communities enabled the state to implement a range of ambitious development initiatives. This capacity was particularly evident in the health sector, where the government pursued large-scale reforms aimed at expanding access to primary healthcare services. These policies were not only designed to improve health outcomes but also to reinforce the regime's legitimacy by demonstrating its capacity to deliver tangible benefits to the population.

Like many of their other development policies, the EPRDF's health policies were built on values derived from their days in the bush. (Croke, 2020, p. 1321) Among the many centrifugal forces in health policy implementation was self-reliance (Lavers, 2023, pp. 211-212). As Lavers (2023, pp. 213-214) notes, much of the EPRDF's social policies were built as temporary fixes for the nation's woes, with a greater emphasis placed on broad-based development as a permanent fix. As Lavers quotes Former Deputy Prime Minister Addisu Legesse, the goal was to wean the rural population of dependence (Lavers, 2023, p. 212).

Despite the emphasis on restricted social policy and broad-based development, the EPRDF made great strides in social policy related to health. As Croke (2020, pp. 1321-1322) explains, the government's emphasis on primary healthcare services departed significantly from the urban-centric health policy of previous governments, which saw 92% of healthcare spending

going to hospital construction. The model for this expansion was built on the TPLF's experience during their insurgency period, where they established primary healthcare facilities in areas they controlled (Barnabas & Zwi, 1997, pp. 38-48).

As Croke (2020, pp. 1318-1327) argues, this new model was responsible for many of the healthcare gains Ethiopia made in this period, such as the significant increase in prenatal health checkups and the reduction of infant mortality from 101 to 55 per 1,000 (Central Statistical Authority [CSA] & ORC Macro, 2001; CSA & ICF International, 2012; CSA & ICF, 2016; Ethiopian Public Health Institute [EPHI] & ICF, 2021). Freeman et al. (2020, pp. 5-10) argue that the nature of Ethiopia's political system was integral to the implementation of the primary healthcare model, which they describe as decentralized. The EPRDF utilized the HEP to further co-opt the rural population as it created Health Development Armies that had model households and worked closely with HEWs and fell under the political structure of the locality (Assefa et al., 2019; Lavers, 2023, p. 237).

Among the more consequential policies the EPRDF advanced was the Health Extension Program (HEP). The program aimed to shift the nation's health infrastructure further away from facility-based services, which were often difficult for rural populations to access (Croke, 2020, p. 1322). The program trained Health Extension Workers, who were dispatched to serve 3,000 to 4,000 individuals through regular visits and by providing primary care to families (Assefa et al., 2019, p. 2). This program's goal was to provide a low-cost method for the government to expand healthcare services. (Gobezie et al.,2023, p. 76)

As Admassie et al.'s (2009, pp. 435-445) empirical demonstrates, there have been expansions of positive health services, such as antenatal care, that reduce infant mortality;

however, there is no conclusive difference between kebeles where the HEP was rolled out and those where it wasn't. Assefa et al. (2019, pp. 8-9) add to this argument by claiming that the effectiveness of HEW's relied heavily on the political commitments of local government health officials.

Many of these health officials were political cadres that fulfilled the EPRDF's objective of creating a vanguard party that blurred the lines between party and government, as discussed in the previous section. These vanguard officials' commitments not only guided the effectiveness of health policy through cooperation with program providers but also impacted the uptake of other health-related policies. As Lavers (2021, pp.12-30) notes, the uptake of a Community-Based Health Insurance scheme varied by region. Utilization was particularly low in Oromia, where the Oromo Peoples Democratic Party (OPDO), the EPRDF party for Oromia, had lost significant legitimacy, making it difficult for local health officials, who were also party members, to gain popular buy-in. Tigrai, on the other hand, had high utilization of the CBHI as the TPLF still held legitimacy. (Lavers, 2021, p. 28)

Altogether, health policy under the EPRDF focused on creating a decentralized system that emphasized primary healthcare and moved away from urban-centric hospital construction. These developments contributed to the overall improvement in general health metrics, such as infant and maternal mortality, in this period. However, the roll-out of policies remained inextricably linked to the EPRDF's local political vanguard, shaping program success and utilization.

IV. The role of state capacity in delivering health policy

Although improvements in development metrics are often attributed to policies, the success of these policies depends on the state's reach within its territory. A state's reach within a given territory is known as state capacity, and existing state capacity often determines a government's ability to accomplish objectives. Although authoritarian and democratic regimes may have some different incentives to expand state capacity, many have found it imperative to do so, and Ethiopia is no different in this context.

State capacity is an abstract concept that broadly encompasses the government's ability to govern and deliver services to citizens. From the basic ability to levy taxes and maintain order to the more micro-ability to deliver services such as healthcare to citizens (Khemani, 2019). As Andersen et al. (2025) explain, state capacity can be split into two broad categories: administrative and coercive capacity. While coercive largely refers to the resources and ability that the government must maintain order, administrative capacity refers to the resources and ability of the government to provide services (Andersen et al., 2025, pp. 3-4).

Although coercive capacity appears to be the intuitive example of the type of capacity pursued by authoritarian regimes, as previously discussed, legitimacy building is an important concern of authoritarian regimes. As a result, Khemani (2019) argues that authoritarian regimes aggressively pursue an expansion of administrative capacity through the pursuit of infrastructure programs and general development. From military Brazil to China, regimes have used projects to give themselves legitimacy in ways that democratic governments receive through elections (Monetti, 2024; Holbig & Gilley, 2010).

Regimes use administrative state capacity expansion for legitimacy purposes, not only because infrastructure projects are visible examples of accomplishments but also because they help spur development that can quell unrest by improving livelihoods (Chen & Zhan, 2022). As Moon and Dixon find (1985) the expansion of state capacity in generally leftist authoritarian regimes improved quality of life metrics such as infant mortality. Although Dawson (2010) finds that the rule of law, as measured through the World Bank metric, and acting as a metric for governance quality, is statistically significant and important in reducing infant mortality, no research has been done in exploring infant mortality divergence in authoritarian contexts.

In Ethiopia, the EPRDF inherited a strong level of coercive state capacity from the Derg but little beyond that (Croke, 2020, p. 1320). Since Ethiopia's "federal" constitution made the regions heavily dependent on the federal government for funds and due to the EPRDF's control of every regional government, state capacity expansion was largely in the hands of the federal government (Constitution of the FDRE, art. 51 & 55, 1995).

In summation, state capacity assesses the government's ability to deliver services and maintain order for its citizens. Although counterintuitive, authoritarian regimes have an incentive to expand administrative capacity, as it allows them to build legitimacy. This pursuit of legitimacy often has positive effects on development metrics, such as infant mortality. In the Ethiopian context, the expansion of state capacity was driven by the discretion of the federal government, leading to resource allocation to favored groups. However, the EPRDF years saw a broad expansion of administrative capacity.

V. Regional favoritism in the Ethiopian context

Federal control of most fiscal powers gave the government considerable discretion in allocating resources to the regions and in helping to construct state capacity. This discretion led to notable examples of regional favoritism where the EPRDF allocated more resources to Tigrai, the home of the TPLF. Although these examples of favoritism are notable and most prevalent in infrastructure development, studies have shown that investment in Tigrai was not as broad-based as one would expect.

Although the Constitution gave regional governments the power to raise certain types of tax revenue, the de facto practice differed from the de jure law (Constitution of the FDRE, art. 97, 1995). According to an IMF report, regional governments remained heavily dependent on the federal government for their funds, managing to raise only around 30% of their budget revenue (Tulin, 2025, p. 3). Dependency on the federal government for grant transfers to meet shortfalls effectively removed much policy discretion at the regional level (Tulin, 2025). Even though these grants came in unconditional blocks, continued dependency, coupled with EPRDF political control, gave the top effective say over regional development.

Additionally, the Constitution gave the federal government discretion on infrastructure expansion, a key component of administrative capacity, further limiting the regional governments' discretion in building state capacity and providing another mechanism for favoritism (Constitution of the FDRE, art. 51, 1995). A notable example of this is found in the implementation of Ethiopia's Road Sector Development Program (RSDP). Perra (2026) argues that the RSDP saw heavy regional favoritism, with Tigrai receiving 8.7 percent higher road investment than other regions. This study found that the policy gave high-ranking officials

discretion in choosing the locations of road development projects (Perra, 2026, pp. 4-5). The World Bank (Kanth & Geiger, 2017) also found similar data showing heavy road construction in Tigrai and little to no construction in Amhara.

Although many studies have found federal favoritism in the distribution of resources towards Tigrai, the story is slightly more complex (Aragaw, 2017; Mergo et al., 2019; Adugna, 2019). In fact, Adugna (2019) argues that the misdirection of resources to Tigrai did generate significant development in Tigrai. However, this development was largely concentrated around the regional capital of Mekele, and when comparing Wealth Indexes, Tigrai was found to be slightly poorer and much more unequal than Amhara (Adugna, 2019, pp. 7-10).

Altogether, the weak fiscal powers coupled with the almost total control of federal and regional power by the EPRDF gave the federal government significant power over capacity building, both at the federal and regional levels, leading to resource misallocation. Although Tigrai strongly benefited from this favoritism and saw a rapid buildup of capacity, resources tended to be concentrated around the regional capital, and the region's population was, overall, poorer than the population of Amhara.

VI. Conclusion

Taken together, the literature suggests that while authoritarian regimes can improve health outcomes through centralized policy initiatives, the effectiveness of these policies depends critically on how they are implemented at the local level. In the Ethiopian context, existing scholarship highlights two closely related mechanisms that may shape variation in policy outcomes across regions. First, differences in party organization and integration into local communities may influence levels of compliance, political buy-in, and the effectiveness of policy

implementation. Second, variation in administrative state capacity, shaped in part by patterns of resource allocation and infrastructure investment, may affect the state's ability to deliver services and expand access to healthcare. Importantly, these mechanisms are interconnected, as stronger party penetration may enhance implementation capacity by facilitating coordination, monitoring, and citizen compliance. While prior research has examined these dynamics at the national level or in specific policy areas, it has not fully explained why regions operating under the same national framework experience divergent health outcomes. This study builds on these insights by examining whether differences in political organization and state capacity help account for variation in infant mortality trends between Tigrai and Amhara.

Methodology

This study employs a mixed-methods design using qualitative and quantitative resources to test the two hypotheses. The analysis of the divergence in the spread of infant mortality decline in Amhara and Tigrai and the impact of state capacity on this divergence will rely mostly on empirical testing. Meanwhile, the hypothesis on the impact of parties will rely on qualitative research. We will quickly examine data collection methods, sampling strategy, data analysis procedure, limitations, and justifications to understand why the research was conducted this way.

I. Data Collection:

A robust group of sources was utilized to test the empirical hypotheses. Of all the empirical sources, the Demographic and Health Survey (DHS) was utilized the most. This provided granular-level survey data that was collected starting in the early 1990s and ending in 2019. The questionnaires characterized respondents by region, age, and other useful demographic factors. I merged the datasets by year and region, extracting information on child

death and age of death, years of education received by mothers, the family wealth index, difficulty of reaching a medical facility, and how one would characterize the region they lived in in terms of urban, rural, etcetera.

Additionally, I gained access to Michelin Road Data on Africa's road networks from Carl Múller-Crepon and Philipp Hunziker. I utilized data on the road networks along with speed and road quality from this data set. I utilized the geospatial datasets to gather road density in Amhara and Tigrai along with road speed and quality over time in these regions. However, one notable constraint was that the Michelin Data was measured around every 5 years as opposed to an annual basis.

In terms of the qualitative data, I gathered documents from a host of institutions and sources. The documents relating to party structure, history, and policy directives were retrieved from the Institute of Ethiopian Studies. Additionally, literature by authors such as Aregawi Berhe and interviews were used to construct the party studies. For the policy case study of the HEW rollout, policy reports by organizations such as the World Bank and United Nations International Children's Emergency Fund.

II. Sampling Strategy:

Although the data was collected to span from 1994 to 2020, the period from the implementation of the federal system to the dissolution of the EPRDF, the last DHS survey wave did not include a question on ease of access to a medical facility. As a result, the data set was restricted to 2015, note 2016 was dropped from the DHS survey wave for 2016 because the children born in that year could not have completed one year of their lives and safely be discounted from infant mortality metrics.

The road data, or more specifically, the road density, road quality, and road speed metrics were taken together with the ease of access to a medical facility to create the state capacity index. Road density helps demonstrate a state's ability to reach its citizens and do its most fundamental tasks, such as maintaining order. Meanwhile, road quality and speed demonstrate the state's ability to maintain, regulate, and invest in infrastructure. Lastly, ease of access to medical facilities demonstrates the state's ability to provide services to its citizens.

These metrics were combined to create a comprehensive measurement of state capacity. To combine these metrics with different units of measurement, I had to take the z-scores of each to normalize them. To find the annual z-scores, the annual observation was subtracted from the sample mean and then divided by the sample standard deviation. Then all the metrics were added together and divided by four to create the state capacity index.

The control variables are the DHS Wealth Index, Years of Education, and the Urban share of the region. These metrics were chosen because they represent a comprehensive method to control for regional wealth, education levels, and urbanization, all of which were found to impact infant mortality in Ethiopia. (Central Statistical Agency [Ethiopia] & ICF, 2016, p. 128)

Table 1: Amhara

Variables	**MEAN**	**S.D.**	**MIN**	**MAX**
INFANT MORTALITY	.0784	.017	.0421	.109
STATE CAPACITY INDEX	.099	.412	-.436	.871
WEALTH INDEX	2.833	.088	2.626	2.981

YEARS OF EDUCATION	.855	.402	.472	2.05
URBAN SHARE	.115	.027	.083	.171

Table 2: Tigrai

Variables	**MEAN**	**S.D.**	**MIN**	**MAX**
INFANT MORTALITY	.060	.019	.030	.092
STATE CAPACITY INDEX	-.131	.453	-.846	.660
WEALTH INDEX	2.729	.111	2.572	2.991
YEARS OF EDUCATION	1.475	.792	.587	3.250
URBAN SHARE	.163	.029	.121	.234

The summary statistics for the empirical variables provide some interesting insights. The data show that in the Amhara region, the average infant mortality rate over the period was .0784 or 78.4 deaths per 1,000 children born. In contrast, Tigrai had a lower mean at .060 or 60 deaths per 1,000 births, and the minimum and maximum for Tigrai appeared to be lower than Amhara.

In terms of State Capacity, Amhara region has a decently larger mean at .099 compared to Tigrai's -.131. Additionally, the minimum and maximum State Capacity are also larger in the Amhara region than in Tigrai region. This is interesting given the literature demonstrated clear favoritism to Tigrai in areas such as road investment, whose outcomes were used to measure State Capacity.

The control variables, on the other hand, were a mixed bag. Tigrai had a larger mean year of education and a slightly higher urban share. However, the Amhara region had a higher wealth index, which is consistent with the fact that the literature indicated that Tigrai has higher wealth inequality but a lower wealth index than Amhara (Adugna, 2019, pp. 7–9).

The qualitative sources were selected purposively based on their ability to provide evidence on the mechanisms identified in H1. Sources were organized around three areas of interest: the historical development and organization of the TPLF and ANDM; each party's relationship with the populations it governed; and the development and implementation of regional health policy before and after the introduction of the HEP. Because the documentary record differs considerably between the two parties, identical types of sources were not always available for each case. The TPLF case draws more heavily on established secondary histories and primary materials relating to its insurgent organization, while the ANDM case relies more heavily on archival materials, historical accounts of the EPRP/EPRA and EPDM, and available interviews concerning the party's formation and development. Regional government documents, including health-policy directives and legal publications, are used to compare policy activity in Amhara and Tigrai, while reports from government agencies and international organizations provide additional evidence on implementation and health-system development. Where available, expert interviews supplement and clarify the documentary record rather than serve as

the sole basis for evaluating H1. Claims are therefore assessed through triangulation across multiple source types, particularly where individual accounts may reflect partisan, institutional, or retrospective biases.

III. Data Analysis Procedure:

I plan to use rigorous statistical models to test my empirical data and hypotheses Hypothesis 1 (H2). To test the data, I will use two quantitative models on the datasets. To assess whether Tigrai and Amhara had similar initial infant mortality conditions, I will use a two-sample z-test for proportions for the start year, 1995. Additionally, I will evaluate whether the infant mortality rate dropped more rapidly over time in Tigrai than in Amhara through a longitudinal log-linear ordinary least squares (OLS) regression with an interaction term that will look like this:

$$\ln(IMR_smooth_{rt}) = \beta_0 + \beta_1(Year_t) + \beta_2(Region_r) + \beta_3(Year_t * Region_r) + \epsilon_{rt}$$

Where $\ln(IMR_{rt})$ is the natural log of the infant mortality rate for region r and time t; $Year_t$ is a continuous variable that tracks time, while $Region_t$is a dummy with 1 representing Tigrai and 0 Amhara. Lastly, $Year_t * Region_r$represents an interaction term. Divergence will be supported if the interaction coefficient (β_3) is negative and statistically significant, demonstrating a significantly faster annual decline in Tigrai.

To test Hypothesis 2 (H2), I will use a multivariate regression. The regression will assess the impact of state capacity on infant mortality and if there is a divergent impact between Tigrai and Amhara. The regression will look like this:

$$IMR_smooth_{rt}$$

$$= \beta_0 + \beta_1(State\ Capacity_{rt}) + \beta_2(State\ Capacity_{rt} * Region_r)$$

$$+ \ \beta_3(Urban\ Share_{rt}) + \beta_4(Years\ of\ Education_{rt}) + \beta_5(Wealth\ Index_{rt})$$

$$+ \delta_t + Region_r + \epsilon_{rt}$$

Where IMR_{rt} represents the smoothed infant mortality rate for region r in time t; $State\ Capacity_{rt}$ represents the state capacity of region r in time t, while the interaction term, $State\ Capacity_{rt} * Region_r$ multiplies the state capacity of region r in time t by either a 1 for Tigrai and a 0 for Amhara. The remaining variables are control variables represented by $Urban\ Share_{rt}$ for urban share in region r, at time t, Years of Education for the average years of education for women in region r at time t, and Wealth Index in region r at time t. Finally, to isolate the true institutional impact of state capacity, I include the parameters $\delta_t$and $Region_r$. δ_t represents year fixed effects, or the unobserved time-varying shocks affecting both regions simultaneously, such as shifts in federal healthcare funding. Meanwhile, $Region_r$, captures the baseline cross-regional differences such as geographic endowments.

Moving on to the qualitative section, H1 will be evaluated through both primary and secondary sources. To support H1, the evidence must demonstrate not only that the TPLF and ANDM possessed differing levels of political legitimacy within the regions they governed, but also that these differences shaped policy implementation and/or uptake. Evaluating this hypothesis therefore requires an understanding of the origins and objectives of the two political parties, the development of the regional health systems before and after the introduction of the Health Extension Program (HEP), and the implementation of the HEP itself.

To examine the origins and objectives of the two parties, the study draws on both primary and secondary sources. Much has been written on the TPLF; however, one of the most comprehensive accounts of its origins is Aregawi Berhe's *A Political History of the TPLF (1975–1991): Revolt, Ideology, and Mobilisation in Ethiopia*. Given the scope of the account and Berhe's role as a founder of the organization, this work will serve as a central source for reconstructing the TPLF's development. Primary sources held by the Institute of Ethiopian Studies (IES) at Addis Ababa University, together with additional secondary literature, will supplement this account. Reconstructing the development of the ANDM presents a greater challenge because comparatively little scholarship has focused on the party's origins and objectives. Interviews conducted by Yared Tibebu (nom de guerre Getachew Jebessa), together with primary materials collected from the IES, will therefore form an important part of the ANDM case study. The analysis will also draw on historical studies of the EPRP (Ethiopian People's Revolutionary Party) and the subsequent emergence of the EPDM/ANDM in order to trace the organizational origins of the party and the development of its relationship with rural communities.

To understand regional health systems before and after the implementation of the HEP, the study will draw on primary materials from the IES, interviews, and regional health reports. Primary documentary sources will consist largely of government directives and other materials concerning health-policy implementation, while secondary sources will include regional health reports produced by government agencies, NGOs, and other relevant organizations.

Taken together, these case studies will be used to assess the extent to which the two parties possessed political legitimacy within their respective regions and whether differences in legitimacy were associated with differences in policy implementation and uptake. Evidence of

legitimacy will include indications of durable grassroots support, organizational embeddedness within local communities, and popular acceptance of party authority, whether these characteristics were present from the parties' origins or developed later. The analysis will also consider whether the sources of political legitimacy differed between the two regions and whether those differences affected relations between regional political institutions and the population, including patterns of compliance with government initiatives.

IV. Justification:

Now, these methodological choices raise several questions: Why focus on Amhara and Tigrai? Why employ a mixed-methods design? Why use these particular indicators of state capacity and socioeconomic controls? Why does the quantitative analysis cover 1995–2015 while the broader historical analysis extends beyond that period? Finally, why employ multiple specifications and year fixed effects?

Amhara and Tigrai provide a useful comparative framework because they operated under the same federal political system and national policy framework while possessing importantly different regional political histories. Their geographic proximity and intertwined historical trajectories also reduce some sources of cross-regional heterogeneity that would complicate comparisons among more dissimilar regions. At the same time, differences in regional party organization and political relationships provide meaningful variation in the mechanisms of interest. Rather than assuming that the two regions began with identical health conditions, the analysis directly evaluates their baseline infant mortality rates before examining the subsequent divergence.

A mixed-methods design is necessary because the two hypotheses concern different types of evidence. Differences in infant mortality trajectories and the relationship between state capacity and infant mortality can be evaluated quantitatively. Political legitimacy, however, cannot be adequately represented by a single numerical indicator. Election results alone are insufficient as a measure of legitimacy in the political context examined here. Qualitative analysis of party histories, archival documents, interviews, organizational practices, and relationships with local populations is therefore used to evaluate variation in political legitimacy and the mechanisms through which it may have affected policy implementation.

The quantitative analysis covers 1995–2015. The starting point corresponds to the establishment of Ethiopia's post-1991 federal institutional system, while the endpoint occurs in 2015 because the 2016 Ethiopia Demographic and Health Survey was the final DHS wave containing the measure of difficulty accessing a medical facility used in the construction of the state-capacity index. Later survey waves did not contain a directly comparable measure, preventing the index from being extended consistently beyond this period. Although the 2016 DHS was used as a data source, births occurring in 2016 were excluded from the infant-mortality analysis because children born during the survey year had not necessarily completed a full year of life and therefore had not been fully exposed to the period in which infant mortality is measured. Consequently, 2015 serves as the final year of the quantitative panel. The broader qualitative analysis covers a longer period because archival and historical evidence is used to trace the development of the regional political organizations and health systems before and after the quantitative window. The quantitative analysis is further divided into pre- and post-HEP periods because the Health Extension Program represented a major change in Ethiopia's national primary-health-care strategy. The descriptive trends in Graph 1 also suggest that the relative

infant mortality trajectories of Amhara and Tigrai changed around the period of HEP implementation.

The state-capacity index is intended to capture administrative and service-delivery capacity. Road density measures the physical reach of transportation infrastructure, while road quality and travel speed capture the usability and maintenance of that infrastructure. These factors are particularly important in the Ethiopian highlands, where difficult terrain can constrain the state's ability to reach rural populations. Medical-facility accessibility provides an additional measure of the extent to which basic public services are geographically available. Together, these indicators provide a multidimensional measure of the state's administrative reach.

Wealth, maternal education, and urbanization are included as socioeconomic controls because each provides a plausible alternative explanation for variation in infant mortality. Household wealth affects the resources available for nutrition and healthcare; maternal education can influence health knowledge, healthcare utilization, and household decision-making; and urbanization affects proximity to infrastructure and medical services. Controlling for these characteristics therefore helps distinguish the relationship between state capacity and infant mortality from broader socioeconomic differences between the two regions.

Finally, the quantitative analysis uses three progressively demanding specifications within each historical period, producing six models in total. The first estimates the baseline relationship between state capacity, region, and infant mortality. The second introduces socioeconomic controls to determine whether this relationship persists after accounting for observable differences in wealth, maternal education, and urbanization. The third introduces year fixed effects to account for shocks shared by both regions in a given year, including national

policy or economic changes. Repeating these specifications in both the pre- and post-HEP periods makes it possible to assess whether the relationship between state capacity, region, and infant mortality changes following the introduction of the HEP.

Results

I. Infant Mortality in 1995:

With the collected data, we can now work to better understand why different policy outcomes arose in an authoritarian state where policy implementation was top-down. To do this, we must first establish whether or not infant mortality rates in Tigrai and Amhara were statistically equal at the start of the federal period. Then, we must use the models we created to assess the impact of state capacity on the regions' divergence. Finally, we must use the qualitative information to weave a story on the impact of party legitimacy and incentives on infant mortality rates.

Table 3: Two-Sample Proportion z-test for Baseline Infant Mortality(1995)

Region	Sample Size (Births)	Smoothed IMR(p)	Standard Error	z-statistic	p-value
Amhara	951	10.90%	.0101	—	—
Tigrai	691	9.24%	.0110	—	—
Difference	—	1.66%	.0151	1.09	.274

Table 3 shows the results of a z-test for the baseline Infant Mortality rates in 1995. The table shows that the smoothed Infant Mortality Rate for Amhara Region was around 10.9% or

109 deaths per 1,000 births, while Tigrai Region had an IMR of 9.24% or 92.4 per 1,000 births. At first glance, these numbers appear to show different regional IMRs; however, because these are survey estimates, a z-test for differences can show if the difference is statistically significant and indicates a real IMR difference that year. The difference between the IMRs is 1.66% or 16.6 children per 1,000, yielding a z-score of 1.09 and a p-value of .274. The p-value indicates that there is a 27.4% chance of encountering a difference if the two regions had the same IMR. Based on standard p-value significance levels of 10%, 5, and 1%, we can conclude that the data is consistent with the IMRs being the same.

However, Graph 1 demonstrates that Tigrai's IMR rapidly decreased before the start of the HEP (roughly 1998–2003), and Amhara declined at a more measured pace. Post-HEP, Amhara deaths appear to decline at a much faster but steadier pace, as opposed to Tigrai, which appears to have slightly slowed. To truly test whether the graphical divergence (with Tigrai's slope before 2004 allowing it to be much lower than Amhara's) is real, a log-linear OLS model is necessary.

Graph 1:

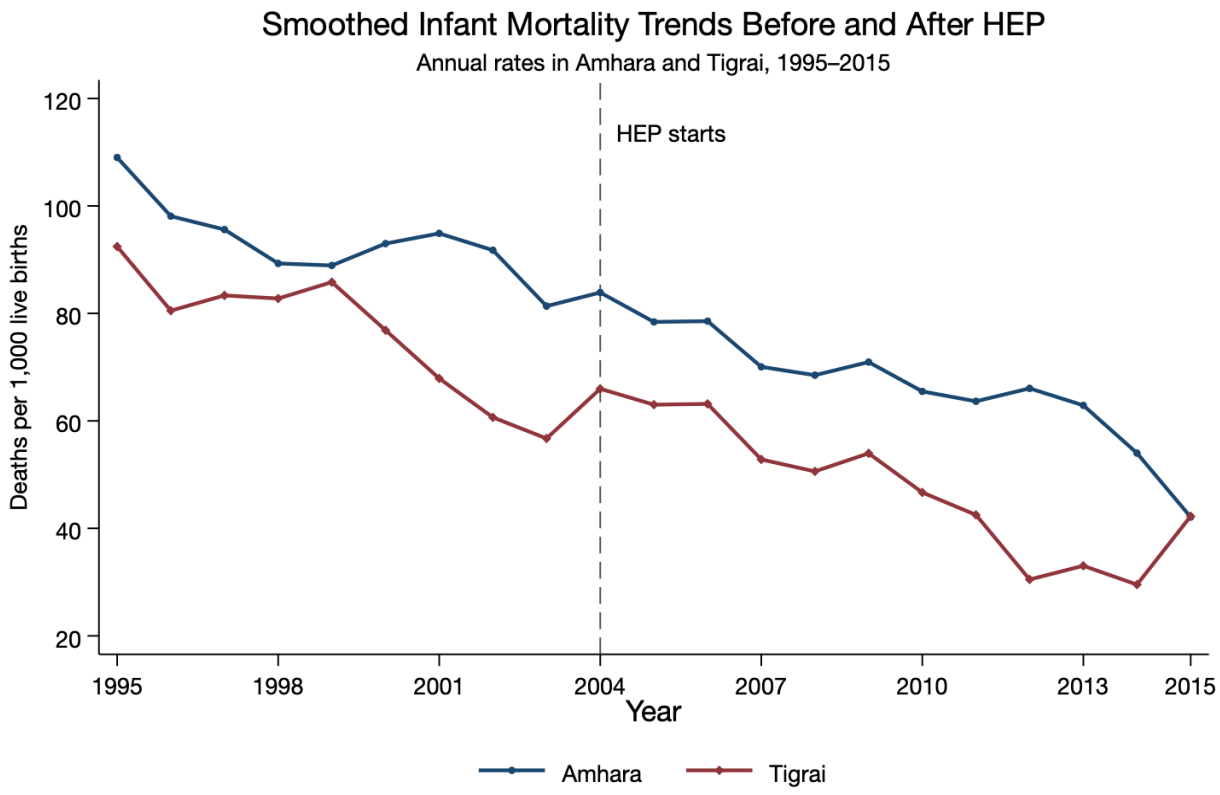


Table 4: Log-Linear OLS Regression Models of Regional Infant Mortality Rates

Independent Variables	Model 1: Pre-HEP Era (1994-2003)	Model 2: Post-HEP Era (2004-2015)
Year (Centered)	-.0224***	-.0465***
	(.0074)	(.0069)
Tigrai (Region Dummy)	-.0505	-.2864
	(.0639)	(.2273)
Tigrai*Year (Slope Difference)	-.0323**	-.0024
	(.0112)	(.0164)
Constant	-2.2600***	-1.9986***

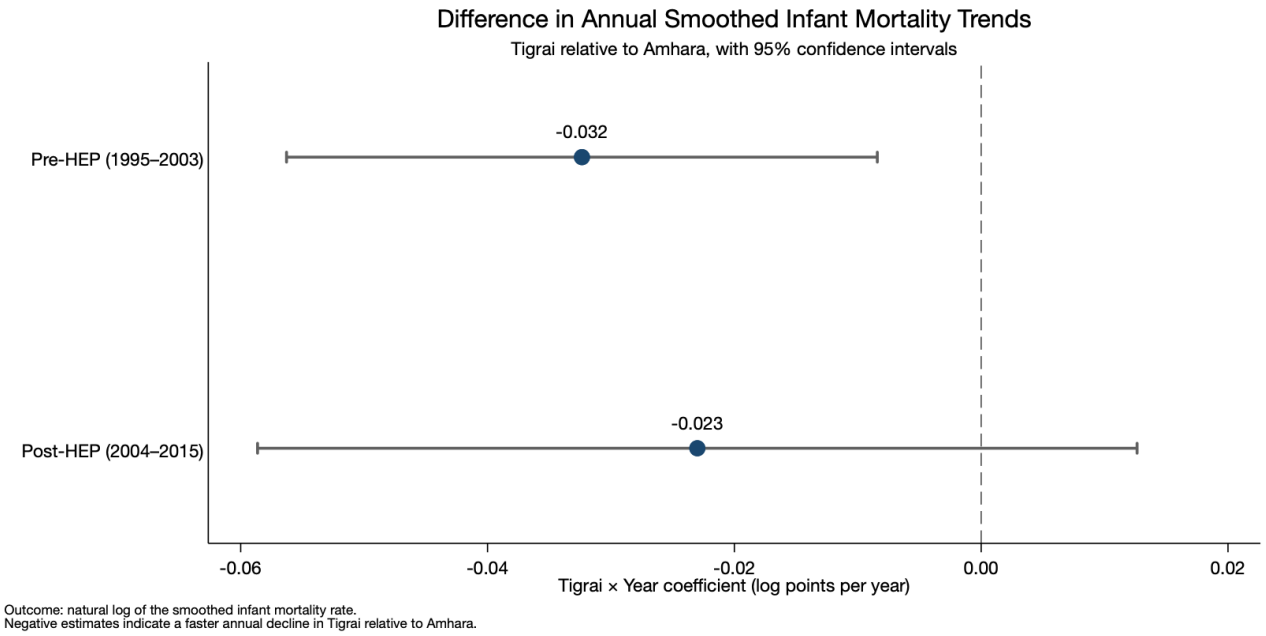
	(.0409)	(.0938)
N	18	28
R^2	.8701	.7649

* $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. Robust standard errors are reported in parentheses.

The OLS model separates IMR in the pre- and post-HEP years. While the baseline Tigrai dummy is statistically insignificant due to the centering of the time variable, the slope difference before 2004 is highly significant (95% confidence) and negative at -.0323. Meanwhile, the post-2004 difference lacks statistical significance at -.0024. To further this point, Graph 2 shows the 95% confidence interval of the difference in the IMR slope pre- and post-HEP, with the interval encompassing 0 for the post-HEP period.

Taken together, we can conclude that there is enough evidence to suggest IMR was about the same at the start of the federal period. Additionally, we found that the IMR slope was more negative in Tigrai than in Amhara before 2004, but that the difference in the two regions' slopes appears to have disappeared after the adoption of the HEP. But the question remains: why was this the case? To assess this, we must test our hypothesis that greater state capacity caused the gap.

Graph 2:



II. The Role of State Capacity:

To assess the impact of state capacity on IMR, we use the regression function mentioned in the methodology section in two periods/the pre-HEP and post-HEP. To ensure robustness and test the impact of the state capacity index and, more importantly, the state capacity index's relation to Tigrai, we gradually add controls and year fixed effects.

Table 5:

Independent Variables	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
Historical Period	←	Pre-HEP Era(1994-2003)	→	←	Post-HEP Era (2004-2015)	→

State Capacity Index	-.0375** (.0143)	-.0446* (.0238)	.0812* (.0294)	-.0310*** (.0072)	-.0107* (.0060)	.0324*** (.0077)
Tigrai (Region Dummy)	-.0262** (.0097)	-.0302* (.0167)	-.0436** (.0088)	-.0232*** (.0041)	-.0079* (.0044)	-.0183** (.0062)
Tigrai * State Capacity	.0017 (.0193)	.0298 (.0380)	-.0685** (.0189)	-.0071 (.0135)	.0037 (.0129)	.0187 (.0172)
Urban Share	—	.2639 (.2635)	.1433 (.1660)	—	.0723 (.0540)	.1763* (.0791)
Years of Education	—	-.0234 (.0241)	.0240 (.0113)	—	-.0186*** (.0035)	-.0065 (.0054)
Wealth Index	—	-.0338 (.0435)	.0070 (.0179)	—	.0256 (.0217)	-.0116 (.0215)
Constant	.0840*** (.0037)	.1686 (.1079)	.0939 (.0457)	.0793*** (.0135)	.0107 (.0589)	.1053 (.0555)
Socioeconomic Controls	No	Yes	Yes	No	Yes	Yes
Year Fixed Effects	No	No	Yes	No	No	Yes
Observations (N)	18	18	18	24	24	24
R-squared	.7431	.7833	.9783	.7520	.8932	.9752

* $p < 0.10$, ** $p < 0.05$, *** $p < 0.01$. Robust standard errors are reported in parentheses beneath coefficients.

The pre-HEP period shows interesting results regarding both the state capacity index and the Tigrai × capacity interaction. The impact of State Capacity on Infant Mortality Rates remains statistically significant even as we make the regression more robust. However, the significance decreases from a 5% significance level in the first Model to 10% in the second and third models. Nevertheless, the impact of the state capacity index on IMR actually increases, with the first model showing that a one-unit increase in the state capacity index would lead to a .0375 decline in IMR, or 37.5 fewer deaths per 1,000 births. Meanwhile, the 2nd model predicted a one-unit increase would lead to a .0446 decline in IMR, or 44.6 fewer deaths. However, Model 3 predicted a .0812 increase in IMR for a one-unit increase, or 81.2 more deaths per 1,000 births. This can largely be explained by the fact that the year fixed effect was included in Model 3, and this variable was created to control for unobserved factors, removing the decay effect of state capacity because there were downward trends annually.

Incidentally, the Tigrai × State Capacity gained significance and negativity in Model 3, with a value of -.0685, indicating that a one-unit increase in state capacity in Tigrai leads to 68.5 fewer deaths per 1,000 births than in Amhara, where a one-unit increase led to 81.2 more deaths per 1,000 births. Year fixed effects account for annual influences shared by both regions. After their inclusion, the Tigrai × State Capacity coefficient changes from 0.0298 to −0.0685, while its standard error decreases from 0.0380 to 0.0189. The larger coefficient magnitude and smaller standard error make the estimated regional difference statistically significant in Model 3.

Additionally, the dummy variable for Tigrai, which accounted for the impact on the IMR if the region was Tigrai remained negative and statistically significant throughout the pre-HEP period. Model 1 indicates that Tigrai was predicted to have 26.2 fewer deaths per 1,000 births than the Amhara region, at the 5% significance level. Although Model 2 decreased the variable's

significance to the 10% level, the magnitude of the gap expanded to 30.2 fewer deaths per 1,000 births in Tigrai than in Amhara for IMR. Finally, the dummy had a 5%significance level in Model 3 and indicates that Tigrai has 43.6 fewer deaths per 1,000 births than Amhara for IMR.

Interestingly, the control variables don't seem to have statistical significance in the models they are included in within the pre-HEP period. However, we can have reasonable confidence in the models since the R-squared values for Models 1, 2, and 3 are .7431, .7837, and .9783, meaning these models represent around 74.31%, 78.37%, and 97.83% of fluctuations in the regions' IMR.

Using the most rigorous model (Model 3) for the pre-HEP period, we learn some pretty interesting things about the impact of state capacity on both regions overall and Tigrai in particular. The model shows that, counterintuitively, a one-unit increase is actually predicted to lead to 81.2 more deaths per 1,000 births; interestingly, for Tigrai, a one-unit increase in state capacity leads to only a 12.7 increase in deaths per 1,000 births (the impact of state capacity in Tigrai is arrived at by adding the state capacity coefficient to the Tigrai × State Capacity coefficient). However, the coefficient for Tigrai indicates that the region will have 43.6 fewer deaths than Amhara per 1,000 births that are not explained by state capacity, the controls, or the year fixed effects. Although this appears minuscule compared to the impact of state capacity, it should be noted that the State Capacity index is on a scale from -1 to 1 for both regions. As a result, the impact of State Capacity, if we use the region minimum and maximum state capacity, ranges from 10.1 fewer deaths per 1,000 births to 7.92 more deaths per 1,000 births in Tigrai and 35.4 fewer deaths per 1,000 births to 70.7 more deaths per 1,000 births in Amhara.

Moving on to the post-HEP models, we see different, but nevertheless interesting results. Following the same 3-model approach, we find that the state capacity index holds significance in all 3 models, with 1%, 10%, and 1% levels of significance in Models 4, 5, and 6, respectively. In Model 4, the State Capacity Index has a coefficient of -.0310, meaning that for every unit increase, 31 fewer deaths per 1,000 births are predicted to occur. Model 5 has a smaller impact, with a one-unit increase predicted to cause 10.7 fewer deaths per 1,000 births. Finally, Model 6, where year fixed effects are included, leads to a sign flip but of a lesser magnitude than Model 3. Model 6 predicts that a one-unit increase in state capacity will lead to 32.4 more deaths per 1,000 births.

Incidentally, the state capacity × Tigrai interaction term lacked statistical significance in the 3 post-HEP models, indicating Amhara and Tigrai had no measurable difference in terms of the impact of state capacity in the period. However, the dummy variable for Tigrai maintained its statistical significance in all 3 models with a 1%, 10%, and 5% level of significance in Models 4, 5, and 6, respectively. Although the impact of the dummy variable was similar in Models 4 and 6, there is a much smaller impact in the other two post-HEP Models. Model 4 gives the Tigrai dummy a coefficient of -.0232, meaning that Tigrai inherently had 23.2 fewer deaths per 1,000 births than Amhara. Meanwhile, Model 5 indicates that Tigrai inherently has 7.9 fewer deaths per 1,000 births than Amhara. Finally, Model 6 indicates Tigrai has 18.3 fewer deaths per 1,000 births than Amhara.

In terms of the control variables, there were mixed results. The urban share lacked significance in Model 5 but gained significance in Model 6 at the 10% level, with a value of .1763, meaning that for every one-unit increase in urban share, infant mortality is expected to increase by 176.3 per 1,000 births. One possible explanation is that urban expansion outpaced

improvements in sanitation and healthcare provision, creating conditions that increased risks to child survival (World Health Organization & UN-Habitat, 2010, pp. 7, 13). However, this mechanism is not directly tested in this study. On the other hand, years of education gained significance in Model 5 but lost it in Model 6. In Model 5, years of education had a significance at the 1% level, with a value of -.0186, meaning that for every additional year of education, infant mortality was expected to decrease by 18.6 per 1,000 births.

All three of the post-HEP models appear to be good explainers of the IMR variance, with R-squared values of .7520, .8932, and .9752, respectively. Given this, we can use the 6th model as a good representation of the post-HEP IMRs in Amhara and Tigrai, since it has the highest R-squared. With this in mind, we can conclude that post-HEP, state capacity did not have a different impact in Tigrai than in Amhara. Even so, when accounting for year fixed effects, the impact of state capacity was positive, increasing IMR rates. When you look at the possible range of state capacity's impact on the regions post-HEP, you find it ranging from 14.1 fewer deaths per 1,000 births to 28.2 more deaths per 1,000 births in Amhara versus 27.4 fewer deaths per 1,000 births in Tigrai to 21.4 more deaths per 1,000. Interestingly, the impact of state capacity is slightly higher post-HEP than pre-HEP in Tigrai, and the lower bound of the range almost equals the impact of the dummy Tigrai variable.

Taking the two models together, we can conclude that state capacity did have an impact on IMRs. However, this does not mean we can accept hypothesis 2 because the data paint a more nuanced picture. There appears to have been a stronger impact of state capacity on IMRs in the pre-HEP periods. The magnitude of the impact was small compared to the Tigrai dummy. Additionally, post-HEP we don’t see a difference in the impact of state capacity, and the Tigrai dummy has drastically shrunk. This, along with Graph 1, indicates that something beyond state

capacity led to Tigrai's better performance pre-HEP and that this was mitigated in Amhara, reducing the gap post-HEP.

III. Party Legitimacy

The answer to the quantitative hypothesis still leaves some glaring questions that qualitative analyses can address. To organize the qualitative research and test whether legitimacy differed between the TPLF and ANDM in their respective regions, and whether this affected policy, we will conduct case studies on the ANDM and TPLF, along with a study of the HEP, its rollout, and the pre- and post-period.

A. The Tigrayan People's Liberation Front

The TPLF sprang up in the early stages of the Ethiopian Civil War. Channeling the memory of the First Woyane Revolt, a rebellion in 1943 when Tigrayan nobles and peasants resisted the centralizing tendencies of Haile Selassie's government, the group launched its fight at Dedebit in the district of Shire on February 18, 1975 (Young, 1997, pp. 51–54; Berhe, 2008, pp. 67–68).

According to Aregawi Berhe, a founding member of the party, the group initially comprised a small band of university students and activists who returned to their native province in 1975 (Berhe, 2008, pp. 65–68). These students were initially members of the Tigrayan University Students' Association (TUSA), part of the broader student movement (Berhe, 2008, pp. 59–60). Taking up the ethnic pillar of the student movement popularized in Walleligne Mekonnen's "On the Question of Nationalities in Ethiopia," they returned to their home province as they grew disillusioned with the revolution (Berhe, 2008, pp. 59, 65–66). Like other student groups, those in TUSA felt the Derg had betrayed them by refusing to make way for civilian

administration (Berhe, 2008, p. 65). Additionally, these students could not find a home in larger student-movement parties like the Ethiopian People's Revolutionary Party (EPRP) or the All-Ethiopia Socialist Movement (MEISON), because they felt those parties did not give adequate attention to ethnic oppression and the question of nationalities (Berhe, 2008, pp. 63–66).

As a result, the students set out on their own, with the ethnic issue at the center of their struggle, and made their way home to Tigrai. Despite the fact that many of these students had grown up in Tigrai, their time away and education made recruitment difficult in the province without a bridge (Berhe, 2008, pp. 66–69). They found that bridge in Gessesew Ayele, known as Sihul, a former member of parliament from Shire who was popular with the peasantry in that area (Berhe, 2008, pp. 67–68). This example shows how the Front began to gain popular acceptance through a trusted local figure, giving it a foundation of legitimacy within the community.

With a bridge to build a base, they based themselves on some of the same premises that Mekonnen had set forth, and the group began an armed struggle for Tigrayan self-determination. As they saw it, the central state had politically marginalized Tigrai and subjected its people to cultural domination and economic neglect, making armed struggle necessary to bring self-determination to the people of the region in general and the peasantry in particular (Berhe, 2008, pp. 59, 65–66).

With this goal, the TPLF launched its struggle against the Derg from Shire. Although it initially consisted of only eleven men in 1975, Berhe notes that local peasants soon began supporting the Front, not because they understood its aims but because they respected Sihul (Berhe, 2008, pp. 67–68). Although the Front made slow progress, its numbers and organization continued to grow into the 1980s. The Front formed an alliance with the neighboring Eritrean

People's Liberation Front (EPLF), whose logistical and military support helped its efforts to liberate the province (Young, 1997, pp. 156–158). The governing Derg's efforts to crush rebel groups through bombardment and reprisals against youths, including the Red Terror of 1976–78, also pushed many to enter the bush (Young, 1997, pp. 118–119).

Although other rebel groups existed, with different names in other provinces, the TPLF soon became dominant in Tigrai. The Ethiopian People's Revolutionary Party (EPRP) had a substantial foothold in northeastern Tigrai, including its Asimba base and activities in Agame, before the TPLF drove it out (Young, 1997, pp. 109–112). The Ethiopian Democratic Union (EDU), led by the former hereditary governor of Tigrai, Ras Mengesha Seyoum, had a foothold in neighboring Begemeder and attempted to expand into Shire. Although the EDU had more military equipment, the TPLF effectively used guerrilla warfare to push it out of Tigrai by 1978 and capture many of its weapons (Berhe, 2008, pp. 125–137). As a result, those fleeing the Derg in Tigrai were left with the TPLF as the principal organized insurgent alternative.

Utilizing the hostility the Derg's policies produced, the TPLF was able to build on its status as the dominant alternative and swell in the province. Although the Derg's policies, such as land reform, were initially popular, haphazard execution across Tigrai alienated the population (Young, 1997, pp. 181–186). To add to this, the Derg's attacks on the Ethiopian Orthodox Church, along with its push for cooperative farming in the southern lowlands, further alienated the religiously conservative and individualistic population (Young, 1997, pp. 174–178, 182).

The TPLF capitalized on these growing resentments in Tigrai after consolidating itself as the dominant rebel group. The Front initiated its own land reform in the areas it controlled and rejected compulsory cooperative farming (Young, 1997, pp. 182–186). The TPLF's land reform was decentralized, with elected peasant committees responsible for implementing redistribution,

in contrast to the Derg's top-down approach, and allowed peasants to participate in decisions (Young, 1997, pp. 183–186). Additionally, it worked to co-opt priests by painting itself as the foil to the godless Derg, even recruiting priests to encourage their parishioners to support and join the Front (Young, 1997, pp. 174–176). The party went so far as to characterize its aims as falling in line with Christian tradition and used its education system to teach youths about the Front's aims, how the Tigrayan population had long been suppressed, and why they should join the struggle (Young, 1997, pp. 172–176).

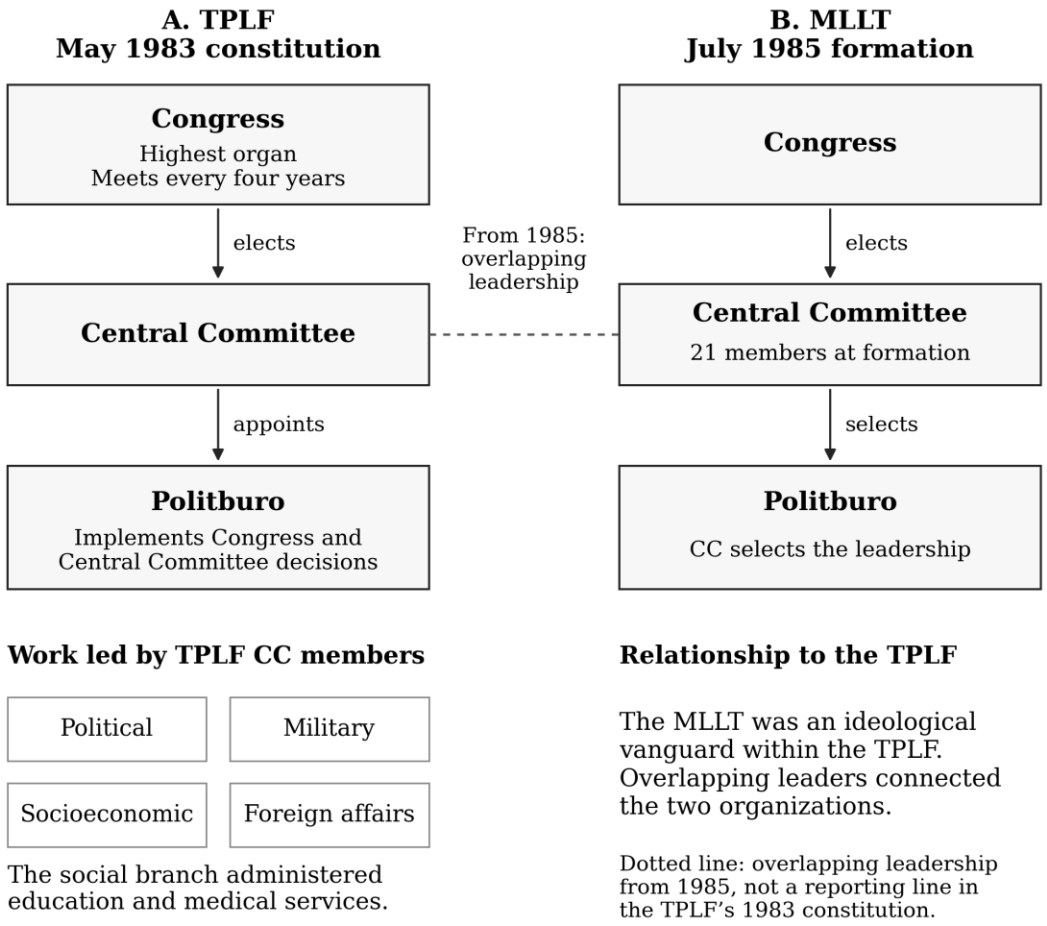
These practices, coupled with the Derg's offensives to crush the rebels, helped the TPLF's numbers swell. The Derg weaponized the 1983–85 famine by restricting food aid across military lines and disrupting relief in rebel-held areas (Young, 1997, pp. 131–133). By the later 1980s, the TPLF controlled much of the countryside and was preparing to remove the Derg's remaining presence in Tigrai (Young, 1997, pp. 160–164). This widespread control allowed it to create a dual governance structure alongside that of the Derg, with local councils, or baitos, created for local administration (Young, 1997, pp. 189–191). Baito members were locally elected and had powers over administration and development, including health and education (Young, 1997, p. 189). Although this was a relatively democratic process, baitos were always under cadre supervision and had autonomy as long as they did not question TPLF authority or its broad directives (Young, 1997, pp. 138–140, 189–191).

This general practice of democratic centralism-relative autonomy alongside adherence to party doctrine—was also present in the party structure. As the party's numbers swelled, its earlier practices of deliberation and decision-making among members no longer worked on the same scale. After an internal struggle, a new group of leaders emerged, and the formation of the Marxist-Leninist League of Tigray (MLLT) in July 1985 reshaped the party's leadership. Leading

this change was Meles Zenawi, who would become Ethiopia's prime minister (Berhe, 2008, pp. 223–227; Young, 1997, pp. 138–140). The TPLF's May 1983 constitution had already placed the Congress above an elected Central Committee, which appointed the Politburo. Central Committee members led political, military, socioeconomic, and foreign-affairs work; the social branch administered services such as education and medical work (Tigrayan People's Liberation Front, 1983, as cited in Mulugeta, 2026, p. 2). The MLLT added a vanguard party with its own Congress, Central Committee, and Politburo. Its influence over the TPLF rested on overlapping leadership and ideological direction (Berhe, 2008, pp. 223–225; Young, 1997, pp. 138–140).

Figure 1

TPLF and MLLT organizational structures



Sources: TPLF (1983), as cited in Mulugeta (2026, p. 2); Berhe (2008, pp. 223–225); Young (1997, pp. 139–140). Author's reconstruction of the dated structures.

TPLF = Tigray People's Liberation Front
MLLT = Marxist-Leninist League of Tigray; CC = Central Committee

The socioeconomic branch is of particular importance because it helped create a channel for local autonomy and participation within the party structure, cementing the party's legitimacy in Tigrai. Cadres were embedded in local communities, while baitos handled local administrative, economic, and social responsibilities (Young, 1997, p. 189). These relationships allowed local demands to influence policy. For example, after the Derg's retreat from the

southern lowlands, a TPLF-organized conference allowed peasants to debate systems of land tenure and reject cooperative farming (Young, 1997, p. 182). This relationship with the peasantry helped the TPLF remove the Derg from Tigrai by the late 1980s and become the de facto government. The responsiveness of this relationship continued after the war: following peasant criticism of unpaid terracing obligations in 1993, the TPLF reduced the annual unpaid commitment from three months to twenty days by 1995 and paid for work on other community projects (Young, 1997, p. 199). For my argument, this responsiveness matters because it links the TPLF's legitimacy to an expectation that the party would respond to local demands and deliver development.

After gaining control of Tigrai, the TPLF set its sights on a much larger prize: Ethiopia. Having restored its alliance with the EPLF in 1988 after a break beginning in 1985, the TPLF also formed the EPRDF with the EPDM, extending its struggle beyond Tigrai (Young, 1997, pp. 156–158, 168; Berhe, 2008, pp. 229–231). This coalition, subsequently broadened to include other ethnic organizations, helped quell fears among other ethnic groups of Tigrayan hegemony. The EPRDF marched into Addis Ababa in May 1991 as the Derg collapsed, took power, and reconstituted the nation along ethnic lines (Young, 1997, pp. 168–169; Lavers, 2023, pp. 86–88).

The TPLF largely replicated its pre-power administrative structure in its governance of the newly constituted Tigrai Region. The region was governed by a regional legislature and divided into four zones with administrative bodies rather than elected zonal councils. Below the zones were woreda councils and executives, and below them were tabias, or local administrative units, with their own councils, or baitos (Aalen, 2002, pp. 94–95). This structure, along with farmers' associations and other mass organizations, gave the party embeddedness in the daily lives of Tigrayans (Aalen, 2002, p. 92). These associations, which checked community progress

on government and party directives, were so embedded in people's lives that they felt they had to attend meetings, even when some perceived them as a waste of time.

The TPLF's embeddedness in the population did not necessarily mean that the population had great say in party machinery and policy. Often, local gimgema meetings saw local officials criticizing cadres for not meeting government development quotas. Despite this, the Tigrayan population felt a close connection to the TPLF (Aalen, 2002, pp. 92–93). Ato Alem, a TPLF official interviewed in August 2000, described the TPLF's relationship to the people in Tigrai as that of "milk and water" that had been mixed and could not be separated (Aalen, 2002, p. 92). Ordinary residents also described the TPLF as their own party and viewed it as the region's legitimate leadership, recalling its struggle and its contributions to peace and development (Aalen, 2002, pp. 92–93).

The people of Tigrai felt this strong loyalty to the TPLF despite the lack of political freedom for reasons beyond its efforts to remove the Derg. Aalen's interviews in 2000 found ordinary residents who saw the TPLF as their own party because it had brought peace and development, and who regarded it as the legitimate ruler of Tigrai (Aalen, 2002, pp. 92–93). To these residents, the TPLF held legitimacy both because it pushed development policies that improved their lives and because it had liberated them from the oppressive Derg.

This loyalty built on development is something the TPLF understood all too well. Young records an unnamed cadre's warning that "if development doesn't succeed Tigray is lost." He also describes the reassignment of senior EPRDF figures to Tigrai in early 1995 to reinforce the regional development programme, interpreting these transfers as evidence of the importance attached to retaining the movement's peasant base (Young, 1997, p. 200). From its days in the bush to the heights of power, the TPLF had made social policy in the form of schooling and

medical improvements central to its relationship with the people of Tigrai. For example, after 1980 the Front expanded camouflaged rural schools in response to community demands, while its wartime health system developed civilian services organized through local baitos (Young, 1997, pp. 172–173; Barnabas & Zwi, 1997, pp. 41–44). Then Prime Minister Meles Zenawi also emphasized the need to quell peasant dissatisfaction in a 1995 speech to parliament (Lavers, 2023, p. 87). This relationship translated into a strong electoral base in Tigrai, which came out for the TPLF en masse in the contested 2005 election. In Ishiyama's dataset, the EPRDF and its allies garnered approximately 93% of the vote in Tigrai, and the ruling coalition won all of the region's federal parliamentary seats, despite great strides by the opposition elsewhere (Ishiyama, 2009, pp. 44–45; Arriola, 2008, pp. 121–123). Although the 93% should be taken with a grain of salt given the lack of opposition presence in the region, the dynamics of ruling-party voter coercion were the same as in other regions but produced very different results, demonstrating genuine popular support for the TPLF. This support lasted through the 2010s, as opposition protests roiled other parts of the country while Tigrai remained relatively unimpacted (Lavers, 2023, pp. 265–269).

Altogether, the TPLF had a loyal base in the population of Tigrai. This loyalty, built during the Ethiopian Civil War as the TPLF became the dominant alternative to the brutal Derg, lasted throughout its time in power. Although the people of Tigrai were not necessarily politically free, the TPLF and the people of Tigrai built a relationship in which legitimacy rested on continued development and progress in economic and social services (Young, 1997, pp. 199–200; Aalen, 2002, pp. 92–93). The party and the people knew the terms of this relationship, and it shaped Tigrai from 1991 through 2020.

B. The Amhara National Democratic Movement

The Amhara National Democratic Movement had a much less clear path to power than the TPLF, with a geographically restricted insurgency that was dependent on the TPLF (Young, 1997, p. 168; Abate, 2007, p. 217). In fact, its predecessor, the Ethiopian People's Democratic Movement (EPDM), originated in a split within the larger EPRP and its army, better known as the EPRA, following major military and organizational setbacks (Abate, 2007, p. 82; Adera & Zewdu, 2026, pp. 5, 8–9). Understanding the EPRA's operations in what is now the Amhara Region can provide important insights into its relations with the population.

The EPRA established an early base at Asimba in northeastern Tigrai before expanding its struggle into Begemeder (Young, 1997, pp. 109–112). Unlike the TPLF, the EPRP and its militant wing focused more on class struggle and were a multiethnic organization that sought to topple the Derg (Berhe, 2008, pp. 144–145). The alpine terrain of Begemeder made it an attractive place for guerrilla warfare. Additionally, the significant poverty of the province made many revolutionaries think it would be fertile ground for their class-struggle rhetoric.

Although the EPRA initially found some success in Begemeder, it would not last. It initially built support in districts like Belesa by providing services, such as education for the youth, much like the TPLF. However, the EPRA faced challenges that ultimately alienated it from peasants (Ayele, 2023, abstract) and contributed to the fragmentation from which the EPDM emerged by 1980 (Abate, 2007, p. 82; Adera & Zewdu, 2026, pp. 8–9).

In the late 1970s, the TPLF drove the EPRP from its established presence in Tigrai, including its Asimba base, using military gains that included weapons captured from the EDU (Young, 1997, pp. 109–112). The TPLF did not want a competing pan-Ethiopian party operating in Tigrai (Berhe, 2008, pp. 144–145). This setback greatly crippled the EPRP and its army.

Furthermore, splits in the party leadership led some to side with the government and expose those still loyal to the party. This harmed the people of Belesa greatly as EPRA cadres fled to the bush and government forces took retribution on the population. Feelings soured further between the peasants and the cadres as the government offered amnesty to those who asked for it, and many EPRA members turned themselves in. Fundamentally, these peasants felt as if they were being punished for supporting the EPRP and its army and switched sides.

As the EPRP and its army fragmented, many fighters turned themselves in to the government or escaped to Sudan. However, a small contingent decided to continue the struggle. These fighters, pushed out of Begemeder, found refuge in TPLF-controlled Tigrai (Abate, 2007, p. 82; Adera & Zewdu, 2026, pp. 8–9). According to Abate, 37 members established the Ethiopian People's Democratic Movement at Embera in Tembien on November 16, 1980, and declared armed struggle in 1981 (Abate, 2007, p. 82). Although founding members like Addissu Legesse and Yared Tibebu, also known as Jebesa, agreed that the party was founded to topple the Derg, its independence from the start was disputed (EthiopianInterview, 2012; Arts Tv World, 2025a, 2025b). Those like Aregawi Berhe in the TPLF argue that the EPDM was under the thumb of the TPLF and served to make the TPLF more palatable to the larger Ethiopian population (Berhe, 2008, pp. 206, 229–231). On the other hand, Tibebu argues that in the early years there was relative intellectual independence despite the alliance with and dependence on the larger and stronger TPLF (Tibebu, 2012, pp. 3, 5; Arts Tv World, 2025a, 2025b). This disagreement concerns organizational autonomy rather than the shared objective of toppling the Derg. Military dependence could coexist with intellectual disagreement, even while the TPLF's material support gave it leverage over its ally (Young, 1997, p. 168; Berhe, 2008, p. 206).

Nevertheless, it is clear that by the mid-1980s the TPLF was exerting extreme influence, if not complete control, over the EPDM (Berhe, 2008, pp. 229–231; Young, 1997, p. 168; Tibebu, 2012, pp. 3, 5). Tibebu describes how TPLF leaders, including Meles Zenawi and Sebhat Nega, pressed and convinced a faction of the EPDM leadership, represented by Tamrat Layne, to make the ethnic issue the preeminent issue for the party, much like the TPLF (Arts Tv World, 2025a, 2025b). Additionally, a TPLF press release dated Hidar 1981 E.C., approximately November–December 1988, congratulates the EPDM on forming a Marxist-Leninist vanguard organization similar to the MLLT (Tigrayan People's Liberation Front, 1988b, as cited in Mulugeta, 2026, p. 3). Furthermore, a recording of the 1985 debates that led to the creation of the MLLT shows Tamrat Layne and other EPDM members in the audience as Meles Zenawi and Gidey Zeratsion debated the merits of the TPLF's transition. This is enough to show TPLF intellectual leadership, if not control of the EPDM.

The inability of the EPDM to gain a substantial foothold independent of TPLF support during the struggle years may be emblematic of its relationship with the people of Amhara during its time in power. Its operations were concentrated in northern Wollo and Belesa rather than extending across the territory of the later Amhara Region (Amhara National Democratic Movement, n.d., as cited in Mulugeta, 2026, p. 1). A TPLF press release from approximately 1984–85 indicates TPLF control of Sekota, the seat of Wag Himra, while a May 1988 release describes joint TPLF–EPDM operations in Raya (Tigrayan People's Liberation Front, n.d., 1988a, as cited in Mulugeta, 2026, p. 3). Young reports that TPLF fighters reinforced the EPDM from the mid-1980s, and that the advance in Amhara territory halted when those fighters withdrew in 1989. Peasant mobilization in the EPDM's areas was much less extensive than in

Tigrai (Young, 1997, p. 168). This limited independent presence and reliance on TPLF support demonstrate the weakness of the EPDM's popular peasant base.

The limited presence in what became the Amhara Region, coupled with the political legacy of the EPRP and its army, meant the EPDM did not have much popular legitimacy when it came to power (Abate, 2007, pp. 217, 222–225). In fact, its buy-in to ethnocentric sentiments alienated the mostly pan-Ethiopian nationalist population in Amhara (Abate, 2007, pp. 78–82, 217, 223). Tamrat Layne, who became the party's de facto head and prime minister during the transitional period, further alienated the population by using the words neftegna, or rifle bearer, and chauvinist to refer to Amhara elites, in inflammatory rhetoric that did not distinguish elites from the population.

The EPDM reconstituted itself as the Amhara National Democratic Movement in 1994, during the transitional administration (Abate, 2007, p. 82). Tibebu and others claim the party reconstituted itself due to pressure from Meles and the TPLF, who wanted the EPRDF's constituent parties to be ethnic parties that could govern in the new regions (Arts Tv World, 2025a, 2025b). As a result, the EPDM became the ANDM.

Although Ethiopia's first elections under the constitution in 1995 were largely uncompetitive, amid opposition boycotts and harassment, election complaints signified the lack of popularity of the ANDM in Amhara (Arriola, 2008, pp. 118–119). Of all the regions, Amhara had the highest number of complaints filed to the Election Adjudication Board. There were many complaints of voter intimidation and harassment or arrest of opposition activists, especially in the northern Shewa town of Ankober. Although this does not necessarily show concrete opposition to the ANDM, it does show a belief within the ANDM that force was required to hold on to power. Concrete opposition was displayed in the 2005 election: the CUD won 50 of Amhara's 138

federal parliamentary constituencies in the final disputed results, approximately 36% of all regional seats (Arriola, 2008, pp. 120–122). In Ishiyama's sample, the CUD received almost 48% of the vote in the included Amhara constituencies, compared with approximately 36% for the EPRDF and its allies (Ishiyama, 2009, pp. 44–45).

The lack of legitimacy the ANDM faced in Amhara persisted through its time in office and bubbled into widespread protest in the mid-2010s (Lavers, 2023, pp. 265–266). This led ANDM officials to privately declare that the party lacked support in the region. During an EPRDF Politburo meeting, an ANDM leader confessed that the people of the region saw his party as shills of the TPLF and believed they had been sold out.

However, this lack of popular legitimacy did not mean the ANDM lacked power in the region. The distinction is important for my argument because it points out that the ANDM could secure obedience without depending on the same developmental relationship with residents to sustain popular acceptance. In fact, the party was able to accomplish goals; however, its impetus did not come from a belief that it had a limited social contract to bring development to retain support. Regional leaders embedded cadres into communities and created an administrative structure much like Tigrai's, with a regional legislature, followed by zonal administration, then woreda, and finally kebele (Abate, 2007, pp. 69–70, 77, 224–225). In this case, however, policy direction was almost exclusively top-down (Abate, 2007, pp. 224–225, 245). Peasants described this as being the case, with their perception of governance styles resembling those they held of imperial rulers. Although they did not necessarily support the ANDM, they complied with its directives for fear of retribution (Abate, 2007, pp. 186, 222, 224–225). Even in the 2005 election, rural residents felt comfortable coming out for the opposition partly because they interpreted the

government's acceptance of opposition campaigns as giving up its divine right to rule (Lefort, 2007, p. 253).

The ANDM's ability to secure compliance despite limited popular support was evident in Baso Liben. Residents reported contributing labor and materials for soil and water conservation because they feared harassment, while a Korke kebele administrator explained that local leaders could not refuse directives from the woreda (Abate, 2007, p. 186). Regional and zonal authorities also assigned cadres to supervise local political activity. Officials reported that challenging these cadres could lead to removal through gimgema, while community informants described local officials using political control to demonstrate party loyalty (Abate, 2007, pp. 224–225).

These accounts suggest that local officials faced strong incentives to satisfy political superiors. Where remaining in office depended on maintaining their confidence, pursuing locally identified priorities could become secondary to demonstrating obedience. The capacity to mobilize residents therefore did not necessarily translate into sustained local policy initiative. Instead, political insecurity could weaken long-term planning and make development efforts more dependent on priorities endorsed from above (Abate, 2007, pp. 224–225).

Altogether, the ANDM was a party founded under the shadow of the TPLF (Abate, 2007, p. 82; Berhe, 2008, pp. 229–231). This legacy meant the party lacked broad popular support in the Amhara Region throughout its tenure, and its legitimacy rested on the support of the central power.

C. Party Legitimacy and Developmental Incentives

The TPLF and ANDM entered government with different relationships to the populations they governed. The TPLF had built its authority through the armed struggle and institutions that connected local participation to administration and social services (Young, 1997, p. 189).

Residents subsequently described the TPLF as their own party and associated its legitimacy with liberation, peace, and development (Aalen, 2002, pp. 92–93). The EPDM's more limited peasant mobilization and reliance on TPLF military and political support gave its successor a weaker independent foundation in Amhara (Young, 1997, p. 168; Berhe, 2008, pp. 229–231). Here, popular legitimacy refers to residents' acceptance of a party's authority, while central political backing refers to the support that enabled it to retain power. My argument is that the TPLF depended more directly on maintaining the former, whereas the ANDM's position depended more heavily on the latter.

These different foundations shaped the political incentives for development. The TPLF's relationship with the peasantry created expectations that victory would produce material improvements. Young describes both peasant demands for development and the leadership's recognition that its continued support depended on meeting them (Young, 1997, pp. 199–200). Development was therefore part of the relationship through which the TPLF sustained its regional legitimacy. In Amhara, Abate's account of Baso Liben shows officials facing removal by political superiors, frequent turnover, and pressure to demonstrate party loyalty. These conditions weakened long-term planning and local initiative (Abate, 2007, pp. 224–225). Officials could still mobilize labor and enforce development directives, as the soil and water conservation case demonstrates (Abate, 2007, p. 186). Their political security, however, encouraged them to prioritize the demands of superiors, making development efforts more dependent on direction from above.

This difference provides the political mechanism for H1. I argue that the TPLF's dependence on maintaining a developmental relationship with its population encouraged earlier regional initiative in expanding primary healthcare, while the ANDM's dependence on central

backing made a stronger federal directive more consequential for its priorities. The healthcare cases that follow trace this mechanism through the systems each region inherited, the services they developed before the HEP, and their responses to its national expansion. They also compare how regional governments worked with NGOs and how provision varied between woredas. This connects the party histories to the thesis's explanation of differences in health provision and infant mortality, including the later narrowing of the regional gap.

IV. Health Before and After the HEP in Amhara and Tigrai

The parties' dynamics with their respective populations would manifest themselves in the health operations of the two regions. I argue that these dynamics encouraged Tigrai, unlike Amhara, to build its health infrastructure more rapidly and with less federal impetus. The resulting differences would contribute to the divergence in health outcomes manifested in infant mortality rates. However, implementation of the Health Extension Program (HEP) on a national scale would help reduce the gap between the two regions.

A. The Health Sector in Tigrai

The health sector in Tigrai developed after the EPRDF's accession to power. Building on the health initiatives of the civil-war period, the regional government expanded a primary healthcare network through the 1990s and 2000s that extended access across rural communities (Ghebreyesus et al., 1996, pp. 146–150; Gebrehiwot et al., 2015, p. 3).

As mentioned in the political-legitimacy section, the TPLF built structures within its party apparatus to reach the population, most importantly through the creation of local baitos. Although its early health apparatus focused largely on trauma care and first aid, the stabilization of its control over much of the province by 1980 allowed it to shift priorities (Barnabas & Zwi,

1997, pp. 41–42). The Front's social branch was responsible for social services, including medical work, while its health personnel provided rudimentary curative care, drugs, and basic treatment for civilians (Tigrayan People's Liberation Front, 1983, p. 2; Barnabas & Zwi, 1997, pp. 41–42).

As the local-government structures developed, the Front mobilized the baitos to gather resources and build health clinics. The devastation of the famine of 1984/85 and subsequent policy reviews reinforced the need to move toward preventive care (Barnabas & Zwi, 1997, pp. 41–44). This involved training health workers and policy discussions led by TPLF cadres and health professionals, including Gebre Ab Barnabas (Barnabas & Zwi, 1997, pp. 43–44). This wartime experience helped provide a model for the EPRDF's subsequent emphasis on primary healthcare (Croke, 2020, pp. 1321–1324). The emphasis is also reflected in the health provisions of the EPRDF's 1989 and 1995 programmes and the Transitional Government's August 1993 Prime Minister's Office memorandum on social policy (EPRDF, 1989; EPRDF, 1995; Transitional Government of Ethiopia, Prime Minister's Office, 1993).

However, the strong health foundation built in Tigrai during the insurgency did not necessarily remain intact after the EPRDF took power and the regional administration was restructured. The voluntary nature of the community-health network meant that, when support and supervision were suspended during the transition, many workers became inactive and the network weakened (Ghebreyesus et al., 1996, p. 146). The Tigrai Health Bureau, regional government, and regional branch of the National Malaria Control Programme nevertheless pushed to revitalize community-based services to combat malaria in 1992, in collaboration with the World Health Organization (WHO) (Ghebreyesus et al., 1996, pp. 146–147). Health Bureau and malaria-programme personnel discussed selection criteria with local leaders, and villagers

then elected community health workers (CHWs); WHO supported their malaria training (Ghebreyesus et al., 1996, p. 148). This was coupled with monthly locality meetings at which villagers and elected officials reviewed workers' services, drug delivery, and other activities (Ghebreyesus et al., 1996, p. 150). The programme thus revitalized part of the health apparatus and drew on practices developed during the insurgency to promote primary healthcare.

NGOs also contributed to these services. The Relief Society of Tigrai (REST) worked with health offices and community health committees on health education, community-health-agent training, and preventive services. The Adigrat Diocesan Catholic Secretariat (ADCS) likewise supported worker training and child nutrition in cooperation with public health institutions (Abate, 2007, pp. 153–154).

Primary healthcare was important enough in the region that regional initiatives helped inform subsequent national health policy. By the late 1990s, the regional government's commitment to health was evident in its spending. The Ministry of Health programme recorded in my IES notes reports per-capita health expenditure of 9 birr in Tigrai in FY1996, compared with 4.9 birr in Amhara (Ministry of Health, 1997). The regional role was substantial: in 1996/97, approximately 89% of government health expenditure was recorded at regional and city-administration level, compared with 11% at the center (World Bank, 1998, Annex 4, p. 6).

At the federal level, the early 1990s were dominated by post-conflict reconstruction and political consolidation, while the 1998–2000 war diverted attention and resources. After 2001, the developmental-state strategy gave greater impetus to investment in rural services, including primary healthcare (Croke, 2020, pp. 1322–1324). Health already appeared in national policy before this shift, as the earlier party programmes and social-policy memorandum demonstrate.

The key change was the strength and scale of implementation, not the first recognition of health as a government responsibility.

Against this background, the Regional Health Bureau held a workshop in 2001–02 that produced six guidelines, including a health extension manual distributed to primary healthcare units (Gebrehiwot et al., 2015, p. 3). These regional initiatives preceded the national HEP and formed part of its policy background (Croke, 2020, p. 1324). The HEP directed resources toward health-post construction and the training of health extension workers (HEWs), whose responsibilities included family health services, such as maternal care and family planning; disease prevention and control, including malaria and HIV; hygiene and sanitation; and health education and communication, including model-family training (Banteyerga, 2011, pp. 46–47). Although the HEP was launched nationally in 2003 and became operational through the deployment of workers in 2004–05, Tigrai's earlier efforts meant that more than 500 health posts had been built by 2004/05, and more than 1,200 HEWs were trained and deployed in 2005–06 (Banteyerga, 2011, p. 46; Gebrehiwot et al., 2015, p. 3).

This coordination continued through the 2010s, with increasingly integrated primary healthcare provision. Regular discussions and evaluations linked community groups, health workers, and political leadership at kebele, woreda, and regional levels, while governing boards included zonal and woreda representatives (Tigrai Regional Health Bureau, 2008 E.C., pp. 5–6). Work with NGOs continued within a regional partnership framework, extending the earlier coordination illustrated by REST and ADCS. The Regional Health Bureau chaired a partners' forum designed to align planning, budgets, and monitoring (Abate, 2007, pp. 153–156; Tigrai Regional Health Bureau, 2008 E.C., p. 36).

Overall, the regional government in Tigrai took the initiative to extend primary healthcare throughout the region in ways that helped influence federal policy. I interpret this drive as reflecting the aforementioned limited social contract between the TPLF and the population of Tigrai, which encouraged regional officials to act before the HEP became a national implementation priority.

B. The Health Sector in Amhara

The health sector in Amhara had a slower and more uneven start than in Tigrai. Given the ANDM's limited wartime presence in much of the region, it did not inherit an equivalent party-linked community-health network, and in some cases officials impeded workers trained under the former government (Abate, 2007, pp. 156–157, 167, 217). However, the national emphasis on health under HEP would accelerate the expansion of the region's primary healthcare infrastructure.

Some of the community-health capacity inherited by regional officials, in the form of community workers, were seen as undesirable and hindered in their work. In Baso Liben, community health agents trained under the Derg were ostracized and prevented from contributing to local services because they were accused of collaborating with the former government (Abate, 2007, p. 167). This, coupled with the lack of new training, meant that Baso Liben had no functioning community-health-agent programme in the late 1990s; new training began with support from the Swedish-Amhara Rural Development Programme (SARDP) in 2000 (Abate, 2007, pp. 151, 167). Community health committees were also unevenly developed. Although such committees offered a means of coordinating primary healthcare at woreda and kebele levels, Baso Liben had none at either level, while Bugna's kebele committees were weak

(Abate, 2007, pp. 156–157). Consequently, organizations such as SNV Netherlands Development Organisation and Plan helped establish or support the community networks and local-government capacity through which services were delivered in Bugna (Abate, 2007, pp. 154–157).

Although this paints a bleak picture of parts of the region's pre-HEP health apparatus, health infrastructure was being built. By 1998, construction completed in the preceding five years included 135 health stations, 14 health centres, and 132 health posts (World Bank, 1998, Annex 2, p. 14). Nevertheless, estimated health-service coverage remained only about 37%, leaving much of the population without access (World Bank, 1998, Annex 2, p. 14). Additionally, the Ministry of Health programme recorded in my IES notes reports just 4.9 birr in per-capita health expenditure in Amhara in FY1996, compared with 9 birr in Tigrai (Ministry of Health, 97).

HEP helped change this unevenly organized health apparatus. Although the ANDM may have lacked popular legitimacy, my argument is that its ability to secure administrative compliance allowed it to implement major policy directives. The federal push brought clearer responsibilities, coordination, health-post construction, and HEW training. The programme required government sectors, local leaders, and communities to collaborate in implementation (Banteyerga, 2011, pp. 46–47). Local leaders, religious leaders, and community associations also participated in health activities and community meetings (Banteyerga, 2011, p. 48). By the early 2010s, selected measures of Amhara's primary-care capacity were comparable to Tigrai's (Wang et al., 2016, pp. 73–74). In a later indication of continuing public commitment, health expenditure reached approximately 15% of Amhara's total regional government expenditure in 2020/21 (UNICEF & Ethiopian Economics Association, n.d., pp. 1, 10).

Although Amhara's health apparatus was weak before the mid-2000s, HEP helped change its trajectory. My IES notes on Development Indicators of the Amhara Region State 2007 record an increase in health posts from 927 to approximately 2,396 between the years labelled 2003 and 2007 in those notes (Development Indicators of the Amhara Region State 2007, n.d., as cited in Mulugeta, 2026, p. 3). By 2009/10, Amhara had approximately one HEW for every 2,775 people, giving it denser HEW coverage than Tigrai (Wang et al., 2016, pp. 73–74).

C. Regional Comparison

The study of the two regional health systems relates to the question of where political will comes from and how it affects health outcomes. My argument is that the desire to maintain popular support in Tigrai encouraged a concerted and organized push in health. In Amhara, by contrast, the desire to maintain federal support made stronger federal direction particularly important to implementation. These differences would manifest themselves in the organization and performance of health services before 2005, with implications for infant mortality.

A study by Fenta Mandefro Abate provides a useful comparison of regional health systems before 2005. Abate examined four woredas: Wukro and Degua Temben in Tigrai, and Bugna and Baso Liben in Amhara (Abate, 2007, pp. 6–8). He found substantial differences in the coordination of local health services. In the two Tigrai woredas, community health committees at woreda and tabia levels provided established channels for communication and discussion (Abate, 2007, p. 156). Respondents who assessed woreda leadership rated political will highly in both Tigrai cases, although Wukro received stronger overall leadership-capacity assessments than Degua Temben (Abate, 2007, pp. 118–120). Differences in service performance were also evident: in 2001, antenatal-care coverage was 77% in Wukro and 31% in Degua Temben (Abate, 2007, p. 171). Despite this variation, established links connected public health offices,

community structures, and NGOs in planning, training, and service delivery (Abate, 2007, pp. 151–157).

In the Amhara cases, the pattern was different. Although Bugna performed relatively well compared with Degua Temben on some measures, extensive NGO support was important to its health services. SNV helped initiate community health committees and strengthen the Health Office's capacity, while Plan supported facilities, supplies, and training (Abate, 2007, pp. 154–157). In Baso Liben, no community health committee existed at either woreda or kebele level (Abate, 2007, p. 157). Although Bugna ranked relatively highly in assessments of overall leadership capacity, political will received weaker ratings in both Amhara cases than in the Tigrai cases (Abate, 2007, pp. 118–120). In 2001, antenatal-care coverage was 19% in both Bugna and Baso Liben. Average primary-healthcare coverage during 1996–2001 was 34.4% in Baso Liben, compared with 82% in Wukro, 43.5% in Degua Temben, and 53% in Bugna (Abate, 2007, pp. 161, 171).

These cases show that, before 2005, variation existed within each region, but the two Tigrai cases had a higher minimum level of coverage on some important service indicators. NGO contributions in Tigrai were embedded in established government and community networks, whereas NGO support played a particularly important role in building such arrangements in Bugna. This distinction concerns the organization of assistance, rather than demonstrating that Tigrai was financially independent of NGOs (Abate, 2007, pp. 153–157, 161, 168, 171).

With the advent of HEP, the regional government in Amhara received a stronger national impetus to build its primary healthcare apparatus. The workforce data reported by Wang and colleagues show one HEW per 2,775 people in Amhara, compared with one per 3,600 in Tigrai, using 2009/10 staffing and the 2007 census population. In 2012/13, there was approximately one

health center per 23,000 people in Amhara and one per 22,000 in Tigrai (Wang et al., 2016, pp. 73–74). These figures show that the regions had become more comparable on these measures of primary-care capacity by the early 2010s.

Overall, HEP appears to have played an important role in bringing these aspects of the health systems in Amhara and Tigrai closer together. In this interpretation, the national programme gave the Amhara regional government the impetus to catch up through improved organization and coordination of primary healthcare. The regions consequently became more comparable in extension-worker and health-center provision by the early 2010s, although these measures do not establish equality across all health-system capabilities.

Overall, these findings are important for understanding IMR divergence in the two regions. The embeddedness and limited social contract that the TPLF had with the population of Tigrai gave it very different incentives from the ANDM. The TPLF was incentivized to take initiative and provide development in order to maintain popular support and its grip on Tigrai, and this manifested itself in the party's push to expand primary healthcare in the region. As a result of the ANDM's reliance on federal force and authority to remain in power, it did not give healthcare expansion the same priority and coordination it had in Tigrai, with NGOs playing a large role in establishing some local health structures. This would change as the HEP, introduced nationally in 2003 and expanded through worker deployment in 2004–05, brought a stronger federal push for primary healthcare. The resulting improvements in coordination and primary healthcare access help explain the narrowing of the regional disparities that had developed before 2004. This supports H1, with a qualification: although this study does not establish that there was higher health-policy compliance in Tigrai than in Amhara, subnational variation in legitimacy

appears to have shaped incentives to initiate and coordinate policy, contributing to weaker local initiative in Amhara before the stronger federal push.

Conclusion

In the world of development, there are few metrics as important as infant mortality. Infant mortality is important from a development perspective for two reasons: it is sensitive to policy intervention, and reducing it allows more children to survive and develop. Much research has been done on how and why autocratic regimes target health and the dividends this can pay in reducing infant mortality. However, comparatively less attention has been given to the regional political mechanisms behind differences in infant mortality when autocratic governments pursue these policies. This study aimed to assess this in the context of Ethiopia, where infant mortality fell rapidly during EPRDF rule from 1991 to 2019. Despite these strides, we found that the Amhara and Tigrai regions, which had no statistically significant difference in IMR at the start of the federal period in 1995, subsequently diverged. The study sought to explain this by exploring the roles of state capacity and political legitimacy.

The examination of the initial IMRs in the two regions did not detect a statistically significant difference between them in 1995. Additionally, a log-linear OLS regression showed that Tigrai's IMR declined more rapidly than Amhara's before 2004, with an estimated annual log-slope difference of −0.0323. After 2004, this estimated difference narrowed to −0.0024, becoming very small and no longer statistically significant. To answer why this change in trajectory, exemplified by Graph 1, occurred, we first tested whether state capacity helped account for the variation using OLS models. These models examined the state capacity index and its interaction with the Tigrai indicator before and after HEP. The results showed that the

association between state capacity and IMR varied across specifications, although the fully controlled pre-HEP model estimated a more favorable association in Tigrai than in Amhara. The regional dummy also remained negative and statistically significant. This indicated a remaining conditional regional difference beyond the variables included in the model, warranting investigation of additional explanations. In the post-HEP period, the adjusted regional advantage represented by the Tigrai dummy narrowed from 43.6 fewer deaths per 1,000 births to 18.3 fewer deaths per 1,000 births. Because the models include a capacity interaction, these estimates compare the regions at the capacity index's zero reference point, holding the included controls constant. Although state capacity remained significant in the fully controlled post-HEP model, its coefficient was positive, indicating an association with higher IMR within that specification rather than establishing a harmful causal effect. With the loss of significance in the Tigrai interaction, these results do not establish that state capacity caused the narrowing of the regional gap.

The regional difference remaining in the state capacity results led us to look at political legitimacy in the two regions and how it shaped policy. In Tigrai, we found that the Tigrayan People's Liberation Front (TPLF) had built grassroots support among the people of Tigrai and a limited social contract. The TPLF's grassroots support stemmed from its days struggling against the Derg and its legacy as a major alternative force in the region to the military regime. This, coupled with social policies such as land distribution and local participation through baitos (councils), created deep loyalty among many Tigrayans throughout the period of study, with one civilian describing the relationship as that of mixed milk and water: inseparable. However, both the TPLF and Tigrayans knew the limits the TPLF imposed on certain freedoms, and sustaining popular support depended in part on continued development. On the other hand, the Amhara

National Democratic Movement (ANDM) had a relationship with the population shaped by coercion and relied on federal support to remain in power. The group's heavy reliance on the TPLF in its early days and limited presence in Amhara prior to the EPRDF coalition's seizure of power meant the party maintained a distant and contentious relationship with much of the population. Reliant on the central government for control, the ANDM had stronger incentives to follow federal priorities, whereas the TPLF had an incentive to push regional initiatives for development without waiting for stronger federal mandates.

These varying incentives were reflected in the health sector. Prior to the major national push for the extension of primary healthcare services, the regional health sectors differed substantially in their organization. Although the Amhara region did construct medical facilities during this period, some of the studied woredas lacked coordinated community-health structures or relied heavily on NGOs to establish them. This was in contrast to Tigrai, where experience with health posts during the liberation struggle provided a foundation for renewed efforts to prioritize and expand primary healthcare. Although Tigrai's primary health apparatus was by no means perfect, government initiative and coordination were associated with a higher minimum level of coverage and service use on some indicators in the studied Tigrai woredas. In this interpretation, the legitimacy motives that pushed the TPLF to expand primary healthcare also help explain the regional policy initiatives that informed the national Health Extension Program, including the health extension manual developed through a regional workshop in 2001–02. With the Health Extension Program, the Amhara region received a stronger federal push to train health extension workers, build health posts, and increase local coordination of policy and programmes. This push helped the region become more comparable to Tigrai in extension-worker provision per person by 2009/10 and health-center provision per person by 2012/13. This offers an

explanation for part of the regional advantage observed in Tigrai before 2004 and its subsequent narrowing, although the comparison does not isolate HEP's causal effect on IMR.

Taken together, this thesis provides insights of use to policymakers and academics alike. In relation to development metrics such as IMR that are sensitive to policy intervention, the findings suggest that political incentives and coordination matter for how service-delivery capacity is developed and used. To avoid internal divergence, policymakers can encourage local and regional officials to take initiative while sustaining national coordination and support; otherwise, differences in political incentives may contribute to divergence in outcomes. Although Amhara eventually became more comparable to Tigrai on several measures of primary healthcare provision, the earlier disparities raise the question of how many more children might have had the chance to live had the incentives been there to push policymakers to act earlier for their people.

Limitations

There are several limitations to this study. First, the quantitative analysis is limited to 1995–2015 because comparable data were not available for the entire EPRDF period. This prevents the study from showing whether these relationships continued through the later political changes. Additionally, conflict limited my ability to contact individuals in the two regions, restricting the interviews available to supplement the historical and archival evidence.

Both the data and sources also have limits. The state-capacity index captures infrastructure and access to healthcare but cannot fully account for the quality of government administration or health services. The road data were not collected annually, and regional averages can obscure important differences between woredas. The analysis also rests on a small

number of region-year observations, and some results change when year fixed effects are included. In the qualitative analysis, the available histories are uneven between the parties and may reflect the perspectives of their authors.

Finally, while the findings support an explanation linking political incentives to health policy, the study cannot isolate the effects of legitimacy or HEP from every other factor affecting infant mortality. It also does not directly establish differences in policy uptake between the regions. There is room to build on this research through additional interviews, more detailed woreda-level data, and comparisons with other regions. This could help clarify how political legitimacy shapes policy initiative and how national programmes influence regional differences in development.

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