Budget Brief

National Health and Nutrition Sector Budget Brief: 2006-2016

Key Messages

- National on-budget health expenditure has increased 10 fold in nominal terms from ETB 2.4 billion in 2006/07 to ETB 24.5 billion in 2015/16, at an average annual growth rate of 30.6 per cent. In real terms however, this amounts to a 2.5 fold increase over the same period at an average growth rate of 12.6 per cent. Even though this is an achievement, in light of the pressure of providing health care services to a growing population (91.2 million in 2015/16), greater effort is required to ensure sustained increases in inflation adjusted health expenditure, given that the average growth rate masks the decline in real health expenditure for some years.
- Ethiopia faces critical resource constraints to adequately meet its health care financing needs which can be exacerbated by inefficient budgetary execution in the health care system. Conducting Public Expenditure Tracking Surveys to assess leakages and wastages in the health sector can contribute to further efficiency gains.
- The state budget only reflects a portion of Ethiopia's health spending and therefore significantly underestimates total spending on health. Thus, there is a need to shift off-budget financing of the health sector to on-budget records in order to better track, plan, execute, monitor and direct funding towards sustainable financing of the health sector.
- On-budget per capita health expenditure amounted to only ETB 268 (US$12) in 2015/16, which is very low compared to the sub-Saharan Africa average of US$98 per capita health expenditure in 2014, and has resulted in considerable personal out-of-pocket (OOP) health care fees which is relatively higher for poorer households. Further promotion of health insurance schemes including the provision of formal health care insurance can be considered as a way of reducing the high levels of personal OOP health care charges.
- Ethiopia's health sector is heavily dependent on donor financing. Increasing domestic resource financing towards the health sector will secure more sustainable sources of health care financing and will reduce donor dependency.

This budget brief is one of four and analyses budget and expenditure that are recorded on-budget for the Federal Ministry of Health (MoH) and its affiliated sub-national level Bureaus of Health (BoH) and district level Woreda Health Offices. Hence, what is made reference to as health budget and expenditure also includes finances for nutrition programmes as both health and nutrition programmes are executed jointly through these same public bodies. Audited financial accounts are presented for the years up to 2013/14 while preliminary financial accounts have been made available for the 2014/15 and 2015/16 fiscal years. The main objective is to synthesize complex budget information so that it is easily understood by stakeholders, and to put forth key messages to inform policy and financial decision-making processes.

1. Overview of the Health and Nutrition Sector

Ethiopia's steady growth trajectory in the last decade along with the commitment towards implementing pro-poor health policies and strategies resulted in improved health outcomes. Ethiopia has progressively expanded access to a range of health services and introduced a three-tier public health care delivery system towards achieving universal access to primary health care. The involvement of the private sector in the delivery of health services is also improving progressively.

Table 1: Selected health outcome indicators

Key indicators	2005	2011	2016
Neonatal mortality rate (per 1,000)	39	37	29
Infant mortality (per 1,000)	77	59	48
Under-5 mortality (per 1,000)	123	88	67
Child mortality (per 1,000)	50	31	20
Maternal mortality rate (per 100,000)	673	676	412
Use of modern contraceptive (%)	14	27	35
Antenatal care provided by skilled provider (%)	28	34	62
Total fertility rate (%)	5.4	4.8	4.6
Birth occurred in health facility (%)	5	10	26
Skilled birth attendance (%)	6	10	28
Exclusive breastfeeding (infants < 6 months, %)	49	52	58
Stunting prevalence (children < 5 years, %)	51	44	38
Wasting prevalence (children < 5 years, %)	12	10	10
Underweight prevalence (children < 5 years, %)	33	29	24

Source: Central Statistics Agency. 2016. Demographic Health Survey.

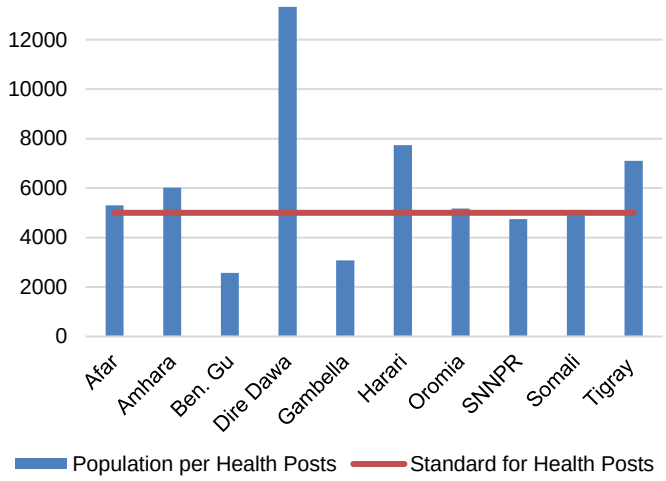
Ethiopia's Flagship Community Health Programme – The Health Extension Programme

Innovative strategies to improve basic health care services have been introduced. In this regard, the Health Extension Program (HEP) is contributing greatly toward universal health coverage in the country and the success achieved in the health sector. Primary health care services such as maternal and child health care, tuberculosis and HIV, and family planning among others, are more accessible to communities through the HEP. Although national directives outline the abolishment of user fees for health posts and for some services at health centres, its applicability has been different across regions. Generally however, maternal health care, immunization, and emergency child health services are universally provided free of charge through these government health services. Under a massive nationwide drive, over 38,000 health extension workers (HEW) have been deployed to over 16,480 health posts[1] to bring basic health services to the doorstep of Ethiopia's large, rural community. The HEP addresses the equity and efficiency dimensions of health care provision.

Health Infrastructure

Considerable efforts have been made to improve the expansion of health infrastructure, human resource development, as well as supplies. For instance, the number of functional health posts, health centres, and hospitals in the country has sharply increased by 16 per cent, 33 per cent, and 108 per cent respectively between 2009/10 and 2015/16.[2] Similarly, an unprecedented increase has been seen in the number of higher health training institutions. As a result, the number of graduating physicians annually has significantly increased, and in 2015/16, the physician to population ratio increased to 1:14,045 compared to 1:17,160 in 2014/15.

Figure 1: Population per health posts across regions in 2015/16.



Source: Data from the "Federal Ministry of Health, Annual Performance Report 2015/2016 of the Health Sector Transformation Plan I".

[1] Ethiopia's Health Sector Transformation Plan-I: Annual Performance Report, 2015/16.
[2] Ethiopia's Health Sector Transformation Plan-I: Annual Performance Report, 2015/16.

Health Insurance

To promote health insurance, the Government of Ethiopia (GoE) in 2008 enacted a National Health Insurance Strategy with the aim of achieving universal health coverage. The Social Health Insurance (SHI) component that was being planned was discontinued in 2015, while the Community-Based Health Insurance (CBHI) scheme, implemented since 2012, is being progressively scaled up and targets informal sector workers and the poor in rural areas. **The CBHI has a 10 per cent indigent provision, which will replace existing health fee waivers in the CBHI areas**. CBHI was piloted initially in 13 *woredas* (i.e. districts) in Amhara, Oromia, SNNP, and Tigray regions, and covered 608,675 beneficiaries[3] in 2013 and has now been scaled up. CBHI has been well received by communities and in the 2015/16 Ethiopian fiscal year went on to cover 320 *woredas* facilitating access to health care services.[4] Originally piloted by the Ministry of Health (MoH) and its partners, CBHI is currently being overseen by the Ethiopian Health Insurance Agency (EHIA), an agency which is still under the MoH and not yet an independent institution. Discussions are also underway to consider informal health insurance coverage such as the CBHI alternative for urban communities.

Box 1: Policy and strategy documents for health and nutrition

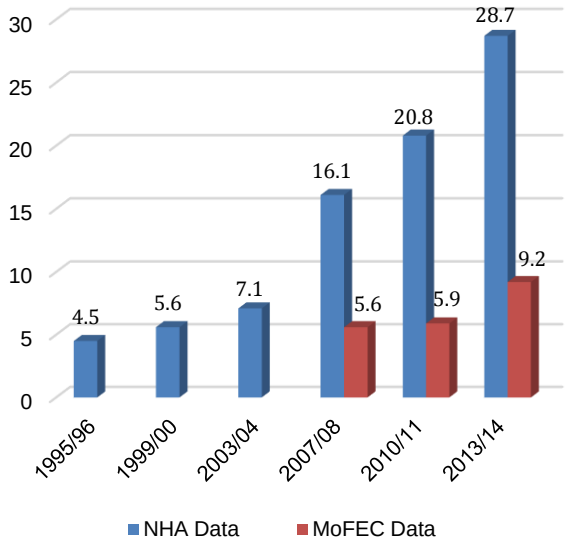
- Growth and Transformation Plan, GTP-II, (2015/16-2019/20) which builds on former national development plans such as GTP-I (2010/11-2014/15)
- National Health Policy, 1994
- Health Sector Transformation Plan (2015-2020) which builds on four former Health Sector Development Plans (HSDPs) implemented between 1997/98 and 2014/15
- National Health Care Financing Strategy, 2015-2035
- National Health Accounts (used to monitor the national health care financing strategy)
- National Nutrition Strategy, 2008
- National Nutrition Programme II (2016-2020), that provides for linkages with other sectors
- National Health Insurance Strategy (2008)
- National Social Protection Strategy, 2016 (2016-2019)
- National Social Protection Action Plan, 2017, (2017-2021), Regional Social Protection Action Plans for Amhara, Oromia, SNNP and Tigray regions

[3] The World Bank. 2016. Public Expenditure Review. p.55.
[4] Federal Ministry of Health, Annual Performance Report 2015/2016 of the Health Sector Transformation Plan I, p.91.

2. National Health Care Spending

The state budget only reflects a portion of Ethiopia's health spending while the National Health Accounts (NHA), set up by the Federal Ministry of Health to monitor and analyse health sector expenditure, attempts to account for a wider scope of health care spending, including conducting household surveys to estimate personal out of pocket expenses on health care (Figure 2).

Figure 2: Trends in Ethiopia's Per Capita Health Spending (in United States Dollars (US$))



Source: Ethiopia Federal Ministry of Health. 2017. Ethiopia Health Accounts 2013/14. p.9. Combined by authors with data from the Ministry of Finance and Economic Cooperation (MoFEC) for comparison.

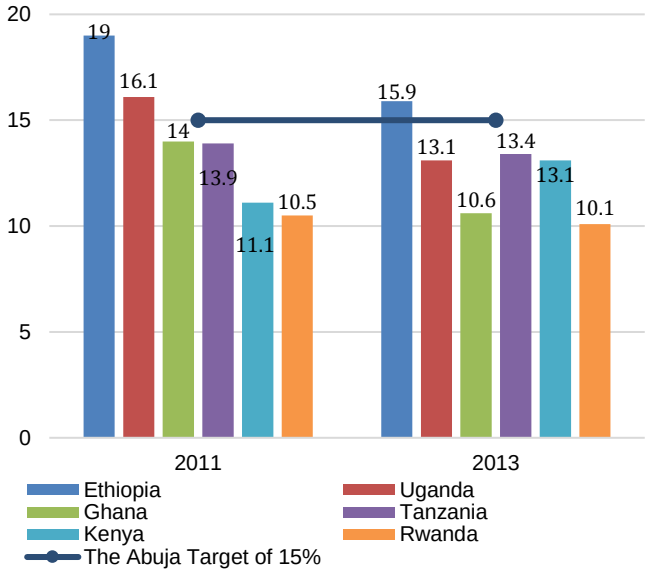
Thus, health expenditure reported through the audited Government Accounts of the Ministry of Finance and Economic Cooperation (MoFEC) underestimate total spending on health, recording per capita health expenditure amounting to only ETB 268 (US$12) in 2015/16 which is very low compared to the sub-Saharan Africa average of US$98 per capita health expenditure in 2014.[5] The low per capita health expenditure has resulted in considerable out-of-pocket (OOP) expenditure by households. To reduce the burden of OOP expenditure, however, the GoE has introduced a fee waiver scheme to members of the society who are not able to pay for their health care needs including their medical expenses. Nevertheless, comparing the National Health Accounts for 2010/11 versus 2013/14, **the share of OOP expenditure in total health spending has still not changed amounting to 33.7**

[5] The World Bank, World Development Indicators, July 2017 edition.

per cent and 33 per cent for 2010/11 and 2013/14 respectively.[6]

According to international data sources presenting country comparisons, Ethiopia performs relatively better compared to the other countries in terms of the percentage of total spending going to health. Figure 3 shows that in 2011 and 2013, Ethiopia met the international target of 15 per cent of total government expenditure going to health set in the Abuja Declaration[7] (Figure 3). However, considering on-budget records from MoFEC, health sector expenditure as a share of total government expenditure was only 7.7, 8.2 and 8.7 per cent in 2012/13, 2013/14 and 2015/16 fiscal years respectively. Hence, **as per on-budget records, Ethiopia has not met the Abuja Declaration target of 15 per cent of total government expenditure going to health**.

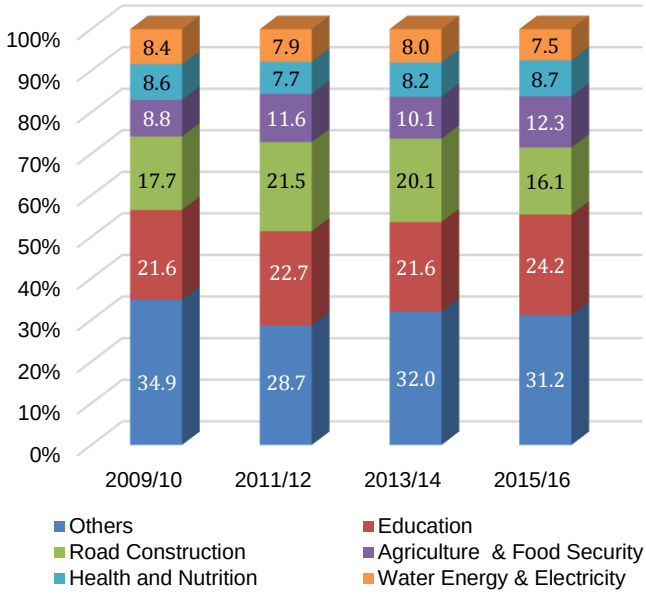
Figure 3: Health expenditure across selected countries (per cent of total expenditure)



Source: Data from the World Bank; World Development Indicators, July 2017 edition.

This budget brief is focused on analysing the health budget and expenditure that are recorded on-budget and reported by MoFEC. Considering the weight of the health sector in total expenditure, health stands third next to road construction and education (Figure 4). However, it should be noted that due to linkages across sectors, spending in education and road construction (especially rural roads) has spillover effects that positively affect health outcomes. For instance, educated mothers are more likely to be better informed regarding health and nutrition, while rural roads facilitate access to health care services.

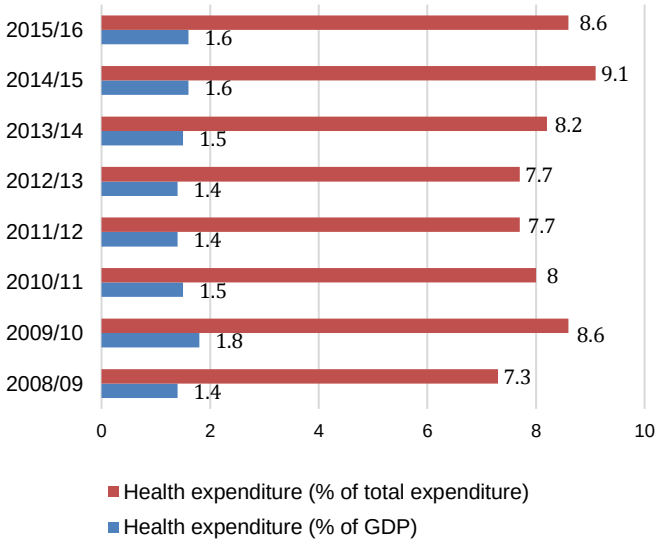
Figure 4: Weight of the health sector among other priority sectors (per cent of total expenditure)



Source: Data from MoFEC.

The trends in national health care expenditure, tracked through the federal and regional governments' budgetary system, have increased from ETB 2.4 billion in 2006/07 to ETB 24.5 billion in 2015/16, in nominal terms. This represents 8.7 per cent of total national expenditure and 1.6 per cent of the GDP in 2015/16 (Figure 5).

Figure 5: Total health expenditure (per cent of GDP and total national expenditure)



Source: Data from MoFEC

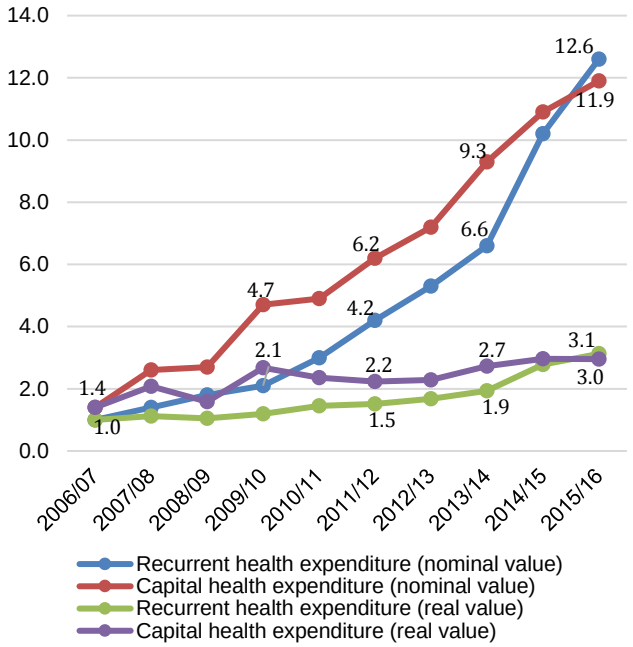
[6] Ethiopia Federal Ministry of Health. 2017. Ethiopia Health Accounts 2013/14, p.10.

[7] This finding is also confirmed by the ODI Briefing Note: Romilly Greenhill. July 2017. "The 'leave no one behind' index".

3. Composition of National Health Spending

Over the last decade, nearly 59 per cent of total national health care spending was allocated to finance capital expenditure (Figure 6). This is in line with the overall national budget allocation trend observed in the last decade, which allocates more than 50 per cent to capital expenditure. Capital expenditure largely finances the construction of health infrastructure such as hospitals, health centres and health posts. The government health service delivery system has the overriding objective of promoting health care services at individual, family, and community levels and the provision of preventive-focused services. Out of the national recurrent health expenditure, the lion's share goes to finance primary health care services. **In real terms however, capital expenditure has only doubled whereas recurrent expenditure has tripled (both at 2006/07 prices) over the span of a decade**.[8]

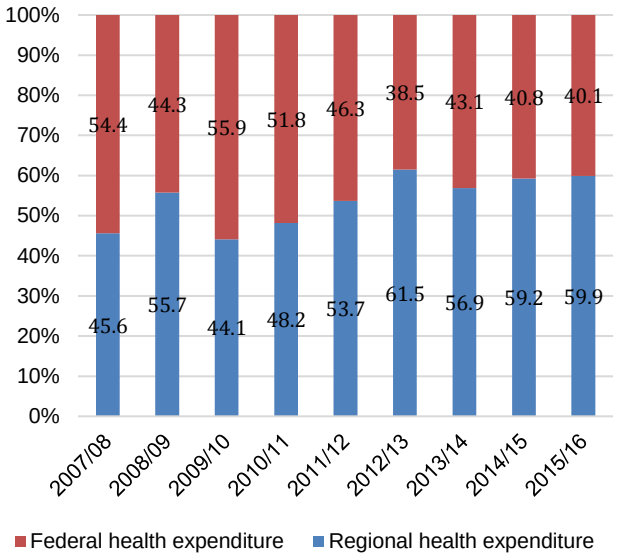
Figure 6: Recurrent versus capital health expenditure (in billion Birr)



Source: Data from MoFEC. Real values are calculated by the authors with 2006/07 as the base year.

As indicated in Figure 7, **more than half of the national public health expenditure was administered by regional and local governments over the last decade**. This demonstrates the Government's effort in promoting health care services at local levels of administration and addressing curative health care services and prevention of communicable diseases including prevention efforts related to maternal and child health.

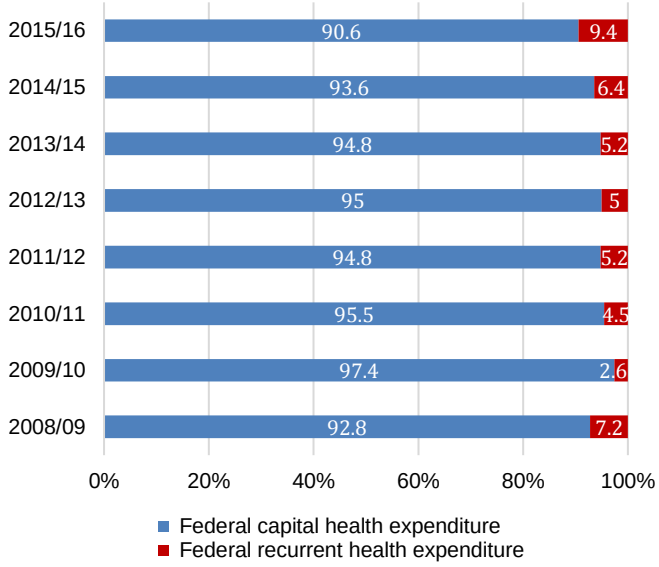
Figure 7: Federal versus regional health expenditure (per cent of total health expenditure)



Source: Data from MoFEC

At the federal level, nearly 90 per cent of the federal health expenditure is utilized for financing capital expenditure (Figure 8). A significant portion of the federal health capital expenditure is financed from external resources and allocated for the construction of mega health infrastructure projects such as referral and tertiary hospitals.

Figure 8: Federal recurrent and capital health expenditure (per cent of federal health expenditure)

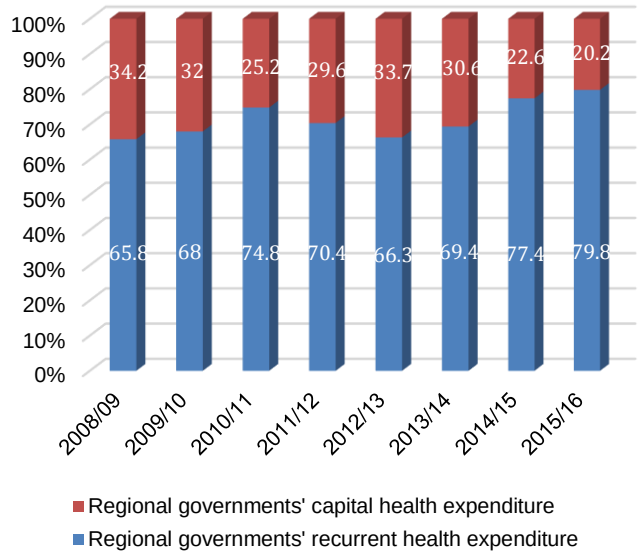


Source: Data from MoFEC

[8] "In real terms" refers to the adjustment of monetary values by taking into account "the rise of consumer prices (i.e. inflation)" over time.

At regional level however the composition is different. **The bulk of regional governments' health expenditure is allocated to finance recurrent health expenditure** (Figure 9). Salaries of health extension workers are covered at the regional level, and recently regional governments' recurrent health expenditure have risen significantly as hospitals and health centres are allowed to retain their revenues to finance their recurrent expenditure.

Figure 9: Regional recurrent and capital health expenditure (per cent of regional governments' health spending)



Source: Data from MoFEC

4. Budget Execution Rates

Like other developing countries, Ethiopia faces critical resource constraints to adequately meet its health care financing needs which can be exacerbated by inefficient budgetary execution in the health care system. Ethiopia's health sector budget execution rate (measured as actual expenditure as a per cent of adjusted budget) has generally improved over time, though gaps still remain. Budget execution rates greater than 100 per cent may signify challenges in the unpredictability of external aid. The gaps in budget execution can be partially explained either by absorptive capacity or allocative efficiency issues, or both, which warrants further investigation. Efficiency gains can be achieved by enhancing sector coordination and planning, addressing the quality and capacity of the health care workforce as well as the quality of health care service delivery to reduce wastage and optimally utilize current expenditure on the health sector. Further evidence generation to better understand and document health care financing, for example by conducting Public Expenditure Tracking Surveys to assess leakages and wastages in the health sector can contribute to additional efficiency gains.

Table 2: Federal government health budget execution rate

	2006/07	2008/09	2010/11	2012/13	2013/14	2014/15
Total health spending	62.6	56.3	75.8	92.4	77.1	111.3
Recurrent health spending	86.1	105.8	95.2	95.6	106	95.5
Capital health spending	61.6	54.4	75.1	92.2	75.9	112.6

Source: Data from MoFEC (information for sub-national levels of government has not been made available). Note: Percentages greater than 100 per cent may signify challenges in the unpredictability of external aid.

5. Health Sector Financing

The Ethiopian national health system is financed through domestic funds from the state budget, private sector investments and household contributions, as well as external funds received from bilateral and multilateral donors. **A significant portion of external financing to the health sector is directed through off-budget channels, the amounts of which are challenging to track through on-budget records**. Hence this budget brief is limited to analysing on-budget finances, and leaves out significant financial resources channelled to the health sector through off-budget resources, private sector investments and citizens' contributions.[9] **It is therefore essential to shift off-budget donor financing to on-budget records to better monitor and direct funding towards sustainable financing of the health sector**.

Ethiopia's health sector is heavily dependent on donor financing while health service seekers are highly burdened with out of pocket expenses to cover health related costs and this burden is relatively higher for poorer households.[10] Ethiopia

[9] Sources of health care financing as reported by the "*Ethiopia Federal Ministry of Health. 2017. Ethiopia Health Accounts 2013/14, p.10"* that tracks spending beyond what is reported in on-budget records, provides comparisons of the health financing landscape in 2010/11 and 2013/14. From a total amount of ETB 26.46 billion spent on health care in 2010/11, the GoE financed 15.6 per cent, 49.9 per cent was financed by external sources, households financed 33.7 per cent and others accounted for the remaining 0.8 per cent. In comparison, from a total amount of ETB 49.57 billion spent on health care in 2013/14, the GoE financed 30 per cent, 36 per cent was financed by external sources, households financed 33 per cent and others accounted for the remaining 1 per cent.

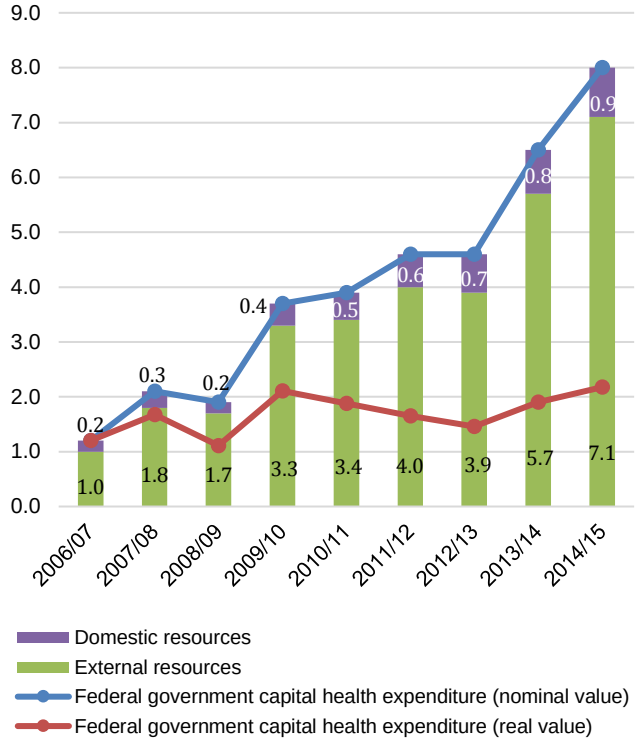
[10] Ethiopia Federal Ministry of Health. 2017. Ethiopia Health Accounts 2013/14.

has endorsed a National Health Care Financing Strategy (2015-2035) that outlines plans to address these concerns, though the implementation of these strategies is at a relatively early stage. Some of these strategies include the need to increase financing from domestic sources, fee exemption for key services, reducing out of pocket expenditure through health insurance schemes, etc. Ethiopia's National Health Care Financing Strategy has the objective of increasing financial resources for health care services. The strategy directs resource mobilization for the health sector from different sources including the government, development partners and households. The strategy also envisions enhanced private sector contributions and specific initiatives to strengthen the collection and use of user fees by health facilities. Accordingly a system has been established for retaining revenue in the form of user fees (in addition to the budget allocated from treasury) at local public health facilities, with the aim of improving the quality of health care services. In 2015/16, a total number of 3,417 health facilities (225 hospitals and 3,192 health centres) started retaining and utilizing their internal revenue.[11] Decentralization of revenue collection and retention of this revenue by health care providing institutions has stimulated a greater sense of community ownership contributing towards the system's sustainability in the long term.

Information on the sources of on-budget health sector financing has been made available only for federal capital expenditure. **Donors finance the majority of on-budget federal Government capital health expenditure which has been rising from ETB 1 billion in 2006/07 to ETB 7.1 billion in 2014/15, though in real value terms the amount has approximately only doubled over the decade** (Figure 10).

Compared to other sectors, health is largely financed by external grants from multilateral organizations, bilateral governments, and other philanthropic organizations. The GoE has been successful in mobilizing finances for the health sector from external sources through proactive resource mobilization mechanisms. It also established effective systems and structures to utilize the resources mobilized. These efforts have attracted development partners to scale up their assistance over the years. **Unlike the infrastructure sectors, the government hardly finances health care services from external borrowing**.

Figure 10: Source of finance for federal Government capital health expenditure (in billion Birr)



Source: Data from MoFEC. Real values are calculated by the authors with 2006/07 as the base year.

[11] Federal Ministry of Health, Annual Performance Report 2015/2016 of the Health Sector Transformation Plan I, p.87.

6. Key Policy Issues

- **Increasing domestic resource financing towards the health sector** to secure sustainable sources of health care financing and to reduce donor dependency.

- **Shifting off-budget support towards health to on-budget records:** Significant financing of the health sector is directed through off-budget channels making it challenging to track and record how much is being spent on health, which calls for shifting all health financing to on-budget records.

- **Reducing the high personal out of pocket health care charges that are relatively more burdening on poorer households** through further promotion of health insurance schemes including the provision of formal health care insurance.

- **Ensuring the sustainability of informal health insurance, the CBHI, by considering pooling resources for insurance coverage from a wider geographical area** than the current boundaries set at *woreda* level. Pooling resources from several *woredas* and going further to have an integrated system that is linked at the regional or federal level for pooling resources to finance insurance coverage would reduce institutional insurance management costs, provide a wider pool of financial resources for insurance coverage, provide better protection against catastrophic expenditure particularly for the most deprived households, and facilitate better health care services as the CBHI does not currently cover health care costs at referral hospitals located at the regional or federal level.

- **Addressing the constrained demand for personal health care insurance** in both the informal and formal sectors by creating and enhancing community awareness on the benefits of health insurance coverage and increasing the demand for quality health service. Insurance provision costs would decline the more people covered by health insurance.

- **Capturing and improving efficiency gains:** although the National Health Accounts are a good start to monitoring health financing, efficiency gains can be improved by enhancing sector coordination and planning, addressing the quality and capacity of the health care work force as well as the quality of health care service delivery to reduce wastage and optimally utilize current expenditure on the health sector.

- **Evidence generation** for further understanding and documentation of health care financing. For example, conducting Public Expenditure Tracking Surveys to assess leakages and wastages in the health sector can contribute to further efficiency gains.

Annex 1: Ethiopia National Health Sector On-budget Records 2006-2016 (source, MoFEC).

Gregorian Calendar Ethiopian Fiscal Year	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Ethiopian Fiscal Year	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Population (in million)	72.0	75.0	77.0	79.0	80.7	82.7	84.8	87.0	89.1	91.2
GDP at current market price (in million Birr)	170280.6	245836.0	332060.3	379134.5	515079.0	747326.0	866921.0	1060825.0	1297961.0	1528044.0
General Inflation Rate (CPI growth rate)	15.8	25.3	36.4	2.8	18.1	34.1	13.5	8.1	7.7	9.7
Exchange Rate (period weighted average)	9.0	9.6	11.8	13.7	16.5	18.0	19.3	19.9	20.1	21.1
Expenditure (in million Birr)										
Total National Expenditure	**32581.1**	**45937.5**	**61543.6**	**78990.6**	**97857.2**	**134065.0**	**162705.7**	**192673.6**	**231015.5**	**280892.9**
Total National Recurrent Expenditure	16728.8	22490.1	26457.9	31712.0	42245.1	55664.2	66444.1	78630.6	112685.2	136708.8
Total National Capital Expenditure	15852.3	23447.4	35085.6	47278.6	55612.1	78400.8	96261.6	114043.0	118330.3	144184.09
Total National Health Expenditure	**2402.6**	**4053.0**	**4509.8**	**6777.0**	**7858.7**	**10348.6**	**12484.9**	**15865.3**	**21123.7**	**24475.7**
National Recurrent Health Expenditure	970.4	1436.9	1796.1	2132.0	3010.9	4160.5	5330.8	6610.8	10241.3	12615.3
National Capital Health Expenditure	1432.2	2616.2	2713.8	4645.0	4847.7	6188.1	7154.2	9254.5	10882.4	11860.3
Total Federal Government Health Expenditure	**1256.7**	**2204.5**	**1997.2**	**3786.1**	**4074.2**	**4795.5**	**4806.9**	**6845.2**	**8613.4**	**9823.4**
Federal Government Recurrent Health Spending	75.3	104.3	143.2	98.5	181.2	249.8	240.3	356.5	555.0	918.4
Federal Government Capital Health Spending	1181.4	2100.2	1853.9	3687.6	3893.0	4545.7	4566.7	6488.7	8058.4	8905.1
Total Regional Government Health Expenditure	**1146.0**	**1848.6**	**2512.7**	**2990.9**	**3784.5**	**5553.0**	**7678.0**	**9020.2**	**12510.3**	**14652.2**
Regional Government Recurrent Health Spending	895.1	1332.6	1652.8	2033.5	2829.7	3910.7	5090.5	6254.3	9686.3	11696.9
Regional Government Capital Health Spending	250.9	515.9	859.9	957.3	954.8	1642.4	2587.5	2765.8	2824.0	2955.3
Source of Finance for Federal Government Capital Health Expenditure (in million Birr)										
Domestic Source	147.3	264.9	188.7	388.9	500.9	596.3	654.3	772.6	934.1	
External Assistance	952.9	1833.7	1656.4	3298.7	3392.0	3949.4	3912.3	5554.0	7124.3	
External Loan	81.1	1.6	8.8					162.1		
Federal Government Health Original Budget, Adjusted Budget, and Actual Expenditure (in million Birr)										
Federal Government Recurrent Health:										
Original Budget	86.6	93.6	112.5	122.4	142.5	199.8	236.1	302.2	409.5	
Adjusted Budget	87.5	111.2	135.4	112.9	190.5	260.5	251.3	336.3	581.2	
Actual Expenditure	75.3	104.3	143.2	98.1	181.2	249.8	240.3	356.5	555.0	
Federal Government Capital Health:										
Original Budget	1298.1	1711.9	1811.5	1947.2	2909.2	2717.8	3370.1	4297.2	4745.5	
Adjusted Budget	1919.2	3152.8	3411.0	3708.4	5185.9	3834.1	4950.9	8545.0	7158.9	
Actual Expenditure	1181.4	2100.2	1853.9	3687.6	3893.0	4545.7	4566.7	6488.7	8058.4	
Total Federal Government Health:										
Original Budget	1384.7	1805.5	1923.9	2069.6	3051.7	2917.6	3606.2	4599.4	5155.0	
Adjusted Budget	2006.7	3264.0	3546.4	3821.3	5376.4	4094.5	5202.2	8881.3	7740.1	
Actual Expenditure	1256.7	2204.5	1997.2	3785.7	4074.2	4795.5	4806.9	6845.2	8613.4	

This budget brief was written by Zeleka Paulos (Social Policy Specialist, UNICEF Ethiopia) and Ademe Zeyede (Consultant, UNICEF Ethiopia) under the guidance of Remy Pigois (Chief Social Policy and Evidence for Social Inclusion, UNICEF Ethiopia). The content has benefited from information and documentation provided by Yejimmawork Ayalew (Health Officer, Information Management, UNICEF Ethiopia). The provision of MoFEC budget and expenditure data and explanations presented for MoFEC data related questions by Ato Fantahun Belew (Technical Expert, MoFEC) is highly appreciated. This budget brief has been reviewed by Macoura Oulare (Chief of Health, UNICEF Ethiopia), Jean Dupraz (Social Policy Regional Adviser, Eastern and Southern Africa Regional Office (ESARO)) and Matthew Cummins (Social Policy Specialist, ESARO).

UNICEF Ethiopia
P.O. Box 1169, Addis Ababa, Ethiopia
Telephone: +251 11 518 4000
E-mail: ethcommunication@unicef.org