



Health Expenditure Analysis for Southern Nations, Nationalities, and Peoples' Region

2012/13 - 2019/20

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KEY MESSAGES

1

Nominal health sector spending in SNNPR increased from ETB 1.5 billion in 2012/13 to ETB 5.1 billion in 2019/20. However, in recent years, this nominal increase has not been matched by an increase in the real value of spending. Although there was a 70 per cent nominal increase in spending between 2017/18 and 2019/20, the real value of spending remained the same.

Recommendation: The regional government should continue to prioritise health spending along with improving efficiency of spending. Inflation is one of the macroeconomic instabilities that needs to be addressed to ensure the value of public investment does not erode over time.

2

Health sector spending in the region is dominated by recurrent expenditure. On average, 68 per cent of SNNPR's expenditure was spent on recurrent expenditure between 2012/13 and 2019/20. The inadequacy of capital budgets to improve access to and quality of health services is a challenge in the region.

3

In 2019/20, 70 per cent of the region's health expenditure was spent at the woreda level. The increment of health expenditure towards woreda-level spending is encouraging, as primary healthcare services delivered through health centres and health posts fall under the mandate of woredas. However, on average, 96 per cent of woreda spending was on recurrent spending.

Recommendation for key messages 2 and 3: The region should increase its domestic resource mobilisation efforts for improved capital budget allocation as well as ensuring resources are available at the woreda level to increase capital spending of primary healthcare facilities.

4

The capital budget credibility is significantly lower than the recurrent budget. Delays in project implementation due to foreign currency shortages, the lack of project management skills, as well as delays in the release of budget contribute towards the under-utilisation of capital budgets.

Recommendation: Proper project planning, timely transfer of budgets, along with technical support to increase the project implementation capacity of staff, particularly at the lower tier of government administration, should be given due attention for efficient and effective utilisation of capital budgets.

5

Available data on development partners' WASH expenditure in the health sector shows that spending increased from ETB 7 million in 2014/15 to ETB 107 million in 2018/19. However, in the absence of programme-based budgeting, it is difficult to identify government expenditure for WASH in the health sector.

Recommendation: Disaggregated budget reporting is imperative to track and monitor the level of public spending going to WASH and advocate for the sustainability of health sector WASH financing.

1. INTRODUCTION

Health sector overview

This health sector budget and expenditure analysis for Southern Nations, Nationalities, and Peoples' Region (SNNPR) covers the period from 2012/13 to 2019/20. The region has seen considerable change since Sidama region and South West region were established in June 2020 and November 2021, respectively, both of which were previously part of SNNPR. To ensure data consistency, this analysis uses budget and expenditure data before 2020, when the newly established regions were part of SNNPR.

Within the country's three-tier health service delivery model, health posts, health centres and primary hospitals are at the first tier of health service delivery. One health centre is connected to five satellite health posts and provides services to approximately 25,000 people, while primary hospitals offer inpatient and ambulatory services to about 100,000 people. In the second tier are general hospitals, which are referral centres for primary hospitals and serve an average of 1 million people. They also serve as training centres for health officers, nurses and emergency surgeons. At the third tier are specialised hospitals that provide services populations of around 5 million people and serve as a referral centres for general hospitals.

The Health Extension Programme (HEP) is the most accessible primary healthcare delivery platform in the country, especially in rural areas. The HEP has played a significant role in improving community access to healthcare services by providing a package of primary healthcare services for family health, disease prevention, hygiene and environmental

sanitation. Primary healthcare services, such as maternal and child healthcare, tuberculosis, HIV and family planning, among others, are more accessible to communities through the HEP. In 2019/20, there were 41,826 health extension workers (HEWs) deployed in the country, of whom 9,123¹ were in SNNPR.² One HEW serves, on average, 2,253 people, which is slightly lower than the national average of 2,407 (Table 1).

Although the region has a better primary healthcare delivery facility to population ratio compared to the national average, its health professional density is much lower than the national average and the Sustainable Development Goal (SDG) threshold. With regard to lower-tier primary health service facilities, the region had 731 health centres and 7,099 health posts in 2019/20 (Table 1). The health facility to population ratio indicates that one health centre serves around 25,114 people, while one health post serves 5,170 people, both of which are better than the national averages. In terms of health workers, there are 17,517 health professionals (medical doctors, nurses, midwives, health officers) in the region. According to the World Health Organization (WHO), the health professional density level is a key criterion to measure health sector staffing in a country. While the SDG index threshold indicates a minimum density for health workers of 4.42 doctors, nurses and midwives per 1,000 population, the health professional density for SNNPR in 2019/20 was 0.93 per 1,000 population, which is a little lower than the national rate of 1.1, but much lower than the SDG threshold, and the Health Sector Transformation Plan (HSTP II) target of 2.3.

¹ Ministry of Health (2020). Annual Performance Report (2019/20).

² Since the budget and expenditure data used in this report is from 2012/13–2019/20, 'SNNPR' refers to the region before the separation of Sidama region and South West region in June 2020 and November 2021, respectively.

Table 1. Number of health facilities and health workers in 2019/2020

	Number	Health facility/health worker to population ratio	
		SNNPR	National
Health posts	3,975	1:5,170	1:5,737
Health centres	731	1:25,114	1:26,957
Medical doctors*	1,611	1:12,727	1:9,979
Nurses, midwives, health officers	17,514	1:1,173	1:1,108
Health extension workers	9,123	1:2,253	1:2,407

Sources: Ministry of Health (2019/20), Annual Performance Report; CSA population estimate for 2020³

* General practitioners, specialists, sub-specialists, dental surgeons

There has been a significant improvement in access to hospitals in the region, with the number of hospitals more than doubling between 2015/16 and 2019/20. The region had only 38 hospitals in 2015/16, but this significantly increased to 79 hospitals

in 2019/20. The region has a low hospital to population ratio compared to regions such as Amhara and Oromia, with one hospital serving 260,147 people. This proportion is also lower than the national average (Table 2).

Table 2. Hospital to population ratio for selected regions in 2020

Region	Public hospitals in 2019/20	Population in 2020	Hospital to population ratio in 2020
Addis Ababa	13	3,686,068	1:283,544
Amhara	82	22,191,890	1:270,633
Oromia	104	38,170,034	1:367,020
SNNPR	79	20,551,606	1:260,147
Tigray	41	5,541,736	1:135,164
National	353	100,684,575	1:285,225

Sources: Ministry of Health (2019/20), Annual Performance Report

³ Central Statistical Agency (2013). Population Projections for Ethiopia 2007–2037.

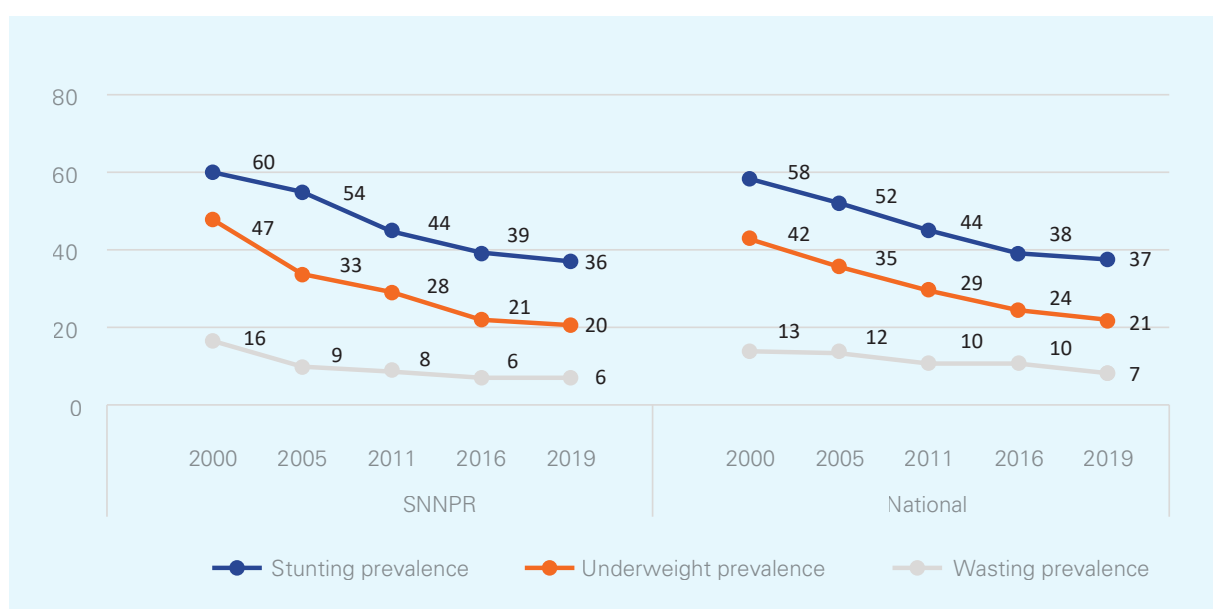
Key health sector performance indicators

Although improvements are observed in some key health performance indicators, high under-nutrition rates continue to challenge the region.

In 2019, 36 per cent of the region's under-5 population were stunted, while the underweight and wasting prevalence rates were 20 and 6 per cent, respectively (Figure 1). Compared to the national averages, the rates of stunting, underweight and wasting prevalence are lower for the region for all the indicators. The under-nutrition prevalence indicators have shown improvement from

their 2000 values. The highest decline was observed for the proportion of children who are underweight, which showed a 27-percentage point decline between 2000 and 2019. Similarly, the prevalence of stunting has declined by 24 percentage points, slightly higher than the 21-percentage point decline nationally. Although the improvement over the years is encouraging, more still needs to be done to address the high level of under-nutrition among under-5 children.

Figure 1. Indicators of under-nutrition in under-5 children: SNNPR and national averages (per cent)



Source: UNICEF Ethiopia, 2019⁴

SNNPR has made significant progress in most of the key health indicators between 2011 and 2019.

For instance, the proportion of births that have occurred in health facilities has increased significantly from 6 per cent in 2011 to 48 per cent in 2019. The proportion of women who received antenatal care by skilled provider also improved from 27 per cent in 2011 to 69 per cent in 2019, although the rate is lower than the national average (74 per cent). Even if the rate of improvements in these indicators is commendable, the proportion of women who do not have access to healthcare

is still high. Around 52 per cent of women did not have births in health facilities and 31 per cent did not receive antenatal care in 2019. This calls for further action within the health sector to ensure improved material and child health outcomes in the region.

⁴ UNICEF Ethiopia (2019). Situation Analysis of Children: SNNP Region. Ethiopia

Although the regional neonatal, infant and under-5 mortality rates have improved between 2011 and 2016, the rates are much higher than the national average (Table 3).

Under-5 mortality declined from 116 deaths per 1,000 live births to 88 deaths per 1,000 live births between 2011 and 2016. The infant mortality rate also declined from 78 to 65 deaths per 1,000 births over the same period. On the other hand, although neonatal mortality has declined over the years, it did so at a much lower rate compared to the national average. Although improvement is observed in terms of the increasing proportion of children aged 12 to 23 months who received basic vaccinations, the immunisation rate in SNNPR is still lower than the national average. The proportion of children who had received all basic vaccinations was

38 per cent in 2019 compared to the national average of 43 per cent. This indicates that 62 per cent of children in the region have not received all basic vaccinations and, therefore, may be susceptible to preventable childhood illnesses. The regional health bureau should give due attention to increasing the rate of vaccination for children, along with designing interventions to decrease neonatal mortality to improve the health outcomes for children in the region.

Table 3. Key health indicators: SNNPR and national level

Indicator	SNNPR			National		
	2011	2016	2019	2011	2016	2019
Neonatal mortality rate (per 1,000)	38	35	-	37	29	30
Infant mortality (per 1,000)	78	65	-	59	48	43
Under-5 mortality (per 1,000)	116	88	-	88	67	55
Child mortality (per 1,000)	41	25	-	31	20	12
Antenatal care provided by skilled provider (%)	27	69	69	34	62	74
Total fertility rate (%)	4.9	4.4	4.1	4.8	4.6	-
Birth occurred in health facility (%)	6	26	48	10	26	48
Children aged 12–23 months who received all basic vaccinations (%)	24	47	38	24	39	43
Under-5 children who had diarrhoea in the two weeks preceding the survey (%)	16	14	-	13	12	-
Prevalence of anaemia in children (%)	37	50	-	44	57	-
Use of modern contraceptive (%)	26	40	45	29	35	41
Skilled birth attendance (%)	6	29	50	10	28	50

Sources: EDHS 2011, 2016, Mini EDHS 2019

WASH in health facilities

Hospitals in the region have basic WASH facilities for delivering the required healthcare services compared to health centres and health posts. Only 7 per cent, 6 per cent and 51 per cent of health posts in the region have drinking water, hand washing and modern toilet facilities, respectively (Table 4). This is concerning, as the health posts are the initial point of contact for the community to seek primary healthcare services. A relatively higher share of health centres have WASH

facilities compared to health posts. Forty-five per cent of health centres have access to clean drinking water services, while only 39 per cent of them have hand washing facilities. Hospitals have better WASH facilities, with 78 per cent of hospitals in the region having all three services. Even if the share of hospitals with WASH facilities is higher compared to health posts and health centres, the fact that 22 per cent of hospitals do not have these vital WASH services strongly affects health service delivery.

Table 4. Number of health facilities with basic WASH facilities

Facilities	Health posts		Health centres		Hospitals	
	No.	%	No.	%	No.	%
Drinking water services	276	7	224	45	43	78
Hand washing facilities	249	6	193	39	43	78
Modern toilet facilities	1962	51	338	69	43	78

Sources: SNNPR Health Bureau (2019/20)

Key takeaways

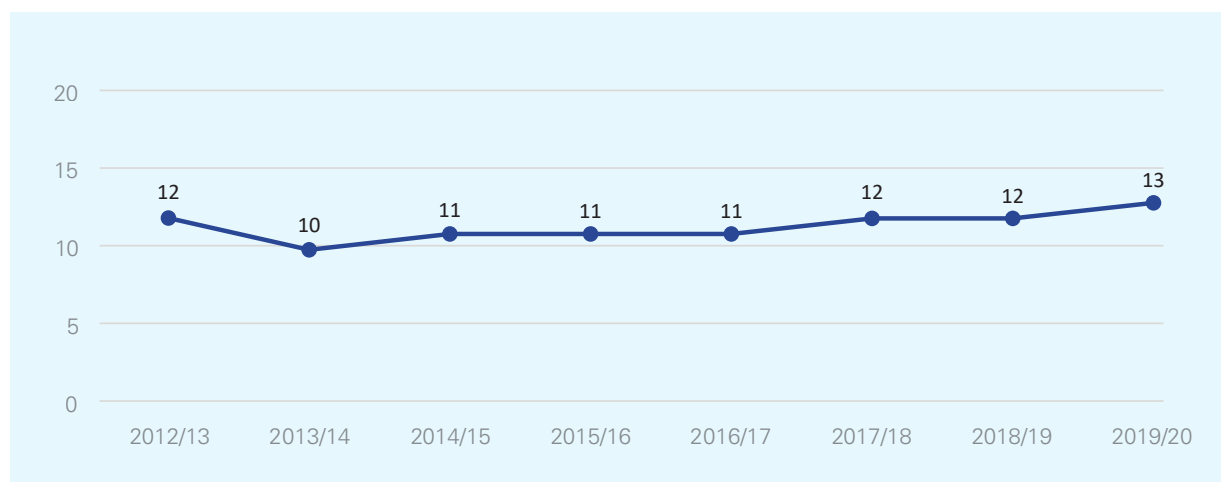
- Although there has been a significant improvement in access to hospitals, with the number of hospitals more than doubling between 2015/16 and 2019/20, the number of hospitals is still not adequate, with one hospital serving 260,147 people. Increasing the number of health facilities that provide services to the population is a key area the regional bureau should focus on.
- Encouraging improvements are observed in some key health performance indicators, such as the increase in the number of births in health facilities and the proportion of women receiving care from a skilled provider. However, high under-nutrition rates, high neonatal, infant and under-5 mortality rates, and low vaccination prevalence continue to challenge the region.
- With increasing population pressure, internal conflicts, drought and displacements, the number of people who require health and nutritional services is increasing. This increased burden on the health system could lead to the reversal of the key improvements in the sector.
- The lack of availability of drinking water services, and hand washing and toilet facilities, at primary healthcare facilities makes service delivery very challenging. The regional government should give due attention to increasing investment to ensure improved WASH services are available at health facilities to deliver better health services.

2. PUBLIC EXPENDITURE FOR THE HEALTH SECTOR IN SNNPR

Due to a lack of disaggregated budget and expenditure data, the expenditure analysis in this section focuses mainly on health spending financed by the regional government. The total health expenditure in the region is financed by the regional government, bilateral and multilateral donors (mostly funds flowing directly to the regional health bureau), out-of-pocket expenditure, Community-Based Health Insurance (CBHI) (voluntary prepayment), and private employers. However, the analysis in this budget brief focuses only on public expenditure the regional government spent on the health sector between 2012/13 and 2019/20. Programme-based budgeting is not yet adopted by the region, making it difficult to conduct disaggregated budget and expenditure analysis by programme. This makes it very difficult to identify nutrition, and maternal and child-related health expenditures from the aggregate budget and expenditure lines. Due to the difficulty of accessing disaggregated expenditure data by child-sensitive programmes, the analysis in the next sections focuses on the aggregate government health expenditure in the region.

The share of health sector spending from the region's total public spending slightly increased from 12 per cent in 2012/13 to 13 per cent in 2019/20. According to the regional health bureau, the strategic plan and activities are the bases for requesting and allocating budget for the health sector. However, there are gaps between budget requested and actual allocation, as the budget ceiling for sectors within the region are decided by the bureau of finance and shared with the sectors for further review and discussion. Within the health sector, maternal and child health (MCH) care, nutrition and WASH are priority areas in the budget allocation process. The share of health spending from total expenditure was on average 11 per cent over the fiscal years under consideration (Figure 2). This is slightly higher than the national average, which was 9.1 per cent in 2019/20, but lower than the 15 per cent target set by the African Union under the Abuja Declaration (2001).

Figure 2. Share of health spending from total regional expenditure (per cent)



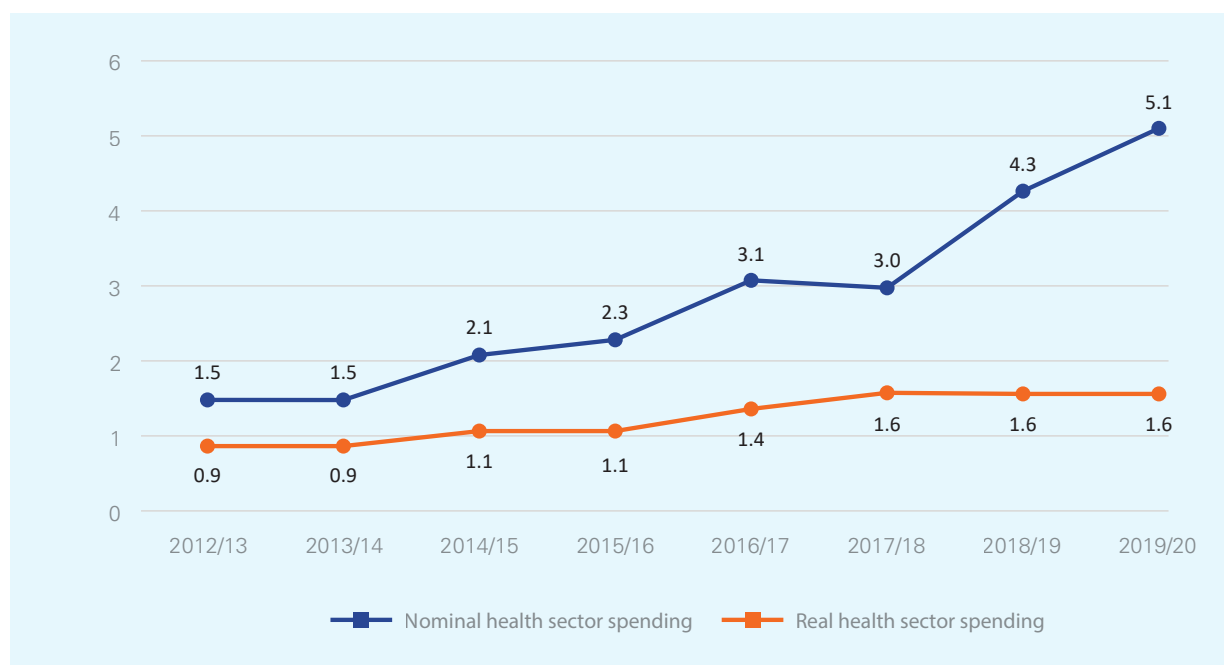
Source: SNNPR Finance and Economic Development Bureau (2012/13–2019/20)

Nominal health sector spending in SNNPR increased from ETB 1.5 billion in 2012/13 to ETB 5.1 billion in 2019/20, which is more than a two-fold increment.

Although the real value of spending has also increased for the same period, the increment is much lower at 77 per cent (Figure 3). The real total health sector spending of SNNPR remained at ETB 1.6 billion between 2017/18 and 2019/20. The nominal increment was only enough to maintain the real spending and could not be translated into increase in real value due to the high inflation. The nominal per capita public health spending increased from ETB 89 (US\$4.6) in 2012/13 to

ETB 256 (US\$8.2) in 2019/20⁵ (Figure 4). The per capita spending in 2019/20 is much lower than the per capita national allocation, which was ETB 443 (US\$14.1)⁶ for the same year. In terms of real values, the per capita spending has slightly declined between 2017/18 and 2019/20.

Figure 3. Trend in nominal and real health expenditure (ETB billion)



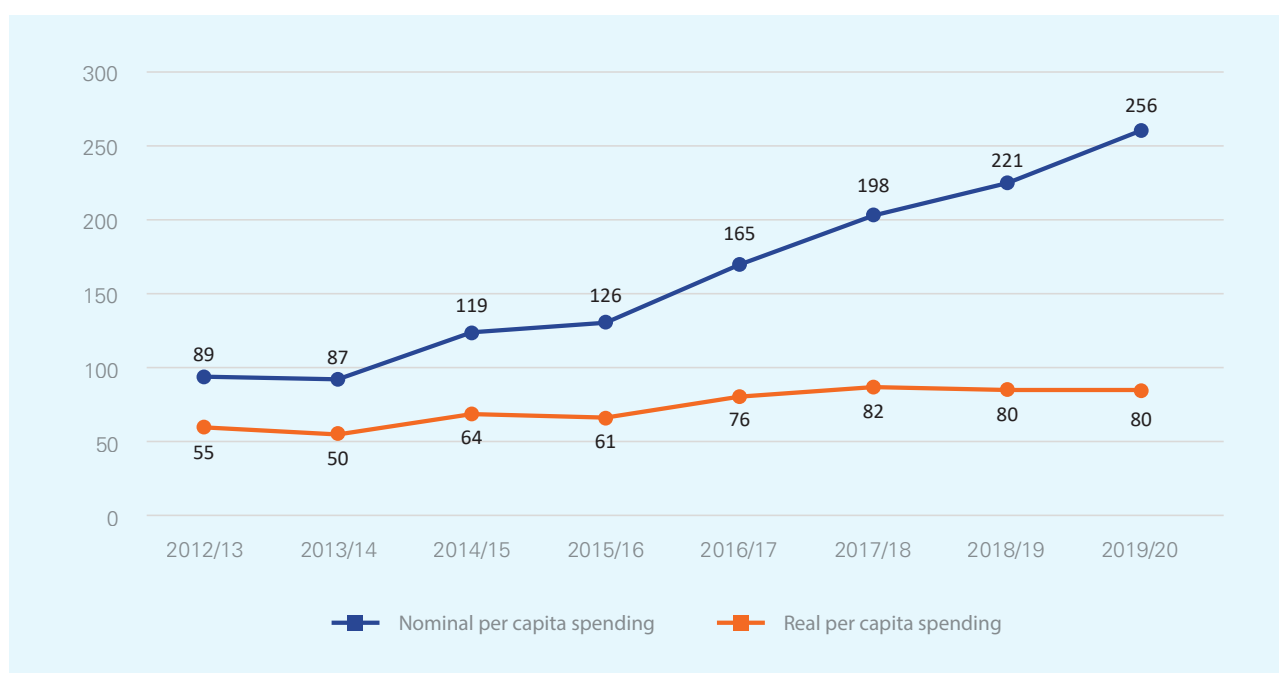
Source: SNNPR Finance and Economic Development Bureau (2012/13–2019/20)

Note: The real expenditure has been computed by using the Consumer Price Index (CPI) by taking 2010 as a base year.

⁵ Exchange rate (period weight average): 1 US\$ = ETB 19.3 for 2012/13 and 1 US\$ = ETB 31.2 for 2019/20.

⁶ UNICEF Ethiopia (2022). Health budget brief: Health investments within a constrained economy. <https://www.unicef.org/ethiopia/documents/ethiopia-budget-briefs-202122>

Figure 4. Trend in nominal and real per capita health expenditure (ETB)



Source: SNNPR Finance and Economic Development Bureau (2012/13–2019/20)

Note: The real expenditure has been computed by using the Consumer Price Index (CPI) by taking 2010 as a base year

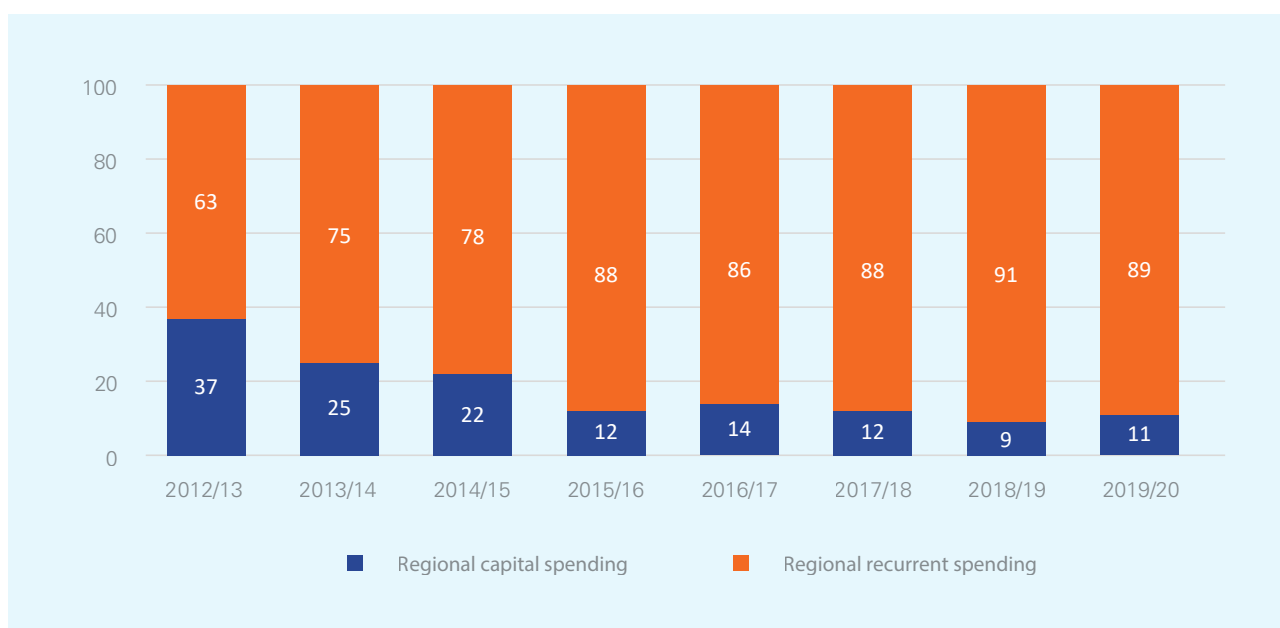
Composition of health sector spending

Recurrent expenditure took significant share of the health sector spending between 2012/13 and 2019/20.

As shown in Figure 5, recurrent expenditure took more than 65 per cent of the health sector spending, on average, over the period considered. The share of recurrent spending has shown an increasing trend over the years, while the share of capital spending has been declining. Substantial amount of the sectorial budget is allocated for salary and operational costs leaving little resource for capital investments. Out of the total recurrent spending, on average, around

82 per cent went towards covering salary expenses. Key informants from the health bureau reported that shortage of operational costs to run health posts, health centres, and hospitals contributes towards low quality healthcare service delivery. Furthermore, inadequacy of capital budgets to improve access to health services is a challenge in the region. Currently, capital expenditure is mainly channelled for the completion of ongoing health projects, as there is inadequate resource to initiate new capital projects.

Figure 5. Share of recurrent and capital expenditure from total expenditure (per cent)



Source: SNNPR Finance and Economic Development Bureau (2012/13–2019/20)

Key takeaways

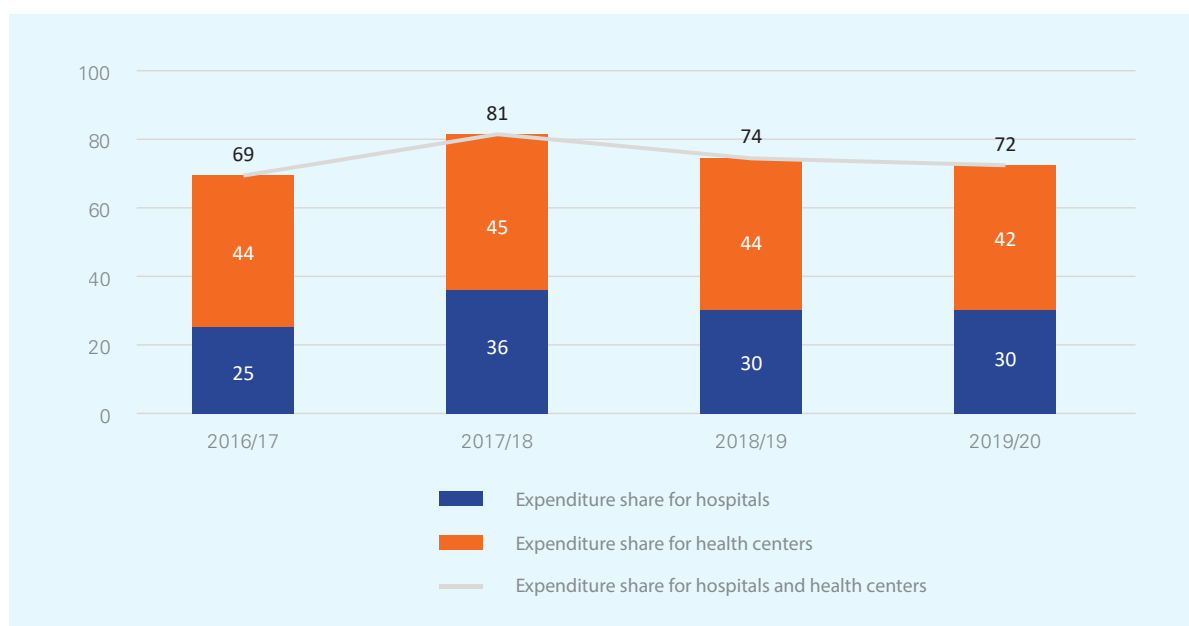
- Nominal health sector spending in SNNPR increased from ETB 1.5 billion in 2012/13 to ETB 5.1 billion in 2019/20, which is more than a three-fold increment. However, the increment in the real value of spending is much lower, at 77 per cent.
- Per capita spending on health is very low at US\$8.2 in 2019/20, which leads to higher out-of-pocket spending by poor households. The regional government should continue to prioritise health spending through enhanced domestic resource mobilisation efforts, as well as improve the efficiency of spending.
- Health sector spending in the region is dominated by recurrent expenditure. On average, 68 per cent of the region’s expenditure was spent on recurrent expenditure between 2012/13 and 2019/20. The inadequacy of capital budgets to improve access to health services is a challenge in the region. The region should increase its domestic resource mobilisation efforts for improved capital budget allocation and build the capacity of its staff for efficient and effective utilisation of capital budgets.

Health sector public expenditure and fiscal decentralisation

SNNPR has three administrative layers comprising of regional-, zonal- and woreda-level administrations. The regional government allocates the budget for the regional-level bureaus and allocates the remaining budget to the zones under it. Zones further allocate budget to woreda administrations. Allocation of budget to the health sector is done at all levels of administration and approved by the respective cabinets.

About 74 per cent of the health sector's spending is directly allocated for hospitals and health centres in the region (Figure 6). On average, 44 per cent of the regional health expenditure was spent on health centres, which are mandated with delivering primary healthcare services. The share of expenditure on hospitals was on average 29 per cent, while the remaining expenditure was spent on expenses for regional-, zonal- and woreda-level health offices, as well as health posts.

Figure 6. Share of spending on hospitals and health centres (per cent)

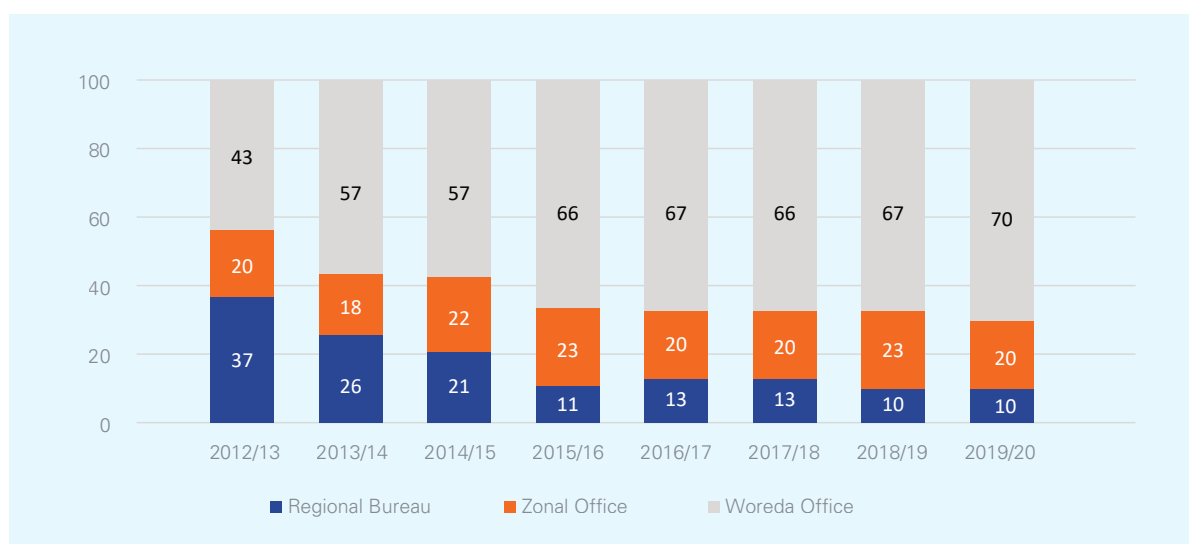


Source: SNNPR Finance and Economic Development Bureau (2016/17-2019/20)

A significant proportion of health sector expenditure was spent at the woreda level for the period under consideration. The share of woreda-level health sector spending increased from 43 per cent in 2012/13 to 70 per cent in 2019/20 (Figure 7). On the other hand, regional-level spending declined from 37 per cent to 10 per cent over the same period while

zonal-level spending remained at 20 per cent. The increment of health expenditure towards woreda-level spending is encouraging, as primary healthcare services delivered through health centres and health posts, including health extension services, is under the mandate of woredas.

Figure 7. Proportion of regional bureau-level and woreda-level spending for the health sector

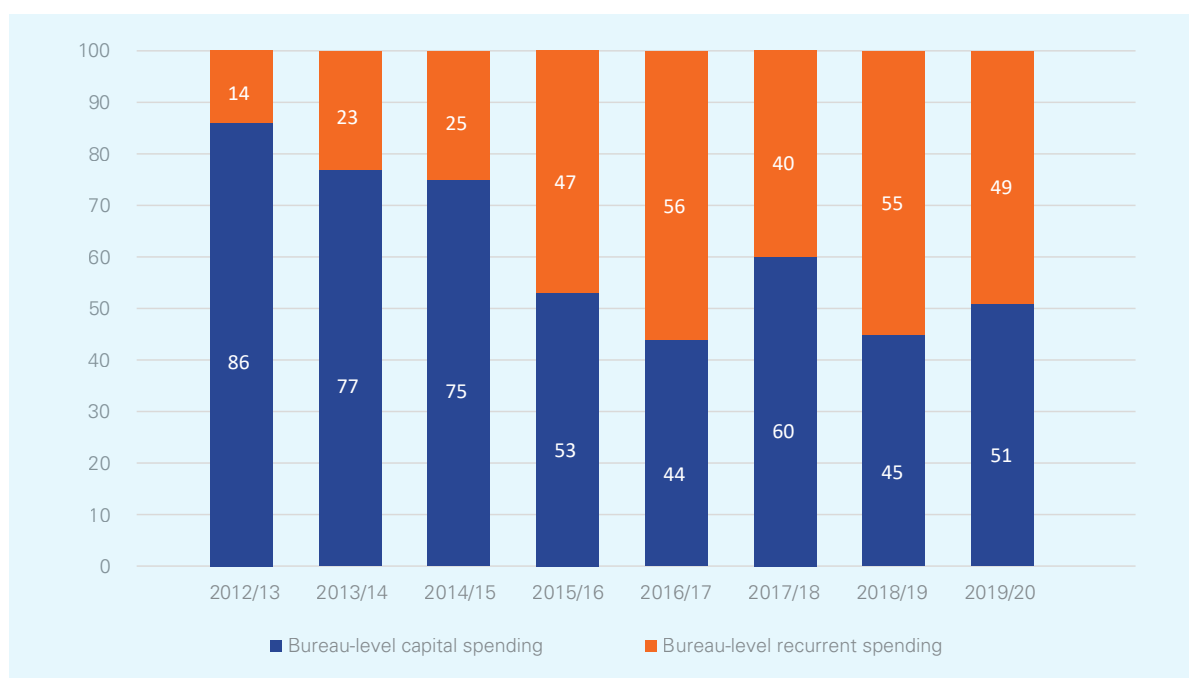


Source: SNNPR Finance and Economic Development Bureau (2012/13–2019/20)

With regard to the composition of spending by level of administration, the regional health bureau has a relatively higher share of capital expenditure. This is because large capital projects managed by the regional health bureau require a longer timeframe and larger budgets. In 2019/20, 51 per cent of the regional-level expenditure was capital spending (Figure 8). This is lower than the 86 per cent share in 2012/13. Between 2012/13 and 2014/15, around

79 per cent of the regional-level spending was on capital investments. In those years, the priority in the region was building major health facilities and infrastructure for improved health service access. Health facilities and infrastructure require recurrent spending as they begin to become operational, resulting in an increase in the share of recurrent spending in the following years.

Figure 8. Regional-level health expenditure as proportions of capital and recurrent health expenditure (per cent)

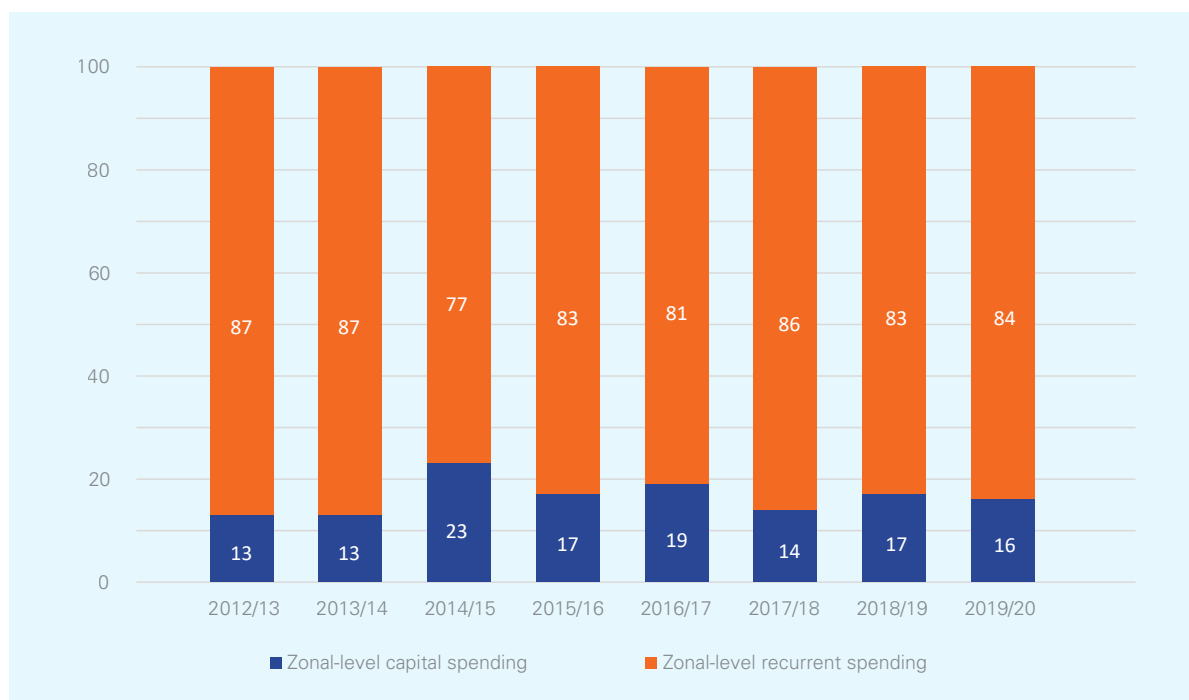


Source: SNNPR Finance and Economic Development Bureau (2012/13–2019/20)

Zonal and woreda-level health sector spending are dominated by recurrent expenditure. The average shares of zonal- and woreda-level recurrent spending were 83.5 and 96 per cent, respectively (Figures 9 and 10). Since woredas are mandated with administering health centres and health posts, the higher share of their spending goes towards paying the salaries of health professionals at the primary health service delivery facilities, including health extension workers. Operational costs required for running the health facilities also require increased

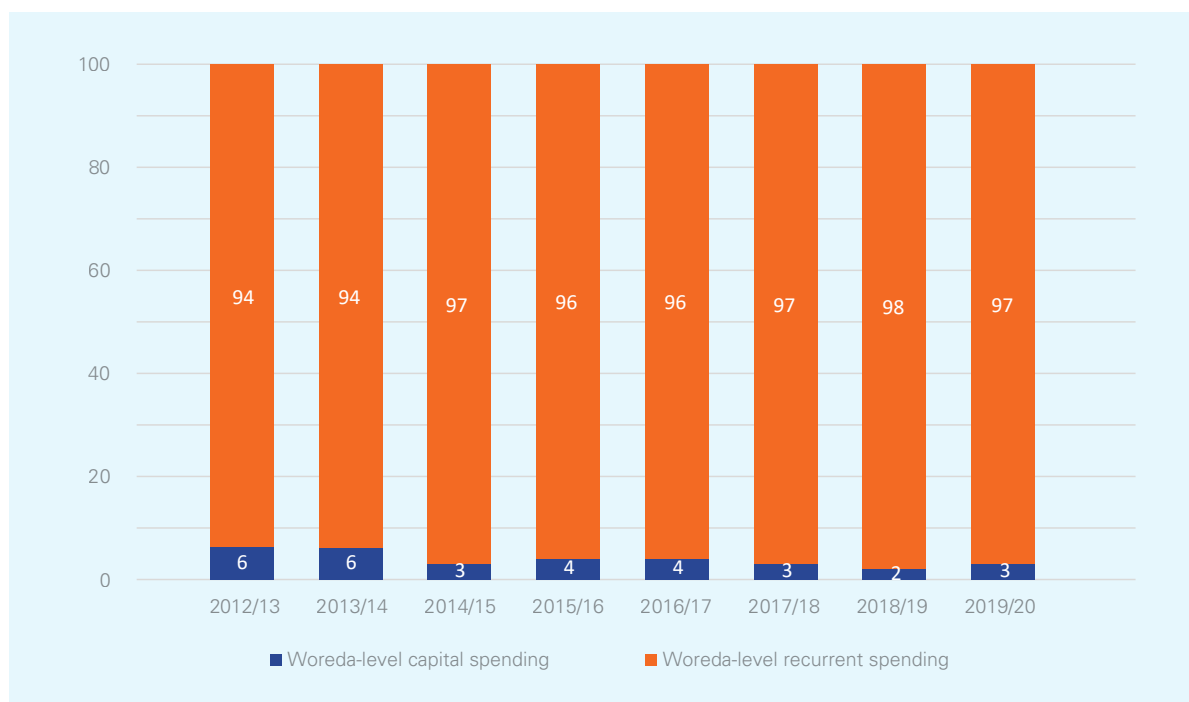
recurrent spending. Although woredas have the mandate to decide on budget allocation between recurrent and capital expenditures, they face budget limitations. Often, the budget is not even enough to cover the operational costs involved in the day-to-day administration of health facilities, as a significant proportion the health budget is spent on covering salary expenses. As a result, the remaining resource allocated for capital expenses is not enough to make any meaningful capital investments at the lower-tier of health service delivery.

Figure 9. Share of capital and recurrent health spending at zonal level (per cent)



Source: SNNPR Finance and Economic Development Bureau (2012/13–2019/20)

Figure 10. Share of capital and recurrent health spending at woreda level (per cent)



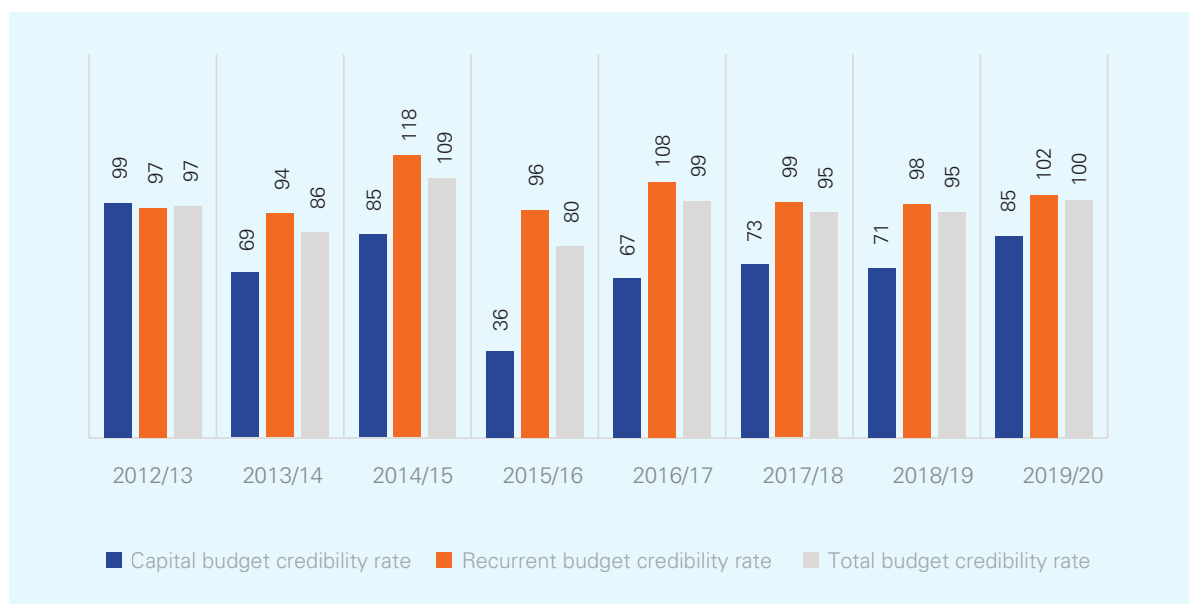
Source: SNNPR Finance and Economic Development Bureau (2012/13–2019/20)

Health sector budget credibility

The region’s health sector budget had an average credibility rate of 95 per cent between 2012/13 and 2019/20. This is measured by the deviation between planned and actual spending – the difference between original budget approved at the start of the fiscal year and actual expenditure at the end of the fiscal year. Although the total budget for the sector was credible, with an average underspend of 5 per cent, looking at the different components of the budget, recurrent and capital budgets had average credibility rates

of 101 per cent and 73 per cent, respectively (Figure 11). The relatively better credibility rate for recurrent expenditure is mainly due to the predictability of salary expenses that dominate recurrent spending. According to the regional health bureau, one of the major reasons for the low capital budget credibility rate is delays in project implementation due to foreign currency shortage and low capacity of contractors to deliver projects to agreed timescales. Delays in the release of budgets is also indicated as a factor for the under-utilisation of capital budget.

Figure 11. Regional health budget credibility rate (per cent)



Source: SNNPR Finance and Economic Development Bureau (2012/13–2019/20)

Key takeaways

- In 2019/20, 70 per cent of the region’s health expenditure was spent at woreda level. The increment of health expenditure towards woreda-level spending is encouraging as primary healthcare services delivered through health centres and health posts, including health extension services, is under the mandate of woredas.
- On average, 96 per cent of the spending at woreda level was on recurrent spending. The remaining 5 per cent allocated for capital expenditure is not enough to make any meaningful capital investments. Attention should be paid to ensuring increased resources are available at the woreda level to cover operational costs at health facilities.
- The average capital budget credibility (73 per cent) is significantly lower than the recurrent budget credibility (101 per cent). Delays in project implementation due to foreign currency shortages, low capacity of contractors to deliver projects on agreed timeframe, as well as delays in release of budgets are indicated as reasons for the under-utilisation of capital budget.

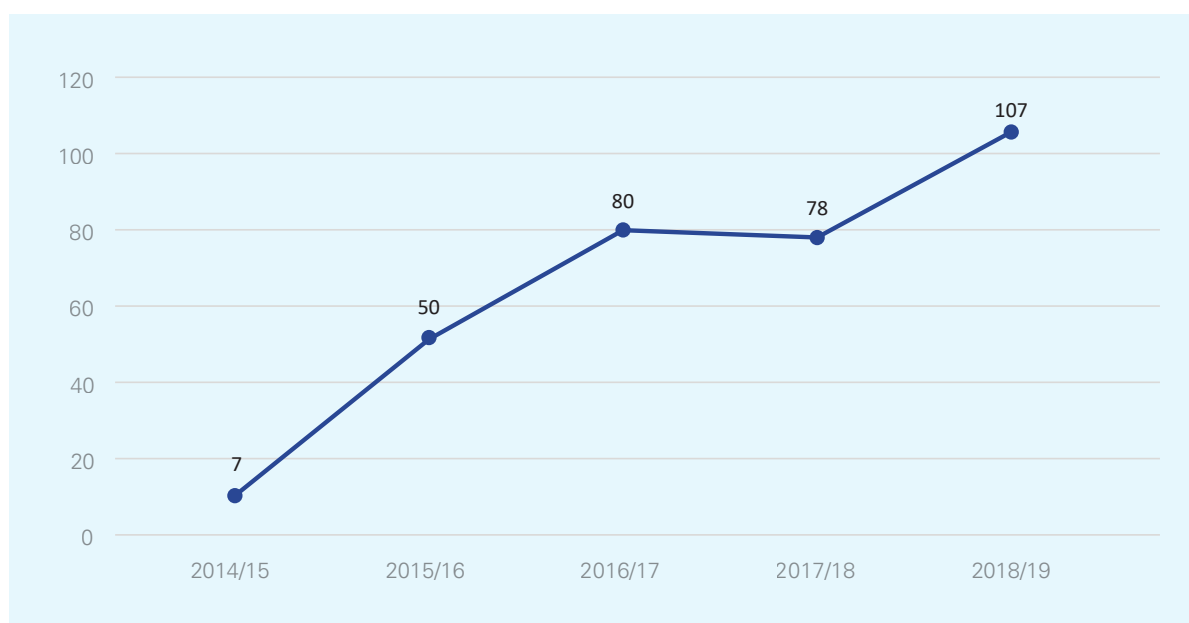
Expenditure on WASH programmes

The expenditure on health WASH programmes financed by development partners has shown an increasing trend between 2014/15 and 2018/19.

As programme-based budgeting is not implemented in the region, expenses related to WASH in the health sector are not identifiable in the budget and expenditure records. What is identifiable in the bureau of health expenditure records is WASH funds channelled to the health bureau from development partners. According

to Figure 12, the expenditure on health WASH financed by development partners increased from ETB 7 million in 2014/15 to ETB 107 million in 2018/19. Although this improvement helped to alleviate some of the pressing WASH issues observed in schools in the region, more needs to be done to make all schools meet the required standards. There is also a need to ensure WASH programmes are identifiable in the budget and expenditure records to track and monitor government's financing of the programme.

Figure 12. Expenditure on health WASH by development partners (ETB million)



Source: SNNPR Finance and Economic Development Bureau (2014/15-2018/19)

Key takeaways

- In the absence of programme-based budgeting, it is difficult to identify government expenditure for WASH in the health sector. Available data on development partners' expenditure indicates that spending on health WASH increased from ETB 7 million in 2014/15 to ETB 107 million in 2018/19.
- Disaggregated budget reporting is imperative to track and monitor the level of public spending going to WASH and advocate for the sustainability of health WASH financing.

3. KEY ISSUES

- **The region's health sector expenditure classification system lacks disaggregation. There is no disaggregated data on health expenditure to track child-related health expenditures or nutrition-specific interventions.** This is a broad national challenge, as programme-based budgeting is only implemented at the federal level, with the sub-national regions, including SNNPR, using line-item budgeting. This calls for the revision of the chart of accounts and budget templates to make sure health programmes are identifiable in the budget and expenditure data. This will allow for better tracking and monitoring to measure and advocate for increased investment in specific programmes, including those that are child sensitive.
- **Although there are funds flowing into the health sector in the region from multiple donors, there is no systematic mechanism to measure off-budget health sector expenditure.** There is a need to shift from off-budget financing of the health sector to on-budget records to better plan, execute and monitor how much is being spent on healthcare services.
- **Internal conflicts, drought, health crises such as COVID-19 and an increasing population are putting additional pressure on the health system in the region.** This highlights the need for more commitment to increasing investment in the health sector in the short, medium and long term, through further increments in public budget allocation and improved budget utilisation in the region.
- **Limited human resource capacity and delays in the release of budget from the federal government are also issues that challenge the health sector in SNNPR.** Required technical support and budget should be delivered on time from the federal government to successfully implement health and nutrition strategic plans within the region.

Annex1. SNNP Regional State Expenditure on Health 2012/13–2019/20

Gregorian calendar	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Ethiopian fiscal year	2005	2006	2007	2008	2009	2010	2011	2012
Regional expenditure (ETB million)								
Total regional expenditure	12,762	14,492	19,701	21,842	27,327	31,600	35,593	40,433
Total regional recurrent expenditure	7,440	8,897	12,409	14,421	19,847	23,053	26,894	31,683
Total regional capital expenditure	5,322	5,596	7,292	7,421	7,481	8,546	8,699	8,750
Regional health expenditure (in million Birr)								
Total regional health expenditure	1,513	1,520	2,126	2,297	3,091	3,805	4,328	5,146
Total recurrent health expenditure	958	1,134	1,652	2,031	2,668	3,331	3,919	4,605
Total capital health expenditure	555	386	474	266	423	474	409	541
Regional bureau-level expenditure	555	393	451	255	405	499	422	514
Bureau-level recurrent expenditure	78	89	115	135	178	200	232	250
Bureau-level capital expenditure	477	304	336	119	227	299	190	263
Zonal-level expenditure	302	267	469	520	628	778	1,003	1,026
Zonal-level recurrent expenditure	261	233	362	434	510	672	830	863
Zonal-level capital expenditure	41	34	107	86	118	106	173	163
Woreda-level expenditure	656	860	1,206	1,523	2,058	2,528	2,903	3,606
Woreda-level recurrent expenditure	619	812	1,176	1,462	1,981	2,460	2,857	3,491
Woreda-level capital expenditure	37	48	31	61	78	68	45	115
Regional health budget (ETB million)								
Total health budget	1,554	1,762	1,951	2,856	3,109	4,020	4,564	5,139
Recurrent health budget	992	1,204	1,395	2,121	2,479	3,370	3,991	4,503
Capital health budget	563	558	556	735	630	650	573	636

Source: SNNPR Finance and Development Bureau (2012/13-2019/20)

This health budget brief analysing the health sector's public budget and expenditure in the Southern Nations, Nationalities, and Peoples' Region (SNNPR) for the period 2012/13 to 2019/20 was produced through a partnership between the Ethiopian Economics Association (EEA) and UNICEF Ethiopia. Technical support and coordination from UNICEF Ethiopia was provided by Fanaye Tadesse Techane ftchane@unicef.org and Zeleka Paulos zpaulos@unicef.org. EEA is responsible for the data collection and accuracy of the information presented. The main objective of this budget brief is to synthesize complex budget and expenditure information so that it is easily understood by stakeholders, to foster discourse, and to inform policy and financial decision-making processes of the regional government. The analysis presents budget and expenditure that are recorded on-budget by SNNPR.

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