

Demographic context

The population of Ethiopia progressively increased from 108M to 123M from 2017 to 2022. Infants less than 12 months and children under five years old accounted for less than 7% and 15% of the entire population respectively. The life expectancy at birth remained constant between 65 and 66 years.

Health system context

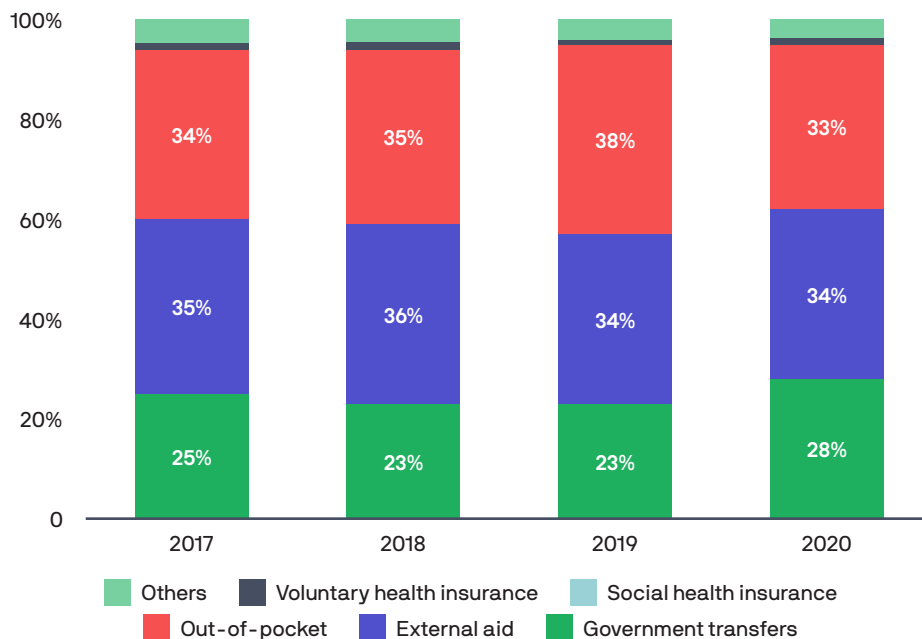
The top three causes of death in the population were neonatal conditions, lower respiratory tract infections and diarrheal diseases. Preterm birth complications, neonatal sepsis, birth asphyxia, acute respiratory infections and diarrhea were the main causes of under-five mortalities.

There was a steady decline in the Infant Mortality Rate (IMR) and Under-five Mortality Rate (UFMR) over the period of analysis. IMR declined from 40 to 34 deaths per 1000 live births, while UFMR declined from 56 to 47 deaths per 1000 live births. The Universal Health Coverage (UHC) Service Coverage index in 2021 was 35% implying that only 35% of the population have access to essential health services including reproductive, maternal, newborn and child health, infectious diseases, and non-communicable disease services.

Health financing context

Government spending on health was at 1% of the Gross Domestic Product (GDP) which was markedly below the minimum of 5% recommended for progression towards UHC (McIntyre et al., 2017). The per capita spending on health was between USD 25 and USD 30, which was substantially below the recommended per capita target of USD 86 (McIntyre et al., 2017). Further, the government expenditure on health relative to other sectors ranged between 5% and 7% across the years, which was substantially below the 15% Abuja target. Out-of-Pocket (OOP) payments and donor funding were the largest sources of financing for health in Ethiopia between 2017 and 2020. OOPs accounted for between 33% and 38% of all health financing while donor funding accounted for between 34% and 36% (Figure 1). This was followed by government funding which accounted for 23% to 28% of all health financing. Other sources accounted for less than 10% of health financing during the period.

FIGURE 1. Health financing sources in Ethiopia

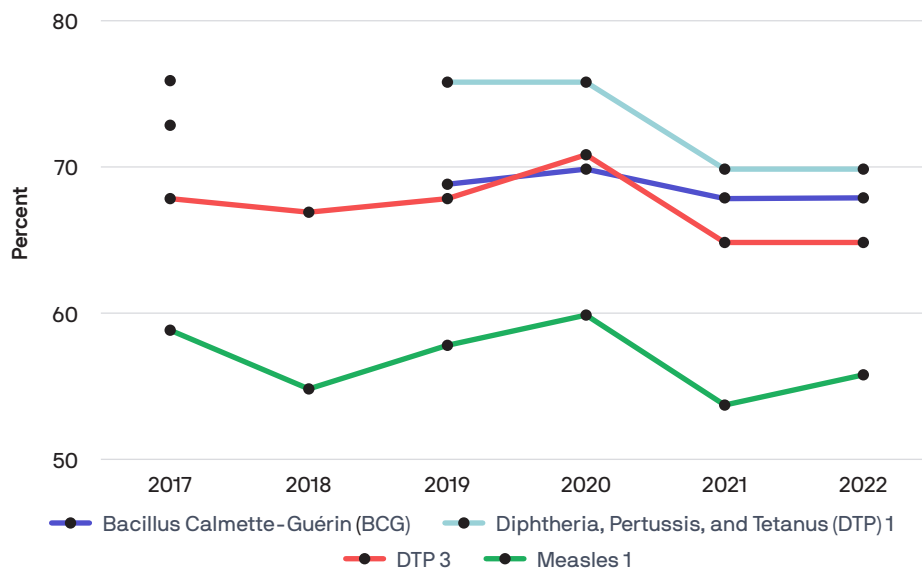


Source: WHO Global Health Expenditure Database

Immunization coverage

Overall, the national immunization coverage rates had stagnated below 80% (Figure 2) but declined further in 2021 likely due to contextual factors such as COVID-related restrictions and disruptions to service delivery.

FIGURE 2. Immunization coverage in Ethiopia

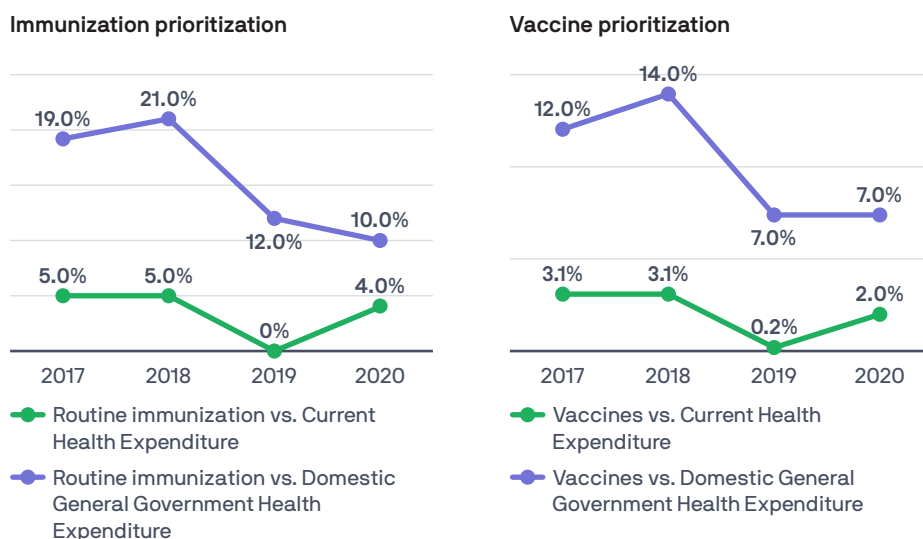


Source: WHO/UNICEF, Joint Reporting Form, Analysis by Consultant

Immunization financing

Expenditures on routine immunization in Ethiopia have been declining during the period of analysis. Routine immunization accounted for between 0% and 5% of the Current Health Expenditure (CHE); and between 10% and 21% of the Domestic General Government Health Expenditures between 2017 and 2020. Vaccine related expenditures while declining accounted for less than 4% of the CHE and declined from 14% to 7% of the Domestic General Government Expenditures (Figure 3).

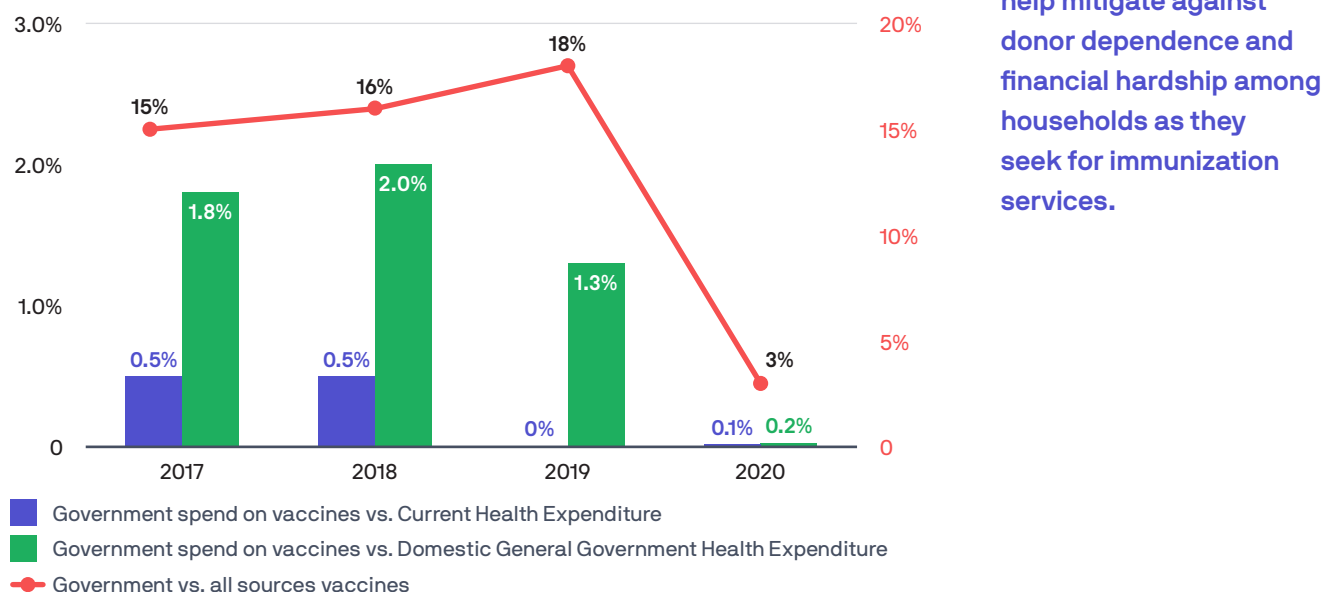
FIGURE 3. Prioritization of immunization and vaccines in Ethiopia



Source: WHO/UNICEF, Joint Reporting Form, Analysis by Consultant

Though declining, Government funding as a source of immunization financing accounted for between 29% and 43% between 2017 and 2020. This accounted for less than 2% of Current Health Expenditures and below 9% of the Domestic General Government Health Expenditure (Figure 4).

FIGURE 4. Government prioritization of vaccines in Ethiopia



Source: WHO/UNICEF, Joint Reporting Form, Analysis by Consultant

HIGHLIGHT

The declining prioritization of immunization financing by government in Ethiopia threatens sustainability of immunization services. Progressive increments in government financing of health and immunization will help mitigate against donor dependence and financial hardship among households as they seek for immunization services.

Challenges to immunization financing in Ethiopia

1. **Over dependency on donor funding:** Ethiopia heavily relies on external donor funding for its healthcare budget. The government's financial capacity to allocate resources to immunization is significantly constrained due to competing demands on the budget at home.
2. **Limited domestic resources:** Limited resources may not always be effectively allocated to immunization efforts, leading to inefficiencies, inequities and disparities in vaccine coverage.
3. **Global health priorities:** Changes in global health priorities and shifting donor funding significantly impact the availability and stability of external funding for immunization programs.

Recommendations to improve immunization financing

1. Prioritize Immunization Financing

- Increase domestic government funding for immunization programs as a proportion of the overall healthcare budget.
- Explore innovative financing mechanisms, such as public-private partnerships, to generate additional resources for immunization programs.
- Improve the transparency and accountability of immunization financing to ensure that resources are used effectively and efficiently.
- Develop multi-year funding commitments for immunization programs, and to ensure that funding is aligned with national priorities.
- Advocate for the prioritization of immunization programs in national and regional development plans.
- Build partnerships with civil society organizations and the private sector to support immunization programs.

References

GAVI. (2022). *Gavi Alliance Eligibility and Transition Policy Version 4*. <https://www.gavi.org/types-support/sustainability/eligibility>

McIntyre, D., Meheus, F., & Rottingen, J. A. (2017). What level of domestic government health expenditure should we aspire to for universal health coverage? *Health Economics, Policy and Law*, 12(2), 125–137. <https://doi.org/10.1017/S1744133116000414>