

Improving Healthcare Financing in Ethiopia: A Policy Brief

Prepared by: IPHC-E

International Institute for Primary Health Care – Ethiopia
Evidence to Policy, Policy to Practice
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What is this policy brief about?

This policy brief addresses the critical challenge of underfunded, fragmented, weak risk pooling, and unsustainable health care financing in Ethiopia. It outlines the scale of the problem, examines key drivers including heavy reliance on external funding and inefficient resource use and assesses viable policy options to mobilize domestic resources and improve their efficient utilization to advance progress toward Universal Health Coverage (UHC).

Who is this policy brief for?

This policy brief is intended for decision-makers in the Ethiopian health system, including politicians, policymakers, and other stakeholders engaged in health financing and strategic planning. It offers evidence-based policy options to support decisions aimed at securing predictable, equitable, and sustainable funding for the health sector.

This policy brief includes:

- An analysis of Ethiopia's current health financing landscape and the major challenges efficiency.
- A review of evidence-based policy options, including innovative domestic financing mechanisms and approaches to optimize the use of existing resources.
- Implementation considerations for implementing the proposed policy options.

This policy brief does not include:

- A detailed implementation plan or budget for the proposed options
- This policy brief does not make recommendations regarding which policy option to choose



Key Message

The Problem

Ethiopia's health system faces a persistent financing gap driven by low domestic revenue, high out-of-pocket spending, and heavy dependence on external funding. Without sustainable and predictable financing sources, progress toward Universal Health Coverage (UHC) will continue to be slow and uneven.

Recommended Policy Options

1. Mobilizing New Domestic Revenues

Introducing new and strengthening existing revenue streams can expand fiscal space for health. These include:

- Strengthening sin taxes on tobacco, alcohol, sugar-sweetened beverages, and khat, with earmarking for health.
- Introducing telecommunication and digital transaction levies with structured health allocations.
- Implementing a solidarity levy on airline tickets to support health security and emergency response, according to the evidence provided, is a stable and predictable method
- Institutionalizing corporate social responsibility (CSR) contributions for health through clear national guidelines.

2. Improving the Utilization of Existing Resources

Efficiency gains can be achieved through:

- Scaling up Performance-Based Financing (PBF) to improve service quality and accountability.
- Increasing CBHI enrollment and retention, supported by sliding-scale premiums, targeted subsidies for vulnerable households, and regional pooling mechanisms
- Accelerating implementation of Social Health Insurance (SHI) for the formal sector.

Key Implementation Considerations

Successful adoption of these financing options depends on addressing several challenges highlighted in the evidence:

- Sin and telecom taxes face challenges of regressivity, low public awareness, industry lobbying, and risks to financial inclusion and sector growth. Clear pro-poor earmarking, targeted exemptions or thresholds for low-income users, phased implementation, behavioral monitoring, complementary subsidies or digital literacy programs, stakeholder engagement, and transparent communication on revenue use are essential to maintain equity, support access, and secure sustainable revenue.
- CBHI implementation is hindered by delays in reimbursements, weak governance, small, fragmented risk pools, and poor provider payment mechanisms. Strengthening scheme management, expanding pooling, and improving claims systems are critical.
- SHI implementation demands strong political commitment, institutional capacity, and clear regulations for benefits, contributions, and purchasing arrangements.
- PBF scale-up must address bottlenecks in facility autonomy, rigid PFM rules, and weak verification and performance monitoring systems.

Supplementary Evidence

Detailed evidence supporting these options, including applicability, equity, impact, economic considerations, acceptability, sustainability, and barriers with corresponding mitigation measures, is provided in the supplementary file. The evidence is primarily based on systematic reviews and meta-analyses; where such evidence was not available, we used high-quality primary studies and relevant reports. All evidence sources were appraised appropriately using the relevant evaluation tools.

The Problem:

Underfunded, Fragmented, Weak risk pooling, and Unsustainable health care financing

Background

Sustainable health care financing is a cornerstone of strong health systems and a prerequisite for achieving Universal Health Coverage (UHC), which ensures that all people have access to essential health services without suffering financial hardship^[1]. According to the World Health Organization (WHO), health financing encompasses three core functions: raising sufficient funds, pooling resources to share financial risks, and purchasing services efficiently to improve access, equity, and quality of care^[2].

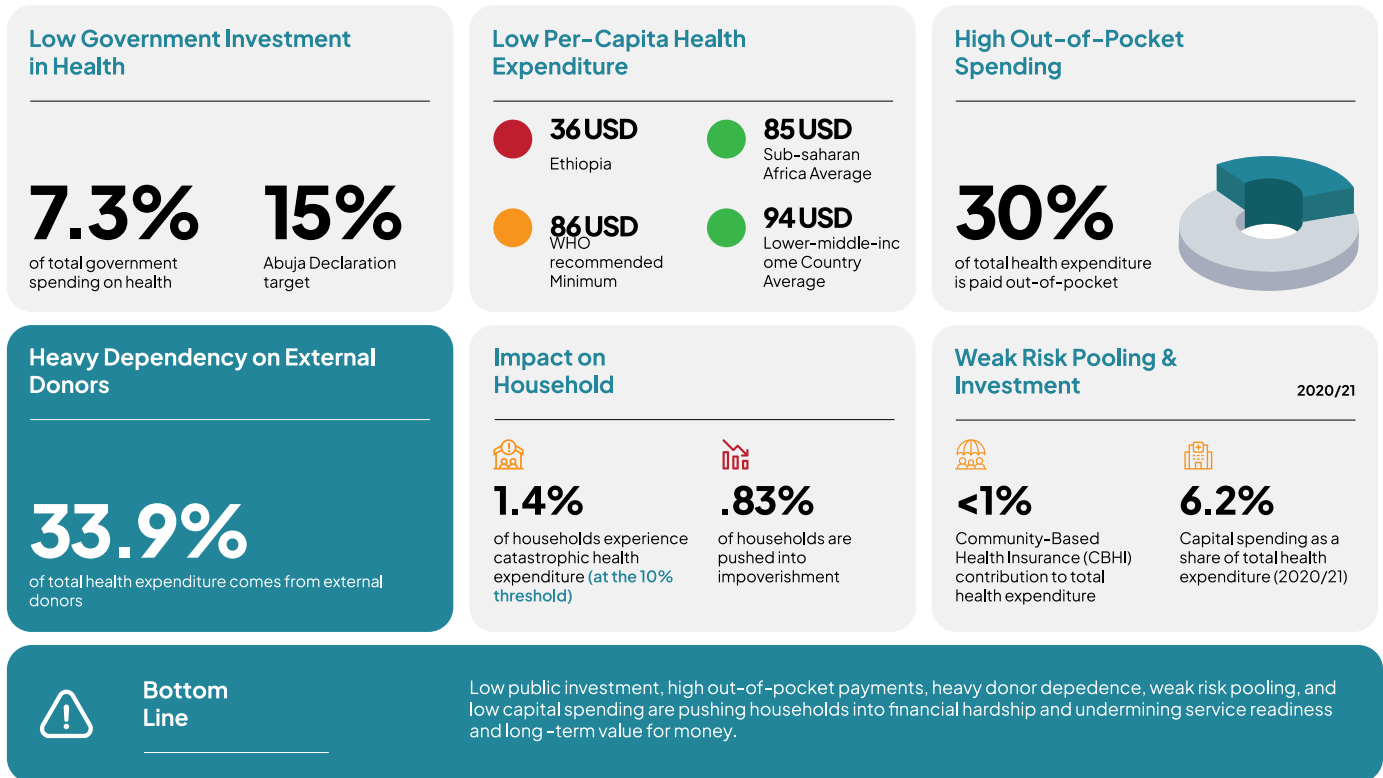
Ethiopia's health system continues to face significant financing challenges that threaten progress toward UHC and the health-related Sustainable Development Goals (SDG3)^[3]. Limited domestic funding, high reliance on external donor support, and substantial out-of-pocket payments constrain the health system's ability to provide equitable and quality services^[3-5]. Recognizing these challenges, the Government of Ethiopia has developed several strategies to strengthen health financing, including efforts to expand domestic resource mobilization, improve efficiency in spending, and implement risk-pooling mechanisms^[6].

During an ongoing series of think tank meetings on primary health care organized by the Institute for Primary Health Care-Ethiopia (IPHCE), unsustainable health care financing was first raised as a key issue during its 9th and 13th sessions for the IPHC-E. Experts from across the health sector emphasized that

limited government funding and heavy reliance on external donor support, particularly amid shifting priorities and funding uncertainties, undermine equitable access to quality health services across all levels of care. Recognizing the critical importance of sustainable financing, this Policy Brief summarizes the best available evidence on the scale and implications of health financing challenges in Ethiopia and highlights potential solutions, including excise and telecom taxes, airline levies, performance-based financing, and scaling up community-based health insurance.

Size of the Problem

Although remarkable progress has been made over the past two decades, government health expenditure in Ethiopia remains critically low, accounting for only 7.3% of total government spending, well below the 15% target set by the Abuja Declaration^[7,8]. The country's per-capita health expenditure is estimated at USD 36.30, less than half of the WHO-recommended minimum of USD 86 and well below the averages for Sub-Saharan Africa (USD 85) and lower-middle-income countries (USD 94)^[9]. Out-of-pocket (OOP) payments account for about 30% of total health expenditure^[10]. Meanwhile, external donors contribute approximately 33.9%^[10], making the system heavily dependent on volatile aid. The consequences are significant: health expenditures push households into financial hardship, with 1.4 of households experiencing catastrophic health expenditure (at the 10% threshold), and 0.83% were pushed into impoverishment^[11]. Meanwhile, Community-Based Health Insurance (CBHI) contributes less than 1% of the total health expenditure (2020/21) while capital spending has declined to 6.2% over the same period, undercutting service readiness and long-term value for money^[10,11].



Key Factors Driving Underfunded, Fragmented, Weak risk pooling and Unsustainable health care financing

1. Insufficient Revenue Generation, Allocation, and Utilization of Health Resources

1.1 Domestic Resource Mobilization

Domestic revenue generation in Ethiopia remains limited, restricting the overall fiscal space available for health. The country's tax-to-GDP ratio has declined from 12.4% in 2014/15 to just 7.5% in 2022/23, marking one of the most significant decreases globally over this period. This decline is attributed to

reductions in value-added tax (VAT), trade taxes, corporate income tax, and employment income taxes. Consequently, domestic sources contribute only about 35% of total health expenditure, with the remainder funded by external aid and out-of-pocket payments^[12].

1.2 Low Budget Allocation to Health

Even within the limited fiscal space, the health sector receives a relatively small share of government resources. Government health expenditure accounts for only 7.3 of total government spending, well below the 15% target set by the Abuja Declaration. Per capita expenditure stands at USD 36.30, far below the WHO-recommended minimum of USD 86. Capital spending has declined to 6.2%.

1.3 Poor Governance and Resource Management

Weak governance practices continue to erode efficiency in Ethiopia's health financing system.

1.3.1 Claims, Contracting, and Purchasing

At the facility level, Community-Based Health Insurance (CBHI) reimbursement processes are plagued by delays, fragmented purchasing, and inconsistent claims management, resulting in cash-flow gaps and service disruptions^[13,14]. The prevailing fee-for-service reimbursement model is retrospective and varies across woredas, lacking standardization across regions, undermining both quality and efficiency^[15].

Resource allocation also exhibits inequities across regions, while routine health information remains underutilized for evidence-based decision-making. External shocks such as pandemics and conflicts further exacerbate financial mismanagement, supply chain disruptions, and workforce shortages. Collectively, these systemic weaknesses undermine the efficiency and equity of health spending^[16–20].

1.3.2. Low Technical Efficiency of Health Facilities

A significant portion of health facilities operate below optimal capacity. Primary care facilities, such as health posts, frequently use less than half of their potential, while many health centers are scale-inefficient, indicating that service output could be substantially increased without additional resources. Inefficiencies are not limited to smaller facilities; some hospitals also underutilize existing infrastructure and human resources, resulting in suboptimal service delivery and wasted investments^[21–23]. Surgical services are particularly affected by operational inefficiencies. Workflow disruptions, delayed start times, high cancellation rates, and underutilized operating rooms limit the productivity of existing infrastructure. These inefficiencies prevent hospitals from maximizing surgical outputs, contributing to unmet patient needs and wasted expenditures^[24–26].

2. Dependency on External Donors and Associated Challenges

Ethiopia's health financing is heavily reliant on external assistance, with donors contributing 33.9% of total health expenditure. This reliance exposes the health system to several critical problems: inefficient allocation of resources, as current financing fails to target the most cost-effective interventions, undermining equitable service delivery and progress toward Universal Health Coverage (UHC); fragmented donor support, which complicates planning and management of health services; and the volatility of donor funding, driven by shifts in donor priorities and global economic conditions, making long-term planning and sustainability challenging^[3,5].

3. Underdeveloped Risk-Pooling Mechanisms

Risk pooling is a central component of sustainable health financing, offering households financial protection and supporting equitable access to services^[2]. In Ethiopia, Community-Based Health Insurance (CBHI) has expanded to about 91% of woredas, marking a significant achievement in geographic coverage. However, membership coverage remains slightly below the national target, with about 84% of eligible households enrolled, compared to the 90% goal set under the Health Sector Transformation Plan II (HSTP II)^[27–29]. Despite this progress, membership retention poses a challenge, as over one-third of beneficiaries have dropped out, undermining the program's effectiveness and sustainability^[30].

In addition to low coverage and high dropout rates, the fixed and often low premiums of CBHI further constrain effective risk pooling. Because all households pay the same amount regardless of income or household size, cross-subsidization is limited, weakening financial solidarity. This structure, combined with voluntary enrollment, can lead to adverse selection, as low-risk households opt out while higher-risk households remain. Even

modest premiums can be a barrier for low-income households, contributing to delayed enrollment or dropout^[31-33]. Furthermore, Social Health Insurance (SHI), intended to provide coverage for the formal sector, has not been fully implemented, leaving large segments of the population outside any risk-pooling mechanism^[34, 35].

Policy Options

Policy Option 1: Mobilizing New Domestic Revenues through Innovative Domestic Financing Mechanisms

Domestic financing is defined as the mobilization of financial resources from within a country through mechanisms such as general taxation, earmarked taxes, and mandatory insurance contributions. It has gained prominence as a means of ensuring long-term sustainability, improving alignment with national needs, and increasing government accountability^[36-38]. Complementing this, innovative financing mechanisms encompass non-traditional approaches for raising or pooling funds beyond conventional tax-based or donor-dependent methods, offering additional avenues to expand fiscal space for health^[39].

Earmarked tax

Earmarked taxes are specific taxes levied on particular goods, services, or activities, with the revenues legally designated for a specific purpose, in this case, health financing^[40]. Several types of earmarked taxes have been identified in different studies as effective mechanisms to strengthen domestic health financing. These include sin taxes, telecommunication levies, and airline ticket taxes.

Policy option 1.1 Sin tax

Sin Tax in Ethiopia



Sin taxes exist under **Excise Tax Proclamation NO. 1186/2020**



Revenues go into the **general treasury** with no direct allocation to the health system.



In Philippines, alcohol and tobacco tax revenues are directed to the health sector with flexible annual allocations


Sin tax refers to excise taxes imposed on products that are harmful to public health, such as tobacco, alcohol, and sugar-sweetened beverages (SSBs), with the dual purpose of discouraging consumption and mobilizing domestic revenue^[41, 42]. They have been widely adopted in many countries as an innovative domestic financing mechanism for health. The Addis Ababa Action Agenda of the Third International Conference on Financing for Development (2015) reaffirmed the global consensus that price and tax measures on tobacco are not only effective in reducing tobacco consumption and associated healthcare costs but also serve as a sustainable revenue stream for development financing, including health^[43]. Sin taxes exist in Ethiopia under the Excise Tax Proclamation No. 1186/2020. However, unlike countries like the Philippines that earmark these revenues for health, Ethiopia's sin tax income goes into the general treasury, with no direct allocation to the health system^[44, 45].

Impact of the sin tax


Evidence from systematic and umbrella reviews shows that sin taxes on tobacco, alcohol, and SSBs provide two main benefits. First, they generate substantial and predictable domestic revenue. Second, they help reduce the economic burden of NCDs, which cost Ethiopia an estimated 31.3 billion birr (US\$ 1.1 billion) per year, equivalent to 1.8% of the GDP. By lowering NCD-related costs, sin taxes indirectly alleviate financial pressure on the health system^[46]. A systematic review conducted revealed that 71% of the included studies reported revenue growth, for instance, a 50% increase in tobacco taxes generated approximately US\$7 million in additional revenue per country (13 out of 16 studies)^[47]. Evidence from LMICs indicates that soft earmarking of sin-tax revenues can strengthen health financing while maintaining fiscal flexibility. According to the World Bank, soft earmarking enhances the visibility of policy priorities yet avoids the rigid revenue expenditure linkages that often undermine efficiency under hard earmarking^[48]. Practical applications support this view; in the Philippines, alcohol and tobacco tax revenues are directed to the health sector, but annual allocations remain adjustable based on evolving needs^[49].

Policy option 1.2 Telecom tax


Telecom Tax



What is it?
A tax on phone usage, airtime, internet, or telecom companies revenues.




Ethio telecom
80.5M
subscribers



Safaricom
8.8M
subscribers

Current Policy

A 5% excise tax on mobile services exists under proclamation No. 1287/2023



Revenue flows into the **general treasury**, not health

These taxes provide governments with a sustainable revenue stream to support health systems and expand coverage, especially in low- and middle-income countries^[50]. Ethiopia's telecom sector is expanding, with Ethio Telecom (80.5M subscribers) and Safaricom Ethiopia (8.8M subscribers) driving growth. A 5% excise tax on mobile services exists under Proclamation No. 1287/2023, but the revenue flows into the general treasury, not health^[51-53].

Impact of Telecom tax

Even though no systematic review or meta-analysis was found on this option, different primary studies from various countries consistently show its positive impact. Looking at country experiences, Gabon introduced a 10% levy on mobile phone company revenues and usage, which was earmarked for the national health insurance program and more than doubled its funding^[54]. In Zimbabwe, a 5% levy on airtime and mobile data sales created a sustainable and reliable revenue stream dedicated to healthcare^[55].

Telecommunication taxes, levies imposed on mobile phone usage, airtime, internet services, or telecommunications companies' revenues, are increasingly being used as innovative domestic financing mechanisms for health.

Policy Option 1.3 Airplane tax

The airline ticket levy is an innovative financing mechanism that imposes a small tax or fee on airline tickets to generate funds for health programs. The structure of airline levies varies by country; some impose the levy solely on international flights, while others apply it to both domestic and international tickets. A well-known application of this levy is the model introduced by France in 2006, which channels funds through UNITAID to support international efforts targeting diseases such as HIV/AIDS, tuberculosis, and malaria. This approach has been adopted by both developed and developing countries, including low- and middle-income countries such as Cameroon, Côte d'Ivoire, Gabon, Mali, Niger, Burkina Faso, and Mozambique, which direct revenues to UNITAID, an international health financing mechanism hosted by the World Health Organization (WHO)^[39, 56].

Impact of Airline Levy

Evidence shows that the airline solidarity levy has generated substantial revenue for health financing globally. Between 2007 and 2015, the levy raised approximately US\$1.7 billion, demonstrating its scale and sustainability. In 2009, airline levies accounted for around 70% of UNITAID's revenue^[57, 58]. Country-level analyses further illustrate the potential impact: in Namibia, modest levies of US\$1–5 per ticket were estimated to generate millions of dollars annually for national health initiatives^[59].

Policy option 1.4: Corporate Social Responsibility

Corporate Social Responsibility (CSR) is a business model in which companies integrate social, environmental, and community considerations into their operations and stakeholder engagements. In developed countries, CSR is a well-established practice, encompassing activities such as community development, environmental sustainability, employee welfare, and health initiatives. CSR can provide additional resources to support health programs, infrastructure, and community health interventions, especially

when aligned with national priorities and implemented strategically^[60–62].

Ethiopia Current status



Types of organizations contribute (banks, telecoms, manufacturers, hospitals, etc.)



Key challenges identified (weak regulation, limited alignment, etc.)



Opportunity: CSR can compliment public health financing.



Main challenge: CSR is fragmented, voluntary, and unevenly distributed



Focus: often concentrated in urban centers or near operation areas.

Impacts of CSR

Although there is no systematic review or meta-analysis, country experiences indicate that CSR has the potential to generate revenue for health programs. In India, the CSR Act 2013 requires eligible companies to allocate 2% of their average profits to CSR initiatives, creating predictable resources for social and health programs^[61]. In Bangladesh, banks' CSR spending on healthcare infrastructure, medical camps, and awareness campaigns, particularly during COVID-19, demonstrates CSR's capacity as a flexible funding source^[63]. CSR by multinational pharmaceutical firms provides a working model of this approach, with companies implementing programs such as differential drug pricing, mHealth initiatives,

and support for health infrastructure in LMICs, demonstrating that CSR can be strategically aligned to support health systems^[64]. Also, such as Johnson & Johnson's HIV/AIDS programs.

Corporate Social Responsibility in Ethiopia represents an emerging, though modest, source of support for health and social development. Different types of organizations contribute in diverse ways. Financial institutions, including banks and microfinance organizations, engage in community development initiatives, health awareness campaigns, and social support programs targeting vulnerable populations^[65]. Telecommunications and ICT companies often support digital health initiatives, public health campaigns, and community education, frequently through in-kind contributions^[65]. Manufacturing and industrial companies focus on employee welfare, occupational health, environmental initiatives, and community outreach, occasionally implementing health-related interventions^[66]. Private hospitals and healthcare providers participate in community health screenings, preventive campaigns, donations of medical equipment, and health education programs^[67]. Despite these contributions, CSR is currently fragmented, voluntary, and unevenly distributed, often concentrated in urban centers or near company operational areas^[65] and several challenges limit its current impact: weak regulation and policy frameworks, fragmented implementation, limited strategic alignment with societal needs, poor stakeholder engagement, and a tendency to prioritize company image over sustainable social outcomes^[66, 68].

Despite these challenges, CSR in Ethiopia presents potential as a complementary domestic health financing mechanism. Experiences from multinational companies in Africa, such as Johnson & Johnson's HIV/

AIDS programs, demonstrate that CSR can be leveraged strategically not only to provide financial resources but also to strengthen service delivery, technical capacity, and community engagement^[63, 69].

To maximize CSR's potential as a supplementary health financing mechanism, Studies recommend the following. First, developing comprehensive CSR guidelines or legal frameworks is essential to institutionalize CSR practices, especially for health-related initiatives. Companies should also be encouraged to align their CSR activities with national health priorities and the specific needs of local communities to ensure strategic relevance. Strengthening stakeholder engagement across corporations, government sectors, health institutions, and communities will further support the design of sustainable and impactful interventions. Additionally, establishing transparent monitoring and accountability systems is crucial for tracking CSR contributions, evaluating their outcomes, and ensuring responsible corporate behavior. Finally, building the capacity of CSR personnel through training in health and public policy will enable organizations to design evidence-based programs that effectively complement government efforts^[66, 68].



Policy Option 2: Optimized utilization of domestic resources

Optimized utilization of domestic resources focuses on making the best use of the limited funds already available within the health system. In Ethiopia, where health care financing remains fragmented and heavily donor dependent, this approach is essential to improve efficiency, reduce wastage, and ensure that existing domestic allocations deliver maximum health gains for the population.

Policy option 2.1 Optimizing Domestic Resources through Performance based financing (PBF)

PBF is a health financing mechanism where health service providers receive financial incentives based on the quantity and quality of services they deliver. Unlike traditional input-based funding, PBF links payments to predefined performance indicators, such as service utilization rates and quality measures. This approach aims to enhance accountability, improve service delivery, and optimize resource utilization within health systems^[70,71]. Ethiopia piloted Performance-Based Financing (PBF) starting in 2015, showing significant success where quality scores in health centers and hospitals rose sharply (from 24 to 81 in health centers). The initiative expanded to Amhara in 2021. While PBF is viewed as a key strategy to address funding gaps and improve care quality, it remains

limited to pilot districts and has not yet been scaled nationally^[72,73].

Impact of PBF

Systematic reviews and meta-analyses with high AMSTAR evaluation scores indicate that Performance-Based Financing (PBF) can enhance the efficiency and effectiveness of domestic health resources. By linking funding to measurable outputs and quality indicators, PBF incentivizes health facilities to optimize resource use, improve service delivery, and strengthen accountability^[74]. Evidence from multiple low- and middle-income countries shows that PBF significantly reduced out-of-pocket expenses from 90% to 3%, can increase service utilization, and improve the financial management of health facilities^[75]. Additionally, it is also suggested that it may enhance the delivery, utilization, and quality of health services, potentially increasing the availability of health workers, essential medicines, and well-functioning infrastructure and equipment^[76]. Overall, PBF demonstrates the potential to make domestic health financing more effective, ensuring that existing resources achieve greater health outcomes^[74,77-79].

Policy option 2.2 Optimizing Domestic Resources through Enhanced CBHI Utilization

What is CBHI



CBHI aims to improve financial protection and increase the use of priority health services in Ethiopia.

Enrollment in CBHI

45%

Enrollment in a meta-analysis

84%

Enrollment reported by the MOH in 2017

Sliding-Scale Premium Pilot

Sliding-scale premium pilot in Oromia is being considered for national scale-up.

Key Recommendation

Improve coverage and retention of CBHI - to strengthen financial protection and maximize health financing gains.

CBHI has demonstrated clear potential to mobilize domestic prepayment revenue and increase the use of priority health services in Ethiopia. However, its effectiveness in offering consistent financial protection against health-related expenditure shocks remains limited^[80, 81]. To translate that potential into meaningful national health-financing gains, it is recommended to improve coverage and retention of CBHI^[81]. CBHI, implemented in Ethiopia since 2011 to improve financial protection, had 45% enrollment in a meta-analysis^[83] versus 84% reported by the Ministry

of Health in 2017, and a sliding-scale premium pilot in Oromia is being considered for national scale-up^{[82][83]}.

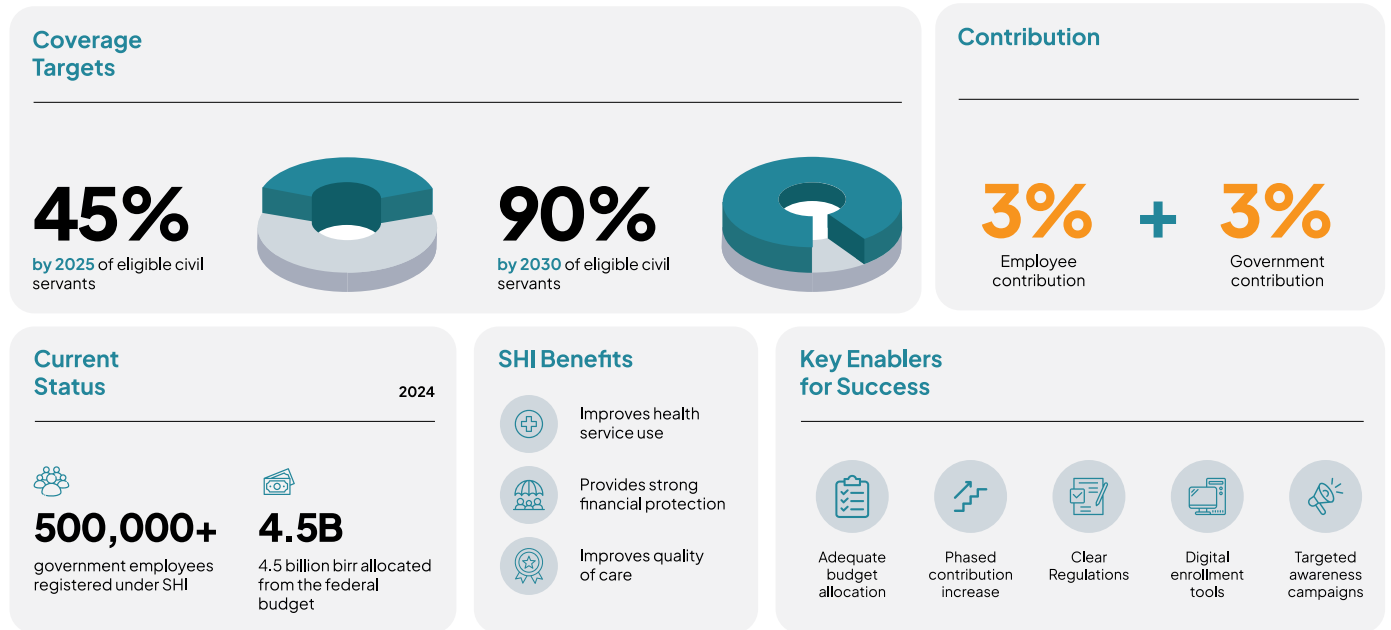
Interventions That Improve CBHI Effectiveness

Community-based health insurance (CBHI) effectiveness is influenced by equitable financing and strong implementation. Sliding payment schemes increase willingness to join compared to fixed premium rates, integrating CBHI with existing social programs, and merging smaller schemes into larger regional or national pools are also effective measures to improve participation and financial protection^[84-86].

Policy option 2.3: Enhancing Social Health Insurance Implementation and Coverage

Social Health Insurance is a health financing approach that mobilizes prepaid contributions largely via mandatory payroll deductions from government sector workers and pools them into a risk fund that pays for health services. Under such a system, only individuals who are enrolled and have contributed become eligible for a defined benefits package^[87]. Evidence shows that SHI consistently improves health service utilization and provides strong financial protection for members by reducing out-of-pocket spending. It is also indicated that it has a positive impact on the quality of care^[83, 84]. Ethiopia's SHI program, established 14 years ago, is a key component of the Ministry of Health's Health Care Financing Strategy 2022-2031, which targets 45% coverage of eligible civil servants by 2025 and 90% by 2030^[88]. Employees contribute 3% of their salaries, with governments providing a matching 3%, supported by federal and regional budgets^[89]. Implementation has been slow in previous years due to limited funding and rising living costs. In 2024, more than 500,000 government employees were registered under the scheme, supported by 4.5 billion birr allocated from the federal budget^[90]. Learning from other countries' experiences, such as challenges with financial sustainability, employee compliance, and governance gaps, together with evidence from Ethiopia,

including low awareness of SHI benefits among civil servants, can help inform strategies for SHI rollout^[91,92]. Addressing these barriers through adequate budget allocation, phased contributions, clear regulations, strengthened governance, digital enrollment tools, and targeted awareness campaigns can accelerate SHI implementation and enhance its role as a sustainable domestic source of health financing^[92-94].



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Conflict of Interest

The authors declare that there are no conflicts of interest related to the development of this policy brief.

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Prepared by: IPHC-E

International Institute for Primary Health Care - Ethiopia
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info@iphce.org

Addis Ababa, Ethiopia