Federal Democratic
Republic of Ethiopia
Ministry of Health

ETHIOPIAN HEALTH ACCOUNTS

HOUSEHOLD HEALTH SERVICE UTILIZATION AND EXPENDITURE SURVEY

2015/16

August 2017, Addis Ababa

Federal Democratic Republic of Ethiopia
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Additional information about the 2015/2016 Ethiopian Health Accounts Household Health Service Utilization and Expenditure Survey may be obtained from the Federal Democratic Republic of Ethiopia Ministry of Health, Resource Mobilization Directorate Lideta Sub City, Addis Ababa Ethiopia. P.O.Box:1234, Telephone: +251115517011/535157; Fax: +251115527033; Email:

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Recommended Citation:
Federal Democratic Republic of Ethiopia Ministry of Health. August 2017. Ethiopian Health Accounts Household Health Service Utilization and Expenditure Survey 2015/2016, Addis Ababa, Ethiopia.

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Breakthrough International Consultancy PLC

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Acknowledgements

The FDRE Ministry of Health would like to express its gratitude to all institutions and individuals involved in data collection and analysis, and writing up of this household health service utilization and expenditure survey. The Ministry is grateful for the work done by Breakthrough International Consultancy PLC and Fenot Project (Harvard T.H. Chan School of Public Health) in conducting this household survey.

The Ministry also acknowledges the Central Statistics Agency (CSA) for selecting sample enumeration areas (EAs) and sharing of the cartographic map and list of EAs, which were critical for successfully completion of the household survey, and the Ethiopian Public Health Institute (EPHI) for checking the quality of data while data was being submitted directly from the enumeration areas to the institute's cloud server. The Ministry also appreciates contribution of UNICEF, WHO, and World Bank for assigning technical persons. The Health Accounts (HA) VI technical working group (TWG) was instrumental in helping the revision of the survey instrument and reviewing the draft report, without which the quality of the report wouldn't have taken the current form. The Ministry congratulates the multi- disciplinary team and would like to acknowledge the contribution of the following individuals:

Dr. Mizan Kiros	FDERE Ministry of Health
Eyerusalem Animut	FDERE Ministry of Health
Mideksa Adugna	FDERE Ministry of Health
Ermias Dessie	FDERE Ministry of Health
Belay Urgessa	FDERE Ministry of Health
Dr. Meseret Molla	FDERE Ministry of Health
Leulseged Ageze	Abt HSFR/HFG
Habtamu Taddesse	Abt HSFR/HFG
Hailu Zelelew	Abt HSFR/HFG
Seyoum Aklilu	Abt HSFR/HFG
Tesfaye Dereje	Abt HSFR/HFG
YenehunTawye	Abt HSFR/HFG
Amsalu Shiferaw	UNICEF
Martha Kibur	UNICEF
Dr. Sofonias Getachew	WHO
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Sarah Hurlburt	Fenot Project, Harvard T.H. Chan School of Public Health
Dr. Girmaye D. Dinsa	Fenot Project, Harvard T.H. Chan School of Public Health
Abebe Alebachew	Breakthrough International Consultancy PLC
Getnet Alemu	Breakthrough International Consultancy PLC
Workie Mitiku	Breakthrough International Consultancy PLC
Surafel Mehari	EPHI
Terefe Gelebo	EPHI

Finally we would like to extend our acknowledgement to the Bill & Melinda Gates Foundation for financing this survey.

Foreword

Generating evidence on household's health service utilization and expenditure is an essential part of the Health Accounts (HA). This 6th round Household Utilization and Expenditure Survey estimates households' utilization of health services and Out-of-Pocket (OOP) payments for health services. The report utilizes the new System of Health Accounts (SHA 2011), which provides an extended classification of health service utilization and expenditure. This enables policymakers and stakeholders to have more detailed information based on health utilization and expenditure among households in Ethiopia. This household survey also attempts to estimate community contributions that are made towards health system development in the form of financial or in-kind contributions.

This report documents the existence of significant inter- and intra-regional as well as income or wealth-related variations in utilization of outpatient and inpatient services. Non-communicable diseases (NCDs) have become a significant reason for people to seek health care services. Government health facilities remain not only the major providers of care but also the main outlets through which the very poor households access care. Out-of-pocket spending is high and likely to be one of the barriers to health service utilization. The findings of this report highlight that greater focus is needed on ensuring equity, improving quality of public health facilities, and expanding financial protection measures in order to achieve Universal Health Coverage (UHC).

The use of the evidence presented in this report, and further analyses of the rich data set from the household utilization and expenditure survey will be vital to inform health system strengthening approaches that seek to improve uptake rates of service utilization, financial protection measures, and quality and responsiveness of health care.

Finally, I would like to take this opportunity to encourage directorates and teams in MoH, the Regional Health Bureaus (RHB), other health sector agencies and the wider stakeholder community to use the evidence in this edition in their planning and policy decision processes.

Professor Yifru Berhan
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Acronyms

BIC	Breakthrough International Consultancy
BG	Benishangul-Gumuz
BMGF	Bill & Melinda Gates Foundation
CAPI	Common Application Programmer's Interface
CBHI	Community Based Health Insurance
CSA	Central Statistical Agency
DHS	Demographic and Health Survey
EAs	Enumeration Areas
EFY	Ethiopian Fiscal Year
EPHI	Ethiopian Public Health Institute
ETB	Ethiopian Birr
FDRE MOH	Federal Democratic Republic of Ethiopia Ministry of Health
GDP	Gross Domestic Product
HA/NHA	Health Accounts/National Health Account
HC	Health Center
HEP	Health Extension Program
HEW	Health Extension Worker
HDA	Health Development Army
HH	Household
HICE	Household Income, Consumption and Expenditure
HSTP	Health Sector Transformation Plan
IRS	Indoor Residual Spray
IPD	Inpatient Department
KM	Kilometers
KMO	Kaiser-Meyer-Olkin
LLTIN	Long-lasting Treated Insecticide Net
NCD	Non-Communicable Disease
NGO	Non-governmental Organization
ODF	Open-Defecation Free
OOP	Out-of-Pocket
OPD	Outpatient Department
PHC	Primary Healthcare
PCA	Principal Component Analysis
SERC	Scientific and Ethical Review Committee
SHA	System of Health Accounts
SQRT	Square Root
TB	Tuberculosis
TBA	Traditional Birth Attendant
THE	Total Health Expenditure
TLU	Tropical Livestock Units
TWG	Technical Working Group
UHC	Universal Health Coverage
USD	United States Dollar
VCT	Voluntary Counseling and Testing
WG	Working Group

Executive Summary

This report summarizes the results of Ethiopia's sixth Health Accounts (HA VI) Household Health Expenditure and Service Utilization Survey conducted mid-2016. The survey explored health-seeking behavior, use of healthcare services, out-of-pocket health spending, community contribution to health systems strengthening, and health insurance coverage of households (HHs). This chapter summarizes survey methodology, key findings, and their policy implications.

Survey Methodology

The specific objectives the HA VI HH survey were: to generate evidence and track household health care utilization and spending on different levels and types of health care services and commodities, as well as to estimate community contributions (investment of money, time and other inputs) on strengthening the health system. The HA VI HH survey sampling used the Central Statistical Agency's (CSA) 2007 population census sampling frame, with three-stage stratification of woredas, enumeration areas (EAs) and HHs. Of the total 86,805 EAs available in the country, this survey randomly selected 400 EAs from 101 woredas (4 EAs per woreda). In each EA, twenty-five HHs were selected systematically from a fresh list of households in each EA sampled for study. The EAs were selected and provided to the survey team by CSA.

Key Findings

Health Service Utilization

Of the total sample, 10% of individuals reported being ill in the 4 weeks preceding the survey, which was higher among females (10.8%) than males (9.3%), and in urban settings (11.1%) than in rural areas (9.9%). About 53% of individuals who reported being ill reported visiting a health facility to seek care, a lower figure than what was reported by NHA5 survey (62.4%), which could be due seasonal differences between the two surveys. Of those seeking care, half of those individuals mentioned infectious or communicable disease as the reason for seeking care, mainly due to malaria (11.1%), pneumonia (9.3%) and diarrhea (8.7%). Non-communicable diseases (NCDs) were cited as a reason for seeking care by 10% of individuals who sought care. There was significant variation among regions in seeking care for an illness: the lowest rate was observed in Amhara, where 39% of those reporting illness had sought care, and the highest rate was in Harari, where 79.5% of those reporting illnesses had sought care. A relatively low level of care seeking was reported by the previous NHA as well as at least one other study. Individuals in the lowest wealth quintile were slightly more likely to report experiencing illness, but they were less likely to report having sought care. The survey documented a clear positive association between economic status and healthcare seeking behavior, as well as a positive association between age and reported incidence of illness, for both males and females. Eleven percent of respondents reported having at least one chronic condition, such as cancer, diabetes, kidney diseases or a mental disorder.

Government healthcare facilities provided the majority of outpatient services (75% of outpatient services nationally, 77% in rural areas, and 63% in urban areas); and for individuals living in the poorest quintile households (80%). Government facilities accounted for a lower percentage of outpatient services provided to the richest quintile households (62%). Proximity of a health facility to a patients home was the main reason for people choosing the outpatient healthcare provider they visited (50%), followed by availability of medicines (8.5%), good counseling by health workers (7.3%), short waiting time (5.5%), qualification of staff (5.3%), and whether the facility accepted patients in the waiver system (5.4%). The majority (73.4%) of outpatient visits were made to the nearest facility, while the remaining outpatient visitors bypassed the nearest facility. The main reason for bypassing was the perception that quality of care at the nearest health facilities was too low - 50% of individuals who bypassed nearest facilities cited either lack of drugs or qualified staff as the reason for bypassing. About 88% of outpatient visitors reported that they were satisfied with the health services they received from the health facilities they visited. The highest rate of

satisfaction (92%) was reported for the 'time spent with the clinician' while the lowest rate of satisfaction (78%) was cited for 'availability of diagnostic facility'. About 93% of outpatient visitors reported that they had completed their prescribed treatments.

The inpatient admission rate was estimated to be 1.1% of the population in the 12 months preceding the survey, which was higher among females (1.2%) than males (1.0%), for individuals living in urban (1.7%) than those living in rural areas (1.0%), and for patients from the richest households (1.7%) than those living in the poorest households (1.0%). The common causes for inpatient admission were reported to be diseases of the respiratory tract, including pneumonia (8.7%), followed by malaria (6.1%), intestinal infections (5.7%) and diarrhea (5.5%). Non-communicable diseases and mental illnesses accounted for 13.9% of all causes of inpatient admissions.

Government healthcare facilities (government hospitals and health centers) accounted for 80.1% of the total inpatient services, while private health facilities provided 18% of inpatient services, and non-governmental organization NGO health facilities were responsible for the remaining 2%. Individuals living in the richest households were about four times more likely to use private hospitals and about five times less likely to use government health centers or NGO hospitals compared with their counterparts living in the poorest households. Individuals living in rural areas predominantly use the government hospitals, followed by government health centers and private clinics. The main reasons reported for choosing the inpatient health service providers visited were proximity of the facility to one's home (25.7%), availability of medicines (15.3%), provision of exempted services (11.1%), presence of qualified staff (9.8%), and less waiting time (9.1%). However, of those who used inpatient services, 46.3% bypassed the nearest health facility to their homes to seek health care at another health facility. The main reasons for bypassing the closest inpatient facility was unavailability of medicines (29.0%), lack of bed (19.1%) and lack of qualified staff (18.9%). Of the individuals admitted to inpatient health facilities, 88.3% reported that they were satisfied with the inpatient health services received. Overall, each aspect of inpatient care was rated as 'good' or 'very good' by at least 80% of inpatient service users, with the exception of 'food quality', which was rated as 'good' or 'very good' by about 70% of inpatient users.

Healthcare Expenditure

The estimated HH contribution to health spending was about 21.7 billion Ethiopian birr (ETB) – of which 18.2 billion ETB was in the form of out-of-pocket (OOP) payments, 2.87 billion ETB was in the form of community contribution to health system strengthening (HDA and malaria control activities), and another 620 million ETB was for premium contributions to insurance. Of the total OOP payments on health, 17.5 billion ETB was for outpatient services, and the remaining 711.6 million ETB was for the inpatient services. The total per capita out of pocket spending for health was estimated to be 231 ETB, of which 222 ETB (96%) was for outpatient services, while 9 ETB was for inpatient services. The estimated total OOP spending has increased by 78% compared with the HA V household survey (2010/11). There is significant variation among regions in the per capita outpatient and inpatient OOP expenditures. Oromia and Addis Ababa spent significantly higher than the national average, with 482 ETB and 460 ETB per capita OOP respectively. The average per capita OOP is higher for urban areas (355 ETB) compared to the rural areas (200 ETB). An analysis of OOP spending by expenditure quintiles show that average per capita OOPs increase as one goes from lower to higher income quintiles (Q1 162.5 ETB, Q2 227.7 ETB, Q3 236.3 ETB, Q4 161 ETB and Q5 372.7 ETB), with the exception of the second richest quintile (Q4).

In terms of type of expenditures, 70% of the total OOP was spent on direct health services (drugs, diagnostics), while 23% was for other health-related service costs such as transportation and bed/accommodation and food; the remaining 7% were not specified. Of the direct health service payments, 45% of the total OOP were incurred for drugs and medical supplies followed by diagnostics and investigation (16%) and consultation costs (9%). Treatment for infections and parasitic diseases accounted for 36% of total OOP expenditure, followed by treatment of non-communicable diseases, which accounted for 23% of total OOP expenditure. Preventive and promotive services accounted for only 7% of the total HH OOP spending, while injuries and nutrition supplements took a share of 3% and 1% of HH OOP respectively. Households were not able to classify 30% of their OOP spending into specific services. The survey documented that about 55% of the total OOP health spending was financed through individuals or families own cash

on-hand, while 35% of OOP came from assistance from friends/family members; 6% from selling livestock and/or cereals and another 4% from borrowing from friends and the community.

Community Contribution to Health Systems Strengthening

The success of the Ethiopian health system in meeting some of the global health goals and targets has been explained by the strategy of ensuring that communities produce their own health through the health extension program (HEP) and the associated health development army (HDA). Community members contribute time and labor to strengthen the implementation of the different health extension packages. Overall, 90% of households in the survey had at least one member of the household participating in HDA. About 39% of households were involved in Long-Lasting Treated Insecticide Nets (LLTIN) distribution, Indoor Residual Spray (IRS) operations, pond drainage and/or awareness creation about controlling malaria epidemics.

Community contribution to health was estimated by converting labor and/or other in-kind contributions into cash using the local input prices. Total community contribution to health system strengthening was estimated at 2.87[1] billion ETB for 2015/16, about 36 ETB per capita. Of this, about 55%, or 19.86 ETB per capita was contributed through the health development army (HDA) and the remaining 45% was contributed through the malaria control program. Communities also contributed an estimated 75 million ETB in the form of in-kind contribution of culturally acceptable food to encourage institutional delivery. When the different components of the HDA are explored, regular meetings among HDA members account for about 40% of the HDAs contribution; followed by environmental management activities (excluding malaria), which accounts for 27% of their contribution. Community contribution in promoting institutional and safe delivery in the form of mothers' conferences and in-kind cereal contribution accounted for about 23% of the total community contributions. Analysis of how community members spend their time on malaria control activities showed that pond drainage accounted for about 41% of time spent, while awareness creation and distribution of LLTIN took 31% and 20% of the time/money spent, respectively.

Health Insurance Coverage

This survey documented that 7.4% of the country's population was covered by health insurance in 2015/16. Community based health insurance (CBHI) was the dominant type of health insurance, constituting 96% of the total health insurance coverage. Farmers constituted 86% of the total households insured. The poorest quintile (Q1) and richest quintile (Q5) households have a smaller share of the total population insured, while Q2, Q3 and Q4 wealth quintiles have either proportional or higher shares of the total population insured. The low insurance coverage among the lowest quintile may be attributed to lack of income to pay for insurance premium (membership contribution), and inadequate government's support for the indigent, while people in the richest quintile may not be buying coverage as they may be able to pay out-of-pocket, or may seek care from private providers that are not included in the CBHI scheme. Most of the insured population (69%) reported that their insurance covered both outpatient and inpatient health services. On the other hand, about 10% of members reported perceived that their insurance covered only outpatient services, while 1.3% thought their insurance covered only inpatient services. The remaining 18% of insured households didn't know the types of health services covered by their insurance, which indicates the need to strengthen communication efforts to increase awareness of insurance coverage.

The average household contribution per insured household for insurance was 38.50 ETB per month, and about 86.5% of insured households contribute less than 50 ETB per month. The main source of payment for insurance among the insured was 'household head' (91.6%) followed by 'employer' (4.92%) and 'government' (2.5%), for indigents. About 11.7% of households that have insurance coverage reported having made OOP payments for health services that are not covered in their specific health insurance scheme, while 80% of the insured didn't pay additional OOP payments, implying that these households were financially protected and were not exposed to catastrophic health expenditure. The total health expenditure among the insured population during the year was 723.3 million ETB. Of this, 620 million

[1] The manual labor contribution in HDA in terms of hours per week was collected for each household and the local wage rate was also collected. The time spent on community work and local wage were used to estimate the value of the contribution in terms of money.

ETB (85.8%) was health insurance expenditure for their premium contributions, while the remaining 102 million ETB (14.2%) was spent in the form of OOP. However, the share of health insurance expenditure/premium to total OOP health expenditure was only 3% (i.e. 3% of total OOP was spent on insurance premiums); which indicates the need to increase coverage of health insurance and its share in the total health expenditure through expanding the existing pre-payment schemes.

Policy Implications

1. This survey documented the existence of significant inter- and intra-regional as well as income or wealth-related variations in utilization of outpatient and inpatient services. This reconfirms the importance of prioritizing equity as a transformational agenda. Given the variation in healthcare utilization among and within regions and among wealth quintiles, there is a need to explore in detail the drivers of these variations and chart out context-specific actions.

2. NCDs have become a visible reason for people to seek health care services, even more than reported in the previous survey in 2010/11. It is therefore important to chart out mechanisms of working with the community on how they can protect themselves from this burden by formulating appropriate health promotion and protection interventions. The lessons and best practices of reducing the burden of communicable diseases by the health extension program can be used to chart out how to move forward in this regard.

3. Government health facilities remain not only the major providers of care in Ethiopia (78% of outpatient and 80% of inpatient services), but also the main outlets through which the very poor, by and large, receive health care. Improving and investing in the quality and readiness of these facilities is likely to be a rational investment for reaching the underserved areas and for enhancing equity.

4. The major reason, next to proximity, for choosing/bypassing the nearest health facility for utilization was reported to be availability/lack of medicines and qualified personnel. Exploring the gaps and challenges, and planning for rational investments to reduce medicines stock out rates and fill positions with qualified staff is likely to more evenly distribute care seeking across facilities. This would reduce the existing burden on some hospitals, and reduce the cost of care born by households by reducing travel cost and time, as well as opportunity cost of traveling to facilities that far from their residence.

5. OOP spending is high and could be one of the major barriers to service utilization. The government's strategy to provide insurance for both formal and informal sectors is likely to help Ethiopia move towards universal health coverage (UHC). However, the expansion of insurance schemes needs close follow up, and regular review of its implementation to ensure that the very poor have adequate protection. The findings of this survey indicate that subsidies to the indigent seem inadequate, which needs to be explored further and addressed.

6. Community contribution to health system strengthening in Ethiopia is significant. Given that this is the first attempt to estimate its monetary value, it may be useful to consider introducing a separate/alternative tool and methodology to subsequent HH surveys to clearly document their contribution and to countercheck the estimates provided by this survey.

7. Investment in improving the readiness of facilities should continue to be the top priority of the health system strengthening efforts, as reinforcement of referral systems and reducing bypassing of the closest facilities could reduce the high OOP spending that is incurred by households.

8. Ethiopia has been undertaking such surveys for the last three rounds of the HAs, including this one. This is costly for future HA related activities. Strengthening the routine health finance information system and enabling it to regularly track facility records on OOP spending by public and private facilities would provide more up-to-date data on OOP health spending more frequently. There is a need to prioritize investing on strengthening the routine health finance information system.

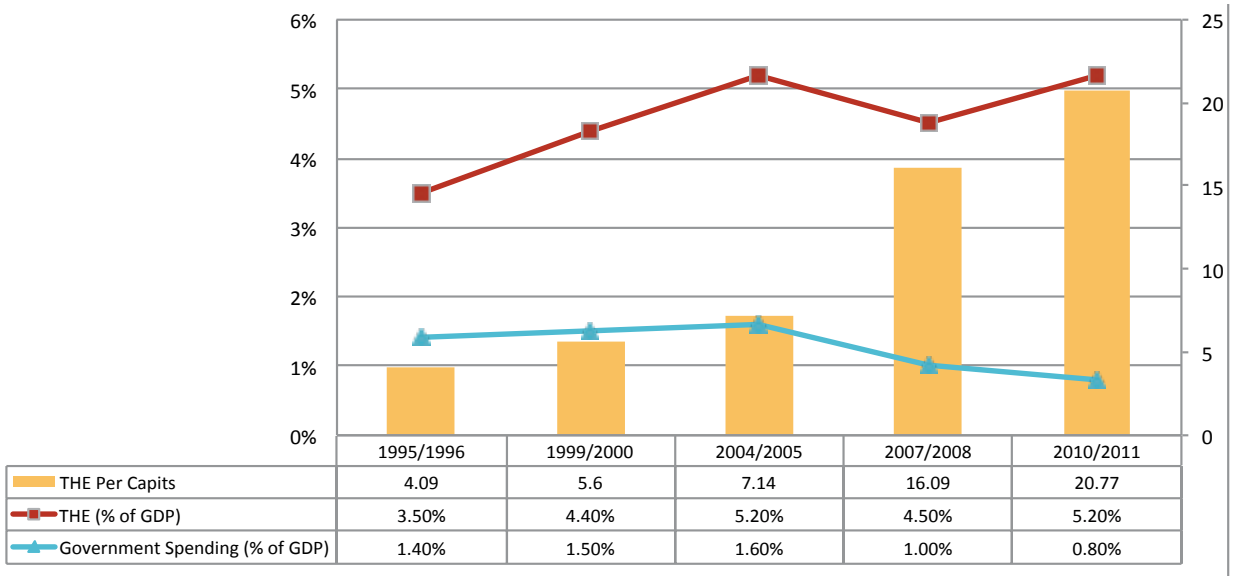
Chapter 1. Introduction and Methodology

1.1 Background

Undertaking Health Accounts (HA) has become a norm in low-income countries. A study of how HA data has been used in 21 low- and middle-income countries gives several examples of good practice on how new data has informed decision-making on how resources are mobilized and managed for the health system, identifying who pays and how much; who provides services, and what resources they use, how health care funds are distributed across the different services, interventions and activities that the health system produces; and who benefits from health care expenditure (De et al., 2003).

Prior to the current HA, the Federal Democratic Republic of Ethiopia Ministry of Health (FDRE MOH) had conducted five HA surveys[1] since 1995/96 to inform its health financing interventions and its health Sector Development and Transformation Plans. The findings of these surveys show that per capita health spending has been rapidly increasing in Ethiopia. Total health expenditure (THE) per capita increased by about 400%, from US$4.09 in 1995/96 to US$20.77 in 2010/11 at current prices. THE as a percentage of gross domestic product (GDP) however increased only from 3.5% in 1995/96 to 5% in 2004/2005, and remained at 5% in 2010/11 (see Figure 1.1).

Figure 1.1 Total Health Expenditure (THE) in Ethiopia, 1995/96 to 2010/11



	1995/1996	1999/2000	2004/2005	2007/2008	2010/2011
THE Per Capits	4.09	5.6	7.14	16.09	20.77
THE (% of GDP)	3.50%	4.40%	5.20%	4.50%	5.20%
Government Spending (% of GDP)	1.40%	1.50%	1.60%	1.00%	0.80%

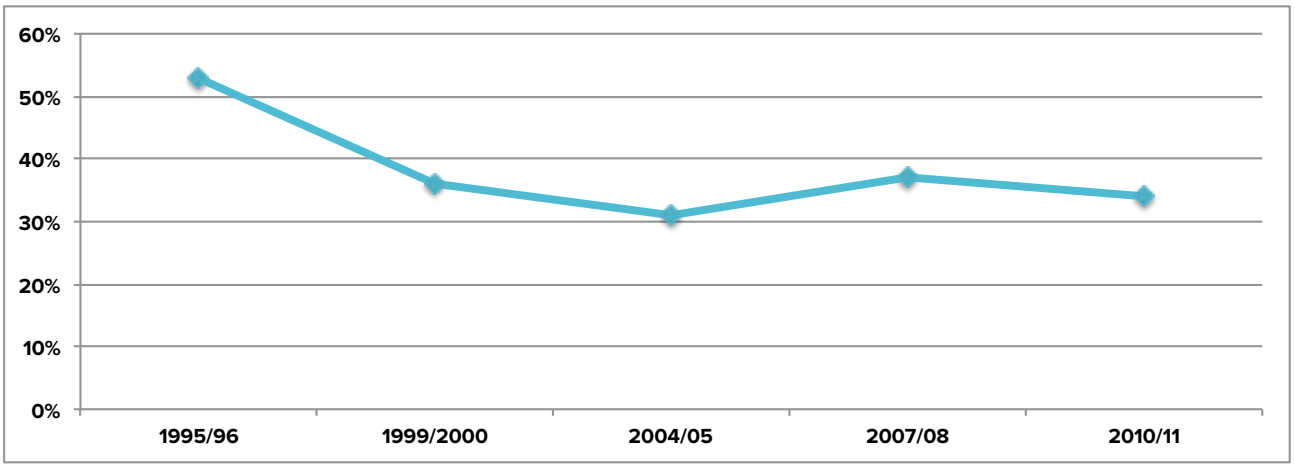
Source: FDRE MOH, NHA study rounds one to five, as documented in health financing review HSPS/BIC 2015 Report

Of this overall health sector spending, out-of-pocket (OOP) payment at the time of seeking care continues to be one of the major sources of financing for health. Direct payment during seeking care is considered as regressive as it inhibits access to health services for the poor. It is also considered to contribute to impoverishment of families due to having to pay for unexpected health care services at the time of illness[2]. In 1995/96, household (HH) OOP health spending accounted for 53% of THE in Ethiopia, which declined, to 34% in 2010/11 (see Figure 1.2).

[1] Five rounds of NHA reports are available, and have informed the health financing policy and strategy making in Ethiopia.

[2] WHO, 2010, health system financing: a path to universal health coverage, where are we now? Page 5.

Figure 1.2 Trends in OOP Spending as a Share of Total Health Expenditure (%)



Source: FMOH, 1996-2011/12 NHA Studies rounds one to five

Ethiopia started undertaking specific household surveys for its HAs in 2007/08 to estimate OOPs and utilization of health care services. The OOP per capita expenditures during HAs 4 (2007/08) and 5 (2010/11) were $7.1 and $ 7.01 per capital[3], respectively.

This current sixth HA household survey adopted tools used by the previous two HH surveys but also incorporated additional questions to address emerging issues in the health sector, such as increased focus on nutrition and accounting for community contributions. Its structure was also aligned with the System of Health Accounts (SHA) 2011 classifications. This survey provided more emphasis on measuring equity, a core goal of the Health Sector Transformation Plan (2015/16-2019/20), including factors such as utilization of health services and OOPs on health among different socioeconomic groups.

1.2 Objectives of the Survey

The purpose of this sixth round HA household survey was to provide reliable evidence on the health service utilization and expenditure, including on nutrition, as well as household contribution to health systems strengthening in Ethiopia.

The specific objectives the HA VI HH survey were:

- **Specific Objective 1:** Generate evidence on households spending (both out of pocket and insurance premiums) on health care by level and types of health care services and major diseases as well as by level of income and other equity features;
- **Specific Objective 2:** Assess health service utilization rates by different socioeconomic characteristics of households and regions;
- **Specific Objective 3:** Generate evidence on specific community contributions (investment of time and other inputs to improve their health at the household level) to strengthen health systems.

[3] FMOH, 2007/08 and 2011/12, National Health Accounts Reports IV and V Reports

1.3 Survey Methodology

The study used a cross-sectional analysis of 9,986 (99.9% of originally planned 10,000) sample households to estimate household health expenditures and utilization. Twenty-five households were randomly selected from the fresh lists done in each EA. Estimating household expenditure requires clarity on what will be measured and estimated following the well-recognized international estimation procedures[4,5]. In this survey, the following issues were taken into account when estimating expenditure on health:

a. **Service and disease categories:** acute illnesses and chronic illnesses, as well as service provisions, were separated and treated differently. The survey questionnaire used the latest internationally accepted SHA 2011 disease classification method.

b. **Hospitalization (inpatient) vs. outpatient care (OPD):** Inpatient and outpatient services were categorized in different sections of the survey and were estimated separately.

c. **Recall period:** This survey used an internationally accepted recall period of 4 weeks for outpatient visits, one year for inpatient services, and four week for community contributions for health systems strengthening.

d. **Types of health expenditure considered:** the health expenditure categories included in this survey can be divided into the following items: registration and consultations, drugs & medicines, diagnostics, hospital stay & related items, and other health related expenditures, including transport to and from the health facility, as well as expenditure of an accompanying person.

1.3.1 Sampling Design

This survey used national sampling frameworks (CSA 2007 sampling frame), which has a total of 86,805 EAs, of which 69,462 are in rural and 17,363 are in urban areas. These EAs are found in 83 zones, 731 woredas including special census woredas, and 16,328 kebeles, of which 1,478 are found in urban and 14,850 in rural areas.

The overall sample size of this survey was set based on its comparability to the previous two HA Household surveys (HA IV and V HH surveys). The sampling allocation of the survey was carried out using a three stage stratified sample procedure, which were:

- **Regional allocation:** Regional distribution of the total sample of households was generated based on the regional distribution of the 2007 population census and the 2016 housing census population projections. A power allocation (of a total of sample size of about 10,000 households) was used to allocate EAs (and 25 HH per EA) to different regions.
- **Rural/urban allocation per region:** once the total regional allocation of EAs were known, the number of rural and urban EAs were determined based on the assumptions that each EA will sample 25 HHs.
- **Selecting of EAs per woreda:** With the assumption that 4 EAs would randomly be selected per sample woreda in each region, a total of 101 woredas were determined. Four EAs were selected from each woreda randomly.

[4] Ravi P. Rannan-Eliya, 2008, National Health Accounts Estimation Methods: Household Out-of-pocket Spending in Private Expenditure; Monograph prepared for WHO/NHA Unit, Geneva, Switzerland.

[5] WHO, 2003, Guide to producing national health accounts: with special applications for low-income and middle-income countries.

The actual selection of EA sites and woredas were carried out by CSA. It provided the data files of the selected EAs, containing information on number of HHs in each EA (according to the 2007 census) as well as EA maps, and the sampling weight that was used to project the findings to regional and national level. Table 1.1 presents the allocation of HH into EAs and woredas in each region.

Table 1.1 Allocation of Sample HHs to Regions, Rural and Urban areas

Region	Total CSA 2016 projected Population (000)	Regional share of SQRT* of population	Total sample HHs**	Population by urban/rural (000)		Urban/rural share of population		Actual Sample HHs		
				Urban	Rural	Urban	Rural	Total	Rural	Urban
Tigray	5152	9%	894	1331	3821	26%	74%	895	670	225
Afar	1769	5%	524	327	1442	18%	82%	525	425	100
Amhara	20770	18%	1795	3492	17278	17%	83%	1799	1501	298
Oromia	34575	23%	2316	5105	29470	15%	85%	2319	1972	347
Somali	5598	9%	932	813	4785	15%	85%	925	276	649
Benishangul Gumuz	1034	4%	400	215	819	21%	79%	400	325	75
SNNP	18719	17%	1704	3018	15701	16%	84%	1699	1424	275
Gambella	422	3%	256	140	282	33%	67%	250	175	75
Harari	240	2%	193	133	107	55%	45%	175	75	100
Addis Ababa	3352	7%	721	3352	0	100%	0%	277	102	175
Dire Dawa	453	3%	265	285	168	63%	37%	722	0	722
Total	**92084**	**100%**	**10,000**	**18,211**	**73,873**	**20%**	**80%**	**9986**	**6945**	**3041**

*SQRT- square Root

**HH-households

1.3.2 Controlling for Sampling and Non-Sampling Errors

Generally there are three types of sampling errors that can occur in these kinds of household surveys: sampling error, recall bias and non-sampling errors. Sampling error refers to the exclusion of some regions, segments of population, or groups from the survey. The second error refers to the recall bias of respondents; the inability to accurately remember the details of the services received, their cost, and their timing. Non-sampling error refers to "not asking the right questions" and "not getting what is required" during the survey. The survey tried to put in place mechanisms to reduce these inherent errors.

- The three stage sampling procedure described above was used to minimize sampling errors. However, one of the possible omissions is the exclusion of people that live in institutions - hospitals, nursing homes and prisons. In the Ethiopian context, these groups are few and do not directly pay for their health service they receive.
- The survey used internationally accepted recall periods, which varied by what was being asked. However, there could still be some errors in responses due to seasonality of some of the services and expenditures, like malaria.
- The survey limited the non-sampling errors by employing a number of measures. It used the internally accepted HA HH questionnaire that was previously used twice in Ethiopia. It was

revised to fit the purpose and was agreed to by stakeholders before training of data collection, to ensure that the right questions were asked in the right way. The recruitment of the data collectors was made based on adequate experience in collecting large sample data sets, ability to read cartographic map of EAs, prior experience with electronic data collection, and knowledge of the local languages and culture. Data collectors were trained for 8 days to create a good understanding of the objectives of the survey and the content of the questionnaire, to ensure that data collectors generated what was required.

1.4 Survey Organization

1.4.1 Management Structure of the Survey

Three Work Groups (WGs) were established carry out this HA general household survey, each responsible for different functions in carrying out the survey. The team leader received guidance and oversight from the HA technical working group. The principal investigators led the development of the questionnaire and drafting of the report. The survey manager, supported by both the principal investigators and statistician, led the field operations.

1.4.2 Revision of the HH survey questionnaire

The main instrument for the survey data collection was a structured HH survey questionnaire. This questionnaire was benchmarked from international practice and was also revised from its two previous rounds to fit to the current Ethiopian context and survey objectives. The HA TWG reviewed the revised questionnaire and provided valuable comments. After reviewing the changes made, the HA TWG approved the revised questionnaire for use. The survey questionnaire was further updated based on the feedback generated from enumerators and supervisors during training and pre-test findings. Finally, it was then converted into CAPI format for the actual data collection, and translated from English into five languages: Afar, Amharic, Oromiffa, Somali and Tigrigna.

The primary respondent of this survey was the head of household, on behalf of all his or her family members, or in his or her absence, any adult member who could answer for each member of the household. This survey did not interview young adults below 18 years. The major content of the standardized interview tool for household is summarized in table 1.2.

Table 1.2 Major Contents of the Health Accounts 6th General Household Survey Questionnaire

Section of the Questionnaire	Units Covered
General information about t he household and it s members	Per household member
Utilization of outpatient and other health related services in the past four weeks	Per Household member
Routine health expenses, including community contributions to health systems	Per household member
In-patient admission in the last one year	Per household member
Mortality	Per household member
Access to and use of health insurance	Per household member
Household conditions and household Assets	Per household
Household Expenditure	Per household
Household Income	Per household

1.4.3 Selection and training of enumerators and data collectors and pretesting the questionnaire

Enumerators and supervisors for this survey were selected based on their experience working on previous surveys. The Ethiopian Economic Association and CSA during the recruitment of the enumerators and supervisors were consulted to ensure that they were skilled, credible and trust worthy. The members of the field team were recruited mainly based on the advice and recommendation of CSA, based on their track record of commitment and use of electronic data collection methods. A Total of 109 enumerators, 22 supervisors and 8 regional coordinators were recruited. The field teams were trained for eight days on data collection tools and processes by the survey team and EPHI, including on:

- Data collection processes, procedures and ethics;
- General training related to basic interview techniques;
- Special sessions on the content of the questionnaire and how to fill it out;
- Working together as a team on mock interviews;
- On the software program, CAPI, and on how to use the tablets;
- On how to transfer the collected information to the IFSS and link with EPHI for comments and revisions;
- Field practice conducted during the pretesting exercise.

Pre-test of the household survey questionnaire was conducted in three regions: in Woreda 7 of Addis Ababa, Gimbichu woreda of Oromia and Chacha woreda of Amhara. The pretest helped to revise survey questionnaire, as well as the CAPI, before deployment. The revised CAPI was re-tested in Addis Ababa.

1.4.4 Data Collection, Processing and Method of Analysis

Data Collection Instruments

Face-to-face interview method was used in collecting the data. The questionnaire was transferred into CSPro programming in the five local languages, plus English, and was loaded into tablets (HP Stream 8 and Nokia Lumia tablets with 3G capability) and mini laptops that were used to electronically enter the data at the time of the interview. Paper instruments (hard-copies) were used to serve only as a back up when the tablets/mini computers failed, which were rare in this survey. The devices were equipped with SIM cards and/or were Wi-Fi-capable, and EPHI's IFSS was used by the team to digitally transfer the data to a central server as soon as Internet connection was available to the enumerators.

1.4.5 Data Quality Control

Enumerators' and Supervisors' Manuals were developed and used to monitor data quality. Field personnel were trained in the required techniques of HA sample surveys. The ratio of supervisors to enumerators was kept to the minimum (one to five) to ensure that there was adequate supervision during data collection. HA technical working group (TWG) members and EPHI were also involved in monitoring the quality of data collection.

The EPHI's previous experience was used to ensure maximum data quality in two ways. The first one involved "close of business day" review and rework processes while in the field, while the second type of effort was a batch data cleanup exercise. EPHI staff helped the team to verify the consistency and completeness of the data entered in the tablets daily

during data collection. The team regularly checked the quality of data and communicated back to the enumerators whenever data quality issues were identified, preferably before leaving the EA. Supervisors and enumerators were able to adjust and correct these issues while still in the field. Fenot and BIC team members were deployed to check the quality of data collection process in Dire Dawa, Oromia, Addis Ababa, and Amhara regions. The EPHI team observed the data collection process in Amhara and Tigray regions.

1.4.6 Analysis

To allow for the comparability of results with previous surveys, standard weighting procedures were used similar to those used in HA IV and V HH surveys. Design weights were adjusted for non-response at EA and household levels. All household members captured in the household questionnaire were assigned the same household weight. All individuals within a cluster who participated in the survey were assigned the same cluster-specific weights for individual interviews.

The data analysts, in conjunction with the report writing team, developed the tabulation plans for the key indicators used in this report. The tabulations were generated using STATA© software. The outputs were then exported to Microsoft Excel© worksheets for formatting and eventual use.

The principal component analysis technique was used for weighting averages of the assets to construct a wealth index (Filmer and Princhett 2001). A wealth index was used as the first principal component of the variables used (see annex 5) to categorize individuals to different wealth quintiles. Service utilization and out-of-pocket spending of households were categorized into five wealth quintiles: Poorest (Q1), second poorest (Q2), middle (Q3), fourth richest (Q4), and richest (Q5). Household spending for outpatient care was requested only for the last four-week period, and this was converted to an annual cost by multiplying the reported spending by 12. Inpatient expenditures were requested for the last year preceding the survey, and were taken as is. Community contribution to health was calculated by estimating the number hours HDA members reported spending per week, and this was multiplied by 52 and divided by 8 (a day with 8 working hours) to generate the number of days spent per year. Local wage rates were collected during the survey and used to convert the yearly number of days spent by the HDA into monetary terms.

1.5 Limitations of the Survey

While every effort was made to control the quality of the survey, this survey has also its limitations. About 14 households of the proposed sample households were not available or had to be replaced, and the total HHs surveyed for this survey was 9,986. One of the limitations of this survey was its inability to capture the seasonality of some of the health service utilization and associated variation in spending. The sample did not take into account institutional based people like those who stay in hospitals, nursing homes and prisons. The population projected from the CSA sampling frame for this survey was 78.8 million for the year EFY 2008. However, the EFY 2008 projection from the EFY 2000 Ethiopian census was higher. CSA's enumeration areas (EA's) are intented to have a population of about 180 households. However, some of the EAs sampled had populations of less than one hundred, and many had a population of less that 150. As a result, when the sample was projected to the population that they represent, the projection fell short of the CSA's projected population size from the census. This difference in population estimates may have resulted in underestimation of the total out of pocket spending, but does not have an impact on per capita spending.

Chapter 2. Demographic and Socioeconomic Characteristics

2.1 Sex composition and age

The sampled/surveyed households/individuals were projected to the population based on the CSA-provided sample weight for each enumeration area, and all discussion under this section is based on the total population represented by this survey. The number of persons represented by this survey is about 78.8 million[6], of which females account for 49.9%. The age profile reveals that a little over 50% of the population is of working age. About 48.8% of the total population is considered a dependent, which means, on average, for nearly every working age individual, there is one non-working individual. Disaggregating dependents by those who are children and those who are elderly, 46.03% of dependents are those whose age is less than 15, while 2.8% of the total population is above 65 years.

Table 2.1 Sex Composition and Age of Individuals by Region (%)

Region	Sex of Individuals				Age of Individuals (years)						Total Individuals	
	Male		Female		Less than 15		15-65		Greater than 65			
	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%	Frequency	%
Tigray	2,198,473	5.87	2,315,350	6.22	1,924,316	5.6	2,360,975	6.2	228,532	11.0	4,513,823	6.0
Afar	382,459	1.02	346,366	0.93	337,803	1.0	386,875	1.0	4,147	0.2	728,825	0.98
Amhara	8,401,127	22.45	8,236,639	22.11	7,008,295	20.4	9,039,813	23.6	589,658	28.3	16,637,766	22.3
Oromia	14,761,588	39.44	14,373,967	38.59	14,617,067	42.5	13,856,951	36.2	664,743	31.9	29,138,761	39.0
Somali	1,139,309	3.04	1,078,918	2.9	1,220,448	3.6	941,835	2.5	56,792	2.7	2,219,075	2.97
B. Gumuz	445,449	1.19	426,334	1.14	362,403	1.0	484,389	1.3	24,991	1.2	871,783	1.17
SNNP	6,960,560	18.6	6,883,228	18.48	6,748,577	19.6	6,824,295	17.8	270,916	13.0	13,843,788	18.5
Gambella	167,281	0.45	164,860	0.44	125,394	0.36	203,491	0.5	3,256	0.2	332,141	0.44
Harari	302,578	0.81	285,438	0.77	271,326	0.8	300,461	0.8	16,229	0.8	588,016	0.79
A. Ababa	2,142,051	5.72	2,627,052	7.05	1,246,898	3.6	3,318,409	8.7	205,948	9.9	4,771,255	6.39
D. Dawa	523,624	1.4	508,066	1.36	513,273	1.5	504,595	1.3	15,538	0.7	1,033,406	1.38
Total	**37,424,499**	**100**	**37,246,218**	**100**	**34,375,800**	**100**	**38,222,089**	**100**	**2,080,750**	**100**	**74,678,639**	**100**
Rural	**32,199,157**	**86.04**	**31,263,664**	**83.94**							**63,467,743**	**85**
Urban	**5,225,342**	**13.96**	**5,982,554**	**16.06**							**11,210,896**	**15**

[6] CSA's enumeration areas (EA's) are intented to have a population of about 180 households. However, some of the EAs sampled had populations of less than one hundred, and many had a population of less that 150. As a result, when the sample was projected to the population that they represent, the projection fell short of the CSA's projected population size from the census.

As can be observed from Table 2.1, about 85% of the total population (represented by this survey) are rural residents. The sex composition does not have significant difference. While 16.06% of the total female population in the country lives in urban areas, only 13.96% of the total male population lives in urban areas.

Table 2.2 Age Categories by Region (%)

Region	Less than 15		15-65		Greater than 65		Total %
	Frequency	%	Frequency	%	Frequency	%	
Tigray	1,924,316	42.6	2,360,975	52.3	228,532	5.1	100
Afar	337,803	46.3	386,875	53.1	4,147	0.6	100
Amhara	7,008,295	42.1	9,039,813	54.3	589,658	3.5	100
Oromia	14,617,067	50.2	13,856,951	47.6	664,743	2.3	100
Somali	1,220,448	55.0	941,835	42.4	56,792	2.6	100
Benishangul Gumuz	362,403	41.6	484,389	55.6	24,991	2.9	100
SNNP	6,748,577	48.7	6,824,295	49.3	270,916	2.0	100
Gambella	125,394	37.8	203,491	61.3	3,256	1.0	100
Harari	271,326	46.1	300,461	51.1	16,229	2.8	100
A. Ababa	1,246,898	26.1	3,318,409	69.6	205,948	4.3	100
D. Dawa	513,273	49.7	504,595	48.8	15,538	1.5	100
Total	**34,375,800**	**46.0**	**38,222,089**	**51.2**	**2,080,750**	**2.8**	**100**

The countrywide demographic distribution shows that 51.2% is in the working age group, aged between 15 and 65. This indicates that nearly there is one dependent for one working age person. Addis Ababa is exception in this regard. About 69.6% of the population is in the working age. Next to Addis Ababa is Gambella which has 61.3% of the population in the working age group. On the other side, Ethiopian Somali region has only 42.4% of its population aged between 15 and 65. This means the dependency ratio among Somali residents is higher than any other region. There is more than one person (about 1.4) dependent for one working age person.

2.2 Religion

The most common religion practiced in the country is Christianity, which accounts for 68.39% of the population. The second most prevalent religion practiced is Islam, which accounts for 30.7% of the population. The majority of Christians follow Orthodox Christianity (47.2% of the population), while Protestants account for 19.6% of population and 0.3% of the population are Catholics. Afar, Somali, and Harari regional states and Dire Dawa city administration are predominantly Muslim. Residents in Amhara and Tigray regional states and Addis Ababa city administration are predominantly Orthodox Christian-more than three-fourth of the population in these areas. Protestants account for more than half of the residents in SNNP and Gambella regional states (see Table 2.3).

Table 2.3 Religion of Individuals by Region and Residence (%)

Region		Christian			Muslim	Others	Total
		Orthodox	Catholic	Protestant			
Tigray	Frequency	3,731,647	29,368	281,587	710,475	16,026	4,769,103
	%	78.25	0.62	5.9	14.9	0.3	100.01
Afar	Frequency	31,874	0	24,807	660,442	11,702	728,825
	%	4.37	0	3.4	90.62	1.6	100
Amhara	Frequency	14,347,523	6,941	3,400	2,263,934	15,968	16,637,766
	%	86.23	0.04	0.02	13.61	0.1	100
Oromia	Frequency	8,610,264	60,983	6,678,911	13,117,931	667,466	29,135,555
	%	29.55	0.21	22.92	45.02	2.3	100
Somali	Frequency	30,100.00	1,974.00	11,792.00	2,164,936	9,312	2,218,227
	%	1.36	0.09	0.53	97.6	0.4	100
B. Gumuz	Frequency	422,740	4,080	50,589	392,616	1,758	871,783
	%	48.49	0.47	5.8	45.04	0.2	100
SNNP	Frequency	3,461,715	68,009	7,356,990	1,997,519	959,555	13,843,788
	%	25.01	0.49	53.14	14.43	6.9	100
Gambella	Frequency	114,529	6,733	171,554	35,731	3,594	332,141
	%	34.48	2.03	51.65	10.76	1.1	100
Harari	Frequency	131,952	790	28,805	425,603	866	588,016
	%	22.44	0.13	4.9	72.38	0.1	100
A. Ababa	Frequency	3,731,647	29,368	281,587	710,475	16,026	4,769,103
	%	78.25	0.62	5.9	14.9	0.3	100
D. Dawa	Frequency	98,774	1,030	9,017	919,011	3,858	1,031,690
	%	9.57	0.1	0.87	89.08	0.4	100
Total	**Frequency**	**35,266,892**	**197,232**	**14,619,030**	**22,896,191**	**1,691,372**	**74,670,717**
	%	**47.23**	**0.26**	**19.58**	**30.66**	**2.3**	**100**
Rural	Frequency	28,668,844	137,542	13,614,033	19,401,102	1,641,300	63,462,821
	%	45.17	0.22	21.45	30.57	2.59	100
Urban	Frequency	6,598,048	59,690	1,004,997	3,495,089	50,072	11,207,896
	%	58.87	0.53	8.97	31.18	0.45	100

Religion by residence reveals important features. The majority of urban dwellers are Orthodox Christians (59%), whereas Orthodox Christians compose as smaller proportion of the rural population (45%). Protestants are much more likely to reside in rural areas, where they compose 21.5% of the rural population (compared to only 9% of the urban population). Muslims are fairly equally distributed between rural and urban areas, with 30.6% of the rural population being Muslim, and 31.2% of the urban population being Muslim (see Table 2.3).

2.3 Marital Status

Of the total sampled population aged 15 and above, 57.1% are currently married to one husband/wife (table 2.4). About 31.7% of the population 15 year and older have never married. However, there are regional differences in marital status. The proportion of married persons in Afar is higher than any other regions (73.8%), while Addis Ababa has the lowest proportion of married adults (42.0%). This difference might be because people in rural areas are more likely to be married at younger ages than people in urban areas. Indeed, a larger proportion of never married are found in Addis Ababa (44.4%). Men marrying more than one wife is most common in Somali region (6.3%), followed by SNNP region (3.7%). While divorce rates are generally low, divorce is highest in Tigray (7.5%) followed by Amhara (6.2%). Being a window is more common in Harari (8.8%) followed by Tigray (7.9%), Addis Ababa (7.2%) and Dire Dawa (7%).

Table 2.4 Marital Status by Region and Residence - Aged 15 Years and Above (%)

Region		Never Married	Married one wife / husband	Married with two or more wives	Lives with a partner	Divorced	Widowed	Separated	Don't know	Total
Tigray	Frequency	844,971	1,400,071	7,635	3,982	201,963	211,871	20,099	0	2,690,592
	%	31.4	52.0	0.3	0.2	7.5	7.9	0.8	0.0	100
Afar	Frequency	73,162	298,942	2,312	0	8,237	21,167	1,430	0	405,250
	%	18.1	73.8	0.6	0.0	2.0	5.2	0.4	0.0	100
Amhara	Frequency	2,959,029	5,971,270	89,921	7,036	631,791	487,764	60,182	3,731	10,210,724
	%	29.0	58.5	0.9	0.1	6.2	4.8	0.6	0.0	100
Oromia	Frequency	4,957,850	8,990,646	323,385	4,248	250,241	678,574	131,841	7,229	15,344,014
		32.3	58.6	2.1	0.0	1.6	4.4	0.9	0.1	100
Somali	Frequency	322,269	591,881	66,467	0	21,134	53,341	6,324	400	1,061,816
	%	30.4	55.7	6.3	0.0	2.0	5.0	0.6	0.0	100
B.Gumuz	Frequency	166,142	314,738	12,268	220	23,022	17,793	1,020	0	535,203
	%	31.0	58.8	2.3	0.0	4.3	3.3	0.2	0.0	100
SNNP	Frequency	2,272,390	4,532,128	281,198	0	70,513	396,476	28,024	0	7,580,729
	%	30.0	59.8	3.7	0.0	0.9	5.2	0.4	0.0	100
Gambella	Frequency	72,078	118,825	1,281	0	9,579	14,532	841	0	217,136
	%	33.2	54.7	0.6	0.0	4.4	6.7	0.4	0.0	100
Harari	Frequency	88,183	195,300	7,052	0	13,933	29,647	3,102	0	337,217
	%	26.2	57.9	2.1	0.0	4.1	8.8	0.9	0.0	100
A. Ababa	Frequency	1,603,099	1,519,133	823	2,152	174,774	259,964	54,197	0	3,614,142
	%	44.4	42.0	0.0	0.1	4.8	7.2	1.5	0.0	100
D. Dawa	Frequency	139,826	339,821	2,891	1,175	17,837	38,646	9,399	1,175	550,770
	%	25.4	61.7	0.5	0.2	3.2	7.0	1.7	0.2	100
Total	**Frequency**	**13,498,999**	**24,272,755**	**795,233**	**18,813**	**1,423,024**	**2,209,775**	**316,459**	**12,535**	**42,547,593**
	%	**31.7**	**57.1**	**1.9**	**0.0**	**3.3**	**5.2**	**0.7**	**0.0**	**100.0**
Rural	Frequency	10,337,393	20,712,278	729,811	13,331	1,068,569	1,676,572	205,721	12,135	34,755,810
	%	29.7	59.6	2.1	0.0	3.1	4.8	0.6	0.0	100
Urban	Frequency	3,161,606	3,560,477	65,422	5,482	354,455	533,203	110,738	400	7,791,783
	%	40.6	45.7	0.8	0.1	4.6	6.8	1.4	0.0	100.0

2.4 Educational Status

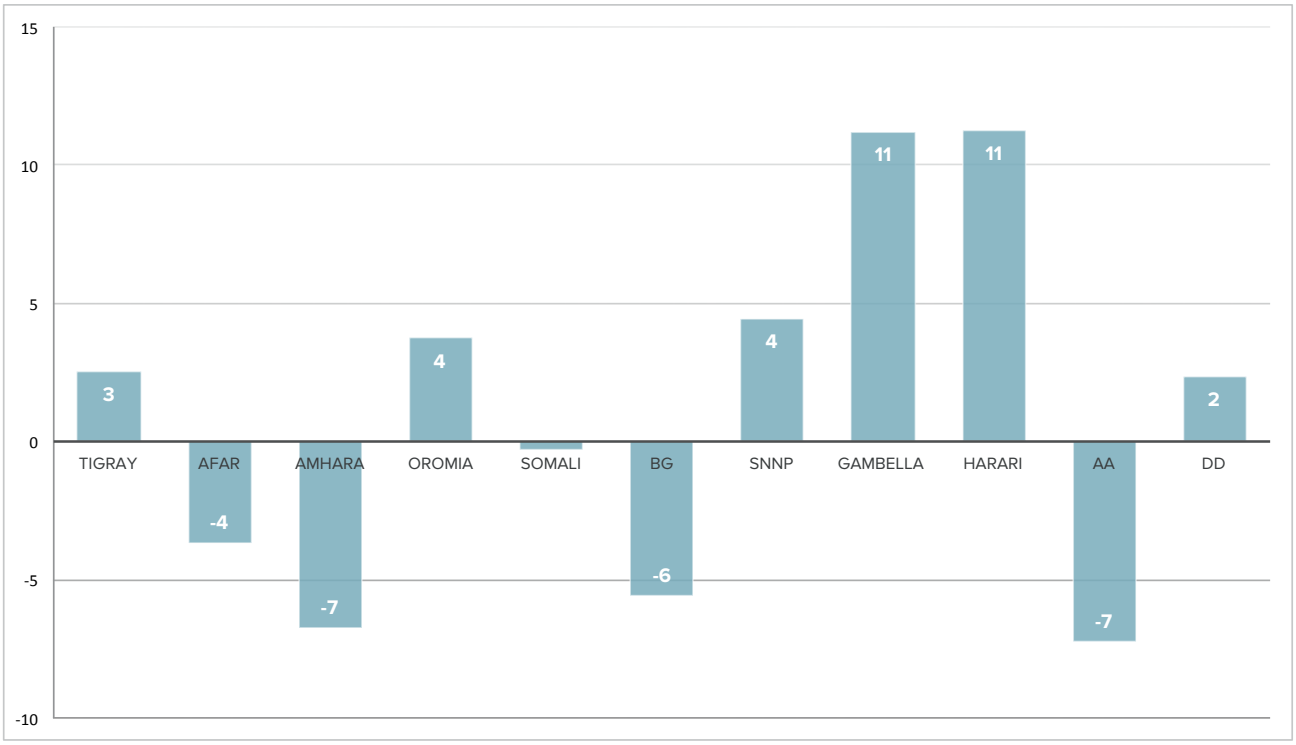
Sampled households were asked about the educational status of each individual whose age was seven years and above. From the population this survey represents, more than half (55%) of the individuals whose age is seven and above had no formal and informal education. This is worse for women (71%) as compared with men (50%). About 2% of the population aged 7 or more went through adult education while 18% and 5% are primary school incomplete and complete respectively. Nationally, 4.9% completed secondary education, and 6% completed university, college, or receive a technical diploma.

Table 2.5 Highest Educational Attainment of Individuals by Sex, Age 7 Years and Above

Highest grade completed	Male	Female	National
No formal or informal education	50.44%	71.47%	55.12%
Adult education	2.25%	1.04%	1.98%
Church/Mosque	2.69%	0.05%	2.10%
Pre-Primary	0.62%	0.18%	0.52%
Primary education incomplete	20.64%	9.98%	18.28%
Primary education complete	5.65%	3.31%	5.13%
Secondary education incomplete	4.84%	3.45%	4.53%
Secondary education (grade 10/12) complete	5.14%	4.08%	4.91%
Tech/Vocational certificate	0.69%	1.27%	0.81%
University /College/Technical diploma	4.39%	4.22%	4.35%
University /college degree or higher	2.44%	0.95%	2.11%
Don't know	0.21%	0.00%	0.16%
Total	**100.00%**	**100.00%**	**100.00%**
Can read and write	Male	Female	National
Yes	52.04%	29.84%	47.13%
No	47.88%	70.11%	52.80%
Don't know	0.08%	0.05%	0.07%
Total	**100.00%**	**100.00%**	**100.00%**

As might be expected, secondary education, and any education beyond secondary level is more commonly observed in urban areas. Urban populations are much more likely to have completed secondary education and received diplomas from higher learning institutions (see Table 2.5).

Figure 2.1 Regional Disparity in Primary Education Completed



2.5 Employment and Occupation

Table 2.6 presents information on employment status. About 36.5% of the total working age population were employed in formal or informal jobs outside of the home in the 12 months preceding the survey. A large proportion of the population were currently students (33.7%), 15.9% of the population reported working in the home as housewives or housemaids, and 9.9% reported "other". A small percent of the population reported either seeking work (2.2%) or being retired (1.1%), with those in urban areas more likely to be 'seeking work' than those in rural areas (5.4% and 1.2% respectively). Afar region has the highest rate of those currently working outside the home (53.3%) and Dire Dawa has the lowest rate (28.6%). As the majority of individuals' main occupation is farming (see Table 2.7), the majority of employed persons were self-employed workers. While the dominant occupation in rural area is farming, private sector constitutes dominant type of employment in urban areas (see Table 2.6).

Of those who are employed, either formally or informally, the main occupation is farming (65.3%). Disaggregating employment by rural and urban; farming is the main occupation for rural areas (77.7%) and the private sector is the main occupation in urban areas (51.6%).

Table 2.6 Employment Status of Individuals by Region and Residence (%)

Region		Currently Working (formal/ informal employment)	Seeking work	Retired	Housewife/ Housemaid	Student	Others	Don't Know	Total
Tigray	Frequency	1,336,738	140,310	81,666	684,450	1,277,444	339,943	27,811	3,888,362
	%	34.38	3.61	2.10	17.60	32.85	8.74	0.72	100
Afar	Frequency	317,955	20,279	1,436	93,960	97,182	61,230	4,128	596,170
	%	53.33	3.40	0.24	15.76	16.30	10.27	0.69	100
Amhara	Frequency	6,309,998	248,806	84,171	2,046,647	5,123,171	1,064,451	25,092	14,902,336
	%	42.34	1.67	0.56	13.73	34.38	7.14	0.17	100
Oromia	Frequency	8,890,270	376,345	248,289	3,653,749	8,433,914	3,194,148	182,239	24,978,954
		35.59	1.51	0.99	14.63	33.76	12.79	0.73	100.00
Somali	Frequency	608,804	40,926	34,475	413,322	460,905	269,413	3,746	1,831,591
	%	33.24	2.23	1.88	22.57	25.16	14.71	0.20	100.00
B.Gumuz	Frequency	316,948	8,932	6,913	95,304	294,935	21,183	25,505	769,720
	%	41.18	1.16	0.90	12.38	38.32	2.75	3.31	100
SNNP	Frequency	3,545,175	201,588	56,247	2,289,767	4,377,555	1,262,654	197,782	11,930,768
	%	29.71	1.69	0.47	19.19	36.69	10.58	1.66	100.00
Gambella	Frequency	116,276	6,537	1,147	40,990	106,240	32,206	586	303,982
	%	38.25	2.15	0.38	13.48	34.95	10.59	0.19	100.00
Harari	Frequency	184,132	15,600	21,035	67,192	162,141	34,775	6,041	490,916
	%	37.51	3.18	4.28	13.69	33.03	7.08	1.23	100.00
A. Ababa	Frequency	1,829,846	303,724	176,357	743,172	1,232,324	35,951	3,010	4,324,384
	%	42.31	7.02	4.08	17.19	28.50	0.83	0.07	100
D. Dawa	Frequency	256,217	32,154	5,229	177,454	337,775	81,809	4,838	895,476
	%	28.61	3.59	0.58	19.82	37.72	9.14	0.54	100
Total	**Frequency**	**23,712,359**	**1,395,201**	**716,965**	**10,306,007**	**21,903,586**	**6,397,763**	**480,778**	**64,912,659**
	%	**36.53**	**2.15**	**1.10**	**15.88**	**33.74**	**9.86**	**0.74**	**100.00**
Rural	Frequency	19,795,957	854,305	402,638	8,617,247	18,821,175	5,978,616	454,200	54,924,138
	%	36.04	1.56	0.73	15.69	34.27	10.89	0.83	100.00
Urban	Frequency	3,916,402	540,896	314,327	1,688,760	3,082,411	419,147	26,578	9,988,521
	%	39.21	5.42	3.15	16.91	30.86	4.20	0.27	100.00

Table 2.7: Occupation Status of Individuals by Region and Residence (%)

Region		Farming	Housewife/ Housemaid	Shepherd	Civil Servant	Private sector	Pastoralist	Agro pastoralist	Fishing	Retail and wholesale trade	Not declared	Other (specify)	Don't know	Total
Tigray	Frequency	827,522	8,599	67,318	109,246	192,751	2,186	2,170	0.00	68,222	6,425	50,322	1,977	1,336,738
	%	61.91	0.64	5.04	8.17	14.42	0.16	0.16	0.00	5.10	0.48	3.76	0.15	100
Afar	Frequency	754	11,840	24,477	55,090	32,034	156,002	844	0.00	29,682	0.00	6,601	631	317,955
	%	0.24	3.72	7.70	17.33	10.08	49.06	0.27	0.00	9.34	0.00	2.08	0.20	1000.0
Amhara	Frequency	4,748,144	316,301	580,536	135,277	259,703	5,343	7,188	0.00	193,299	6,310	54,565	3,332	6,309,998
	%	75.25	5.01	9.20	2.14	4.12	0.08	0.11	0.00	3.06	0.10	0.86	0.05	100
Oromia	Frequency	6,838,728	464,327	344,461	237,793	359,988	28,741	8,604	0.00	396,513	21,537	159,150	34,927	8,894,769
		76.88	5.22	3.87	2.67	4.05	0.32	0.10	0.00	4.46	0.24	1.79	0.39	100
Somali	Frequency	78,795	3,980	146,210	40,273	58,527	148,033	70,316	1,075	31,359	4,236	21,781	4,219	608,804
	%	12.94	0.65	24.02	6.62	9.61	24.32	11.55	0.18	5.15	0.70	3.58	0.69	100
B.Gumuz	Frequency	211,301	1,258	5,217	38,115	36,974	0.00	0.00	0.00	21,096	345	2,376	266	316948.00
	%	66.67	0.40	1.65	12.03	11.67	0.00	0.00	0.00	6.66	0.11	0.75	0.08	100
SNNP	Frequency	2,509,033	44,572	119,115	170,688	242,945	78,953	22,904	0.00	298,963	4,616	48,572	4,814	3,545,175
	%	70.77	1.26	3.36	4.81	6.85	2.23	0.65	0.00	8.43	0.13	1.37	0.14	100
Gambella	Frequency	66,356	1,531		16,540	11,079	815	0.00	0.00	11,339	0.00	8,616	0.00	116,276
	%	57.07	1.32		14.22	9.53	0.7	0.00	0.00	9.75	0.00	7.41	0.00	100
Harari	Frequency	67,333	2,268	866	32,307	33,066	0.00	0.00	0.00	39,187	0.00	9,105	0.00	9,105
	%	36.57	1.23	0.47	17.55	17.96	0.00	0.00	0.00	21.28	0.00	4.94	0.00	100
A. Ababa	Frequency	3,312	23,833	0.00	308,312	1,303,107	0.00	0.00	0.00	132,794	8,407	50,081	0.00	1,829,846
	%	0.18	1.30	0.00	16.85	71.21	0.00	0.00	0.00	7.26	0.46	2.74	0.00	100
D. Dawa	Frequency	144,306	1,175	6,776	28,647	42,703	1,260	0.00	253	29,257	0.00	1,840	0.00	256,217
	%	56.32	0.46	2.64	11.18	16.67	0.49	0.00	0.10	11.42	0.00	0.72	0.00	100
Total	**Frequency**	**15,495,584**	**879,684**	**1,294,976**	**1,172,288**	**2,572,877**	**421,333**	**112,026**	**1,328**	**1,251,711**	**51,876**	**413,009**	**50,166**	**23,716,858**
	%	**65.34**	**3.71**	**5.46**	**4.94**	**10.85**	**1.78**	**0.47**	**0.01**	**5.28**	**0.22**	**1.74**	**0.21**	**100**
Rural	Frequency	15,376,886	826,954	1,188,893	429,937	553,951	326,426	58,285	272	721,800	36,601	236,430	44,021	19,800,456
	%	77.66	4.18	6.00	2.17	2.80	1.65	0.29	0.00	3.65	0.18	1.19	0.22	100
Urban	Frequency	118,698	52,730	106,083	742,351	2,018,926	94,907	53,741	1,056	529,911	15,275	176,579	6,145	3,916,402
	%	3.03	1.35	2.71	18.95	51.55	2.42	1.37	0.03	13.53	0.39	4.51	0.16	100

2.6 Housing and Housing Amenities

Table 2.8 shows that about 79% of the respondents live in permanent dwellings, while 12.8% live in traditional dwellings, 6.2% live in semi-permanent dwellings, and 2% live in temporary dwellings. In terms of regional states, people are most likely to live in permanent dwellings in Benishangul Gumuz regional state (99.8%), Dire Dawa city council (99.03%) and Harari regional state (97.81%). People are least likely to live in permanent dwellings in Afar (36.9%) and Somali (37.5%) regions, as these regions have large pastoral and semi-pastoral populations. It is notable that Addis Ababa has the highest proportion of people living in 'temporary' dwellings (16.7% of the Addis Ababa population).

Table 2.8 Housing Characteristics (types of dwelling) by Region (%)

Region		Permanent building	Semi Permanent	Temporary	Traditional	Total
Tigray	Frequency	976,477	11,812	-	69,636	1,057,925
	%	92.3	1.1	-	6.6	100.0
Afar	Frequency	67,004	25,156	1,569	87,638	181,367
	%	36.9	13.9	0.9	48.3	100.0
Amhara	Frequency	3,161,329	141,372	8,258	490,041	3,801,000
	%	83.2	3.7	0.2	12.9	100.0
Oromia	Frequency	4,943,394	136,589	18,025	412,421	5,510,429
		89.7	2.5	0.3	7.5	100.0
Somali	Frequency	149,265	64,239	49,367	1352,68	398,139
	%	37.5	16.1	12.4	34.0	100.0
B.Gumuz	Frequency	205,329	421	-	-	205,750
	%	99.8	0.2	-	-	100.0
SNNP	Frequency	1,616,724	464,358	15,412	780,137	2,876,631
	%	56.2	16.1	0.5	27.1	100.0
Gambella	Frequency	45,726	1,323	12,980	25,821	85,850
	%	53.3	1.5	15.1	30.1	100.0
Harari	Frequency	147,940	3,310	-	-	151,250
	%	97.8	2.2	-	-	100.0
A. Ababa	Frequency	882,248	132,288	206,639	14,067	1,235,242
	%	71.4	10.7	16.7	1.1	100.0
D. Dawa	Frequency	224,199	1,321	880	-	226,400
	%	99.0	0.6	0.4	-	100.0
Total	**Frequency**	**12,419,635**	**982,189**	**313,130**	**2,015,029**	**15,729,983**
	%	**79.0**	**6.2**	**2.0**	**12.8**	**100.0**
Rural	Frequency		10,087,440	751,083	44,990	1,899,726
	%		78.9	5.9	0.4	14.9
Urban	Frequency		2,332,195	231,106	268,140	115,303
	%		79.1	7.8	9.1	3.9

The majority of respondents reported living in houses they own. Table 2.9 shows that about 85.4% of the total respondents live in their own houses. As one would expect, living in a rented house is much more common in urban areas than rural areas (52.6% and 4.2% respectively) (see Table 2.9). The survey also explored variation of household access to different housing amenities among regions. Addis Ababa has the least number of people living in a house they

own (36.84%) while a little over 93% of the respondents in Oromia reported living in their own houses. While the average figure for respondents who live in rented houses is 13.24%, this is as high as 60.3% in Addis Ababa.

Table 2.9 Dwelling Ownership Status by Region and Residence (%)

Region		Owned by household	Rented	Occupied without payment	Other	Total
Tigray	Frequency	768,110	236,231	53,584	-	1,057,925
	%	72.6	22.3	5.1	-	100.0
Afar	Frequency	154,071	25,536	1,688	72	181,367
	%	85.0	14.1	0.9	-	100.0
Amhara	Frequency	3,404,471	373,410	21,187	1,932	3,801,000
	%	89.6	9.8	0.6	0.1	100.0
Oromia	Frequency	5,144,722	328,218	33,889	3,600	5,510,429
		93.4	6.0	0.6	0.1	100.0
Somali	Frequency	355,295	28,556	12,600	1,688	398,139
	%	89.2	7.2	3.2	0.4	100.0
B.Gumuz	Frequency	154,923	48,563	2,264	-	205,750
	%	75.3	23.6	1.1	-	100.0
SNNP	Frequency	2,668,994	175,747	25,174	6,716	2,876,631
	%	92.8	6.1	0.9	0.2	100.0
Gambella	Frequency	66,076	18,614	931	229	85,850
	%	77.0	21.7	1.1	0.3	100.0
Harari	Frequency	92,459	53,527	-	5,264	151,250
	%	61.1	35.4	-	3.5	100.0
A. Ababa	Frequency	455,024	745,108	15,538	19,572	1,235,242
	%	36.8	60.3	1.3	1.6	100.0
D. Dawa	Frequency	162,791	49,924	10,832	2,853	226,400
	%	72.0	22.0	5.0	1.0	100.0
Total	**Frequency**	**13,426,936**	**2,083,434**	**177,687**	**41,926**	**15,729,983**
	%	**85.4**	**13.2**	**1.1**	**0.3**	**100.0**
Rural	Frequency	12,131,481	533,116	118,341	301	12,783,239
	%	94.9	4.2	0.9	-	100.0
Urban	Frequency	1,295,455	1,550,318	59,346	41,625	2,946,744
	%	44.0	52.6	2.0	1.4	100.0

Table 2.10 shows that 85.2% of respondents live in houses with floors that are made of mud/cow dung. This kind of floor is very difficult to keep clean and signals high levels of poverty. Generally, it is poor people that live in a house with a floor made of mud. This average figure masks regional disparity. A little over 96% of the respondents in Amhara region live in houses with floor made of mud. It is only in Addis Ababa city administration where most households live in a house with relatively better flooring. In Addis Ababa, 24% of the respondents live in a house with a mud floor, while 64.5% live in houses with floor made of cement/bricks.

Table 2.10 Main Types of Floor of the House by Region (%)

Region		Mud/cow dung	Stone	Cement/ bricks	Hall block	Wood	Grass	Iron sheets	Tiles	Other	Total
Tigray	Frequency	843,949	6,353	201,094	1,422	-	-	-	-	5,107	1,057,925
	%	79.8	0.6	19	0.1	0	0	0	0	0.5	100
Afar	Frequency	165,012		14,404	481	907	563	-	-	-	181,367
	%	91	0	7.9	0.3	0.5	0.3	0	0	0	100
Amhara	Frequency	3,675,648	7,007	100,548	-	4,188	4,661	8,948	-	-	3,801,000
	%	96.7	0.2	2.7	0	0.1	0.1	0.2	0	0	100
Oromia	Frequency	4,930,943	28,740	265,385	641	20,292	1,222	845	243,317	19,044	5,510,429
		89.5	0.5	4.8	0	0.4	0	0	4.4	0.4	100
Somali	Frequency	337,316	191	45,511	2,019	4,977	1,818	618	4,415	1,274	398,139
	%	84.7	0.1	11.4	0.5	1.3	0.5	0.2	1.1	0.3	100
B.Gumuz	Frequency	185,424	797	19,529	-	-	-	-	-	-	205,750
	%	90.1	0.4	9.5	0	0	0	0	0	0	100
SNNP	Frequency	2,664,659	11,520	147,824	3,272	300	-	-	6,066	42,990	2,876,631
	%	92.6	0.4	5.1	0.1	0	0	0	0.2	1.5	100
Gambella	Frequency	75,957	9,230	-	-	663	-	-	-	-	85,850
	%	88.5	10.8	0	0	0.8	0	0	0	0	100
Harari	Frequency	74,245	-	75,946	-	-	-	-	1,059	-	151,250
	%	49.1	0	50.2	0	0	0	0	0.7	0	100
A. Ababa	Frequency	298,632	11,843	796,699	11,936	35,023	-	-	8,978	72,131	1,235,242
	%	24.2	1	64.5	1	2.8	0	0	0.7	5.8	100
D. Dawa	Frequency	146,271	7,866	70,657	-	-	-	-	1,606	-	226,400
	%	64.6	3.5	31.2	0	0	0	0	0.7	0	100
Total	**Frequency**	**13,398,056**	**74,317**	**1,746,827**	**19,771**	**66,350**	**8,264**	**10,411**	**265,441**	**140,546**	**15,729,983**
	%	**85.2**	**0.5**	**11.1**	**0.1**	**0.4**	**0.1**	**0.1**	**1.7**	**0.9**	**100**
Rural	Frequency	12,191,211	26,369	229,165	2,181	25,135	6,936	8,948	239,967	53,327	12,783,239
	%	95.4	0.2	1.8	0	0.2	0.1	0.1	1.9	0.4	100
Urban	Frequency	1,206,845	47,948	1,517,662	17,590	41,215	1,328	1,463	25,474	87,219	2,946,744
	%	41	1.6	51.5	0.6	1.4	0.1	0.1	0.9	3	100

The survey also explored household's access to different housing amenities, and access to improved sanitation facilities. Table 2.11 shows that only 5.9% of respondents have access to improved toilet facilities (own flush toilet, shared flush toilet and ventilated improved pit latrine)[7]. This figure is lower than the 2014 DHS estimate, which is 9%. The overwhelming majority (94.1%) of the population, according to the HH survey are using unimproved toilet facilities. About 71.4% are using traditional pit latrines, and 22.4% are using bush/field. Those who are using bush/field are significantly less than the 2014 DHS estimate, which was 34.1%, and the 2016 DHS estimate, which was 32.3%. This might be due to the concerted effort by the government and donors/NGOs for open defecation free (ODF) and health extension works at the grassroots level.

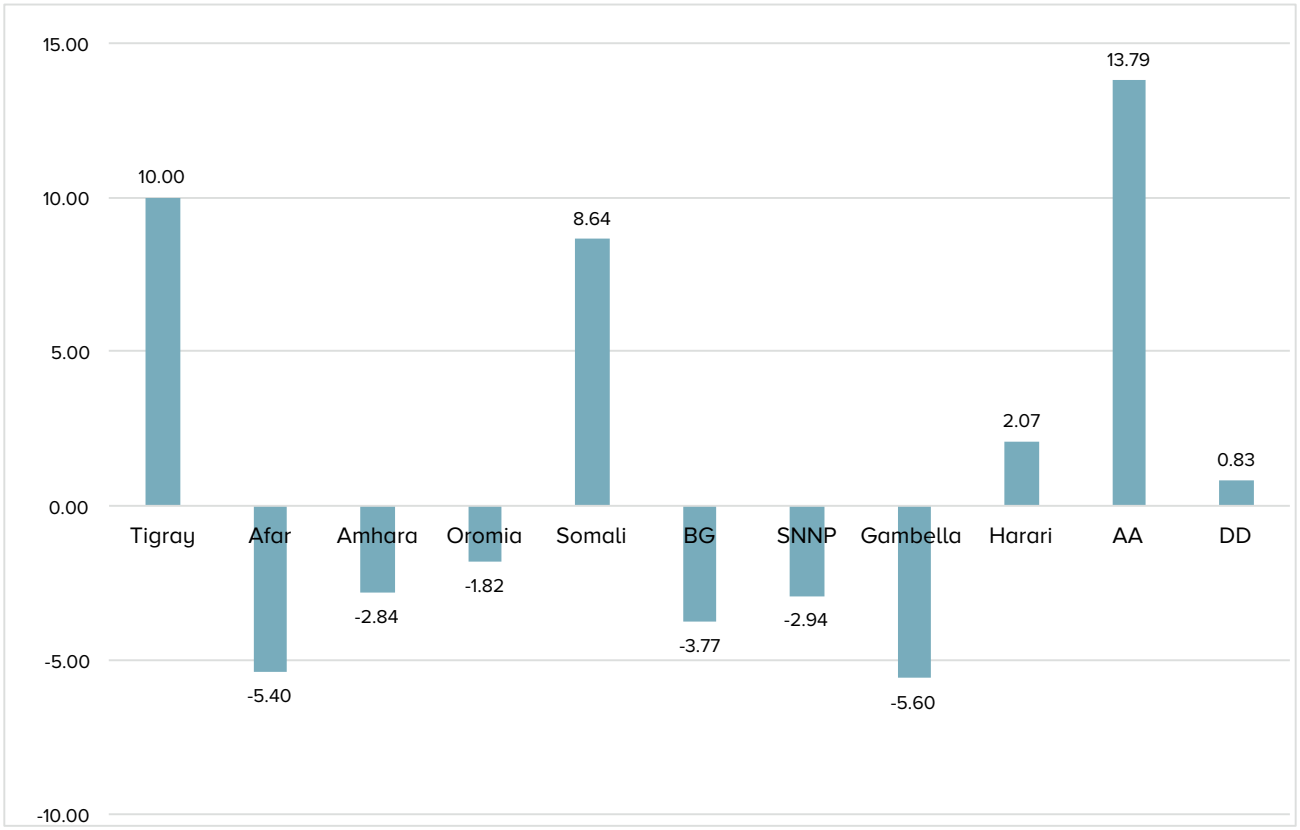
Table 2.11 Type of Toilet Facility by Region and Residence (%)

Region		Own flush toilet	Shared Flush Toilet	Tradi-tional pit latrine	Venti-lated Improved Pit Latrine	Bush or field	Bucket latrine	Other	Total
Tigray	Frequency	14,215	144,185	368,190	10,100	518,115	950.0	2,170	1,057,925
	%	1.3	13.6	34.8	1.0	49.0	0.1	0.2	100.0
Afar	Frequency	-	947	40,898	-	139,522	-	-	181,367
	%	-	0.5	22.6	-	76.9	-	-	100.0
Amhara	Frequency	50,021	34,713	2,761,069	32,395	917,735	-	5,067	3,801,000
	%	1.3	0.9	72.6	0.9	24.1	-	0.1	100.0
Oromia	Frequency	35,917	10,527	3,978,837	179,697	1,297,146	-	8,305	5,510,429
		0.7	0.2	72.2	3.3	23.5	-	0.2	100.0
Somali	Frequency	9,164	16,381	87,747	32,462	250,432	-	1,953	398,139
	%	2.3	4.1	22.0	8.2	62.9	-	0.5	100.0
B.Gumuz	Frequency	530	954	196,761	2,943	4,141	-	421	205,750
	%	0.3	0.5	95.6	1.4	2.0	-	0.2	100.0
SNNP	Frequency	56,715	17,946	2,528,205	11,242	261,650	873	-	2,876,631
	%	2.0	0.6	87.9	0.4	9.1	-	-	100.0
Gambella	Frequency	141	141	75,810	-	9,167	-	591	85,850
	%	0.2	0.2	88.3	-	10.7	-	0.7	100.0
Harari	Frequency	-	1,427	109,490	10,664	29,669	-	-	151,250
	%	-	0.9	72.4	7.1	19.6	-	-	100.0
A. Ababa	Frequency	109,973	75,891	966,604	57,701	6,334	8,228	10,511	1,235,242
	%	8.9	6.1	78.3	4.7	0.5	0.7	0.9	100.0
D. Dawa	Frequency	3,491	2,272	121,009	9,537	90,091	-	-	226,400
	%	1.5	1.0	53.5	4.2	39.8	-	-	100.0
Total	**Frequency**	**280,167**	**305,384**	**11,234,620**	**346,741**	**3,524,002**	**10,051**	**29,018**	**15,729,983**
	%	**1.8**	**1.9**	**71.4**	**2.2**	**22.4**	**0.1**	**0.2**	**100.0**
Rural	Frequency	104,317	36,817	9,181,166	145,468	3,300,849	-	14,622	12,783,239
	%	0.8	0.3	71.8	1.1	25.8	-	0.1	100.0
Urban	Frequency	175,850	268,567	2,053,454	201,273	223,153	10,051	14,396	2,946,744
	%	6.0	9.1	69.7	6.8	7.6	0.3	0.5	100.0

[7] Non-improved facility includes flush/pour flush not to sewer/septic tank/pit latrine, pit latrine without slab/open pit, bucket, hanging toilet/hanging latrine, no facility/bush/field. (CSA 2014: Ethiopia: Mini Demographic and Health Survey 2014.)

There is significant regional disparity in accessing an improved toilet facility, ranging between 0.52% in Afar and 19.7% in Addis Ababa. The following figure graphs the regional disparity from the countrywide average figure for access to improved toilet facility. Use of improved toilet facility in Afar, Amhara, Oromia, BG, SNNP, and Gambella regional states is below the countrywide average.

Figure 2.2 Regional Disparity in Access to Improved Toilet Facility



Source: Table 2.11

Access to improved toilet facilities varies by urban versus rural areas. About 21.9% of the urban populations use improved toilet facilities (shared and not shared), where this is true for only 2.25% of the population in rural area (for details see Table 2.10). The DHS 2014 and 2016 survey estimate for access to improved toilet facilities was higher than this survey findings (45.5% in urban and 3.5% in rural areas in 2014 and 50.5% in urban and 5.7% in rural in 2016)) Significant numbers of people still uses bush/field in both urban areas (7.6%) and in rural areas (25.8%). The 2014 DHS estimated the proportion using bush/field to be as 8.7% in urban areas (6.9 in 2016 DHS) and 37.9% in rural areas (38.8% in 2016 DHS). This leaves a strong message that there is still a lot to work to improve access to improved toilet facilities.

Access to improved water is another household amenity about which the survey collected information. As per the definition of WHO and UNICEF, improved source of water includes piped source within the dwelling, yard, or plot; a public tap/standpipe; borehole; a protected well; a protected spring; and rainwater (WHO and UNICEF, 2010 as quoted by CSA, 2014:7-8)[8]. Based on this definition, and as presented in Table 2.12, about 65.7% of the population has access to improved water sources. This is almost the same with the 2016 DHS survey, which is 64.8% and significantly higher than the DHS estimate in 2014, which was 50.3%.

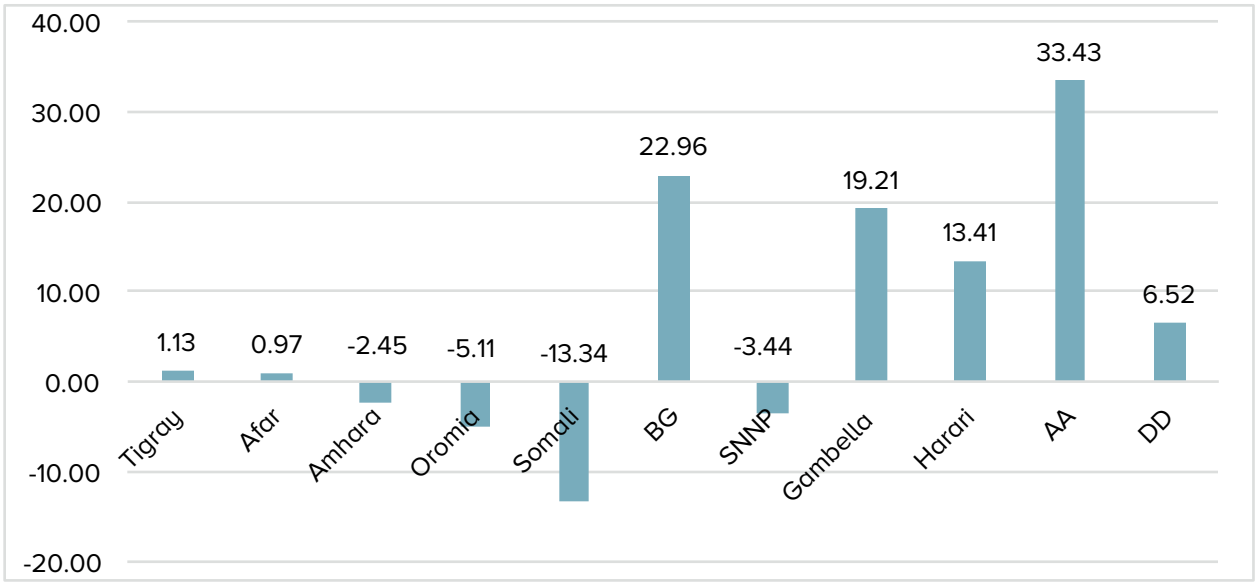
[8] CSA 2014:Ethiopia:Mini Demographic and Health Survey 2014.

Table 2.12 Main Source of Drinking Water by Region and Residence (%)

Region		Piped into residence	Piped into the compound or plot	Public well	Public tap	Well/borehole with pump in the compound	Rainwater collection	Well without hand pump	Pond/ River/ Stream/ Dam	Protected spring	Unprotected spring	Rock catchment	Others
Tigray	Frequency	4,105	225,980	169,613	13,475	167,025	0.00	20,200	67,784	126,547	196,382	2,934	63,880
	%	0.39	21.36	16.03	1.27	15.79	0.00	1.91	6.41	11.96	18.56	0.28	6.04
Afar	Frequency	1,910	34,479	62,296	7,720	1,333	12,639	252	29,363	487	26,574	487	3,827
	%	1.05	19.01	34.35	4.26	0.73	6.97	0.14	16.19	0.27	14.65	0.27	2.11
Amhara	Frequency	11,159	311,664	770,186	153,084	498,440	5,238	92,763	493,000	653,294	801,241	0.00	10,931
	%	0.29	8.20	20.26	4.03	13.11	0.14	2.44	12.97	17.19	21.08	0.00	0.29
Oromia	Frequency	37,594	390,024	1,306,062	134,418	533,130	26,603	102,639	536,862	909,542	1,338,321	109,048	86,186
		0.68	7.08	23.70	2.44	9.67	0.48	1.86	9.74	16.51	24.29	1.98	1.56
Somali	Frequency	2,493	16,274	94,317	41,221	28,667	18,146	17,221	96,646	7,212	42,642	1,840	31,460
	%	0.63	4.09	23.69	10.35	7.20	4.56	4.33	24.27	1.81	10.71	0.46	7.90
B.Gumuz	Frequency	565	52,070	44,464	1,820	79,109	285	2,084	13,734	4,059	7,560	0.00	0.00
	%	0.27	25.31	21.61	0.88	38.45	0.14	1.01	6.68	1.97	3.67	0.00	0.00
SNNP	Frequency	11,430	202,084	1,017,750	30,029	44,008	10,943	10,512	249,020	473,694	814,483	12,378	300
	%	0.40	7.03	35.38	1.04	1.53	0.38	0.37	8.66	16.47	28.31	0.43	0.01
Gambella	Frequency	1,180	15,881	9,836	1,209	4,150		687	1,370	40,619	9,449	0.00	1,469
	%	1.37	18.50	11.46	1.41	4.83	0.00	0.80	1.60	47.31	11.01	0.00	2.00
Harari	Frequency		71,920	10,010	3,464	34,220	0.00	18,013	0.00	0.00	0.00	0.00	13,623
	%	0.00	47.55	6.62	2.29	22.62	0.00	11.91	0.00	0.00	0.00	0.00	9.01
A. Ababa	Frequency	44,741	1,006,203	170,209	2,927	0.00	0.00	0.00	0.00	0.00	0.00	0.00	11,162
	%	3.62	81.46	13.78	0.24	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00
D. Dawa	Frequency	1,224	60,899	64,228	0.00	22,000	0.00	3,525	13,832	15,071	26,196	0.00	19,425
	%	0.54	26.90	28.37	0.00	9.72	0.00	1.56	6.11	6.66	11.57	0.00	9.00
Total	**Frequency**	**116,401**	**2,387,478**	**3,718,971**	**389,367**	**1,412,082**	**73,854**	**267,896**	**1,501,611**	**2,230,525**	**3,262,848**	**126,687**	**242,263**
	%	**0.74**	**15.18**	**23.64**	**2.48**	**8.98**	**0.47**	**1.70**	**9.55**	**14.18**	**20.74**	**0.81**	**1.54**
Rural	Frequency	13,218	221,367	3,333,231	351,315	1,390,897	62,458	245,648	1,430,037	2,217,303	3,238,780	126,019	152,966
	%	0.1	1.73	26.08	2.75	10.88	0.49	1.92	11.19	17.35	25.34	0.99	1.2
Urban	Frequency	103,183	2,166,111	385,740	38,052	21,185	11,396	22,248	71,574	13,222	24,068	668	89,297
	%	3.5	73.51	13.09	1.29	0.72	0.39	0.76	2.43	0.45	0.82	0.02	3.03

While the average figure for access to an improved water source is improving, there continues to be wide regional variation. For instance, in Somali region, access to improved water sources is only 52.3% while it is 99.1% in Addis Ababa. The following figure graphs the regional disparity from the countrywide average figure for access to improved sources of water. Access to improved sources of water is below the national average in Amhara, Oromia, Somali, and SNNP regional states.

Figure 2.3 Regional Disparity in Access to Improved Source of Water



Access to improved sources of water varies by urban versus rural areas (see table 2.12). For instance, while almost all urban populations obtain their drinking water from improved sources (93.0%) the corresponding figure for rural populations is only 59.4%. The 2014 DHS estimates are almost the same for the urban areas (93.2%) but the DHS estimate for rural populations is significantly different than our findings, with rural populations estimated at 43.8%. The most commonly accessed source of safe water for urban populations in this HH survey is piped water, which accounts for 77.1% of urban populations (3.5% piped into residence and 73.51% piped into compound/plot).

Households are using a variety of sources for household energy. The main source of household energy in the country is firewood. About 82.5% of sampled households use firewood as the main source of energy for cooking. This is followed by charcoal (8.1%) and electricity (6.2%). Households in Amhara, Oromia and SNNP regions have the highest use of firewood; over 90% of households use firewood as their main source of energy for cooking. All other regions are below the national average figure.

Access to sources of energy varies by residence in urban and rural areas (see table 2.13). For instance, while almost all rural households use firewood as main source of energy for cooking (95.8%), the corresponding figure for urban households was only 24.57%. The urban population is increasingly using electricity for cooking – 32.5% of urban populations in this survey reported using electricity, compared to only 18.3% in the last HH survey (2010/11).

Table 2.13 Main source of energy for cooking by region and residence (%)

Region		Fire-wood	Charcoal	Kerosine	Gas	Electric-ity	Solar	Other	Total
Tigray	Frequency	766,472	164,007	5,945	-	90,646	-	30,855	1,057,925
	%	72.5	15.5	0.6	-	8.6	-	2.9	100.0
Afar	Frequency	143,770	35,996	-	-	1,270	-	331	181,367
	%	79.3	19.9	-	-	0.7	-	0.2	100.0
Amhara	Frequency	3,459,805	138,199	2,468		47,747	6,537	146,244	3,801,000
	%	91.0	3.6	0.1	-	1.3	0.2	3.9	100.0
Oromia	Frequency	5,055,655	214,295	6,695	-	102,702	3,046	128,036	5,510,429
		91.8	3.9	0.1	-	1.9	0.1	2.3	100.0
Somali	Frequency	290,409	70,159	399	-	7,020	1,209	28,943	398,139
	%	72.9	17.6	0.1	-	1.8	0.3	7.3	100.0
B.Gumuz	Frequency	162,607	37,052	1,174	-	4,477	-	440	205,750
	%	79.0	18.0	0.6	-	2.2	-	0.2	100.0
SNNP	Frequency	2,713,642	121,056	3,937	-	21,037	2,515	14,444	2,876,631
	%	94.3	4.2	0.1	-	0.7	0.1	0.5	100.0
Gambella	Frequency	63,134	19,578	229	-	141	-	2,768	85,850
	%	73.5	22.8	0.3	-	0.2	-	3.2	100.0
Harari	Frequency	74,260	45,868	11,569	1,427	14,361	-	3,765	151,250
	%	49.1	30.3	7.7	0.9	9.5	-	2.5	100.0
A. Ababa	Frequency	70,979	396,798	66,243	6,554	682,651	-	12,017	1,235,242
	%	5.8	32.1	5.4	0.5	55.3	-	1.0	100.0
D. Dawa	Frequency	171,390	35,216	5,878	-	9,803	318	3,795	226,400
	%	75.7	15.6	2.6	-	4.3	0.1	1.7	100.0
Total	**Frequency**	**12,972,123**	**1,278,224**	**104,537**	**7,981**	**981,855**	**13,625**	**371,638**	**15,729,983**
	%	**82.5**	**8.1**	**0.7**	**0.1**	**6.2**	**0.1**	**2.4**	**100.0**
Rural	Frequency	12,248,131	181,366	9,508	-	25,015	12,098	307,121	12,783,239
	%	95.8	1.4	0.1	-	0.2	0.1	2.4	100.0
Urban	Frequency	723,992	1,096,858	95,029	7,981	956,840	1,527	64,517	2,946,744
	%	24.6	37.2	3.2	0.3	32.5	0.1	2.2	100.0

2.7 Ownership of land, household consumption and income

In addition to the demographic characteristics, housing infrastructure and related amenities, the survey collected data on land ownership, income and expenditure. Table 2.14 presents land ownership. Generally, people own relatively small parcels of land, if they own any land at all. As can be observed in Table 2.14, 73.6% of the population has less than one hectare (including those who do not own any land). Only 10.0% of the population own greater than 2 hectares of land.

Table 2.14 Land Ownership in Hectare by Region and Residence (%)

Region		Less than 0.1	0.10-0.50	0.51-1.00	1.01-2.00	2.01-5.00	5.01-10.00	Total
Tigray	Frequency	328,007	341,345	270,743	90,550	25,544	2,607	1,058,796
	%	31.0	32.2	25.6	8.6	2.4	0.3	100
Afar	Frequency	165,159	-	8,043	5,064	2,828	273	181,367
	%	91.1	-	4.4	2.8	1.6	0.2	100
Amhara	Frequency	549,917	1,215,432	1,150,570	722,673	158,181	4,828	3,801,601
	%	14.5	32.0	30.3	19.0	4.2	0.1	100
Oromia	Frequency	792,270	1,345,624	1,229,014	1,117,213	924,671	107,978	5,516,770
		14.4	24.4	22.3	20.3	16.8	2.0	100
Somali	Frequency	181,382	23,625	73,378	64,073	46,360	9,321	398,139
	%	45.6	5.9	18.4	16.1	11.6	2.3	100
B.Gumuz	Frequency	72,485	10,882	30,465	41,009	44,167	6,742	205,750
	%	35.2	5.3	14.8	19.9	21.5	3.3	100
SNNP	Frequency	413,215	870,782	879,602	495,371	212,456	5,205	2,876,631
	%	14.4	30.3	30.6	17.2	7.4	0.2	100
Gambella	Frequency	35,353	15,241	14,233	10,811	9,919	293	85,850
	%	41.2	17.8	16.6	12.6	11.6	0.3	100
Harari	Frequency	78,882	7,721	36,869	21,838	5,940	-	151,250
	%	52.2	5.1	24.4	14.4	3.9	-	100
A. Ababa	Frequency	1,113,293	3,312	118,637	-	-	-	1,235,242
	%	90.1	0.3	9.6	-	-	-	100
D. Dawa	Frequency	87,087	78,252	49,742	9,574	2,976	485	228,116
	%	38.2	34.3	21.8	4.2	1.3	0.2	100
Total	**Frequency**	**3,817,050**	**3,912,216**	**3,861,296**	**2,578,176**	**1,433,042**	**137,732**	**15,739,512**
	%	**24.3**	**24.9**	**24.5**	**16.4**	**9.1**	**0.9**	**100**

Land ownership in rural areas is more meaningful than for urban populations, as farming is the major rural livelihood. As presented in Table 2.14, it is 40.05% of rural residents that have up to half a hectare to farm and generate their main food/income for the family. About 68.5% of rural residents have up to one hectare. Given the agricultural context where modern technology is limited and various structural and institutional problems exist, the size of landholding is generally not sufficient for a family to produce enough food, even during years of good rainfall.

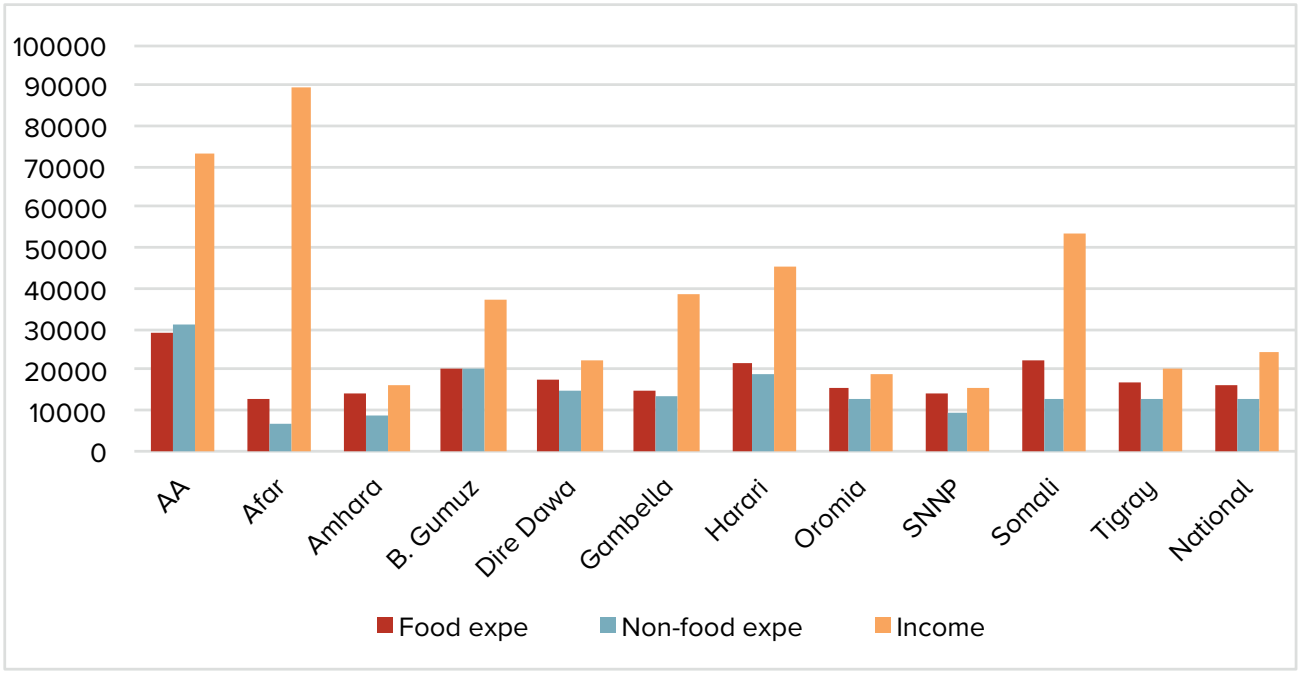
The household income and expenditure data available from this survey creates an estimate built from respondents reporting of different kinds of expenditure and income for different recall periods. The average annual income per capita in the country according to this survey is 24,227 ETB ranging from 89,337 ETB in Afar region to 15,213 ETB in SNNP region. The per capita income in Amhara, Dire Dawa, Oromia, and Tigray regions is less than the national average (see Table 2.15). Expenditure is expected to be the mirror of income. However, according to Table 2.15, on average nationally, household expenditure is 109% of their income. Household food and non-food expenditure per annum at country level is 29,310 ETB. The average total expenditure ranges between 60,033 birr in Addis Ababa and 20,084 in Afar region. Average expenditure is more than income in most regions, including the national average. The only exceptions are Somali, Afar, Addis Ababa, Gambella, and Harari regions. Of household's expenditure, approximately 56% is spent on food, while the remaining 46% is non-food expenditure. The proportion of expenditure on food does not vary greatly region to region, it ranges from 49% in Addis Ababa and Benishangul Gumuz, to 65% in Afar region.

Table 2.15 Household Consumption Expenditure and Income by Region (ETB)

Region	Stat	Food consumption expenditure	Non-food consumption Expenditure	Total expenditure	Income	Average expenditure as percent of income	Average food Expenditure as percent of total expenditure
Addis Ababa	Mean	29,156	30,878	60,033	73,158	82%	49%
	SD	20,177	34,806	47,138	173,768		
Afar	Mean	13,106	6,978	20,084	89,337	22%	65%
	SD	12,360	8,416	19,470	649,712		
Amhara	Mean	14,077	8,753	22,830	16,130	142%	62%
	SD	10,916	8,630	16,286	39,665		
B. Gumuz	Mean	20,160	20,628	40,788	37,030	110%	49%
	SD	18,408	42,338	51,977	76,903		
Dire Dawa	Mean	17,377	14,811	32,188	22,642	142%	54%
	SD	9,466	14,853	20,486	29,003		
Gambella	Mean	14,909	13,283	28,192	38,917	72%	53%
	SD	11,859	32,659	39,935	84,416		
Harari	Mean	21,700	18,831	40,531	45,478	89%	54%
	SD	16,405	18,912	28,701	69,034		
Oromia	Mean	15,697	12,869	28,566	18,852	152%	55%
	SD	10,356	21,083	25,807	29,507		
SNNP	Mean	14,492	9,473	23,965	15,243	157%	60%
	SD	10,234	11,613	18,201	19,297		
Somali	Mean	22,353	12,713	35,066	53,721	65%	64%
	SD	18,635	23,504	33,757	309,793		
Tigray	Mean	17,052	13,129	30,182	20,020	151%	56%
	SD	11,946	26,972	33,790	32,875		
National	**Mean**	**16,508**	**12,802**	**29,310**	**24,227**	**121%**	**56%**
	SD	**12,767**	**20,640**	**28,184**	**104,658**		

As is vividly clear from Figure 2.4 below, the two emerging regions are the highest in terms of average income compared with most developed regions (the exception is Addis Ababa). Hypothetically, the high incomes reported in Afar and Somali regions are attributed to a high level of livestock sales (particularly camels).

Figure 2.4 Mean consumption expenditure and income in Birr



Chapter 3. Household Self-Reported Health Status and Mortality

3.1 Self-Reported Health Status

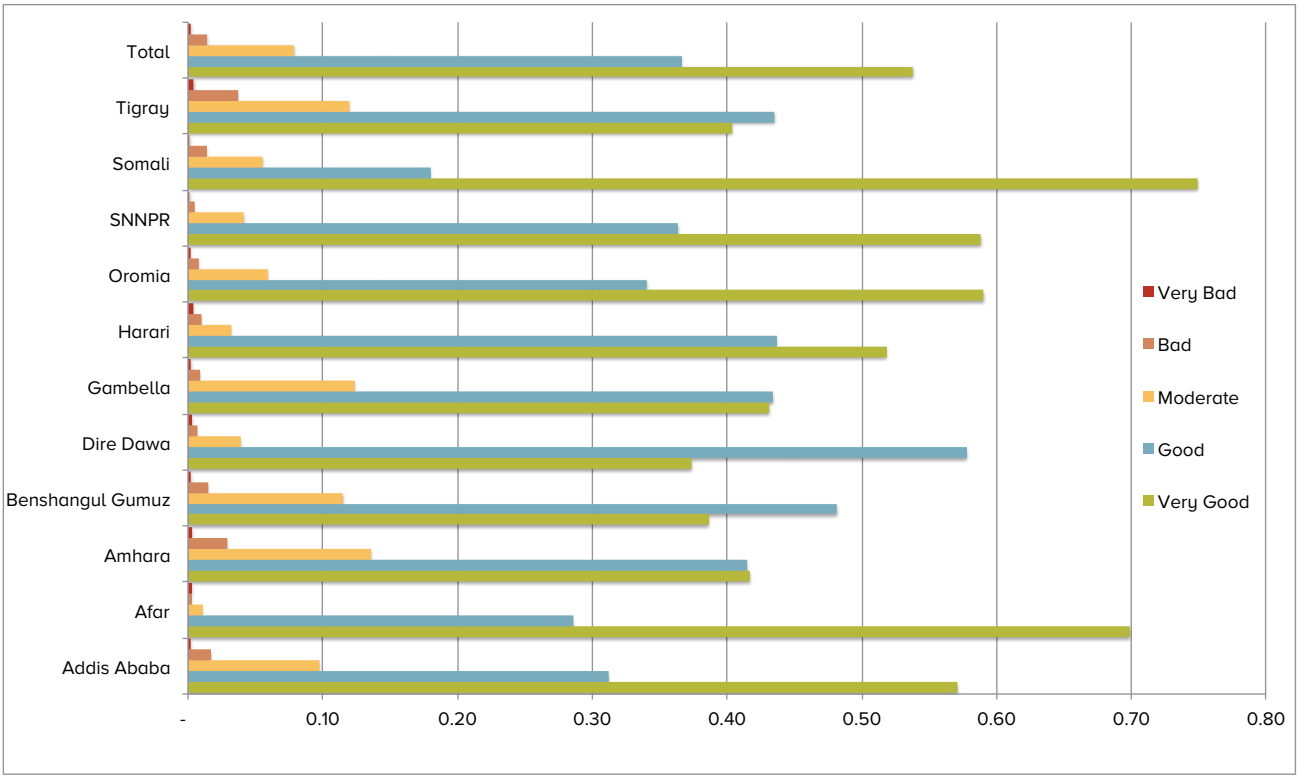
Respondents were asked to assess the general health status of each member of their household, compared with their peers. Respondents rated each member's health status from one to five - one showing the worst or 'very bad' health status and five being the best or 'very good' health status. This rank is similar to the five-point Likert scale of self-rated health, which is strongly correlated with objective health status and is considered to be a robust predictor of mortality (Idler EL, Benyamini 1997; Baron-Epel O., 2014). Table 3.1 shows the self-reported health status of household members as evaluated by the respondents. Overall, 90.4% of the population viewed their general health status as 'good' or 'very good'. On the other hand, the self-reported health status was perceived as 'bad' or 'very bad' for just 1.6% of the population.

Table 3.1: Self-Reported General Health Status

	Very Good (%)	Good (%)	Moderate (%)	Bad (%)	Very Bad (%)	Don't Know (%)
Gender						
Male	55.92	35.6	7.02	1.22	0.22	0.02
Female	51.38	37.8	8.90	1.70	0.20	0.02
Residence						
Urban	59.19	31.02	8.04	1.58	0.14	0.03
Rural	52.85	37.61	7.87	1.43	0.22	0.02
Wealth quintiles						
Poorest	49.43	39.14	9.24	1.88	0.28	0.04
Q2	52.85	37.01	8.47	1.44	0.23	-
Q3	52.99	37.92	7.54	1.34	0.19	0.02
Q4	56.50	35.54	6.51	1.22	0.20	0.03
Richest	58.66	32.30	7.56	1.33	0.13	0.02
Total	**53.77**	**36.65**	**7.9**	**1.46**	**0.21**	**0.02**

Based on the assessment of respondents, the self-reported health status appears to be slightly better among males than females, and among urban than rural residents. Similarly, self-reported health status is perceived to be slightly better among households in the richest wealth quintile compared with those in the poorest quintile. There is considerable regional variation on self-reported general health status. For example, health status was assessed as 'very good' for 75% of individuals in Somali region (the highest rate) compared with 37% of individuals in Dire Dawa (the lowest rate) (see Figure 3.1).

Figure 3.1: Self-Reported General Health Status by Region (%)



% refers to percentage of weighted population

3.2 Self-Reported General Illnesses

Table 3.2 shows the percentage of individuals who reported being ill over the four weeks preceding the survey (respondents reported for each individual in his or her household). Overall, 10% of individuals reported being ill in the four weeks preceding the survey, a slight decrease from the last survey where 11.5% of the population reported an illness in the last four weeks (see Table 3.2). The prevalence of illness varied between male and female populations, urban and rural areas, as well as across regions. Self-reported illness was marginally higher among females (10.8%) than males (9.3%), and in urban settings (11.1%) than in rural areas (9.9%). Higher rates of self-reported illness among females and urban residents were also documented by previous surveys (FMOH 2014; CSA 2012).

Table 3.2 presents the prevalence of self-reported illnesses by region and sex. Self-reported illness varied across regions and within a region by sex. The highest rate of self-reported illness was reported in Benishangul Gumuz region (20.5%), followed by Gambella (16.8%) and Tigray (13.2%). Dire Dawa had the lowest prevalence of self-reported illness (6.5%), followed by Harari (7.5%).

Table 3.2 Self-Reported Illness by Sex and Place of Residence and Region

	% of individuals who were ill in the last 4 weeks preceding survey		
	Male	Female	Total
Rural	9.2	10.6	9.87
Urban	10.1	11.96	11.05
Total	9.32	10.81	10.05
Residence			
Addis Ababa	10.79	12.55	11.73
Afar	8.24	10.35	9.24
Amhara	11.86	12.72	12.29
Benishangul Gumuz	19.16	21.93	20.52
Dire Dawa	6.04	7.06	6.54
Gambella	15.69	17.97	16.82
Harari	7.91	7.49	7.51
Oromia	7.52	9.24	8.35
SNNPR	8.43	9.48	8.92
Somali	8.99	11.75	10.28
Tigray	12.00	14.16	13.20
Total	**9.32**	**10.81**	**10.05**

Figure 3.2 shows the association between household wealth status and self-reported illnesses. Individuals in the lowest wealth quintile households were slightly more likely to report illness, but were less likely to visit a health facility (see health seeking behavior in Chapter 4 below). In contrast to the result of this report, the previous survey did not find a clear or significant association between wealth status and self-reported illness (See FMOH 2014, pp.31-32). Figure 3.2 also shows that individuals in the richest wealth quintile households were marginally more likely to report illness compared with those in the second to fourth quintiles, hypothetically due to increasing chronic conditions or greater awareness of signs of illness and earlier recognition of illness among the rich.

Figure 3.2 Self-Reported Illness by Wealth Status

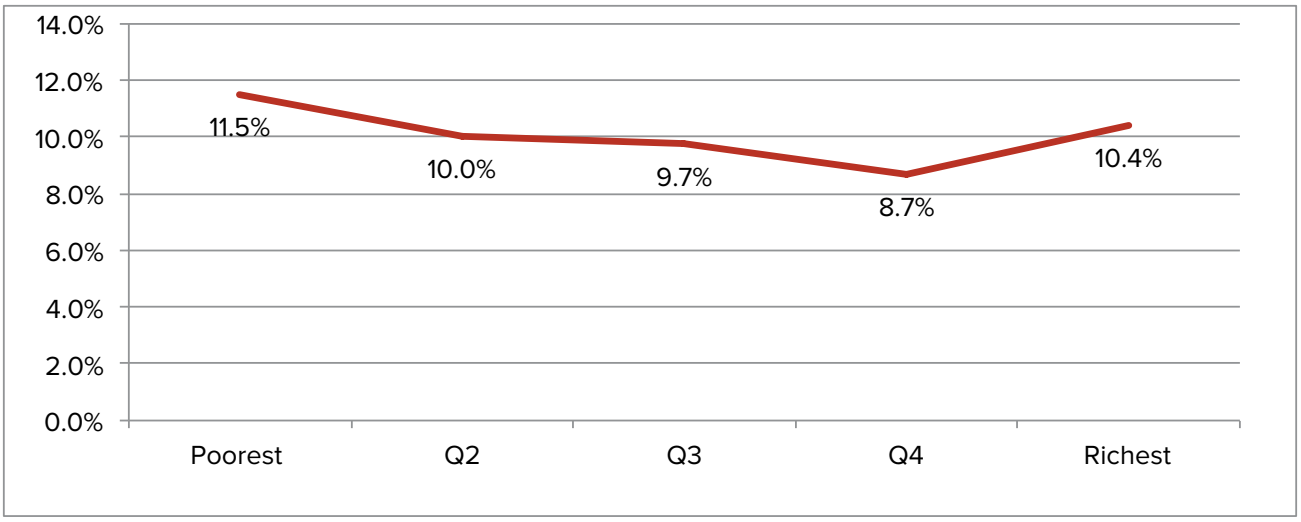
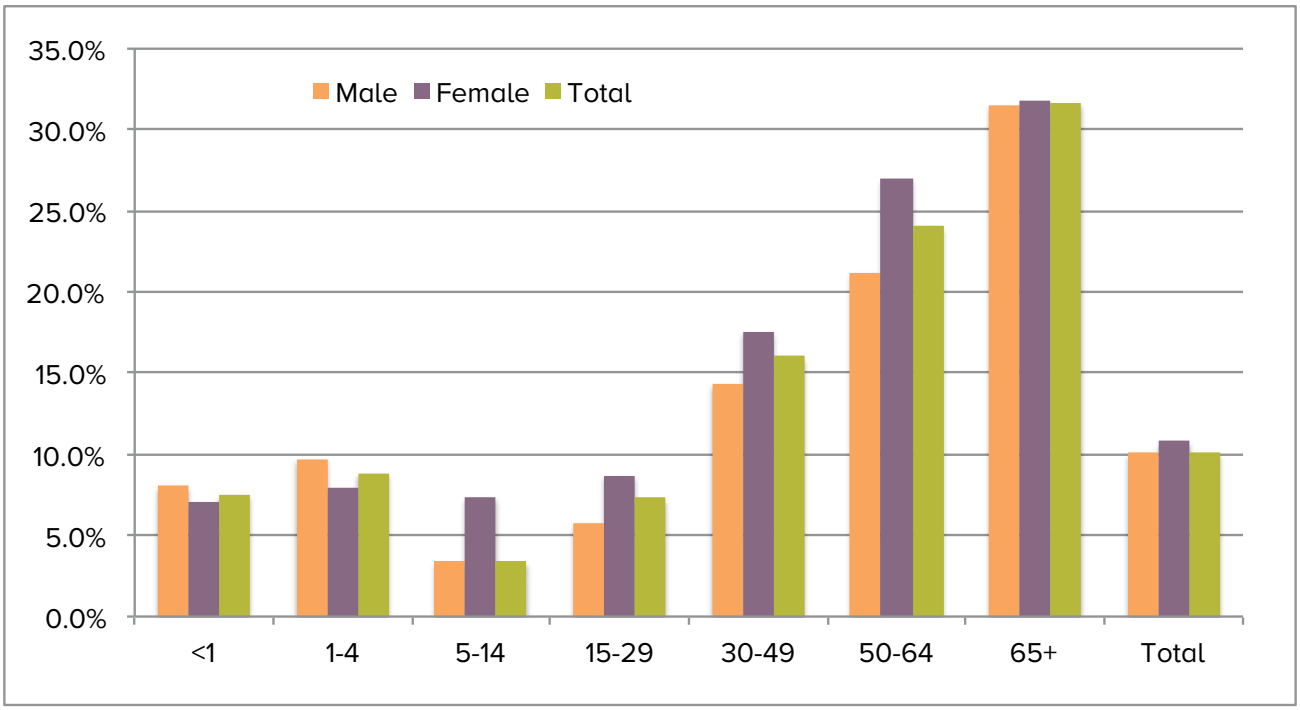


Figure 3.3 depicts the relationships between age and self-reported illness. A generally positive association can be observed between age and reported incidence of illness for both males and females, as shown in Figure 3.3. A closer look at this relationship shows that 10% or less of the younger population (aged<30) reported an illness, while a higher and increasing rate of self-reported illnesses was observed among older populations.'

Figure 3.3 Self-Reported Illness by Age (Years) and Sex



3.3 Self-Reported Chronic Illnesses

The survey sought to understand the prevalence of self-reported chronic illnesses among the population, and asked respondents whether any member of their household has chronic conditions such as hypertension, diabetes, cardiac disorder, mental illness, cancer, etc. over the past year. Table 3.3 presents the prevalence of self-reported chronic illnesses among the population. Overall, 11% of the population reported having at least one chronic condition. Men reported a higher prevalence of self-reported chronic illnesses (12.9%) than women (9.4%). The prevalence of self-reported chronic illnesses has increased substantially since the last survey, in which it was reported to be 5.2% for males and 5.9% for females (FMOH 2014). This increase was particularly significant among male populations. As expected, self-reported chronic illnesses were more common in urban settings than rural areas. In four regions (Amhara, Benishangul Gumuz, Gambella and Tigray), however, the prevalence of self-reported chronic illnesses even in rural areas was high compared with other regions, and in some cases was about as high as the prevalence reported in urban areas within the region (see Table 3.3). Further investigation is required to understand why the prevalence of chronic diseases is reported to be significantly higher in the rural areas of these regions.

Table 3.3 Self-Reported Chronic Illness by Sex, Residence and Region

Region	Male	Female	Rural	Urban	Total
Addis Ababa	19.7%	15.6%	-	17.4%	17.4%
Afar	2.8%	3.4%	3.2%	2.6%	3.1%
Amhara	21.3%	14.0%	17.7%	17.8%	17.7%
Benishangul Gumuz	21.0%	13.9%	17.2%	19.4%	17.5%
Dire Dawa	7.0%	5.3%	2.3%	14.6%	6.1%
Gambella	17.1%	15.4%	16.1%	16.7%	16.2%
Harari	7.8%	7.5%	2.9%	13.2%	7.6%
Oromia	9.7%	7.5%	8.5%	11.3%	8.6%
SNNPR	8.2%	4.8%	6.1%	12.4%	6.5%
Somali	9.2%	4.5%	6.3%	7.1%	6.9%
Tigray	14.2%	14.5%	14.4%	14.2%	14.4%
National	**12.9%**	**9.4%**	**9.5%**	**14.2%**	**11.1%**

% refers to prevalence of chronic diseases among the weighted population

3.4 Self-Reported Mortality

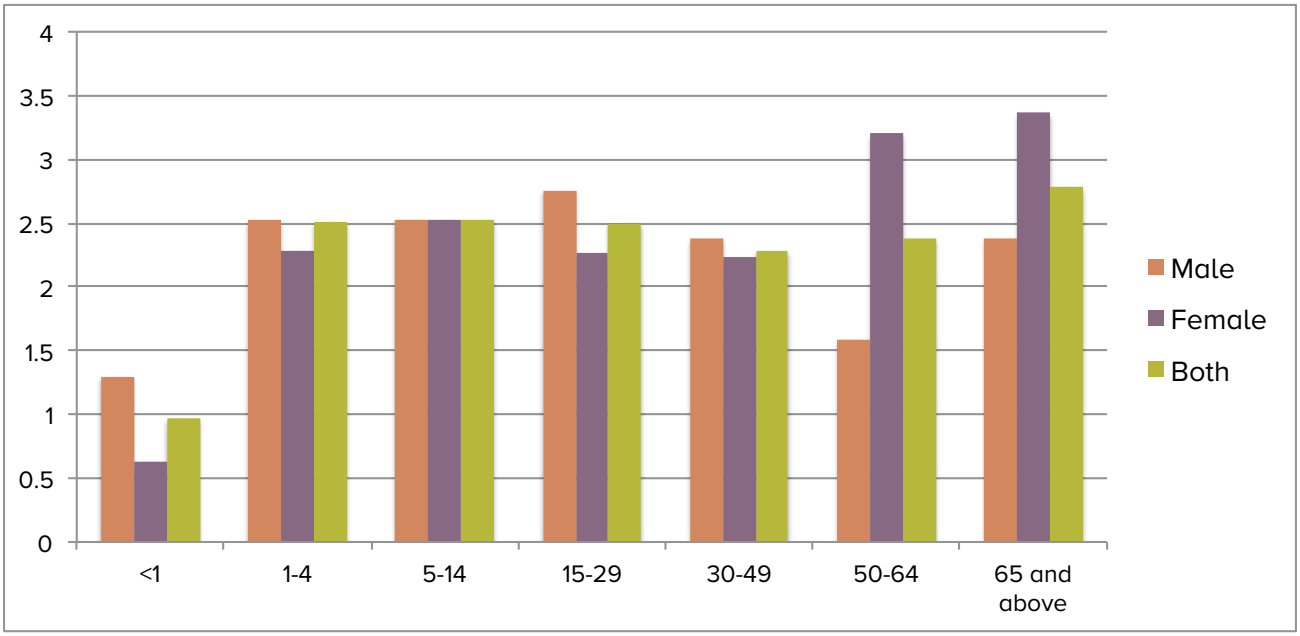
Table 3.4 shows the incidence of death of family members reported by households. As the table shows, 2.4% of households reported a death of at least one family member in the last 12 months, a substantial reduction from 4.2% of households who reported death of at least one family member in the last similar survey (in 2011/12).

Table 3.4 Reported Mortality by Geographic Location

	Percent of households reporting death of a family member in last 12 months
Residence	
Rural	2.33%
Urban	3.02%
Total	2.43%
Regions	
Addis Ababa	3.23%
Afar	4.17%
Amhara	2.33%
Benishangul Gumuz	4.50%
Dire Dawa	0.47%
Gambella	3.81%
Harari	3.43%
Oromia	2.23%
SNNPR	1.82%
Somali	7.41%
Tigray	2.27%
Wealth quintiles	
Poorest	2.49%
Q2	2.35%
Q3	3.09%
Q4	1.87%
Richest	2.32%
Total	**2.43%**

The reported deaths of family member vary across regions and residential areas. Afar, Benishangul Gumuz and Somali have a higher incidence of reported deaths compared to other regions. Particularly, incidence of death in Somali region was reported to be about 3 times higher than the national average, and nearly twice as high as reported in the last survey (in 2011/12). Notably, SNNP and Gambella regions had much higher than average incidence of death reported in the previous survey, and their rates have dropped significantly (from 5.8% to 1.8% in SNNP and from 8.6% to 3.8% in Gambella). A higher incidence of death was reported in urban centers (3.02%) than in rural areas (2.33%). On the other hand, differences in the incidence of mortality appear to be small among households in richer versus those in poorer wealth quintiles. The reported mortality rates were lower for infants (less than one year) and higher for persons aged greater than 64 years (Figure 3.4) compared to other age groups. The last survey showed a higher mortality rate among infants compared to other groups, which indicates a marked reduction in infant mortality in the last few years.

Figure 3.4: Age and Sex Distribution of the Deceased in the Last 12 Months



Chapter 4. Health Seeking Behavior and Health Service Utilization

4.1. Health Seeking Behavior

Table 4.1 shows the percentage of individuals who reported seeking care at a health facility over the four weeks preceding the survey. Overall, 52.9% of individuals who reported being ill sought care in the four weeks preceding the survey, a 10% drop from the figure reported in the last similar survey where 62.4% of the ill individuals reported seeking care (see Table 4.1).

Health seeking behavior varied between male and female populations, urban and rural areas, as well as across regions. The likelihood of seeking health care was marginally higher among females (53.2%) than males (52.3%), and significantly higher among individuals living in urban areas (67.4%) than those residing in rural areas (50.0%). While the latter result is consistent with the previous findings (CSA 2012; MOH 2014), a marginally higher rate of health seeking behavior among females than males in this survey appears to be a new development.

Table 4.1 Health Care Seeking Behavior by Sex, Place of Residence and Region (%)

	% of individuals who reported being ill who visited a health facility		
	Male	Female	Total
Residence			
Rural	49.49	50.32	49.95
Urban	67.98	66.50	67.41
Total	**52.28**	**53.19**	**52.85**
Regions			
Addis Ababa	77.11	70.35	73.50
Afar	76.16	65.58	70.53
Amhara	39.48	38.89	39.26
Benishangul Gumuz	74.73	73.93	74.32
Dire Dawa	69.64	49.64	59.01
Gambella	50.50	62.40	56.81
Harari	68.99	90.09	79.47
Oromia	51.79	57.04	54.63
SNNPR	59.80	58.74	59.33
Somali	48.74	46.16	47.50
Tigray	52.14	47.43	49.53
Total	**52.28**	**53.19**	**52.85**

Health care seeking behavior was not uniform across regions, varying between the lowest rate of 39.3% in Amhara to the highest rate of 79.5% in Harari region, a finding consistent with the previous survey (FMOH 2014). A relatively low level of care seeking in Amhara region was reported by the previous NHA as well as at least one other study (Fitsum Girma et al. 2011). Regions with relatively lower rates of care seeking behavior include Somali (47.5%) and Tigray (49.5%), while those with higher rates of care seeking behavior include Benishangul Gumuz (74.3%) and Addis Ababa (73.5%) (See Table 4.1).These results suggest that proximity of health facilities is not the only factor that influences care seeking decisions. For example, high care seeking behavior was reported in Afar (70.5%), a region with a sparsely populated, predominantly pastoral population where one has to travel a longer distance to reach a health facility, whereas relatively lower care seeking behavior was reported in Dire Dawa City Council (59%), where a number of health facilities are readily available in relatively convenient locations. Further analysis is required to better understand factors affecting health-seeking decisions among regions.

Figure 4.1 shows the association between household wealth status and health seeking behavior. As described above, individuals in the lowest wealth quintile households were slightly more likely to report an illness, but they were less likely to visit a health facility (compare Figures 3.2 and 4.1). In this survey, a particularly clear positive association was observed between economic status (proxied by wealth quintile) and healthcare seeking behavior. This is in contrast to the previous survey, which found that individuals in the poorest households (those in the poorest wealth quintile) were more likely to seek curative care, which was contrary to expectation. In contrast to the result of the current report, the previous survey also did not find a clear or significant association between wealth status and self-reported illness (See FMOH 2014, pp.31-32).

Figure 4.1 Percent of Ill Who Sought Health Care by Wealth Status

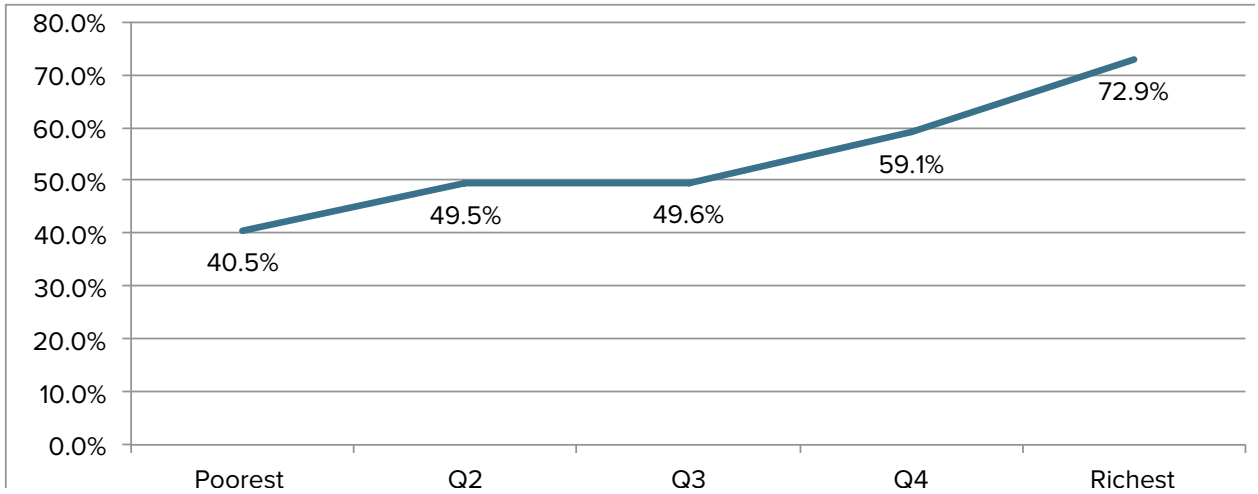
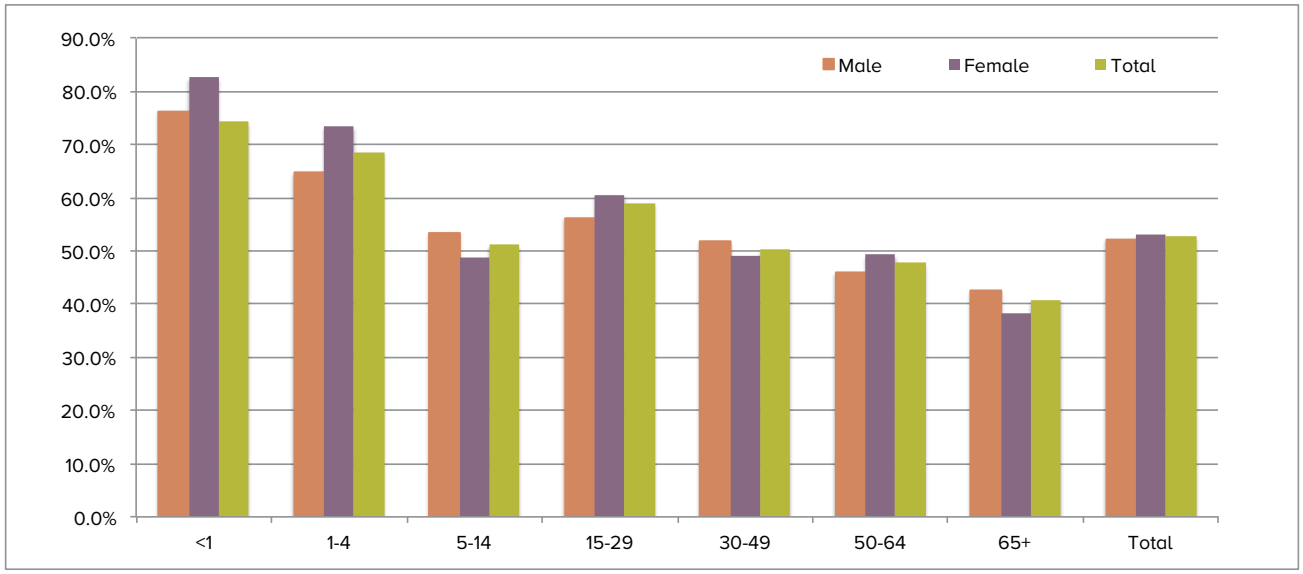


Figure 4.2 depicts the relationship between age and healthcare seeking behavior, which shows a clear inverse correlation. Interestingly, individuals in the age group that reported the highest incidence of illness (particularly individuals aged 65 years or older) were less likely to seek healthcare for both male and female populations (see Figure 3.3 above). A further investigation is required to understand why older people were less likely to seek care, despite carrying the highest burden of illnesses. While infants in this survey were reported to be less ill than other age groups, care was sought for their illnesses at a higher rate than other age groups, which is a positive sign, and is in-line with the reductions observed in infant mortality over the last several years (EDHS 2016)

Figure 4.2 Percent of Ill Individuals Who Reported Visiting a Health Facility by Age and Sex



4.1.1 Use of Health Care in an Emergency

Results from the assessment of the use of healthcare in an emergency – defined as having spent at least one night in a health facility in the 12 months prior to the survey - are presented in Table 4.3 for males and females by region. About 1.1% of the population reported use of healthcare in an emergency as defined above, which was slightly higher among females (1.2%) than males (1.0%). The largest rate of care utilization in an emergency was observed in Benishangul Gumuz region (2.34%), followed by Tigray (2.16%). Healthcare use in an emergency doubled from 0.55% in the last household survey (2011/12) to 1.1% in 2016. In both surveys, the lowest rate of health care utilization in an emergency was observed in Amhara region. Use of care in an emergency was higher in this survey among the rich than the poor for both males and females (see Table 4.3). Similarly, use of healthcare in an emergency was higher in urban than rural areas (see Figure 4.4).

Table 4.3 Percent of Ill Population who Reported Spending a Night in a Health Facility in the 12 Months Prior to the Survey

Region	Male (%)	Female (%)	Total (%)
Regions			
Addis Ababa	1.38	1.78	1.60
Afar	0.82	0.19	0.52
Amhara	0.60	0.78	0.69
Benishangul Gumuz	1.78	2.95	2.35
Dire Dawa	1.69	1.14	1.42
Gambella	0.78	0.25	0.52
Harari	1.05	2.59	1.80
Oromia	1.00	1.09	1.04
SNNPR	0.87	1.08	0.98
Somali	1.56	2.18	1.86
Tigray	1.64	2.65	2.16
Total	**0.98**	**1.22**	**1.10**

Figure 4.3 Percent of People Who Reported Spending a Night in a Health Facility During the 12 Months Prior to the Survey by Wealth Status

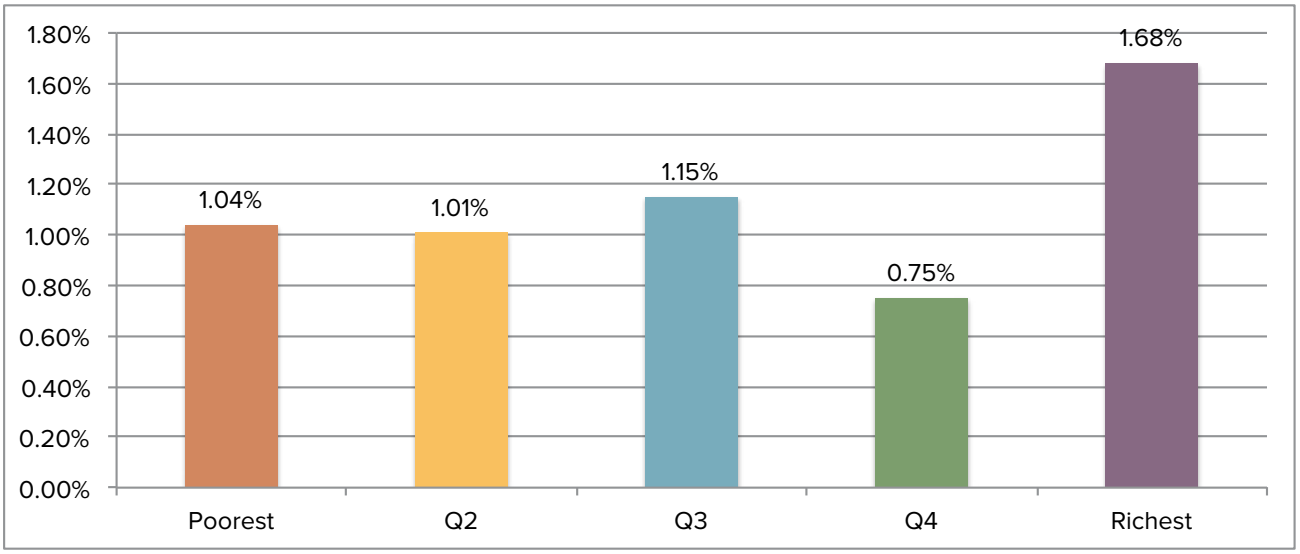
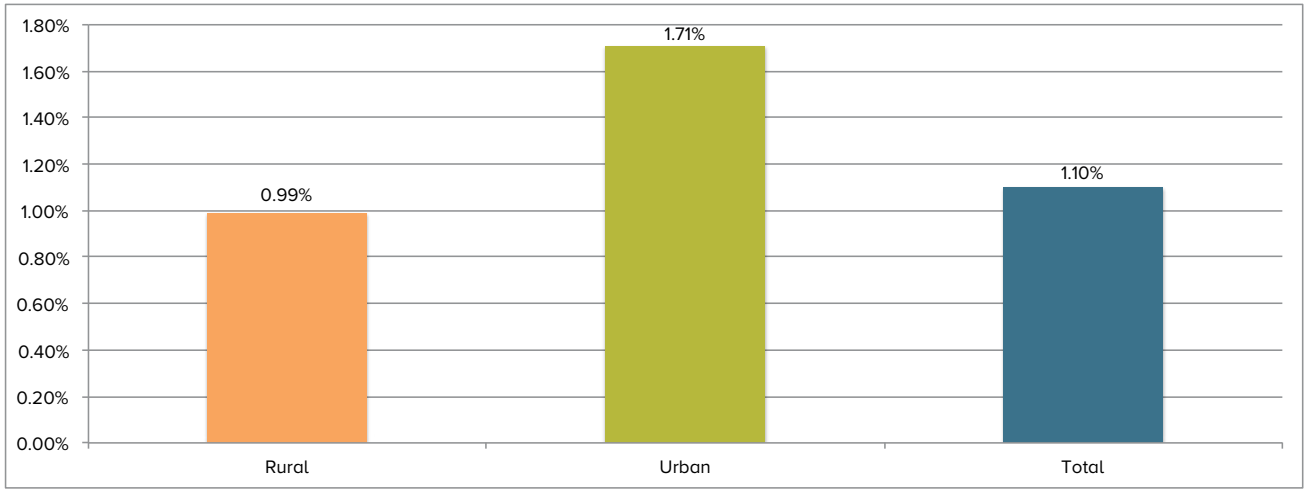


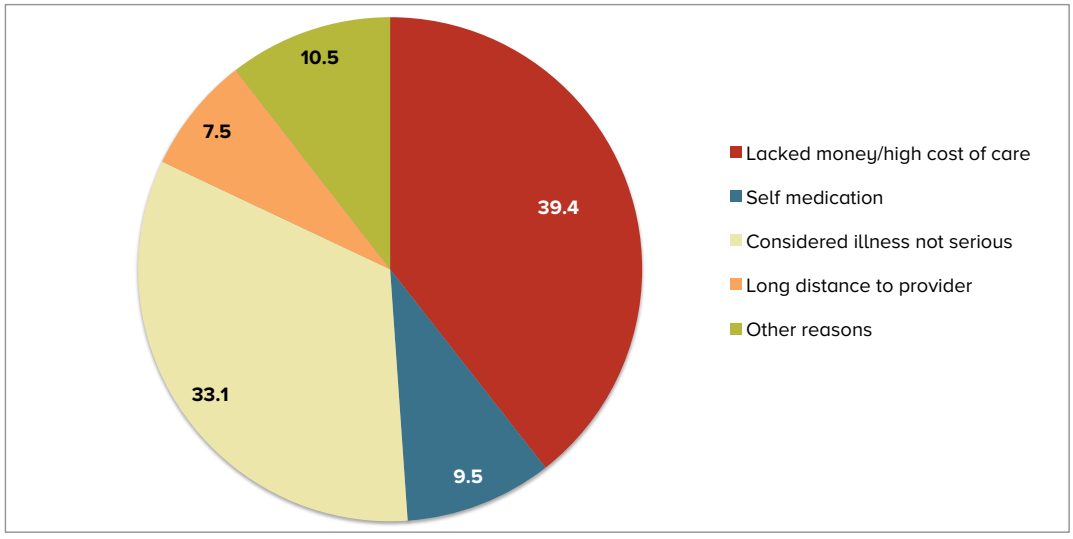
Figure 4.4 Use of Emergency Health Care by Residence



4.1.2 Reasons for Not Seeking Health Care

This report finds that a little over half of the individuals who reported being ill sought healthcare. Furthermore, the above figures indicate that individuals in the age groups that reported a higher rate of illnesses were less likely to seek healthcare in a health facility. In an attempt to understand why people who reported being ill did not often seek care, the survey asked reasons behind not seeking care. This sub-section presents major reasons reported for not seeking care in a health facility. Four main reasons reported for not seeking healthcare include: lack of money, considering illness not serious, self-medication at home, and long distance to facility. Factors often considered important barriers to seeking care such as cultural/religious reasons, poor quality of care, or fear of discovering serious illnesses each contributed 2% or less among reasons reported for not seeking care, and were therefore included all under "other reasons" (see Figure 4.5).

Figure 4.5 Percent of Ill Who Did Not Seek Care by Main Reasons for Not Seeking Health Care



Reasons reported for not seeking healthcare vary significantly by place of residence and economic status, while gender difference in reasons for not seeking care is relatively small. Rural residents were twice as likely to mention lack of money as a reason for not seeking care (38.5%) compared with urban residents (19.0%). Likewise, individuals in the poorest wealth quintile households were four times more likely (43.9%) to mention lack of money as a reason for not seeking care as their counterparts in the richest wealth quintile households (10.6%). Lack of money was the main reason for not seeking care for individuals living in rural areas or in the poorest wealth quintile households, while considering illness 'not serious' was the main reason for not seeking care among individuals in urban areas and those in the wealthiest households (see Table 4.4). Lack of money as a barrier to seeking care has not changed significantly since the previous survey, in which 42.5% cited either shortage of money or high cost of care as the reason, compared to 39.4% in this survey.

The previous survey (FMOH 2014), against expectation, found that individuals from households in the richest wealth quintile were more likely to mention lack of money as a reason for not seeking healthcare. The other findings of the current report are consistent with the result of the previous HA report (FMOH 2014) as well as other earlier findings, such as the ones reported by the FMOH (2010b) and CSA (2012). In all of these studies, lack of money or services being too expensive, perceptions that illnesses were not severe, as well as self-medication were among the three main reasons reported for not seeking care. While further studies are required to explain the above findings, the following factors could be considered as some of the potential explanatory factors. First, urban residents are more likely to have access to information and are more likely to be educated, which potentially enables them to assess the nature of their illness better than rural residents can. Second and more importantly, urban residents have better access to medicines through private pharmacies and other drug vendors that are more abundantly available in urban than in rural areas, which enables self-medication among urban residents. As indicated above, further investigations are needed to empirically test these hypotheses and understand the determinants of self-medication in both rural and urban areas.

There was considerable variation among regions in reported reasons for not seeking care. For example, in the more urbanized regions such as Addis Ababa, Dire Dawa and Harari, lack of money was not reported as a main reason for not seeking care. Rather, the majority of individuals who were reportedly ill in these regions failed to seek healthcare because they did not consider their illnesses to be severe. On the other hand, in the more agrarian regions such as Amhara, Oromia and SNNPR, lack of money was reported to be the main reason people did not seek healthcare (See Table 4.4).

Table 4.4 Main Reasons for Not Seeking Care by Sex, Wealth Status, Residence and Region

	Lacked money	Self medication	Poor quality of care	High cost of care	Religious/ cultural reasons	Fear of discovering serious illness	Considered illness not serious	Long distance to provider	Other	Total
Sex										
Male	34.4	11.2	1.9	2.7	1.4	1.1	35	6.7	5.7	100
Female	38	8	2	3.4	1.7	1	31.5	8.2	6.3	100
Residence										
Rural	38.5	9.2	1.9	3.3	1.5	1	31.5	7.8	5.4	100
Urban	19	11.3	2.6	1.3	2.2	1.5	45.9	4.8	11.4	100
Regions										
Addis Ababa	7.7	4.7	2.3	0.0	2.3	2.6	61.7	0.6	18.1	100
Afar	25.3	9.2	2.4	0.0	0.0	0.0	22.1	21.9	18.3	100
Amhara	36.9	6.2	2.3	3.0	1.0	1.6	36.3	7.7	5.1	100
Benishangul Gumuz	38.2	13.1	4.5	2.8	0.7	0.0	17.6	21.7	1.4	100
Dire Dawa	27.7	0.0	10.8	1.6	9.2	0.8	49.1	0.8	0.0	100
Gambella	36.9	17.2	1.5	0.0	0.0	0.0	32.5	6.5	5.5	100
Harari	12.5	4.3	0.0	0.0	0.0	0.0	59.0	10.0	14.3	100
Oromia	42.0	13.7	1.1	3.4	0.0	0.2	28.4	7.4	3.7	100
SNNPR	39.6	11.6	0.6	1.6	1.8	0.3	30.8	3.0	10.9	100
Somali	37.6	9.5	6.4	1.4	0.2	0.3	18.0	18.4	8.3	100
Tigray	23.7	7.1	2.6	6.9	8.8	2.5	34.1	9.2	5.1	100
Wealth quintiles										
Poorest	43.9	7.2	1.6	4.2	1.2	1	28.3	8.3	4.3	100
Q2	35.5	9.1	3.4	2.8	1.5	0.6	31.3	9.1	6.7	100
Q3	36.8	9.8	1.8	2.8	2.2	1.3	29.7	9.4	6.4	100
Q4	35.4	11.1	0.9	2.7	0.6	0.9	39.3	4.6	4.5	100
Richest	10.6	14.9	2.1	1.2	3.1	1.8	53.2	0.7	12.6	100
Total	**36.3**	**9.5**	**2.0**	**3.1**	**1.5**	**1.0**	**33.1**	**7.5**	**6.0**	**100**

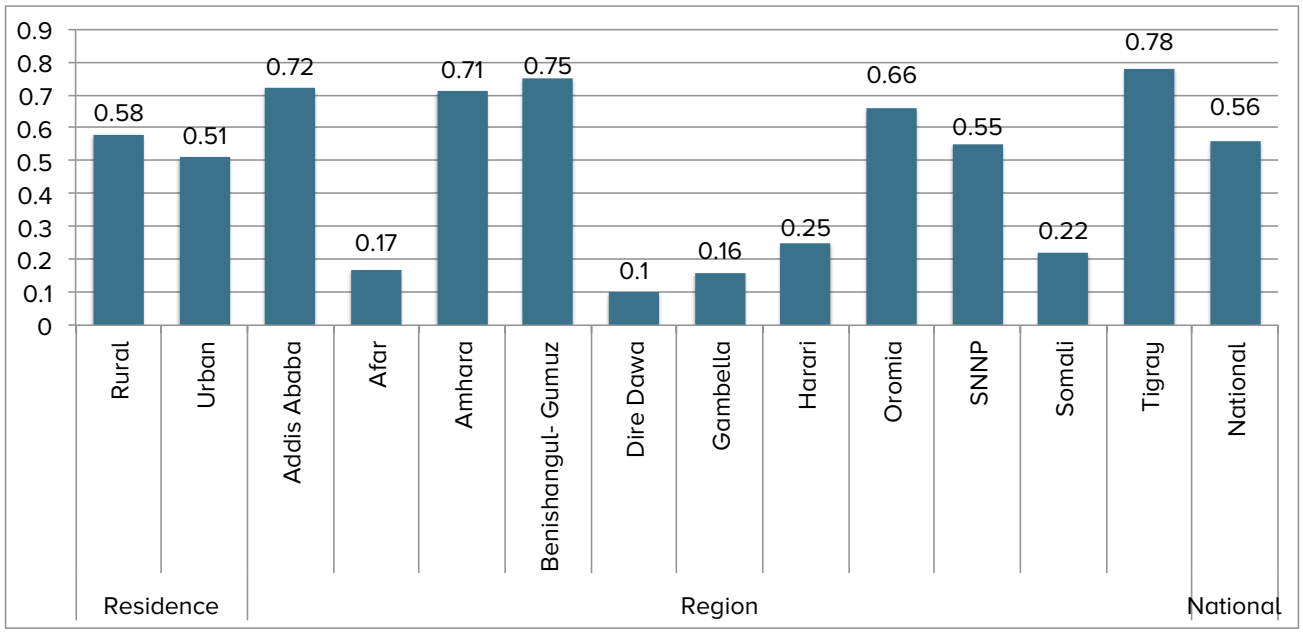
4.2. Use of Outpatient Health Services

The sixth round household survey included a number of questions that sought to understand outpatient healthcare[9] seeking behavior, such as reasons for seeking healthcare, where care was sought, choice of outpatient service providers, distance travelled to seek care, reasons for using or bypassing the nearest outpatient service provider, and the level of compliance with prescribed care. This section provides analysis of data collected on use of outpatient services in Ethiopia.

4.2.1 Outpatient Health Care Seeking Behavior

As can been seen from fig 4.6 below, there was variation in outpatient service between rural and urban areas as well as among regions. The per capita visit per year was estimated at 0.58 visits in rural areas, 0.51 visits in urban areas, and 0.56 visits nationally. However, outpatient health care utilization rates showed considerable variation when the survey data were disaggregated by region. The per capita per year outpatient health services utilization rate was the highest in Tigray region (0.78 visits) followed by Benishangul Gumuz and Addis Ababa with 0.75 and 0.72 visits respectively. The lowest per capita per year outpatient services utilization rate was reported in Dire Dawa, Gambella, Afar, Harari and Somali regions, which was 0.25 visits and lower.

Figure 4.6 Per Capita Outpatient Visits per Year by Residence and Region



4.2.2 Causes of Outpatient Visits to a Health Facility

Table 4.6 provides self-reported causes of outpatient visits. As stated earlier, about 10% of individuals residing in the sampled households reported being ill in the four weeks preceding the survey. Over half (53%) of those individuals who were ill reported seeking care. Seeking nutritional supplements (such as baby formula) was cited as a major reason for making an outpatient visit, followed by treatment of intestinal worms and malaria (see Table 4.6 for top 5 causes of outpatient visits).

[9] An **out-patient** is a person who goes to a health care facility for a consultation/treatment, and who leaves the facility within several hours of the start of the consultation without being "admitted" to the facility as a patient.

Table 4.7 shows self-reported causes of outpatient visits by service/disease categories. Over half of those individuals who sought care mentioned an infectious or communicable disease as the reason for seeking care – the three major causes in this category being malaria (11.1%), pneumonia (9.3%) and diarrhea (8.7%). Chronic or non-communicable diseases such as cancer, diabetes, kidney diseases and mental disorder caused 10% of the total outpatient visits. The number of outpatient visits arising from non-communicable diseases has increased significantly since the last survey (FMOH 2014), where non-communicable diseases caused just 4.8% of outpatient visits.

Table 4.6 Causes of Outpatient Visits to a Health Facility Among Those Using a Health Facility

Top 5 illness and services	%
Nutritional supplements	21.7%
Intestinal worms	11.8%
Malaria	11.1%
Diseases of Respiratory organ including pneumonia	9.3%
Diarrhea	8.7%

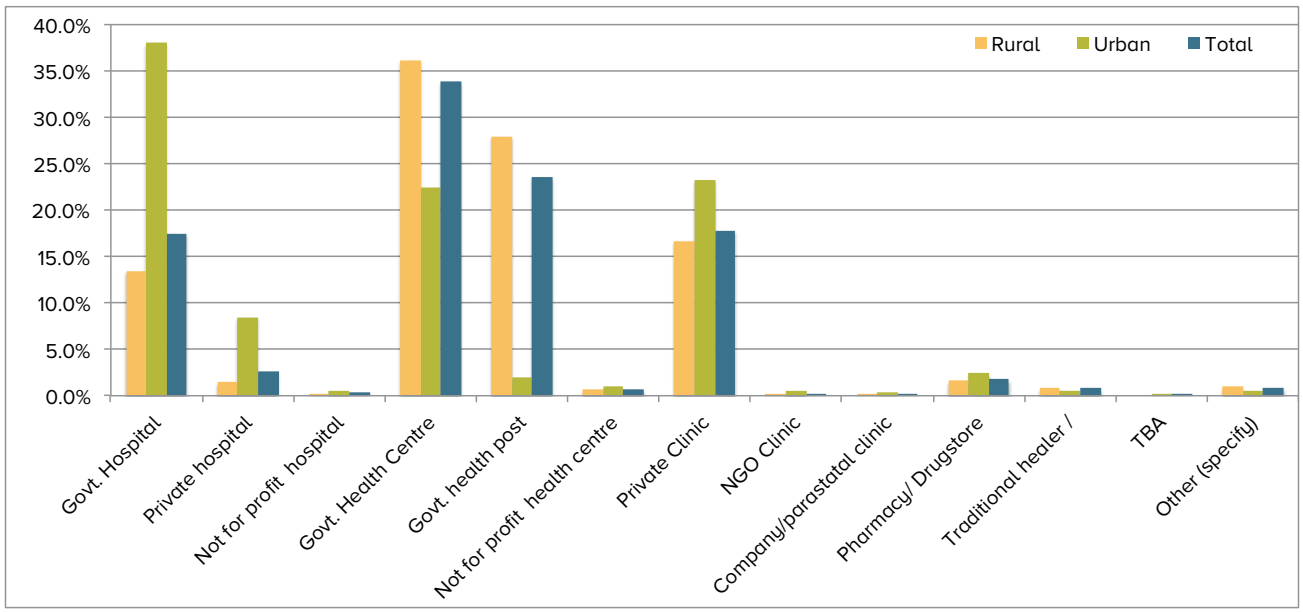
Table 4.7 Causes of Outpatient Visits by Disease/Service Categories from those reported use of health facilities

Illness and services categories	%
Communicable diseases (malaria, pneumonia, TV, HIV, diarrhea, intestinal worms)	54.1%
Nutritional supplements (baby formula, micronutrients and minerals)	25.7%
Non-communicable diseases (cancers, diabetics, chronic kidney diseases, mental disorder)	10.1%
Family planning and reproductive health (including delivery care)	6.6%
Physical check-up and immunizations (prevention)	4.8%
Injuries	2.1%
Other Services	3.3%
Total	**100.0%**

4.2.3 Choice of Outpatient Service Providers

Figure 4.7 shows types of service providers used by outpatient visitors among rural and urban residents. Overall, government healthcare providers were responsible for the majority of outpatient services provided (77% in rural and 63% in urban areas) in the country. The types of health facilities chosen by outpatients were affected by place of residence of service users. For instance, rural residents were more likely to use lower-level government facilities (i.e. health centers and health posts), while urban residents were more likely to use higher-level government facilities (government hospitals) and private facilities. More specifically, urban residents who sought outpatient health care were about three times more likely to use government hospitals, and more than five times more likely to use private hospitals than rural residents.

Figure 4.7 Choice of Providers by Residence



Government health facilities were used by a larger proportion of individuals living in the poorest households (80%) than individuals living in the richest households (62%). Conversely, private health facilities were more likely to be used by individuals living in the richest households (See Figure 4.8). Individuals living in the richest households were at least two times more likely to use outpatient care provided by private health facilities (34%) than individuals living in the poorest households (16%).

Figure 4.8 Health Care Providers Used for Outpatient Services by Wealth Status

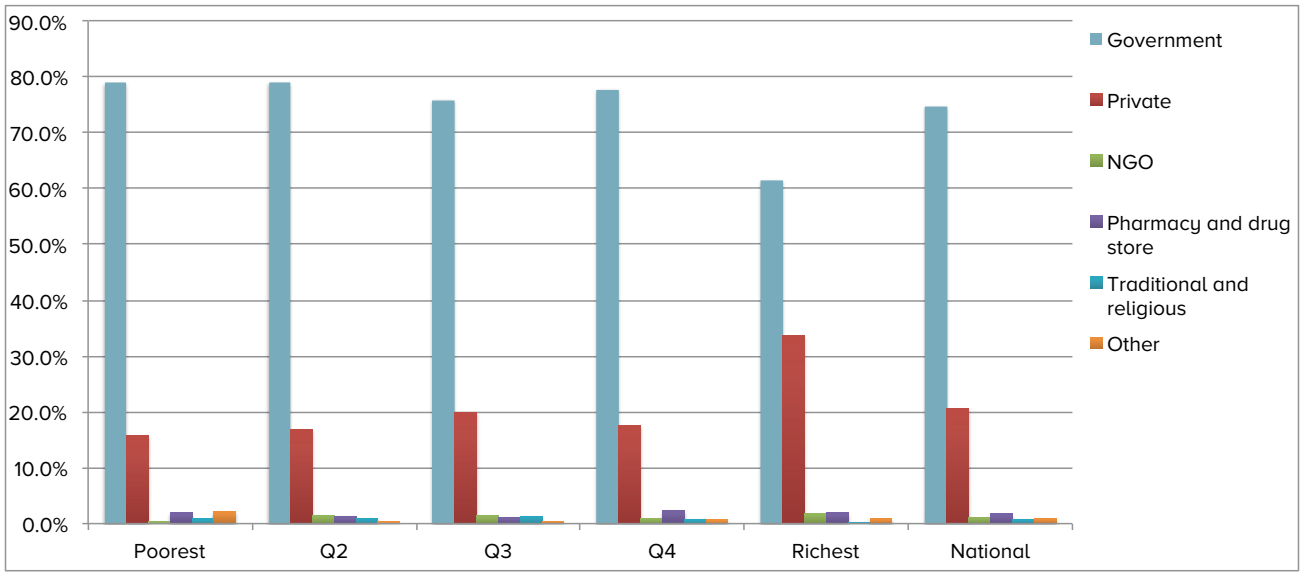


Table 4.8 shows that proximity of health facility to home is the main reason people chose the outpatient healthcare provider they visited. About half of the outpatient healthcare seekers indicated that proximity of the provider to their homes influenced their choice of outpatient facility. Other main factors that were reported to influence patients' choice of outpatient health service providers include availability of medicines (8.5%), good counseling by staff (7.3%), waiting time (5.5%), qualification of staff (5.3%), and whether the facility accepts patients of the fee waiver system (5.4%).

Proximity of facility to home and availability of medicines were more important to rural residents in choosing a facility than to urban residents. Interestingly, cost of services was more important to urban residents while acceptance of users of waiver system was more important to rural residents.

Table 4.8 Reasons for Choice of Outpatient Health Service Providers

Reasons	Rural	Urban	Total
Close to home	51.3%	43.3%	49.9%
Medicine available	9.1%	5.8%	8.5%
Staff give good advice	7.0%	9.0%	7.3%
Less waiting time	5.4%	6.0%	5.5%
Accept users of waiver system	5.8%	3.3%	5.4%
Staff are qualified	4.5%	9.2%	5.3%
Knew someone in the facility	4.0%	2.8%	3.8%
Good staff attitude	3.1%	4.7%	3.4%
Less costly	2.1%	3.6%	2.3%
Accept insurance (CBHI)	1.5%	3.7%	1.9%
Provide exempted services	1.9%	1.7%	1.8%
Other (specify)	1.1%	2.7%	1.4%
Was referred	0.9%	2.1%	1.1%
Felt not seriously ill (minor ailment)	0.9%	0.6%	0.9%
Cleaner facility	0.5%	0.6%	0.5%
More privacy	0.3%	0.4%	0.3%
Don't know	0.7%	0.6%	0.7%
Total	**100.0%**	**100.0%**	**100.0%**

4.2.4 Bypassing the Nearest Outpatient Health Service Providers

As indicated above, distance was a key determinant of the healthcare provider that patients chose. However, distance was not the only variable that influenced patients' choice of facility. Respondents were asked whether the outpatient health facility they chose was the closest to their home, and reasons for choosing the provider they visited. Table 4.9 provides survey data on the percentage of patients visiting or bypassing the nearest health facility, disaggregated by sex, place of residence and region. The majority of outpatient visits (73.4%) were made to the nearest (public or private) facility, an increase from what was reported in the previous survey (FMOH 2014) where 66% of outpatient visits were made to the nearest health facility. This implies that only 26.6% of outpatient visitors in the current survey bypassed the nearest health facility, which was slightly lower among women (26.1%) than men (27.0%). Outpatient visitors living in urban areas were more likely to bypass the nearest facility (31.7%) compared with outpatient service users living in rural areas (25.5%).

Significant regional variation was observed on the level of using or bypassing the nearest outpatient care facility. Most outpatient visitors in Gambella (57.9%) reported bypassing the nearest facility, more than patients in any other region, while outpatients in Tigray were least likely to bypass the nearest facility (12.4%). Similarly, outpatients in Amhara (18.4%) and Dire Dawa (22.1%) were also less likely to bypass the nearest outpatient health facility. Outpatients in these regions were more likely to use the nearest facility (Table 4.9).

Table 4.9 Outpatient Health Service Users Who Bypassed the Nearest Health Facility, by Sex, Residence and Region

	Used nearest health facility (%)			Bypassed nearest health facility (%)		
	Male	Female	Total	Male	Female	Total
Residence						
Rural	67.1%	69.2%	68.3%	32.9%	30.8%	31.7%
Urban	74.1%	74.9%	74.5%	25.9%	25.1%	25.5%
Regions						
Addis Ababa	72.0%	77.1%	74.8%	28.0%	22.9%	25.2%
Afar	66.8%	73.7%	70.0%	33.3%	26.3%	30.0%
Amhara	82.9%	80.2%	81.6%	17.1%	19.8%	18.4%
Benishangul Gumuz	56.5%	58.6%	57.6%	43.5%	41.4%	42.5%
Dire Dawa	70.3%	75.6%	77.9%	29.7%	24.4%	22.1%
Gambella	42.4%	41.8%	42.1%	57.7%	58.2%	57.9%
Harari	69.5%	61.2%	65.3%	30.5%	38.8%	34.7%
Oromia	65.0%	66.5%	65.7%	35.1%	33.5%	34.3%
SNNPR	73.1%	74.9%	74.0%	26.9%	25.1%	26.0%
Somali	62.3%	61.9%	62.1%	37.7%	38.1%	37.9%
Tigray	86.8%	88.3%	87.6%	13.2%	11.7%	12.4%
Total	**73.0%**	**73.9%**	**73.4%**	**27.0%**	**26.1%**	**26.6%**

4.2.5 Reasons for Bypassing the Nearest Outpatient Health Service Providers

Table 4.10 shows reasons provided by individuals who bypassed the nearest health facility to seek outpatient health services at another facility. The main reason for bypassing the nearest facility was a perception that the quality of care at the nearest health facilities is too low. In particular, about 50% of individuals who bypassed the nearest facility cited either lack of drugs or qualified staff as reasons for doing so (30.0% of those who bypassed nearest facility mentioned "unavailability of medicines" and 17.1% stated "unqualified" health staff in the nearest facility). This shows a significant decrease in percentage of individuals who cited unavailability of medicines and unqualified staff as reasons for bypassing the nearest facility, which were 55.6% and 23% respectively in the previous survey (FMOH 2014).

Another 19% of patients who bypassed the nearest outpatient facility stated reasons that could be attributed to poor facility management - 10.4% for "long waiting time" and 8.6% for "unfriendly staff". Facility closure at the time of visit (13.6%) and failure to provide exempted services or accept patients who use the fee waiver system (7.0%) were also cited as reasons for bypassing the nearest facility. Overall, while there appears to be a significant improvement compared with what was reported in the previous survey, (perception on) unavailability of drugs, and unqualified, uncooperative or unfriendly staff members are still some of the major problems perceived by patients who bypassed the nearest facility.

Table 4.10 Reasons Reported by Outpatient Health Service Users for Bypassing the Nearest Health Facility

	Percent (of weighted population)
Individuals who received outpatient care at nearest health facility	**73.4%**
Individuals who bypassed nearest the health facility	**26.6%**
Reasons for bypassing	
Medicine unavailable	33.0%
Staff are unqualified	17.1%
Facility closed (at the time)	13.6%
Long waiting time	10.4%
Unfriendly staff	8.6%
Would have paid (facility doesn't provide exempted service)	5.3%
More expensive services	3.5%
No privacy	3.4%
Facility not in operation	1.8%
Would have paid (facility doesn't accept waiver system users)	1.7%
Would have paid (facility didn't sign agreement with insurance scheme)	1.1%
Dirty facility	0.6%
Total	**100.0%**

4.2.6 Distance Traveled to Obtain Outpatient Health Services

Patients who sought outpatient care reported traveling an average distance of about 27.9 kilometers to reach a health facility and return back home (Table 4.11), representing an increase from 17 kilometers in the previous survey (FMOH 2014). Part of this increase could be because the reported distance by kilometers were mainly estimated, rather than measured, which could lead to under/over estimation. About 70% of the outpatient health service seekers reported obtaining the health services they needed by traveling less than 15 kilometers. As expected, distance traveled by outpatient health service seekers differs between people living in urban and rural areas. A larger proportion of rural patients (32.6%) traveled a long distance (greater than 15 km round-trip) to seek outpatient services than patients from urban settings (13.0%). The proportion of patients who reported traveling 15 km or more round-trip to seek outpatient services seems to have increased since the previous survey in both rural (21.6%) and urban (5.6%) areas, which appears implausible given the continuous expansion of facilities. However, it is important to note that expressing distance in kilometers is often challenging for respondents, particularly in rural areas.

The majority of outpatient service users (67.1%) traveled on foot to reach the health facility. In rural areas, over 70% of outpatient service users walked to the facility they visited while less than 30% of them used public or other means of transportation to reach the facility of their choice. In urban areas, about half of the outpatient service users reported walking to health facility while the remaining half reported using either public transport, taxi or private means of transportation (Table 4.11).

Table 4.11 Distance Traveled and Type of Transportation Used by Outpatient visitors

	Rural	Urban	Total
Distance Traveled to Facility (roundtrip)			
0 – 1 KM	19.6%	35.0%	22.2%
1.001 – 5 KM	21.2%	39.0%	24.3%
5.001 – 10 KM	19.4%	10.3%	17.8%
10.001 – 15 KM	7.2%	2.8%	6.4%
Greater than 15 KM	32.6%	13.0%	29.2%
Average KM travelled	30.3	16.3	27.9
Means of transport			
Woreda/HC/Hospital Ambulance	0.5%	0.4%	0.5%
Public transport (e.g. Bus, minibus, taxi, truck)	11.9%	5.1%	10.7%
Private (own means)	0.8%	2.6%	1.1%
Taxi (private)/Bajaj/Gari	6.8%	40.4%	12.4%
Boat	0.0%	0.1%	0.0%
Walked	70.7%	49.2%	67.1%
Bicycle/motor cycle	2.7%	0.7%	2.4%
Animal (e.g. horse, mule, camel)	3.2%	0.1%	2.7%
Air	0.1%	0.0%	0.1%
Traditional ambulance	1.1%	0.0%	0.9%
Other (specify)	2.4%	1.4%	2.2%
Total	**100.0%**	**100.0%**	**100.0%**

4.2.7 Patient Satisfaction with Outpatient Services

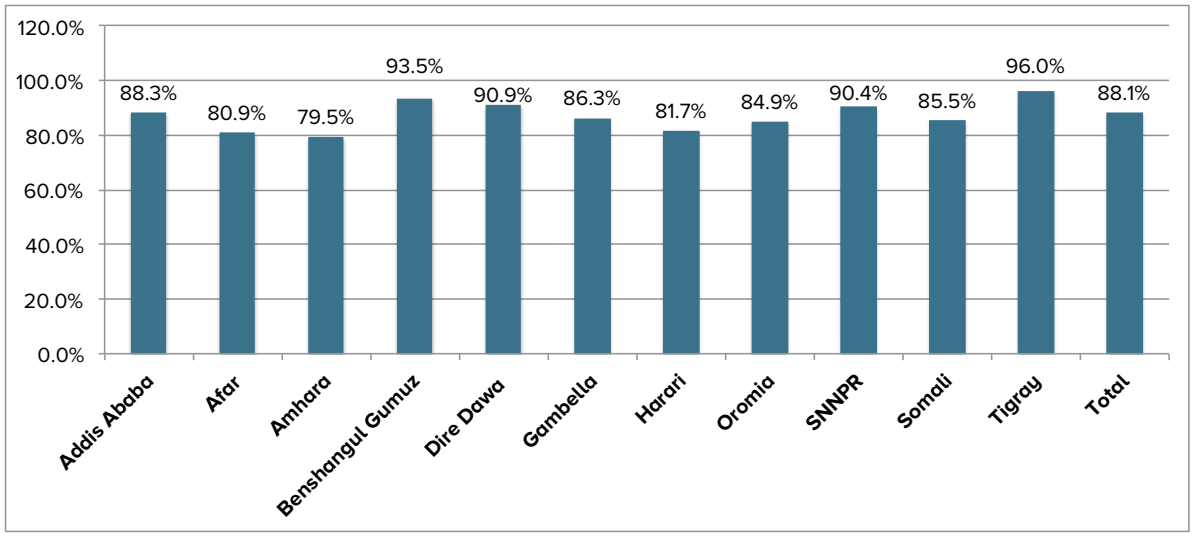
Self-reported patient satisfaction was used as a proxy to assess health care quality. Table 4.12 shows self-reported satisfaction ratings of individuals who made outpatient visits by wealth status. Overall, about 88% of the outpatient visitors reported that they were satisfied with the health services they received from the health facilities they visited, a slight increase from the previous survey where 86.8% reported they were satisfied. However, there appears to be some variation in the rating of patient satisfaction depending on economic status. Patients in the poorest households reported a higher rate of satisfaction with the outpatient services they received compared with patients with better economic status. This result is consistent with the finding of the previous survey (FMOH 2014).

Table 4.12 Patient Satisfaction with Outpatient Health Services

Wealth Quintiles	Is patient satisfied with the outpatient services he/she received?			
	Yes	No	Don't know	Total
Poorest	90.7%	8.6%	0.7%	100.0%
Q2	85.7%	12.7%	1.5%	100.0%
Q3	87.4%	11.3%	1.3%	100.0%
Q4	88.1%	11.6%	0.4%	100.0%
Richest	88.3%	11.2%	0.5%	100.0%
Total	**88.1%**	**11.0%**	**0.9%**	100.0%

In terms of regional distribution, the highest proportion of satisfied or very satisfied outpatient visitors was found in Tigray (96%) followed by Benishangul Gumuz (93.5%) regions. Amhara (79.5%) and Afar (80.9%) regions were among the regions with the lowest rate of satisfaction with the outpatient services they received. (Figure 4.9)

Figure 4.9 Percent of Outpatient Visitors who Reported Being 'Satisfied' or 'Very Satisfied' with Outpatient Health Services Received by Region



Patient satisfaction rates were collected for different aspects of outpatient services. Patients' satisfaction differed among the different dimensions of outpatient health care quality. Overall, the majority of outpatient visitors were satisfied or very satisfied with the various aspects of service they received; however, the highest rate of satisfaction (92%) was reported for "time spent with the clinician" while the lowest rate of satisfaction (78%) was reported for "availability of diagnostic facility". This is also consistent with the finding of the previous report, where higher rate of satisfaction was reported for 'time spent with clinician' and a lower rate of satisfaction was documented with regards to availability of pharmaceuticals and waiting time (see Table 4.13).

Table 4.13 Patient's Satisfaction with Respect to Different Aspects of Outpatient Health Services Level of patient's satisfaction (%)

	Level of patient's satisfaction (%)					
	Very satisfied	Satisfied	Not satisfied	Not at all satisfied	Do not know	Total
Time spent with the clinician	33%	59%	7%	0%	1%	100%
Waiting time	26%	59%	13%	1%	1%	100%
Courtesy of staff	28%	63%	7%	1%	1%	100%
Availability of drugs	29%	58%	11%	1%	1%	100%
Cleanness of facility	26%	65%	7%	0%	2%	100%
Privacy during consultation	26%	60%	8%	0%	5%	100%
Motivation of staff	25%	64%	8%	1%	2%	100%
Skill of provider	27%	61%	8%	0%	4%	100%
Availability of diagnostic facility	20%	58%	12%	1%	9%	100%

Individuals who visited a health facility in the event of illness were asked to report whether they have taken all the prescribed treatments (Table 4.14). About 93% of outpatient visitors reported that they completed their prescribed treatments (an increase from 90.5% reported in the previous survey).

As expected, patients' compliance rate was higher for urban than rural areas, and for the richest than the poorest individuals (both inconsistent with the finding of last survey). The most significant reasons cited among those who reported not taking the complete outpatient treatment as prescribed by health professional were lack of money (53.5%), not considering illness as serious (23.3%), long distance to provider (7.5%) and self-medication (5.5%).

The importance of these inhibiting factors varies by place of residence and economic status of households. For instance, 55.4% of rural residents who did not complete treatment cited lack of money as a reason for not taking all of the prescribed outpatient treatments, while only 33.8% of patients in urban area reported this as a reason. Likewise, only 4.2% of rural residents mentioned self-medication, while 20.2% of urban residents stated it as a reason for not completing the prescribed treatment.

Patients in the poorest households were more likely to indicate lack of money (55.2%) compared with those in the richest households (25.4%) as a reason for not completing outpatient treatment. The previous survey (FMOH 2014) reported that, "surprisingly, shortage of money was a more constraining factor for individuals in urban than rural areas, and for individuals in the richest households than in the poorest households." Interestingly, in the current survey, 'poor quality of service' was six times more likely to be cited by patients in the richest households (13.1%) as a reason for not completing outpatient care compared with those in the poorest households (1.9%).

Table 4.14: Compliance with Prescription for Outpatient Services

		Residence		Wealth Quintile					
		Rural	Urban	Poorest	Q2	Q3	Q4	Richest	Total
Completed all prescribed outpatient treatments at the visited health facility		92.20%	97.20%	91.90%	92.80%	91.00%	92.60%	97.20%	93.30%
Reasons for not taking complete outpatient treatment as prescribed by health professional among those who reported not completing treatment	**Lacked Money**	55.40%	33.80%	55.20%	57.60%	62.50%	49.10%	25.40%	53.60%
	Self medication	4.20%	20.20%	5.60%	5.70%	4.10%	0.40%	20.50%	5.50%
	Poor quality service	3.20%	9.50%	1.90%	7.80%	1.30%	0.90%	13.10%	3.80%
	High Cost of Care	3.20%	12.30%	7.30%	2.50%	3.40%	0.00%	9.00%	3.90%
	Religious /cultural reasons	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Fear of discovering serious illness	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Considered illness not serious	24.00%	16.40%	17.70%	23.80%	23.10%	28.20%	26.10%	23.30%
	Long distance to provider	7.60%	6.20%	8.40%	2.60%	5.60%	14.70%	4.50%	7.50%
	Others	2.50%	1.60%	3.90%	0.00%	0.00%	6.60%	1.40%	2.40%
	Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

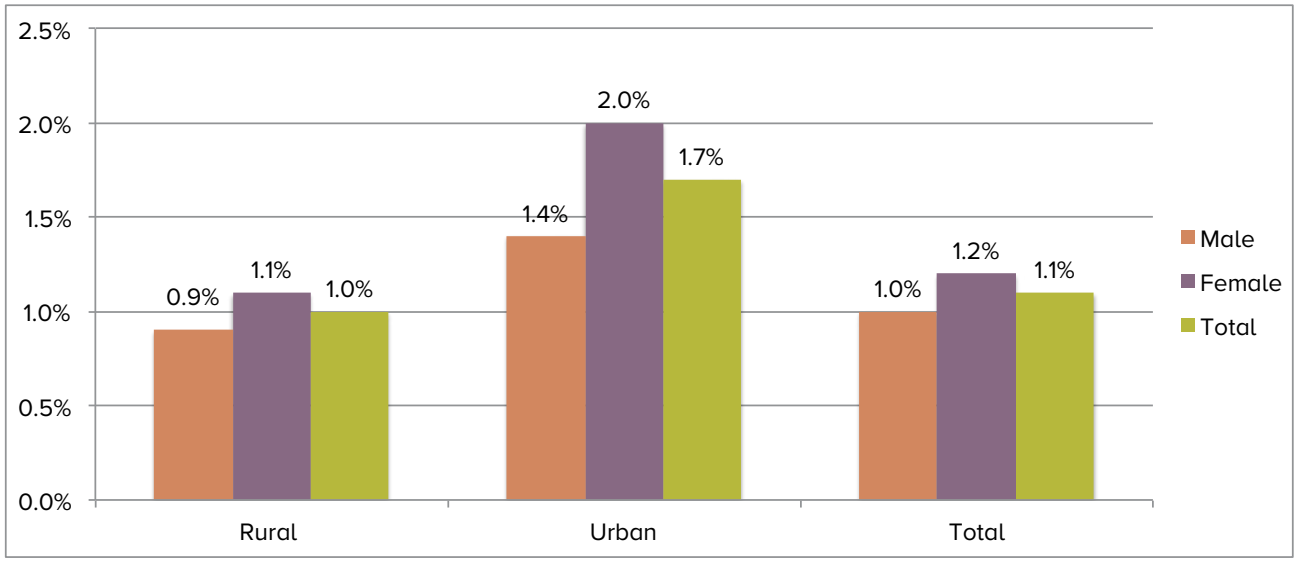
4.3. Use of Inpatient Health Services

This household survey included a number of questions that sought to understand inpatient[10] healthcare seeking behavior such as reasons for inpatient admission, type of facility where care was sought, choice of inpatient service providers, distance travelled to seek inpatient care, reasons for using or bypassing the nearest inpatient service provider, and compliance with prescribed care. Inpatient healthcare in this document refers to services provided to patients admitted for care in a facility with doctor's decision. This section presents an analysis of data collected from households on use of inpatient services in Ethiopia.

4.3.1 Inpatient Health Service Utilization

The inpatient admission rate was reported to be 1.1% of the total population, an increase from 0.9% reported in the previous survey (FMOH 2014). Use of inpatient health services was reported to be higher among females (1.2%) than males (1.0%) and for individuals living in urban (1.7%) than rural (1.0%) areas (see Figure 4.10). One reason for a higher use of inpatient services by females than males could be because of health care utilization associated with delivery (such as C-section). A significant difference was observed across regions in inpatient care utilization (see Table 4.15). The highest inpatient admission rate was observed in Benishangul Gumuz (2.4%), followed by Tigray (2.2%). The lowest inpatient admission rate was reported in Afar and Gambella (0.5%), followed by Amhara (0.7%). As indicated above, females are more likely to use inpatient services compared with males, except in Afar, Dire Dawa and Gambella where inpatient care utilizations were reported to be higher among males (see Table 4.15).

Figure 4.10 Inpatient Admission by Sex and Residence



[10] An **in-patient** is a patient who is formally admitted (or "hospitalized") to an institution for treatment and/or care and stays for a minimum of one night in the hospital or other institution providing in-patient care.

Table 4.15 Inpatient Admission by Region

Region	Male	Female	Total
Addis Ababa	1.4%	1.8%	1.6%
Afar	1.0%	0.2%	0.5%
Amhara	0.6%	0.8%	0.7%
Benishangul Gumuz	1.8%	3.0%	2.4%
Dire Dawa	1.7%	1.1%	1.4%
Gambella	0.8%	0.3%	0.5%
Harari	1.1%	2.6%	1.7%
Oromia	1.0%	1.1%	1.0%
SNNPR	0.9%	1.1%	1.0%
Somali	1.6%	2.2%	1.9%
Tigray	1.6%	2.7%	2.2%
Total	**1.0%**	**1.2%**	**1.1%**

Individuals who were admitted for inpatient care to a health facility in the 12 months preceding the survey were asked to report the main causes for their inpatient admission. Table 4.16 shows that diseases of respiratory infections, including pneumonia, have overtaken malaria (which was the main cause of admission in the previous survey) as the main reason for inpatient admission. Malaria was reported as a second reason for admission (6.1%) followed by intestinal worms (5.7%) and diarrhea (5.5%).

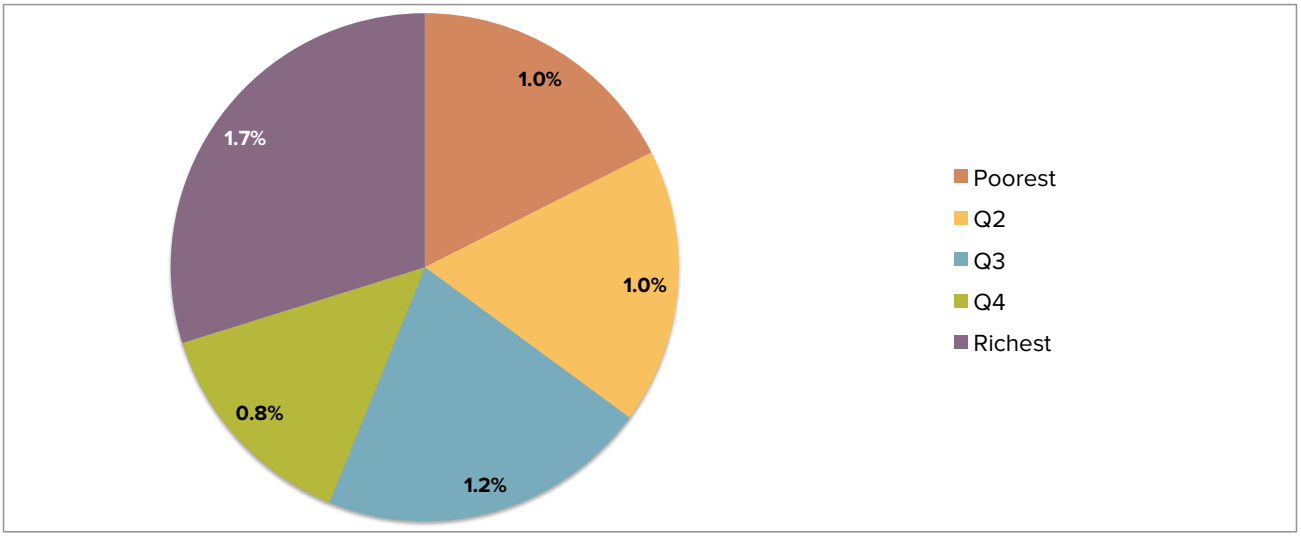
Non-communicable diseases accounted for 13.9% of total causes of inpatient admissions in the 12 months prior to the survey. In the previous survey, non-communicable diseases were reported to account for just 7.44% of all inpatient admissions in the 12 months preceding the survey.

Table 4.16 Top 5 Reasons for Inpatient Admissions

Reasons	Percent
Diarrhea and intestinal worms	11.2
Diseases of Respiratory including pneumonia	8.7%
Malaria	6.1%
Diabetics	5.5%
Delivery	**4.3%**

Inpatient health seeking behavior appears to be closely associated with households' wealth status (see Figure 4.11). Inpatient health services utilization was reported to be higher among individuals living in the richest households (1.7%) than those living in the poorest households (1.0%). A similar association was reported by the previous household survey, where these figures were reported to be 1.3% and 0.8% for individuals living in the richest and poorest households, respectively.

Figure 4.11 Inpatient Admission Rate by Wealth Status



4.3.2 Choice of Inpatient Health Service Providers

Table 4.17 shows a breakdown of inpatient health services provided by types of inpatient service provider. As expected, government health facilities (hospitals and health centers) were the providers of the majority of inpatient services. The share of government healthcare facilities (government hospitals and health centers) in inpatient care increased from 60.8% in the previous survey (FMOH 2014) to 78% in this survey (See Table 4.17). Private health facilities provided 18% of inpatient services (a slight decline from 20.8% reported in the last survey), while NGO health facilities were responsible for the remaining 2% of inpatient care provided in the country.

Choice of inpatient service provider appears to vary based on economic status of households. Individuals living in the poorest households were more likely to use government health centers or NGO hospitals than patients from the richest households. Inversely, individuals living in the richest household were about four times more likely to use private hospitals and five times less likely to use government health centers or NGO hospitals compared with their counterparts living in the poorest households. Inpatient services provided by government hospitals appear to be used more equitably by individuals from all economic statuses compared to government health centers and private facilities, although those from the richest households appear marginally more likely to use government hospitals than patients living in the poorest households (see Table 4.17). This could be because poorer household are more likely to use inpatient services in government health centers.

Table 4.17 Type of Chosen Inpatient Health Service Providers by Wealth Status

Facility Type	Poorest	Q2	Q3	Q4	Richest	Total
Govt. Hospitals	62.8%	68.8%	59.2%	69.4%	65.3%	64.8%
Private hospitals	4.6%	6.9%	2.4%	11.0%	17.4%	9.6%
Not for profit hospital	2.6%	1.0%	5.0%	0.0%	0.5%	1.8%
Govt. health center	26.5%	11.9%	12.5%	18.4%	5.7%	13.2%
Private clinic	3.3%	11.4%	20.9%	0.4%	10.8%	10.5%
Not for profit health center	0.0%	0.0%	0.0%	0.8%	0.3%	0.2%
Abroad (care sought abroad)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Traditional healer	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

More than 60% of individuals living in both rural and urban areas received inpatient care from government hospitals. Among individuals living in rural areas, the inpatient service provider most used was a government hospital, followed by government health center and private clinics (See Figure 4.12). For patients living in urban areas, however, the second most commonly used inpatient facilities were private hospitals and private clinics.

Figure 4.12 Type of Inpatient Health Service Providers Visited, by Residence

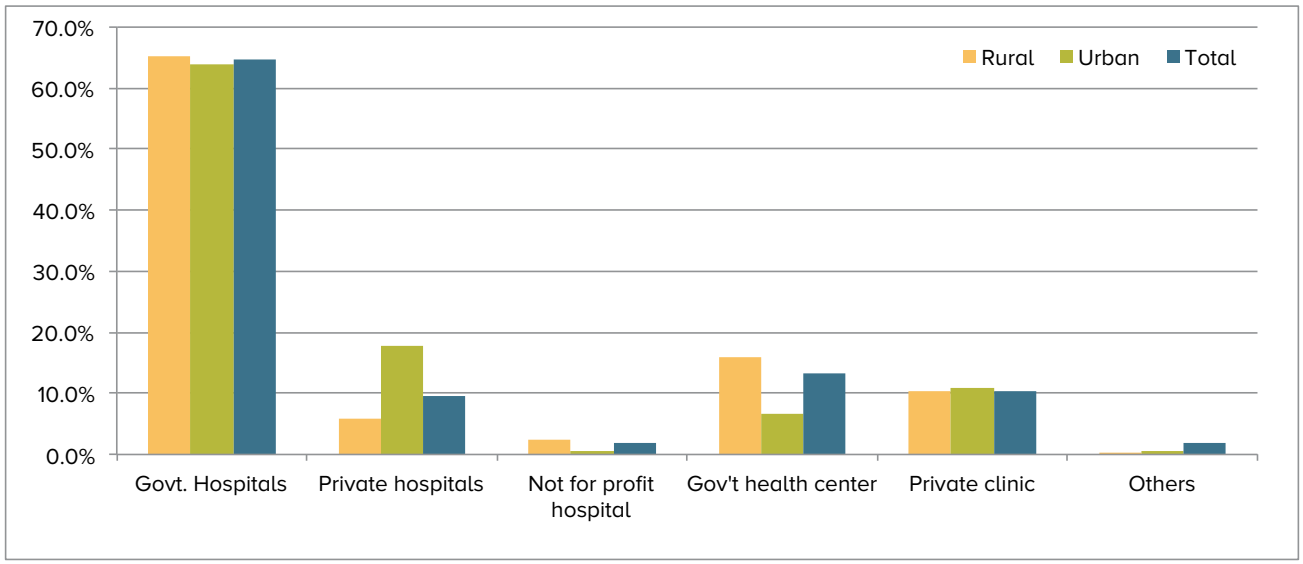


Table 4.18 provides the main reasons inpatient service users reported for choosing the inpatient health service providers they used. Proximity of the facility to one's home (25.7%) and availability of medicines (15.3%) were the dominant reasons for choosing the facility they visited. The provision of exempted service (11.1%), presence of qualified staff (9.8%), less waiting time (9.1%), and having known someone working at the facility (8.6%) were some of the other key reasons reported for choosing inpatient facilities. While most of the findings of this report are consistent with that of the previous report (FMOH 2014), being referred to a facility, which was reported as a significant determinant of where patients received care in the previous survey, was not reported as a major factor for choosing an inpatient provider in this study. On the other hand, waiting time was not as an important determinant of facility choice in the previous survey as it is reported in the current study, which may imply an improvement in quality of care.

Table 4.18 Reasons for Choosing the Preferred Inpatient Health Service Providers (%)

Reason	Rural	Urban	National
Close to home	25.8	25.3	25.7
Staff give good advice	6.7	8.2	7.1
Good staff attitude	4.5	4.9	4.6
Knew someone in the facility	8.3	9.3	8.6
Less waiting time	9.2	8.8	9.1
Medicine available	17.0	9.9	15.3
Staff are qualified	9.9	9.5	9.8
Less costly	0.6	8.5	2.5
Would have paid (facility didn't sign agreement with insurance scheme)	1.7	2.0	1.8
Would have paid (facility doesn't accept waiver system users)	1.4	0.9	1.3
Would have paid (facility doesn't provide exempted service)	12.0	8.2	11.1
Cleaner facility	1.2	1.7	1.3
More privacy	1.6	2.8	1.9
Total	**100.0**	**100.0**	**100.0**

4.3.3 Bypassing the Nearest[11] Inpatient Health Service Providers

Individuals who sought inpatient care were asked whether the inpatient health facility they used was the nearest one to their home or not. Table 4.19 shows that 46.3% of the inpatient health service users bypassed the nearest health facility to seek health care at another health facility. Bypassing the nearest inpatient facility increased significantly since the previous survey, where about 32% of inpatient health service users reported bypassing the nearest facility. The level of bypassing the closest inpatient facility varies by sex and place of residence. The likelihood of bypassing the nearest inpatient facility was lower for females (42.9%) than for males (49.5%), which is consistent with the rate of bypassing the nearest facility in outpatient care but inconsistent with what was reported by the previous survey (where 36.5% of inpatient females and 27.1% of males bypassed the nearest inpatient care provider). Hypothetically, the decrease in the rate of bypassing the nearest facility among women could be due to expansion of health facilities or services. Males were more likely to bypass the nearest inpatient facility in both urban and rural areas (Table 4.19).

Table 4.19 Inpatient Health Service Users Who Bypassed the Nearest Health Facility, by Sex and Residence

Residence	% Used nearest health facility			% Bypassed nearest health facility		
	Male	Female	Total	Male	Female	Total
Rural	51.17	56.13	53.48	48.83	43.87	46.52
Urban	49.93	58.09	53.98	50.07	41.91	46.02
Total	**50.55**	**57.11**	**53.73**	**49.45**	**42.89**	**46.27**

[11] The nearest facility was defined as the closest health facility that provides the kind of care sought. Patients or respondents determine which facility is closest to their home among the facilities, if more than one, providing such care.

A significant variation among regions was observed in bypassing the nearest facility (see Table 4.20). Only 8% of inpatient care-seekers in Afar and 8.4% of those in Gambella bypassed the nearest inpatient facility, by far the lowest rate of bypassing compared with other regions. On the other hand, the highest rate of bypassing the nearest in-patient facility was observed in Addis Ababa (63.0%), followed by Dire Dawa (61.7%). These rates likely reflect the greater options of facilities to chose from in urban areas.

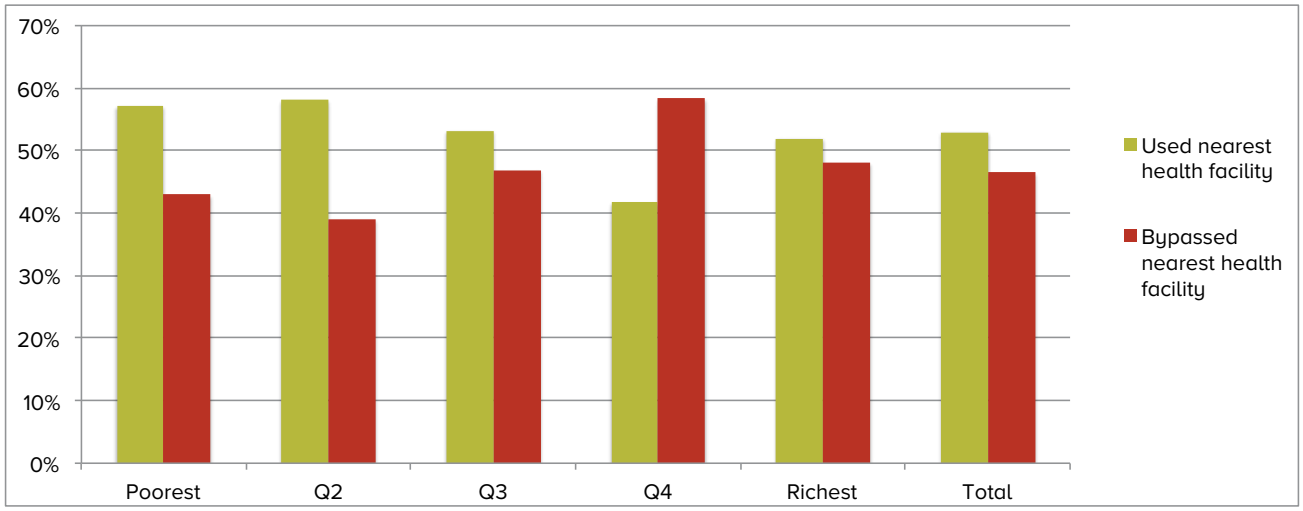
Table 4.20 Inpatient Health Service Users Who Bypassed the Nearest Health Facility, by Sex and Region

Residence	% Used nearest health facility			% Bypassed nearest health facility		
	Male	Female	Total	Male	Female	Total
Addis Ababa	31.5%	47.8%	40.1%	68.5%	52.2%	59.9%
Afar	93.6%	91.3%	92.6%	6.4%	8.7%	7.4%
Amhara	57.0%	57.0%	57.5%	38.2%	39.5%	38.9%
Benishangul Gumuz	61.9%	63.3%	62.6%	39.8%	38.4%	39.1%
Dire Dawa	30.9%	48.1%	38.3%	69.2%	51.9%	61.7%
Gambella	100.0%	83.4%	91.6%	0.0%	16.6%	8.4%
Harari	71.7%	63.4%	68.1%	28.3%	36.6%	31.9%
Oromia	44.9%	54.8%	49.3%	55.1%	45.2%	50.7%
SNNPR	58.4%	62.8%	60.4%	42.1%	39.5%	40.9%
Somali	48.7%	46.5%	47.7%	51.3%	53.5%	52.3%
Tigray	54.2%	55.4%	54.8%	48.5%	47.4%	48.0%
Total	**50.9%**	**56.6%**	**53.6%**	**49.4%**	**44.3%**	**47.0%**

Note: Don't know' is excluded from the table; hence, summation of 'bypassed' and 'used' nearest facility may not come to 100%

The prevalence of bypassing the nearest health facilities for inpatient health care appears to increase with wealth – prevalence of 'bypassing' the nearest facility was lower for individuals residing in the poorest (43%) than the richest (46%) households (see Figure 4.13). The probable reasons for this might be that the wealthy are capable of paying the cost of transportation and potentially other costs to obtain what they perceive to be a better quality services at a facility that is located farther away from home, something poorer households may not be able to do.

Figure 4.13 Proportion of Inpatients Who Bypassed the Nearest Health Facility, by Wealth Quintile



Individuals who bypassed the nearest inpatient facility to their home were asked the reason behind bypassing the facility. Unavailability of medicines (accounting for 29.0%) was reported to be the main reason why individual patients bypassed the nearest facility to their homes (Table 4.21). This was followed by two other key reasons - lack of bed (19.1%) and lack of qualified staff (18.9%) at the nearest inpatient facility. This is consistent with the previous survey, where the top two reasons for bypassing facility were reported to be unavailability of pharmaceutical supplies (33.0%) and unqualified health staff (26.0%) in the closest inpatient health facility. Other important reasons reported include long waits for an appointment (9.0%), and unfriendly staff (7.7%), which is once again consistent with the finding of the previous survey.

Table 4.21 Reasons Reported for Bypassing the Nearest Inpatient Health Facility

Reason	Percent
Unfriendly staff	7.7%
Long waiting time	9.0%
Medicine unavailable	29.0%
Staff are unqualified	18.9%
More expensive services	3.0%
Dirty facility	1.6%
Would have paid (facility didn't sign agreement with insurance scheme)	2.9%
Would have paid (facility doesn't accept waiver system users)	1.5%
Would have paid (facility doesn't provide exempted service)	2.9%
No privacy	2.1%
Facility closed (at the time)	0.2%
Facility not in operation	2.1%
No bed	19.1%
Other	0.0%
Total	**100.0%**

4.3.4 Distance Traveled to Obtain Inpatient Health Services

Table 4.22 presents distance traveled to reach inpatient health services and return home (round trip). As expected, inpatient health service users traveled longer distances on average to seek care (88.8 kilometers) compared with outpatient health care users (27.8 kilometers). These figures were 75.6 kilometers and 17 kilometers respectively in the previous survey. The increase in reported kilometers travelled to use inpatient care, despite expanding inpatient facilities, could be due to the challenge of estimating kilometers accurately, particularly in rural areas where facilities are spread further apart and travel is longer. The majority (60.0%) of inpatient health seekers reported traveling over 15 kilometers to access health service providers, again, a slight increase from the figure reported in the previous survey (57.7%).

Table 4.22 Distance Travelled to Receive Inpatient Care

Distance to Facility (Roundtrip)	Rural	Urban	Total
0 – 1 KM	2.1%	14.0%	5.5%
1.001 – 5 KM	4.5%	30.1%	11.8%
5.001 – 10 KM	14.0%	25.1%	17.2%
10.001 – 15 KM	6.5%	2.7%	5.5%
Greater than 15 KM	72.8%	28.0%	60.0%
Average kilometers travelled	**88.8**	**34.2**	**73.2**

The majority of individuals in urban areas (69.2%) traveled shorter distances (less than 10 kilometers) to use inpatient health services in the 12 months preceding the survey. In contrast, 72.8% of individuals in rural areas had to travel more than 15 kilometers to obtain health services from an inpatient health facility.

4.3.5 Patient Satisfaction with Inpatient Health Services

Table 4.23 shows that 88.3% of the individuals admitted to health facilities reported that they were satisfied with the inpatient health services they received (very close to satisfaction rates for outpatient care). However, satisfaction in inpatient services varied by economic status: individuals in the richest households (83.4%) were less likely to be satisfied with the inpatient health services they had obtained than individuals living in the poorest households (93.4%). This is consistent with the patients' satisfaction with outpatient health services in this and previous survey. However, the finding of the current report contrasts with that of the previous survey where patients from the wealthiest households were more likely to report being satisfied.

Table 4.23: Patient Satisfaction with Inpatient Health Services by Wealth Status

Wealth quintiles	Is patient satisfied with inpatient services received?			Total
	Yes	No	Don't know	
Poorest	93.4%	6.6%	0.0%	100.0%
Q2	85.3%	14.2%	3.5%	103.0%
Q3	89.1%	10.9%	0.0%	100.0%
Q4	96.2%	2.1%	1.8%	100.0%
Richest	82.8%	15.8%	1.5%	100.0%
Total	**87.6%**	**11.1%**	**1.3%**	**100.0%**

The level of patient's satisfaction was also evaluated for the different aspects of services provided by inpatient facilities. Table 4.24 presents patient satisfaction ratings for selected indicators of quality of care. Overall, 80% or more of inpatient service users rated each aspect of inpatient care as 'good' or 'very good', with the exception of food quality, which about 70% of inpatient users rated as 'good' or 'very good'. Quality of care indicators such as facility cleanness, courtesy of staff, skills of providers and time spent with the clinician were rated as 'good' or 'very good' by over 90% of inpatient service users. On the other hand, service quality indicators such as food quality, availability of drugs, availability of laboratory/diagnostics and waiting time were rated as 'good' or 'very good' by less than 85% of inpatient service users.

Table 4.24 Patient Satisfaction by Major Reasons for Satisfaction

	Level of patient's satisfaction (%)					Total
	Very satisfied	Satisfied	Not satisfied	Not at all satisfied	Do not know	
Time spent with the clinician	34.30%	55.90%	7.10%	0.70%	2.10%	100.00%
Waiting time	30.70%	53.80%	11.40%	1.60%	2.60%	100.00%
Courtesy of staff	31.20%	59.40%	5.90%	1.00%	2.60%	100.00%
Availability of drugs	26.50%	53.60%	16.00%	1.00%	3.00%	100.00%
Availability of lab/ diagnostics	25.10%	56.50%	10.80%	2.00%	5.70%	100.00%
Cleanliness	29.60%	61.40%	6.00%	0.40%	2.60%	100.00%
Bed linen	25.40%	60.00%	11.20%	0.90%	2.60%	100.00%
Food quality	19.20%	51.50%	10.10%	2.60%	16.60%	100.00%
Consultation privacy	26.40%	62.90%	3.60%	0.90%	6.20%	100.00%
Motivation of staffs	**25.30%**	**64.50%**	**6.80%**	**0.90%**	**2.60%**	**100.00%**

Chapter 5. Household Health Expenditure

Households as a source for health financing in Ethiopia contribute in three major ways: OOP expenditure, community contributions to support the health sector, and premium payments for health insurance schemes. Total OOP expenditures and insurance premium payments are reviewed in this chapter, and consist of expenditures on outpatient, inpatient, and routine health expenses. Community contributions are explained in more detail in the next chapter.

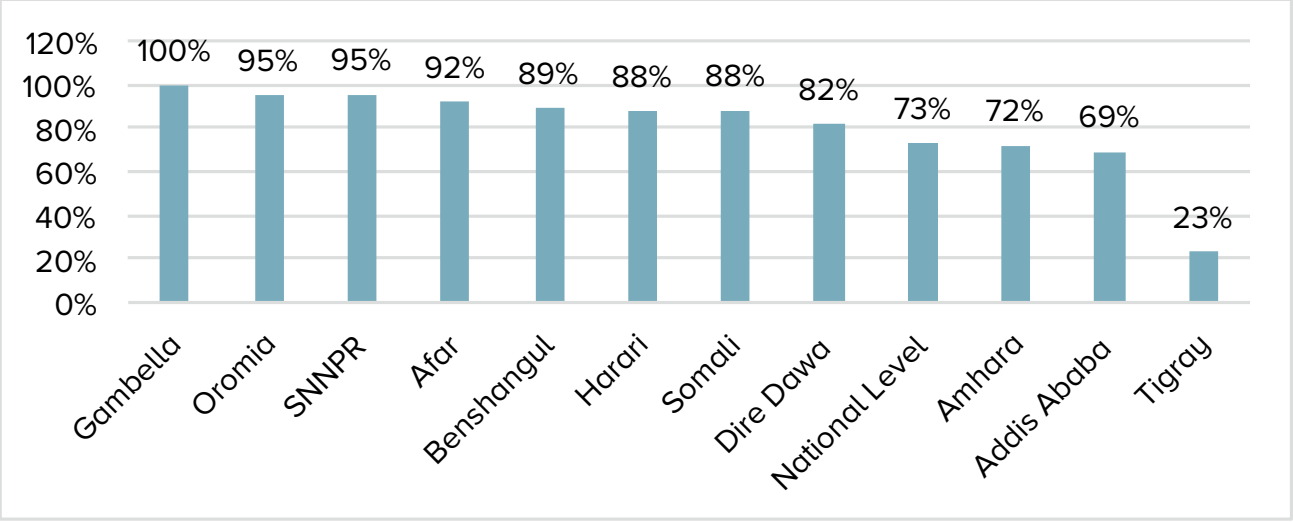
To generate the outpatient expenditure, households were requested to report illness visits made to a health provider in the four weeks preceding the survey and the amount of money paid for each visit. A sum of payments was then calculated and annualized to obtain household expenditure on outpatient services. The same methodology was adopted to generate annual expenditures for routine expenses.

In the case of households' inpatient expenditure, information on all admissions in the last 12 months was collected, including the corresponding expenditures for each admission. A sum of expenditures for all admissions was estimated to give the total household expenditure for inpatient services.

5.1 Payment for Health Services and Reasons for Not Paying

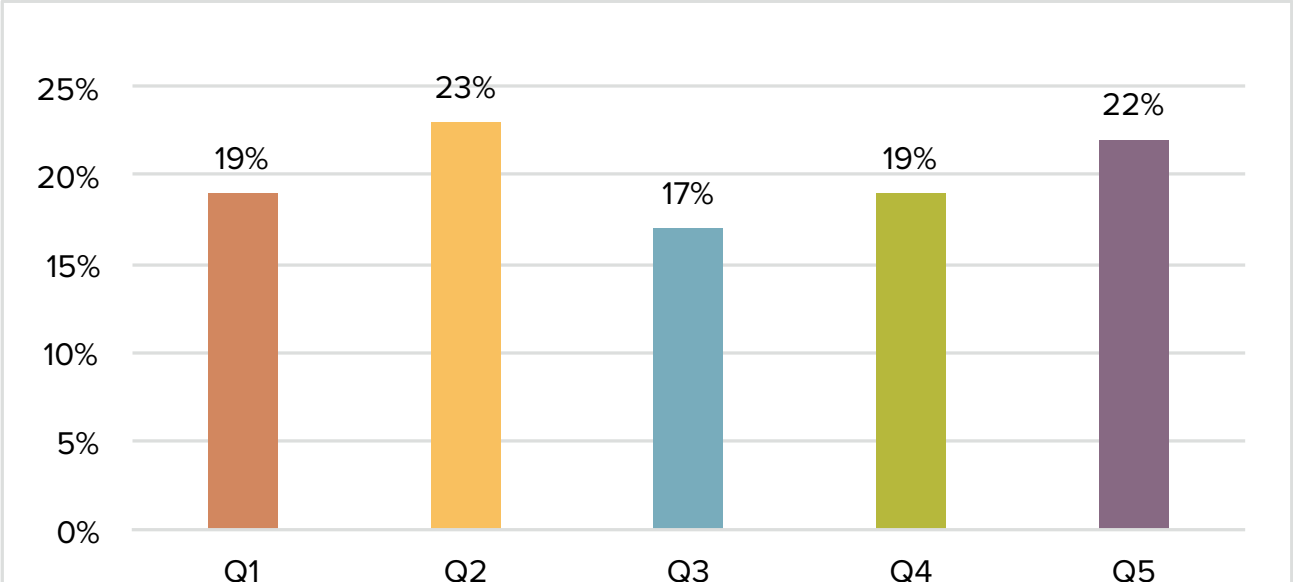
Of the total survey population that sought outpatient care during the survey period, about 73% paid for health services that they received from health providers. There is a very high regional variation in those reporting paying, ranging from the highest in Gambella (100%) to the lowest in Tigray (23%). The only other regions with lower than the national average were Amhara (72%) and Addis Ababa (69%), which were not too far from the national average (figure 5.1).

Figure 5.1 Percentage of Individuals Paying for Outpatient Services by Region



When we explore the proportion of people that paid for health services by income quintiles, the data does not show a clear pattern. Only 19% of the very poor (Q1) paid for services, which was similar to Q4 but higher than Q3 (figure 5.2).

Figure 5.2 Percent of Individuals Paying for Outpatient Services by Economic Quintiles



Further analysis of those who paid for the health services by their insurance status, showed that 87% of those that paid for health services were not members of any type of insurance and paid OOP, while only 12% of those who paid for services reported that they were members of insurance schemes. Of the insurance members, 42% of them paid money to seek care that was in addition to their premiums (table 5.1). These include payments for transport and accommodation, which are not part of the insurance benefit package (see the details in chapter 7).

Table 5.1 Percentage of Individuals Paying for Outpatient Services by Insurance Membership

Membership status	% of People Paying OOP	% Not paying OOP	Total (%)
Insurance Members	42%	58%	12%
No Membership of insurance	78%	22%	87%
Do not know	-	-	1%
Total	**73%**	**27%**	**100%**

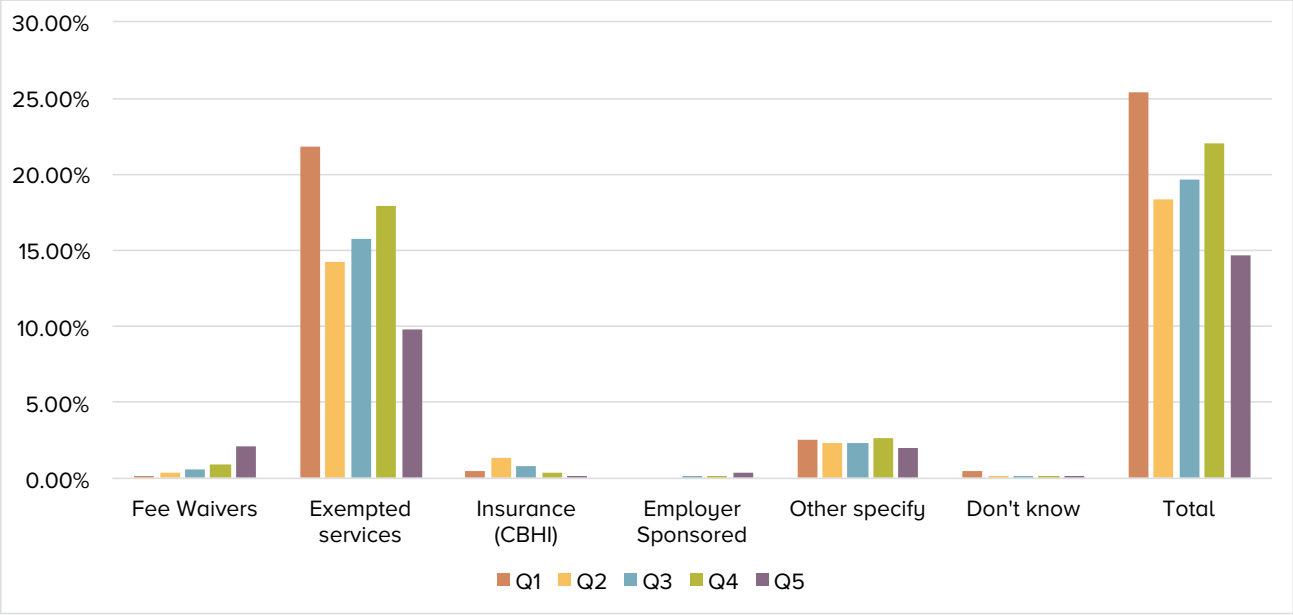
When we explore the 27% of individuals that did not pay for services, 80% did not pay due to the fact that they accessed exempted services; a further 4% did not pay because they are financed as fee waiver beneficiaries, another 3% because they are members of CBHI, and about 12% did not specify the cause of non-payment. If we explore further by region, most of the shares of exempted services were observed in Tigray, SNNPR, Oromia and Amhara (see Table 5.2)

Table 5.2 Percent of People Not Paying for Outpatient and Inpatient Services by Major Reasons for Not Paying by Region, Income Quintile and Insurance Status

	Fee Waiver	Exempted services	Insurance (CBHI)	Employer Sponsored	Others (not specified and don't know)
Addis Ababa	2%	3%	0%	0%	0%
Afar	0%	0%	0%	0%	0%
Amhara	1%	8%	2%	0%	3%
Benishangul Gumuz	0%	1%	0%	0%	0%
Dire Dawa	0%	0%	0%	0%	0%
Gambella	0%	0%	0%	0%	0%
Harari	0%	0%	0%	0%	0%
Oromia	0%	10%	0%	0%	4%
SNNPR	0%	11%	0%	0%	1%
Somali	0%	1%	0%	0%	0%
Tigray	0%	44%	0%	0%	2%
Total	**4.14%**	**80.15%**	3.23%	0.6%	12%

When the percent of people not paying for services is explored by different reasons of not paying by income quintiles, 22% of the very poor (Q1) did not pay due to exempted services, which is higher than all other quintiles. However, this survey shows that the very poor (Q1) were not the highest beneficiaries of fee waivers (in fact the wealthiest households appear to be the highest beneficiaries), indicating the probability that there are significant challenges in targeting fee waivers -reflected in leakage of support to those other than the very poor.

Figure 5.3: Reasons for Not Paying for Health Services by Income Quintiles



Among the surveyed people who paid for services, all of them reported paying in cash. The survey data documented that there were no health providers that were receiving any payment in the form of in-kind payment.

5.2 Estimates of Per Capita Out of Pocket Spending

Households who had sought care were requested to provide information on how much they spent on various categories of health spending when they visited health facilities during care seeking, including both health related and non-health related expenditures. The total OOP spending was estimated to be 18.2 billion ETB, of which 45% was for drugs and medical supplies; while 16% was for diagnosis and investigation. The third most important category was food and accommodation expenditures (12%), including for those that are accompanying the patient. Of the total OOPs, about 17.5 billion ETB (96%) was spent on outpatient services, while the remaining 711.6 million (4%) was on inpatient services. Table 5.3 shows the estimated spending by different categories of spending. Further analysis of OOP spending by expenditure categories shows that 70% of total OOP spending was on health services, while 22% was for bed, accommodation and transport, and the remaining 7% was not specified. Analysis of the composition of spending shows that about 45% of the total OOP spending is incurred for drugs and medical supplies, followed by diagnostics (16%). The registration and consultation expenditures accounted for only about 9% of the total OOP spending (see table 5.3).

Table 5.3: Estimated Inpatient and Outpatient OOPs by Expenditure Category and Region

	Outpatient OOP		Inpatient OOP		Total OOP	
	Amount (ETB)	**Share (%)**	Amount (ETB)	Share (%)	Amount (ETB)	Share (%)
By expenditure categories						
Registration/Consultation	1,666,453,293	10%	8,653,191	1%	1,675,106,484	9%
Drugs and medical supplies	7,839,667,066	45%	303,658,655	43%	8,143,325,721	45%
Surgical operation			63,029,148	9%	63,029,148	0%
Diagnosis and imaging	2,882,230,539	16%	51,841,724	7%	2,934,072,263	16%
Bed /accommodation	2,096,167,665	12%	135,847,293	19%	2,232,014,958	12%
Transport	1,834,146,707	10%	59,932,629	8%	1,894,079,336	10%
Other (non specified)	1,184,334,731	7%	88,700,291	12%	1,273,035,022	7%
Total	**17,503,000,000**	**100%**	**711,662,932**	**100%**	**18,214,662,932**	**100%**
By Region						
Tigray	512,000,000	3%	52,800,000	7%	564,800,000	3%
Afar	335,000,000	2%	3,910,545	1%	338,910,545	2%
Amhara	2,320,000,000	13%	65,600,000	9%	2,385,600,000	13%
Oromia	8,740,000,000	50%	222,000,000	31%	8,962,000,000	49%
Somali	880,000,000	5%	38,800,000	5%	918,800,000	5%
Benishangul Gumuz	327,000,000	2%	12,000,000	2%	339,000,000	2%
SNNPR	1,610,000,000	9%	134,000,000	19%	1,744,000,000	10%
Gambella	71,500,000	0%	1,558,262	0%	73,058,262	0.41%
Harari	89,300,000	1%	6,894,125	1%	96,194,125	1%
Addis Ababa	2,540,000,000	15%	135,000,000	19%	2,675,000,000	15%
Dire Dawa	78,200,000	0%	39,100,000	5%	117,300,000	1%
Total	**17,503,000,000**	**100%**	**711,662,932**	**100%**	**18,214,662,932**	**100%**

The total per capita OOP expenditure of households for health is estimated at 231 ETB per year. Of this, on average 222 ETB per capita was for outpatient services and 9 ETB was for inpatient services (Table 5.4). The reason for the lower inpatient per capita expenditure as compared to outpatient service visit is the very low incidence of admission

compared to the outpatient services visits (637,000 for inpatient admissions compared with 4 million outpatient visits). Of the total people who sought care during the survey period, only 16% accessed inpatient care. The mean outpatient and inpatient OOP spending for each of the incidences/contacts of utilization was 392 ETB and 1,916 ETB respectively.

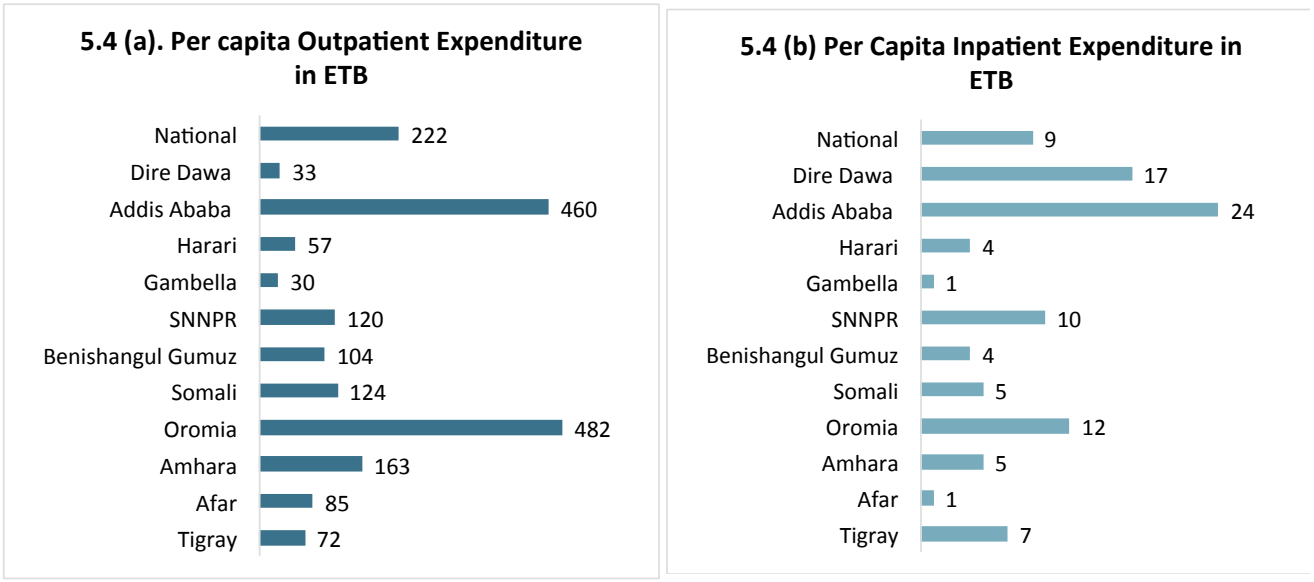
Table 5.4: Per Capita Outpatient and Inpatient OOP by Residence, Region and Wealth Quintile

	Per capita Outpatient Expenditure		Per capita Inpatient Expenditure		Per capita total expenditure	
	ETB	USD	ETB	USD	ETB	USD
Residence						
Rural	191	8.8	7.8	0.36	199	9.2
Urban	341	15.8	14	0.6	355	16.4
Total	**231**	**10.7**	**9**	**0.4**	**231**	**10.7**
By Region						
Tigray	72	3.4	7	0.4	80	3.7
Afar	85	4.0	1	0.1	86	4.0
Amhara	163	7.6	5	0.2	168	7.8
Oromia	482	22.4	12	0.6	494	23.0
Somali	24	5.8	5	0.3	129	6.0
Benishangul Gumuz	104	4.8	4	0.2	108	5.0
SNNPR	120	5.6	10	0.5	130	6.1
Gambella	30	1.4	1	0.0	31	1.4
Harari	57	2.6	4	0.2	61	2.8
Addis Ababa	460	21.4	24	1.1	485	22.6
Dire Dawa	33	1.5	17	0.8	50	2.3
National	**222**	**10.3**	**9**	**0.4**	**231**	**10.8**
Wealth Quintile						
Q1 (The very poor)	154.80	7.2	7.7	0.4	162.5	7.5
Q2 (The poor)	213.70	9.9	8.9	0.4	227.7	10.5
Q3 (Lower middle)	228.30	10.6	8	0.4	236.3	10.9
Q4 (Upper middle)	154.1	7.1	6.8	0.3	161	7.4
Q5 (The rich)	**359.00**	**16.6**	**13.7**	**0.6**	**372.7**	**17.2**

There is a significant variation among regions on the per capita outpatient and inpatient OOP expenditures. In terms of per capita outpatient expenditure, Oromia and Addis Ababa are way higher than the national average with 482 ETB and 460 ETB per capita respectively. Further analysis of the data shows that these two regions had higher bypassing rates of nearest primary health care facilities (Oromia 35;% Addis Ababa 30%) and higher use of private facilities (Oromia 37%; Addis Ababa 20%, Amhara 8% and Tigray 3%), which have higher fee rates than the lower PHC and public health facilities. This may explain to some degree the higher expenditures in Oromia and Addis Ababa as compared to other regions. When we break down the OOPs by residence, the average per capita OOP is 77% higher for urban areas, with 355 ETB per capita, compared with the rural areas (200 ETB) as shown on table 5.4.

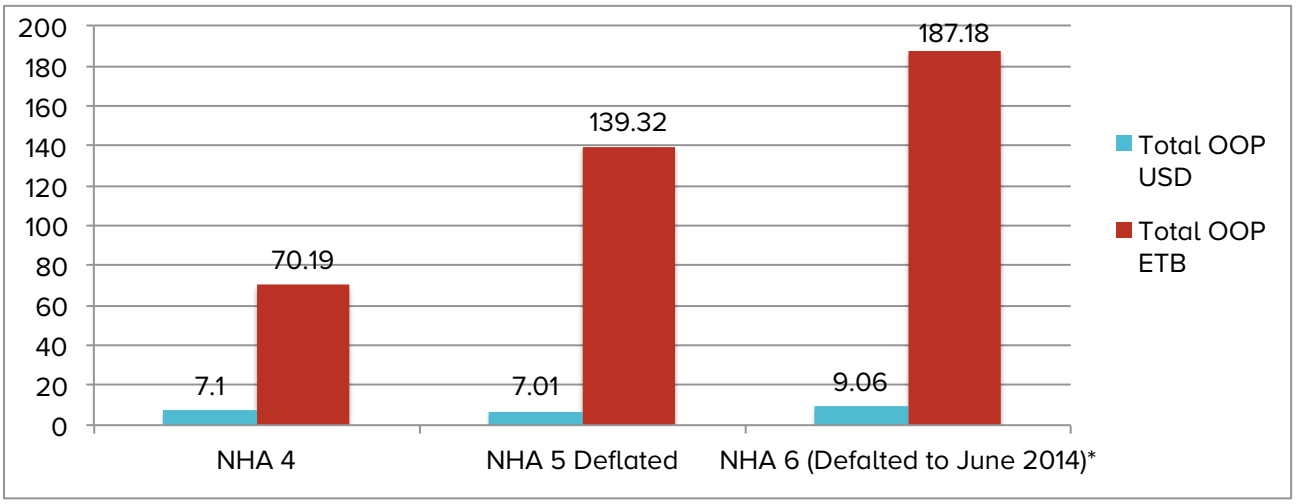
An analysis of the out of pocket spending by expenditure quintiles show that average per capita outpatient OOPs increased as one goes from lower to higher expenditure quintiles, with the exception of Q4 (table 5.4).

Figure 5.4 (a and b): per capita outpatient and inpatient OOP by region



The estimated per capita OOP spending has increased by 34% compared with the HA V household survey result, increasing from 139 ETB to 187 ETB. This is less of an increase compared to the 69% increase in per capita OOP spending between HA 4 and 5. However, the total per capita OOP in USD increased by only 29% between HA 5 and the current HA 6 (Figure 5.5). This could be caused by a depreciation of the Ethiopian Birr, and the increased cost of mainly imported drugs and medical supplies associated with the increasing burden of communicable diseases (documented in the preceding section).

Figure 5.5 Comparison of Estimated OOP Spending Among the Three Available HA HH Surveys



* The NHA 6 is being prepared using the latest available audited government expenditures, 2013/14. This OOP estimate therefore needs to be deflated to the same period for consolidation.

Analysis of which type of providers households paid for the services they received show that 50% of the total OOP spending was paid to government hospitals and health centers. The share of private-for-profit and private-not-for-profit providers is estimated at 47% and 1% respectively (See table 5.5).

Given that government health facilities provided 75% and & 78% of the total outpatient and inpatient services covered in this survey respectively, compared to 20.1% and 20.5% in the private sector (see the preceding sections), the analysis demonstrates that private health providers are much more expensive than public health facilities.

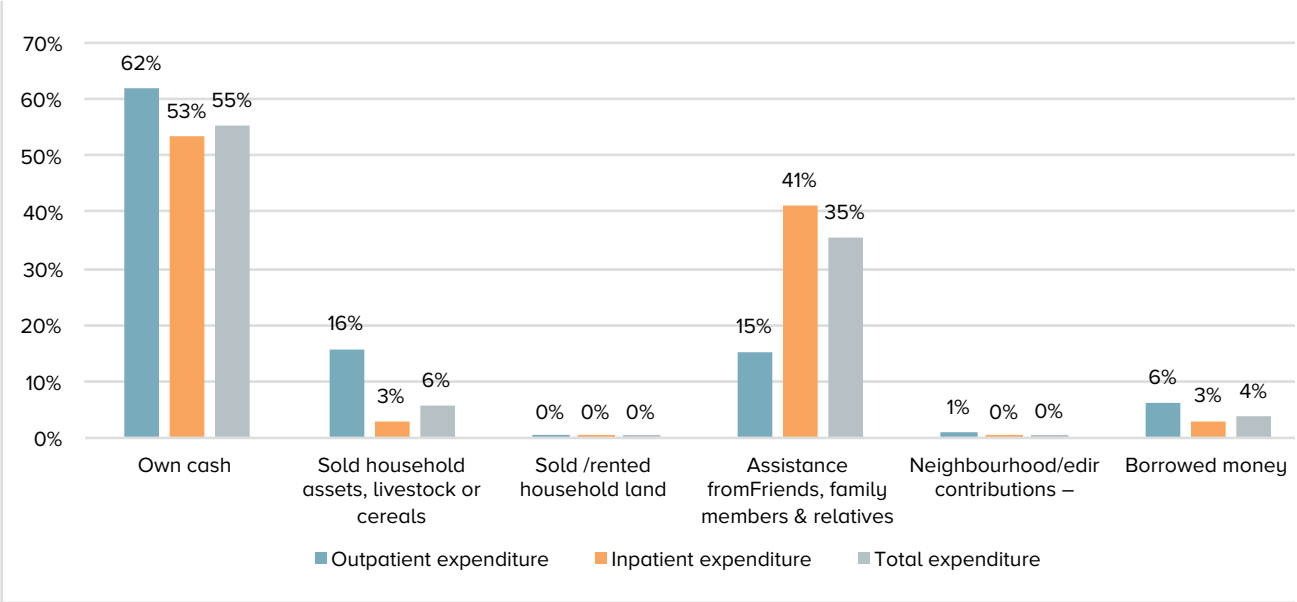
Table 5.5 Outpatient, Inpatient and Total OOP Spending by Health Provider Type

Provider Type	Outpatient OOP		Inpatient OOP		Total OOP	
	Amount (ETB)	Share (%)	Amount (ETB)	Share (%)	Amount (ETB)	Share (%)
Govt. Hospital	6,275,378,640	36%	454,343,933	64%	6,729,722,573	37%
Private hospital	2,568,108,775	15%	138,799,575	20%	2,706,908,350	15%
Not for profit hospital	78,841,939	0%	7,350,511	1%	86,192,450	0%
Govt. Health Centre	2,428,211,799	14%	26,461,789	4%	2,454,673,588	13%
Govt. health post[10]	128,905,071	1%	-	0%	128,905,071	1%
Not for profit health centre	112,916,845	1%	1,579,069	0%	114,495,914	1%
Private Clinic	5,495,952,631	31%	80,184,215	11%	5,576,136,846	31%
NGO Clinic	2,987,486	0%	-	0%	2,987,486	0%
Company/parastatal clinic	-	0%	-	0%	-	0%
Pharmacy/ Drugstore	142,894,768	1%	-	0%	142,894,768	1%
Traditional healer / religious	233,827,803	1%	-	0%	233,827,803	1%
TBA	-	0%	-	0%	-	0%
Other (specify)	34,974,244	0%	2,943,840	0%	37,918,084	0%
Total	**17,503,000,000**	**100%**	**711,662,932**	**100%**	**18,214,662,932**	**100%**

5.3 Expenditure by Sources of Household Financing Mechanisms

Analysis of the financing source for OOP spending shows that there were two main sources of funding for households – the household itself on one hand, and friends and family members on the other. About 55% of the total OOP spending was financed through the household's own cash, while another 6% was financed through selling the household's own livestock and cereals. The second major source of financing was assistance from friends and family members, serving as the source for 35% of total OOP spending. Borrowing money sourced the remaining 4% of OOP expenditure. Households were more likely to pay for outpatient care through their own funds, and more likely to receive assistance from friends and family to pay for inpatient care (see figure 5.6).

Figure 5.6: Sources of Funding of OOP Health Expenditure



5.4 Out of Pocket Spending by Health Service Functions

The survey asked households about what services their OOP spending was used to pay for during health service provision. Overall, of the total OOP spending, infections and parasitic disease prevention and treatment stand out as the major area of spending, with 37% of total OOP spending going to these services (see figure 5.7 and Table 5.6). As can be seen in table 5.6, the major illnesses paid for with OOP spending were intestinal worms, disease of respiratory infection including pneumonia, malaria, and diarrhea, resulting in about 85% of OOP spending going towards infectious and parasitic disease treatment. The second major functional areas where OOPs were spent, other than those not specified, were non-communicable diseases (NCDs). NCDs are emerging as one of the major disease burdens in the country, accounting for about 23% of the total OOP expenditures. Of the NCDs, the major sources of OOP spending were kidney related infections and failures, mental disorders and cancer. The next major source of OOP spending was the provision of preventive and promotive services. These primary care services account for about only 7% of the total OOP spending borne by households. The main promotive services paid for through OOP payments were family planning, physical check up, and dental services. A new area of spending documented in the current HH survey was OOP spending on nutrition related services. The survey documented that, excluding routine costs included as part of the community contributions, households spent about 116.9 million ETB on nutrition related services[12], accounting for only 1% of the total OOP spending.

[12] The nutrition services here are defined as those payments related to direct and indirect cost of addressing Nutritional deficiencies (severe malnutrition). The type of services to be included was given by the nutrition experts during the development of the questionnaire.

Figure 5.7 The Share of OOP Spending by Major health Service Categories Provided as Outpatient, Inpatient and Total

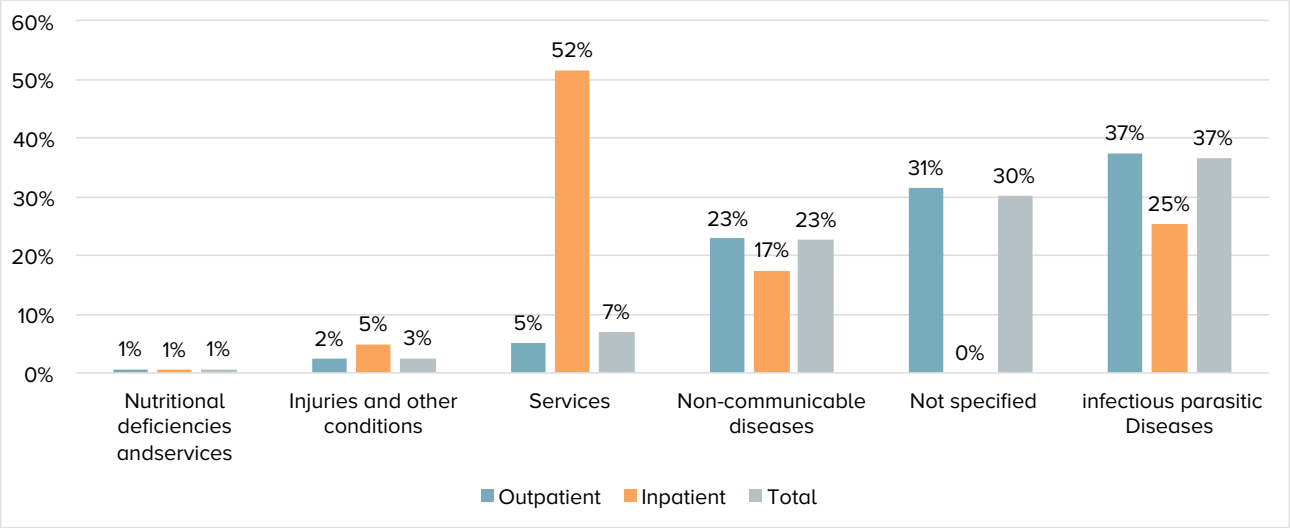


Table 5.6 OOP Expenditure by Different Service Categories

Service Types	Outpatient OOP		Inpatient OOP		Total OOP	
	Total OOP in ETB	**Share in (%)**	Total OOP in ETB	Share in Percent	Total OOP in ETB	Share in Percent
Infectious and Parasitic Diseases						
Malaria	1,290,000,000	7%	22,800,000	3%	1,312,800,000	7%
Diseases of Respiratory including pneumonia	1,360,000,000	8%	44,400,000	6%	1,404,400,000	8%
TB	519,000,000	3%	34,300,000	4%	553,300,000	3%
HIV/AIDS	42,000,000	0%	-		42,000,000	0%
Diarrhoea	798,000,000	5%	10,600,000	1%	808,600,000	4%
Intestinal worms	2,060,000,000	12%	42,900,000	5%	2,102,900,000	12%
Vaccine preventable diseases	19,500,000	0%	1,206,804	0%	20,706,804	0%
Neglected tropical diseases	173,000,000	1%	6,159,130	1%	179,159,130	1%
Other infectious and parasitic diseases	232,000,000	1%	36,600,000	5%	268,600,000	1%
Nutritional deficiencies (severe malnutrition)	96,200,000	1%	4,373,267	1%	100,573,267	1%
Non-communicable diseases						
Cancer	926,000,000	5%	37,400,000	5%	963,400,000	5%

Diabetics	278,000,000	2%	14,300,000	2%	292,300,000	2%
Kidney failure	1,720,000,000	10%	40,000,000	5%	1,760,000,000	10%
Mental disorders	1,050,000,000	6%	45,100,000	6%	1,095,100,000	6%
Injuries and other conditions	418,000,000	2%	38,900,000	5%	456,900,000	3%
Services						
Physical check-up (prevention)	502,700,000	3%	22,300,000	3%	525,000,000	3%
Immunizations (prevention)	46,100,000	0%	7,241,035	1%	53,341,035	0%
Family planning (prevention)						0%
Oral contraceptives	118,000,000	1%	5,015,864	1%	123,015,864	1%
Condoms	1,014,547	0%	2,666,421	0%	3,680,968	0%
Intrauterine device	4,977,297	0%	-	0%	4,977,297	0%
Injectable	12,500,000	0%	5,313,977	1%	17,813,977	0%
Norplant	15,800,000	0%	361,000,000	46%	376,800,000	2%
Sterilization	4,977,297	0%	-	0%	4,977,297	0%
Delivery	23,000,000	0%			23,000,000	0%
Dental	117,000,000	1%	-	0%	117,000,000	1%
Circumcision	308,730	0%	-	0%	308,730	0%
Physiotherapy	42,800,000	0%	-	0%	42,800,000	0%
Nutrition supplements		0%		0%		0%
Vitamins/minerals	13,700,000	0%	-	0%	13,700,000	0%
Micronutrient powder	2,582,845	0%	-	0%	2,582,845	0%
Baby formula		0%		0%		0%
Not specified Services	5,460,000,000	31%	-	0%	5,460,000,000	30%
Total	17,347,160,716	100%	782,576,498	100%	18,129,737,214	100%

Chapter 6. Community Contribution to Health Systems Development

The second major role that households play as a source of financing for the health system, apart from OOP spending, is their contribution to health system strengthening in Ethiopia. The success of the Ethiopian health system in meeting some of the international goals and targets in health has been explained by the strategy used to ensure communities produce their own health through the health extension program (HEP) and its associated health development army (HDA) and malaria control programs. Community members contribute their labor, time, food, and in some cases money to contribute to the implementation of the different health extension packages.

The estimation of community contributions included in this survey is the first of its kind in estimating the contribution of communities to health, outside OOPs. There has not been any experience documented of such an exercise in a HA process in other countries either. Consequently, the tools used for this survey are not part of the international experience, and were not as tested as the other components of the HH survey, either in the Ethiopian context or elsewhere. To generate the outpatient expenditure on routine health spending and community contributions, two different methodologies were used. Households were requested to identify the type of services they pay for routine services in the four weeks preceding the survey and the amount of money paid for each service. A sum of these payments were then calculated and annualized to obtain household expenditure on annual expenditures for routine expenses.

In this survey, each household was asked whether a member of the household is involved in the HDA and if so, the amount of time they spent on average on HDA/Malaria control program per week, which was then annualized per year. The local wage rates , collected as part of this survey, were used to convert the time spent on HDA and malaria control into monetary contributions. Communities also contribute crops and coffee to health facilities for the preparation of culturally acceptable food and ceremony after facility deliveries. They also contribute to the rehabilitation and construction of health facilities and maternity waiting homes. Hence households were also requested to provide information on how much time, foodstuffs, and money they contributed to such efforts. These contributions were also monetized. The summation of HDA, Malaria control, facility construction and rehabilitation, and delivery related activities provided the total community contributions to strengthen the health system in Ethiopia.

6.1. Health Development Army

Overall, 90% of the households in the survey reported that members of their HHs are in the HDA. Some of the regions that are contributed in the form of social mobilization are also reported to be members of the HDA and included as so. While it is documented in the routine health information system that Tigray, Amhara, Oromia and SNNPR have better HDA participation the findings from this survey indicate that other regions, including Addis Ababa, Benishangul Gumuz and Harari have a higher HDA membership rate than these well-performing regions (see Table 6.1).

Table 6.1 Percent of HHs Surveyed Who Report Having a HH Member in the HDA by Region

	One HDA member in HH	No HDA member in HH	Share from national
Addis Ababa City	100%	0%	2%
Amhara	90%	10%	32%
Benishangul Gumuz	100%	0%	2%
Dire Dawa	98%	2%	4%
Gambella	62%	38%	0%
Harari	100%	0%	1%
Oromia	86%	14%	17%
SNNPR	86%	14%	24%
Tigray	93%	7%	18%
Total	**90%**	**10%**	**100%**

6.2. Involvement in Malaria Control Program

Households were also asked to provide information on whether a member of the household was involved in Malaria control activities. Of the surveyed population, about 39% of the HHs were involved in long-lasting insecticide treated net (LLITN) distribution, indoor residual spraying (IRS) operations, pond drainage, and awareness creation about controlling malaria epidemics (table 6.2).

Table 6.2 Percent of HHs Involved in Malaria Prevention Operations

	Yes		No	
	Frequency	%	Frequency	%
Is the household involved LLITN	459,409	38.8	723,355	61.2%

6.3 Estimates of Community Contribution in Monetary Terms to Health System Strengthening

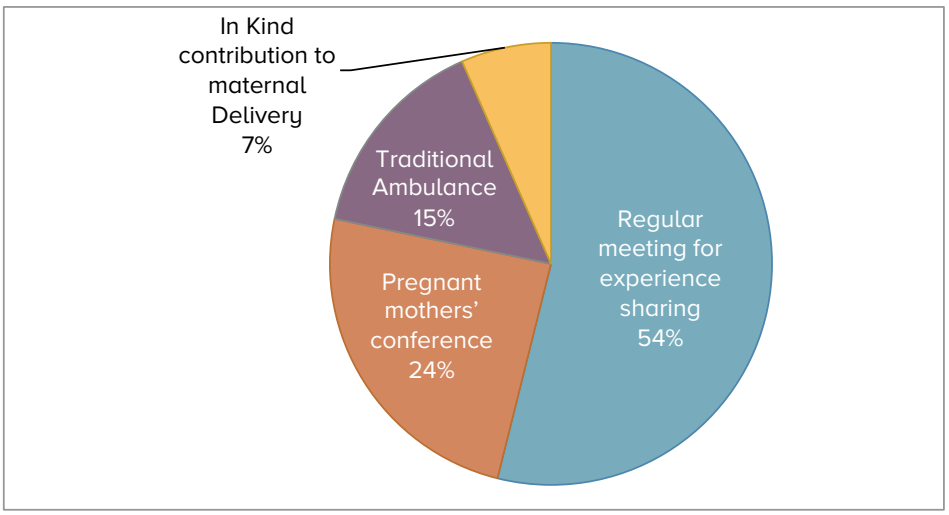
The total community contribution to health system strengthening is estimated to be 2.87 billion ETB for 2015/16, which is equivalent to 36.41 ETB per capita. Of this, about 55% or 19.86 ETB per capita was contributed through the HDA. The remaining 45% was contributed through the malaria control program, as shown in table 6.3. The effort to estimate the community's contribution towards facility construction and rehabilitation was not successful, as most HHs did not respond to the survey questions regarding this activity. This might be due to the fact that most of the health facilities (health posts and health centers) were constructed well before the survey, and community labor for construction was not needed during the period data was requested for.

Table 6.3 Estimated Community Contributions to Health System Strengthening

	Estimated contribution by different Health Development Army Activities in ETB					
	Regular meeting for experience sharing	**Environment control activities excluding malaria**	Pregnant mothers' conference	Traditional Ambulance	In Kind contribution to maternal Delivery	Total
1 to 5 network	387,000,000	243,000,000	146,000,000	62,400,000		838,400,000
1 to 30 network	230,000,000	178,000,000	133,000,000	111,000,000		652,000,000
Total	617,000,000	421,000,000	279,000,000	173,400,000	75,400,000	1,565,800,000
Per capita contribution (ETB)	7.83	5.34	3.54	2.2	0.96	19.86
Malaria control activities						
	LLITN	IRS operation	Awareness creation	Pond drainage		Total
1 to 5	141,000,000	54,700,000	285,000,000	393,000,000		873,700,000
1 to 30	115,000,000	53,700,000	123,000,000	139,000,000		430,700,000
Total	256,000,000	108,400,000	408,000,000	532,000,000		1,304,400,000
Community contribution per capita	3.25	1.38	5.18	6.75		16.55
Total community contribution for health development army and malaria control						
Total community contribution	873,000,000	529,400,000	687,000,000	705,400,000		2,870,200,000
Total community contribution per capita	11.07	6.72	8.71	8.95	0.96	36.41

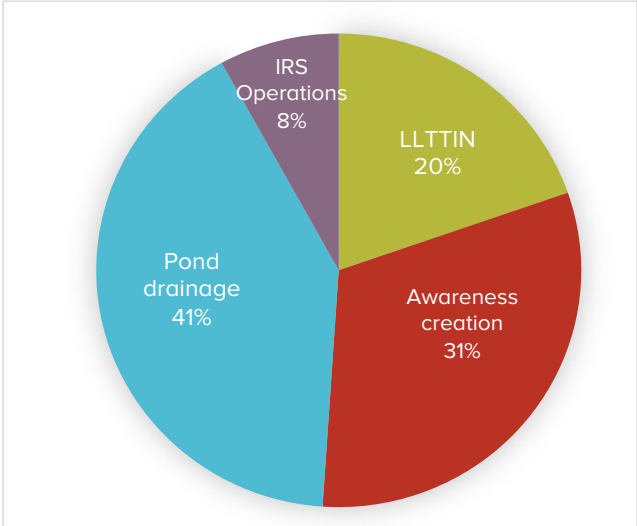
When the different activities of the HDA are explored, regular meetings among the members to share their experiences and best health practices account for about 40% of their contribution to the health system. This is followed by environmental management activities excluding malaria, with 27% of their contribution. Contribution to maternal delivery in the form of pregnant mother conferences and in-kind crop contribution accounted for about 23% of the total HDA estimated monetary contributions (see figure 6.1)

Figure 6.1 Share of Different Activities of the HDA



The analysis of the malaria control activities shows that pond drainage is the first area where community members spend their time, accounting for about 41% of the monetary value of community contribution. This is followed by awareness creation and distribution of LLITN with 31% and 20% respectively. IRS operation accounts for the least community contribution to malaria prevention, with 8% of the monetary value of community contribution (see figure 6.2).

Figure 6.2 Shares of Different Components of Community Malaria Control Activities



Chapter 7. Health Insurance Coverage

The third form of payment from households as a source of financing for the health system is in the form of paying for premiums and to be enrolled in insurance schemes. This section presents the survey findings on insurance coverage, reported benefit package coverage, and expenditures on insurance in Ethiopia.

7.1. Population Covered in Health Insurance

Of the total population of the country, based on the survey, it is estimated that about 7.4%[13] of the population is covered by health insurance. The coverage of health insurance at the national level has increased significantly compared to the 1.25% coverage estimate in the last HH survey in 2010/11. This increase is due largely to the expansion of the Community Based Health Insurance (CBHI) scheme over the last five years[14]. In terms of residence, 95% of the population covered in insurance resides in rural areas and the remaining 5% resides in urban areas. This high coverage of health insurance in rural areas is mainly attributed to the implementation of CBHI targeting rural areas. Of the total insurance population in this survey, 51% are males and 49% are females. The total insured population projected as per this survey and its regional distribution is depicted in Table 7.1 below.

Table 7.1 Regional Distribution of Surveyed Population Covered by Health Insurance

Region	Number of surveyed people covered in insurance	% of surveyed people covered by insurance
Tigray	1,117,373	19.19
Afar	-	-
Amhara	2,536,456	43.57
Oromia	819,878	14.08
Somali	14,560	0.25
Benishangul Gumuz	14,670	0.25
SNNPR	1,202,404	20.65
Gambella	511	0.01
Harari	2,338	0.04
Addis Ababa	109,907	1.89
Dire Dawa	3,681	0.06
Total	**5,821,778**	**100**

As presented in the above table, the four major regions (Tigray, Amhara, Oromia, and SNNP) constitute 97.5% of the population covered by insurance. This is again attributed to the implementation of CBHI targeting these four regions.

In terms of level of education of the insured population, about 56% don't have any type of formal education, while the remaining have varying levels of education ranging from adult to university education. Of those educated, about 75% have completed either primary education or adult/religious education. With regard to employment status, 92 % of the insured household heads are currently employed, either in formal or informal sectors, while the remaining are either seeking work, retired, housewives or students.

[13] This reported coverage might not reflect the true coverage rate, as routine data reports compiled from CBHI schemes show higher CBHI coverage than what is estimated in this survey.

[14] The number of Woredas that implemented CBHI in the last financial year was 227. Only 12 woredas that implemented CBHI were included in the sample of 100 woredas in this survey.

The vast majority of insured household heads are farmers, which comprise 86% of insured households, followed by those employed in the private sector (4.8%) and civil servants (4.7%). Civil servants are generally covered through other forms of insurance, such as employer-provided and private individual insurance. The detailed distribution of the projected insured household heads that are currently working by occupation is shown in Table 7.2 below.

Table 7.2 Number and Percent of Households Covered in Insurance by Occupation

Occupation	Number of HH enrolled in insurance	Head of HH enrolled in insurance by occupation (%)
Farmer	1,075,429	86
Housewife	736	0.06
Shepherd	1,248	0.01
Civil Servant	58,128	4.65
Private Sector	59,880	4.79
Pastoralist	0	0
Agro-Pastoralist	1,509	0.12
Fishing	0	0
Retail and Wholesale trade	30,360	2.43
Not declared	2,170	0.17
Other (specify)	18,309	1.46
Don't know	2,800	0.22
Total	**1,250,569**[13]	**100**

Understanding the health status of the covered population is important to estimate the effect of risk-pooling, as well as to measure changes in the covered population's health over time. Regarding the health status of the insured population at the time of this survey, about 87% of insured individuals rated their health condition either 'very good' or 'good'. This is slightly lower than the national average – 90% of the national sample rated their health as 'good' or 'very good'. CBHI membership is by household level instead of individual level, which includes both currently healthy household members, as well as ill household members. The majority of insured households (80.4%) enrolled all of their family members, while the remaining 19.6% of insured households didn't enroll all of their family members. The household level membership policy deters the effect of adverse selection (more sick people enrolling) and spreads the risk between the sick and healthy, sustaining the financial capacity of the insurance schemes.

In terms of distribution of CBHI coverage by economic status, the very poor (Q1) and very wealthy (Q5) households have smaller shares than expected of the total population insured, while Q2, Q3 and Q4 have either proportional or higher shares. The detailed distribution of household coverage by income quintile is shown in Table 7.3 below.

[15] As per the projection of this survey, the number of households covered in insurance is 1,354,009 but in some Tables, this number varies due to missing data problem.

Table 7.3 Number and % of HHs Enrolled in Insurance by Wealth Quintile

Expenditure quintile	Number of households enrolled in insurance	% of households enrolled in insurance
Quintile 1	151,428	11.18
Quintile 2	295,495	21.82
Quintile 3	393,835	29.09
Quintile 4	340,258	25.13
Quintile 5	172,993	12.78
Total	**1,354,009**	**100.00**

The low share of the lowest quintile could be attributed to lack of income to pay the premium insurance. This low coverage of health insurance among the poorest people indicates the need to strengthen the fee waiver system and include the poor in the insurance schemes, particularly in CBHI, through government subsidy.

On the other hand, the reason for the low share of insurance coverage among the highest income population (Q5) could be due to absence of high-level benefit packages that could attract the wealthiest segment of the population, and private providers, which are used at a higher rate by the wealthy, not being covered under the CBHI program. As stated previously, CBHI is the dominant type of health insurance scheme available in Ethiopia at the time of the survey. However, it has a limited benefit package and is accepted only in government health facilities. This limitation might not attract the highest income bracket of the population. This implies the need to devise some mechanism, such as expanding the benefit packages to add tiers with corresponding higher premium, to attract this segment of the population to utilize CBHI. The types of currently available health insurance schemes and their estimated population coverage are presented in following Table.

Table 7.4 Number and % of individuals covered in insurance by type of Insurance

Type of health insurance	Number of individuals covered	% of individuals covered
Community based health insurance	5,474,801	96.35
Private individual insurance	21,164	0.37
Employer	172,893	3.04
Others (specify)	13,328	0.23
Total	**5,682,186**	**100**

7.2. Health Services Covered by Insurance

Apart from being a member of an insurance scheme, the extent of health service coverage under insurance schemes is a critical factor in terms of financial protection of individuals. In this regard, about 69% of insured households report being covered under insurance that entitles them to both inpatient and outpatient health services. This type of coverage reduces OOP payment and improves financial protection[16]. About 18% of insured households don't know the types of health services covered by their insurer, which indicates the need to strengthen communication efforts to increase awareness of benefit packages. Such awareness creation effort would enable members to make use of their entitlement, attract additional members, and improve the overall health insurance coverage in the country. The remaining insured

[16] However, the comprehensiveness of the benefit packages included in outpatient and inpatient services also affect the extent of financial protection by an insurance scheme. This is reflected in the share of OOP to total health expenditure by the insured population. The following sub-section on health insurance expenditure sheds some light in this regard.

households, 10% report having only access to outpatient services, and 1.3% report having access only to inpatient services. The types of services reported by insured households to be covered under their insurance are presented in the following table.

Table 7.5 Number and Percent of Households Covered by Insurance by Type of Health Services Coverage Reported by Household Head

Type of health insurance	Number of individuals covered	% of individuals covered
In patient	18,537	1.37
Out patient	139,786	10.32
Both	937,424	69.23
Others (specify)	10,645	0.79
Don't Know	247,617	18.29
Total	**1,354,009**	**100**

7.3. Health Insurance Expenditure

Members of health insurance schemes contribute premium payments to the insurance schemes for the health services for which they are entitled. According to this survey, the average household contribution for insurance per month is 38.50 ETB, and about 86.5% of the insured households contribute less than 50 ETB per month.

The main source of payment for insurance among the insured is the household head (91.6%) followed by employer (4.9%) and government (2.5%) for indigents[17]. As the level of poverty in Ethiopia is high[18], the current coverage of the poor by government subsidy (only 2.5% of insured households), is low and needs to be improved to ensure access to health services by the poor. Details on the source of insurance premium payments are stated in the table below.

Table 7.6 Sources of Payment for Health Insurance

Source of Payment for Insurance Premium	Number of households	Source of payment (%)
Household head	1,182,994	91.63
Government (for Indigent HHs)	31,863	2.47
Employer	63,576	4.92
Self	1,290	0.1
Others (specify)	6,433	0.5
Household head & Government (for Indigent HHs)	1,064	0.08
Household head & Employer	3,770	0.29
Total	**1,290,990**	**100**

As most members of the insurance schemes are farmers, 85% of the insured household's means of payment for insurance is cash. Only 3.6% of households contribute to their insurance from their salary. The remaining households means of payment for insurance includes family support and pension.

[17] However, routine data reports from CBHI schemes indicate a higher proportion of indigents (about 10% of the insured population) are supported by government subsidy

[18] It was projected that about 22.25% of the population of the country was below the poverty line in 2014/15 (Ministry of Finance and Economic Development, Nov. 2010, GTP (2010/11-2014/15)).

In addition to insurance contribution, some members of health insurance schemes also incurred OOP payment for health services that were not covered in their specific health insurance scheme. In this regard, of the total households enrolled in insurance and sought care, only 11.7% of households were required to pay OOP, while 80% did not make any additional OOP payment. The remaining 8% of insured households did not know or recall whether they were required to pay OOP or not. The low occurrence of OOP payments among the majority of insured households (80%) implies that these households were financially protected through their insurance and were not exposed to possible catastrophic health expenditure.

With regard to health expenditure among the insured, the total health expenditure among the insured population during the year was 723.3 million ETB. Of this, 620 million ETB (85.8%) was health insurance premium expenditure, while the remaining 102 million ETB (14.2%) was OOP payment for health services by members of health insurance schemes. This relatively low share of OOP payments compared to the total health expenditure of the insured population again confirms that OOP payment was not a barrier to accessing health services among the insured population. However, the share of health insurance expenditure to total national health expenditure was only 3%, which implies the need to increase coverage of health insurance through expanding the existing pre-payment schemes such as CBHI and introducing/expanding other schemes for formal sector employees and their families.

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Chapter 8. Annexes

ANNEX 1: CONSTRUCTION OF WEALTH INDEX

The wealth index constructed and used for the National Health Account Six Household Health Expenditure and Utilization Survey 2016 took steps needed to determine national wealth quintiles survey respondents fall into. In so doing, preparation, analysis of dataset, and interpreting the results took place step by step. Technically, these are preparation of variables for Principal Component Analysis (PCA), run the PCA analysis, assign wealth index scores to each respondent, and apply wealth quintile cut-off points.

Filmer and Pritchet (2001) introduced principal component analysis (PCA) as a way of creating wealth index in order to construct socio-economic indices. The index is created by aggregating large number of household assets, such as groups of productive assets (plough, livestock such as ox, cow, sheep, goat, horse, donkey and camel which are expressed in terms of Tropical Livestock Units, TLU), non-productive assets (radio, mobile and jewelry), household amenities (household owned their own houses, household houses' roof, wall and floor made of, better sources of cooking fuels, lighting, protected drinking water and type of facility does the household used) and land in order to obtain a univariate measure of household welfare. More weight was given to assets which vary most across households, so that an asset owned by all households is given zero weight and an asset owned by only a few household is given the highest weight.

In the construction of wealth index, using STATA 14 for analysis (Stata Corporation, College Station, TX, USA) applied principal factor component estimation, which is available in the STATA factor analysis procedure. In the implementation of this procedure, the main steps followed were:

1. Asset data were recorded as one if a household possesses a given asset or better asset, and zero otherwise. All variables recoded as 1/0 except TLUs and Land size, which were used in the PCA calculation in the form of continuous variables. The conversion factor for computing the TLUs: one cattle is equal to 0.7 TLUs, one sheep equal to 0.1 TLUs, one goat equal to 0.1 TLUs, one donkey equal to 0.5, one horse equal to 0.8, one chicken equal to 0.01 and one camel equal to 1.0 TLUs

2. Generate principal factor component based on data on values of indicators of possession of the different assets.

3. Compute a household wealth index score using the first factor component. In the computation of the index score, data pertaining to values of indicators of possession of each asset are multiplied by its own coefficient (also known as factor loading) on the factor component and summed to obtain the household's wealth index value.

4. Rank the wealth index scores from lowest to highest and generate household wealth quintiles. \

5. Then for each household, record quintile score, in a separate wealth quintile variable. This variable can be used for further analysis using wealth as a proxy for economic status. The Kaiser-Meyer-Olkin (KMO) test of sampling adequacy gave an overall KMO value of 88 percent suggesting that performing factor analysis is appropriate.

In general, based on in-built STATA command PCA along with the post estimation command provided the wealth index, quintiles and KMO measures of sampling adequacy

ANNEX 2: ESTIMATION OF THE TOTAL OOPS TO THE PROJECTED POPULATION

	Survey Results using the sample data	Projections to 2016 estimated population	
Populations projected	78,833,595.00	92,206,005.00	1.169628316
People who were ill	7,530,186.00	8,807,518.77	1.169628316
Outpatient consultation	3,984,979.00	4,660,944.28	1.169628316
inpatient admission	636,556.00	744,533.92	1.169628316
Outpatient total cost	17,515,889,686	20,487,080,564.66	222.188138
inpatient total cost	797,520,005	932,801,980.79	10.11649925
Total Cost	**18,313,409,691.00**	**21,419,882,545.45**	**232.3046373**

ANNEX 3: ESTIMATION OF OOPS BY SERVICE PROVIDERS

	Outpatient			Inpatient		
	Population 78,833,595*		Population 92,206,005**	Population 78,833,595*		Population 92,206,005**
Govt. Hospital	6,280,000,000	36%	7,345,265,827	455,000,000	64%	532,180,883.99
Private hospital	2,570,000,000	15%	3,005,944,773	139,000,000	20%	162,578,335.99
Not for profit hospital	78,900,000	0%	92,283,674	7,361,125	1%	8,609,780.24
Govt. Health Centre	2,430,000,000	14%	2,842,196,809	26,500,000	4%	30,995,150.39
Govt. health post	129,000,000	1%	150,882,053		0%	-
Not for profit health center	113,000,000	1%	132,168,000	1,581,349	0%	1,849,590.57
Private Clinic	5,500,000,000	31%	6,432,955,741	80,300,000	11%	93,921,153.81
NGO Clinic	2,989,686	0%	3,496,821		0%	-
Company/parastatal clinic	-	0%	-		0%	-
Pharmacy/ Drugstore	143,000,000	1%	167,256,849		0%	-
Traditional healer / religious	234,000,000	1%	273,693,026		0%	-
TBA	-	0%	-		0%	-
Other (specify)	35,000,000	0%	40,936,991	2,948,091	0%	3,448,170.71
Total	**17,515,889,686**	**100%**	20,487,080,565	712,690,565	100%	**833,583,065.69**

* Sample projected 78,833,595

** 2016 population estimate 92,206,005

ANNEX 4: CAUSES OF OUTPATIENT VISITS TO A HEALTH FACILITY

Illness and services	%
Nutritional supplements	21.7%
Intestinal worms	11.8%
Malaria	11.1%
Diseases of Respiratory including pneumonia	9.3%
Diarrhea	8.7%
Kidney failure	3.5%
Diabetics	3.2%
Micronutrient powder	3.1%
Other infectious and parasitic diseases	2.9%
Physical check-up (prevention)	2.9%
Mental disorders	2.5%
Delivery	2.2%
HIV/AIDS	2.1%
Injuries and other conditions	2.1%
Neglected tropical diseases	1.9%
Immunizations (prevention)	1.9%
TB	1.6%
Injectable	1.1%
Cancer	0.9%
Oral contraceptives	0.9%
Vaccine preventable diseases	0.8%
Norplant	0.8%
Nutritional deficiencies (severe malnutrition)	0.7%
Prenatal/antenatal care	0.7%
Dental	0.5%
Intrauterine device	0.4%
Sterilization	0.3%
Condoms	0.2%
Vitamins/minerals	0.2%
VCT	**0.1%**
Total	**100.0%**

ANNEX 5: REASONS FOR INPATIENT ADMISSIONS

Reasons	%
Diarrhea and intestinal worms	11.2%
Diseases of Respiratory including pneumonia	8.7%
Malaria	6.1%
Diabetics	5.5%
Delivery	4.3%
TB	4.0%
Mental disorders	3.8%
Other infectious and parasitic diseases	3.5%
Caesarean	3.4%
Kidney failure	3.2%
Vaccine preventable diseases	2.9%
Injuries and other conditions	2.7%
HIV/AIDS	2.1%
Neglected tropical diseases	2.1%
Nutritional deficiencies (severe malnutrition)	1.8%
Cancer	1.4%
Vaginal delivery	1.4%
Community management of Acute malnutrition	1.3%
Treatment/surgery for reproductive health related cancers etc.	0.7%
Sterilization	0.2%
Other Services	29.6%
Total	**100.0%**

ANNEX 6: ESTIMATION OF OUT OF POCKET PAYMENTS (OOP) BY SERVICES

	Outpatient			Inpatient Services			Total OOP in ETB	
	Total OOP in ETB	Share in %	Projected to 2016 population*	Total OOP in ETB	Share in %	Projected to 2016 population*	Total OOP in ETB for Sample**	Projected to 2016 population**
Not specified	5,460,000,000	31%	6,386,170,608				5,460,000,000	6,386,170,608
Intestinal worms	2,060,000,000	12%	2,409,434,332	42,900,000	5%	50,177,055	2,102,900,000	2,459,611,387
Kidney failure	1,720,000,000	10%	2,011,760,704	40,000,000	5%	46,785,133	1,760,000,000	2,058,545,837
Diseases of Respiratory including pneumonia	1,360,000,000	8%	1,590,694,510	44,400,000	6%	51,931,497	1,404,400,000	1,642,626,008
Malaria	1,290,000,000	7%	1,508,820,528	22,800,000	3%	26,667,526	1,312,800,000	1,535,488,054
Disorders	1,050,000,000	6%	1,228,109,732	45,100,000	6%	52,750,237	1,095,100,000	1,280,859,969
Cancer	926,000,000	5%	1,083,075,821	37,400,000	5%	43,744,099	963,400,000	1,126,819,920
Diarrhea	798,000,000	5%	933,363,397	10,600,000	1%	12,398,060	808,600,000	945,761,457
TB	519,000,000	3%	607,037,096	34,300,000	4%	40,118,251	553,300,000	647,155,347
Injuries and other conditions	418,000,000	2%	488,904,636	38,900,000	5%	45,498,542	456,900,000	534,403,178
Physical check-up (prevention)	406,000,000	2%	474,869,096	22,300,000	3%	26,082,711	428,300,000	500,951,808
Diabetics	278,000,000	2%	325,156,672	14,300,000	2%	16,725,685	292,300,000	341,882,357
Other infectious and parasitic diseases	232,000,000	1%	271,353,769	36,600,000	5%	42,808,396	268,600,000	314,162,166
Neglected tropical diseases	173,000,000	1%	202,345,699	6,159,130	1%	7,203,893	179,159,130	209,549,592
Oral contraceptives	118,000,000	1%	138,016,141	5,015,864	1%	5,866,697	123,015,864	143,882,838
Dental	117,000,000	1%	136,846,513		0%	-	117,000,000	136,846,513
Prenatal/antenatal care	96,700,000	1%	113,103,058		0%	-	96,700,000	113,103,058
Nutritional deficiencies (severe malnutrition)	96,200,000	1%	112,518,244	4,373,267	1%	5,115,097	100,573,267	117,633,341
Immunizations (prevention)	46,100,000	0%	53,919,865	7,241,035	1%	8,469,320	53,341,035	62,389,185

	Outpatient			Inpatient Services			Total OOP in ETB	
	Total OOP in ETB	Share in %	Projected to 2016 population	Total OOP in ETB	Share in %	Projected to 2016 population	Total OOP in ETB for Sample	Projected to 2016 population
Physiotherapy	42,800,000	0%	50,060,092		0%	-	42,800,000	50,060,092
HIV/AIDS	42,000,000	0%	49,124,389		0%	-	42,000,000	49,124,389
Delivery	23,000,000	0%	26,901,451		0%	-	23,000,000	26,901,451
Vaccine preventable diseases	19,500,000	0%	22,807,752	1,206,804	0%	1,411,512	20,706,804	24,219,264
Norplant	15,800,000	0%	18,480,127	361,000,000	46%	422,235,822	376,800,000	440,715,950
Vitamins/minerals	13,700,000	0%	16,023,908		0%	-	13,700,000	16,023,908
Injectable	12,500,000	0%	14,620,354	5,313,977	1%	6,215,378	17,813,977	20,835,732
Intrauterine device	6,337,319	0%	7,412,308	7,001,200	1%	8,188,802	13,338,519	15,601,110
Sterilization	4,977,297	0%	5,821,588		0%	-	4,977,297	5,821,588
Micronutrient powder	2,582,845	0%	3,020,969		0%	-	2,582,845	3,020,969
Condoms	1,014,547	0%	1,186,643	2,666,421	0%	3,118,722	3,680,968	4,305,364
Circumcision	308,730	0%	361,099		0%	-	308,730	361,099
Total	17,348,520,738	100%	20,291,321,104	789,577,698	100%	923,512,434	18,138,098,436	21,214,833,537

** Sample projected 78,833,595

* 2016 population estimate 92,206,005

ANNEX 7: LIST OF ENUMERATION AREAS BY REGIONS AND WOREDAS

EA No	Region	Zone	Woreda	Kebele	Cluster	CSA EA HH Size	HH Size (Fresh Listing)	Final Weight
1	TIGRAY	NORTH WEST TIGRAY	TAHTAY ADIYABO	DAGUALA	Rural	188	176	1305.1
2	TIGRAY	NORTH WEST TIGRAY	TAHTAY ADIYABO	ADITETER	Rural	214	145	944.6
3	TIGRAY	NORTH WEST TIGRAY	TAHTAY ADIYABO	ZABANGEDENA	Rural	203	316	2170.2
4	TIGRAY	NORTH WEST TIGRAY	TSELEMTI	MAY TEHILIT	Rural	220	253	1059.2
5	TIGRAY	NORTH WEST TIGRAY	TSELEMTI	MAY AYENE	Rural	194	326	1547.8
6	TIGRAY	NORTH WEST TIGRAY	TSELEMTI	SEKOTA SILASSE	Rural	218	221	933.7
7	TIGRAY	NORTH WEST TIGRAY	TSELEMTI	MECHARA	Rural	173	260	1384.3
8	TIGRAY	NORTH WEST TIGRAY	TSELEMTI	CHACHORE	Rural	167	158	871.4
9	TIGRAY	CENTRAL TIGRAY	ADWA	KEREN	Rural	179	215	1539.9
10	TIGRAY	CENTRAL TIGRAY	ADWA	WEYENITI	Rural	169	214	1623.4
11	TIGRAY	CENTRAL TIGRAY	ADWA	MAY TUOM	Rural	146	160	1405.0
12	TIGRAY	CENTRAL TIGRAY	ADWA	TAHTAY YILOGOMITI	Rural	190	231	1558.7
13	TIGRAY	CENTRAL TIGRAY	DEGUA TEMBEN	AREBAYI	Rural	213	220	1156.7
14	TIGRAY	CENTRAL TIGRAY	DEGUA TEMBEN	MIZANE BIRIHAN	Rural	166	192	1295.3
15	TIGRAY	CENTRAL TIGRAY	DEGUA TEMBEN	MIZAN	Rural	199	205	1153.6
16	TIGRAY	EASTERN TIGRAY	HAWUZEN	D/ABAY	Rural	186	205	1248.1
17	TIGRAY	EASTERN TIGRAY	HAWUZEN	MOZITEY	Rural	200	220	1245.7
18	TIGRAY	EASTERN TIGRAY	HAWUZEN	D/HIYWET	Rural	171	197	1304.6
19	TIGRAY	EASTERN TIGRAY	HAWUZEN	FIREWYINI	Rural	244	333	1545.5
20	TIGRAY	EASTERN TIGRAY	ADIGRAT/TOWN/	KEBELE 01	Town	194	158	862.9
21	TIGRAY	EASTERN TIGRAY	ADIGRAT/TOWN/	KEBELE 02	Town	250	160	678.1
22	TIGRAY	EASTERN TIGRAY	ADIGRAT/TOWN/	KEBELE 03	Town	142	94	701.4
23	TIGRAY	SOUTHERN TIGRAY	HINTALO WAJIRAT	DEJEN	Rural	174	207	993.4
24	TIGRAY	SOUTHERN TIGRAY	HINTALO WAJIRAT	HAREKO	Rural	207	248	1000.4
25	TIGRAY	SOUTHERN TIGRAY	HINTALO WAJIRAT	GONIKA	Rural	189	201	888.1
26	TIGRAY	SOUTHERN TIGRAY	HINTALO WAJIRAT	WAZA ADI AWANA	Rural	173	222	1071.6

EA No	Region	Zone	Woreda	Kebele	Cluster	CSA EA HH Size	HH Size (Fresh Listing)	Final Weight
27	TIGRAY	SOUTHERN TIGRAY	HINTALO WAJIRAT	ADI KEYIH	Rural	153	167	911.4
28	TIGRAY	SOUTHERN TIGRAY	ALAMATA	LAELAY DAYO	Rural	251	153	820.4
29	TIGRAY	SOUTHERN TIGRAY	ALAMATA	SELAM BEQALESI	Rural	212	183	1161.8
30	TIGRAY	SOUTHERN TIGRAY	ALAMATA	TEMUGA	Rural	166	186	1508.0
31	TIGRAY	MEKELE TOWN	SEMEN MEKELE/ TOWN/	AEYDER	Town	149	260	1848.8
32	TIGRAY	MEKELE TOWN	SEMEN MEKELE/ TOWN/	AEYDER	Town	179	195	1154.2
33	TIGRAY	MEKELE TOWN	SEMEN MEKELE/ TOWN/	KEDAMY WEYANE	Town	174	156	949.9
34	TIGRAY	MEKELE TOWN	SEMEN MEKELE/ TOWN/	HEWULTI	Town	195	103	559.6
35	TIGRAY	MEKELE TOWN	SEMEN MEKELE/ TOWN/	SEWI NIGUS	Town	184	137	788.9
36	TIGRAY	MEKELE TOWN	SEMEN MEKELE/ TOWN/	INDUSTRY	Town	225	302	1422.1
37	AFAR	ZONE 1	ELIDAR	MANDANA MUSALI	Rural	421	74	76.2
38	AFAR	ZONE 1	ELIDAR	GEWAHINAGEBELTILE-HI	Rural	282	47	72.2
39	AFAR	ZONE 1	ELIDAR	DOBI PARADIZO	Rural	150	82	236.9
40	AFAR	ZONE 1	ELIDAR	AKULE	Rural	111	184	718.2
41	AFAR	ZONE 1	ASAYITA	KEBELE 01	Town	299	225	331.0
42	AFAR	ZONE 1	ASAYITA	KEBELE 01	Town	177	110	273.3
43	AFAR	ZONE 1	ASAYITA	KEBELE 02	Town	185	251	667.7
44	AFAR	ZONE 1	ASAYITA	KEBELE 02	Town	214	209	480.6
45	AFAR	ZONE 2	ERABTI	LE'AD	Rural	192	110	279.2
46	AFAR	ZONE 2	ERABTI	DALEGOSO	Rural	178	126	345.0
47	AFAR	ZONE 2	ERABTI	ADU	Rural	187	280	729.7
48	AFAR	ZONE 2	ERABTI	ALBO	Rural	201	201	487.3
49	AFAR	ZONE 3	AMIBARA	GELSA	Rural	471	90	94.8

EA No	Region	Zone	Woreda	Kebele	Cluster	CSA EA HH Size	HH Size (Fresh Listing)	Final Weight
50	AFAR	ZONE 3	AMIBARA	BURI	Rural	329	167	251.7
51	AFAR	ZONE 3	AMIBARA	BONTA	Rural	309	154	247.1
52	AFAR	ZONE 3	AMIBARA	BEDUL ALE	Rural	111	189	844.3
53	AFAR	ZONE 4	YALO	WELEA	Rural	121	111	416.2
54	AFAR	ZONE 5	YALO	GIDAELANA MUDALE-LINA	Rural	283	125	200.4
55	AFAR	ZONE 6	YALO	UDEYLE	Rural	789	193	111.0
56	AFAR	ZONE 7	YALO	REKREK	Rural	221	70	143.7
57	AFAR	ZONE 8	YALO	MESGID	Rural	217	123	257.2
58	AMHARA	NORTH GONDAR	DABAT	AYEREFEDA	Rural	226	237	2509.1
59	AMHARA	NORTH GONDAR	DABAT	AREBUR	Rural	166	175	2522.4
60	AMHARA	NORTH GONDAR	DABAT	KAREHA	Rural	184	191	2483.7
61	AMHARA	NORTH GONDAR	DABAT	DOROMAMAYE	Rural	228	217	2277.2
62	AMHARA	NORTH GONDAR	CHILGA	DANGURA	Rural	154	169	1720.5
63	AMHARA	NORTH GONDAR	CHILGA	MINIBAKS DENGORSA	Rural	223	213	1497.5
64	AMHARA	NORTH GONDAR	CHILGA	ADIS ALEM	Rural	182	192	1654.0
65	AMHARA	NORTH GONDAR	CHILGA	DL AMBA	Rural	206	198	1506.9
66	AMHARA	NORTH GONDAR	CHILGA	DENGEL WENBELSEG	Rural	216	206	1495.2
67	AMHARA	NORTH GONDAR	CHILGA	KWAKGEMBELWA	Rural	209	185	1387.8
68	AMHARA	NORTH GONDAR	GONDER/TOWN/	DIB ABO DEFECHA	Town	240	221	382.5
69	AMHARA	NORTH GONDAR	GONDER/TOWN/	GEBIREAL	Town	215	226	436.7
70	AMHARA	NORTH GONDAR	GONDER/TOWN/	LIDETA	Town	230	216	390.1
71	AMHARA	NORTH GONDAR	GONDER/TOWN/	MEHAL ARADA	Town	138	162	487.7
72	AMHARA	NORTH GONDAR	GONDER/TOWN/	AZEZO T/HAYIMANOT	Town	203	352	720.3
73	AMHARA	NORTH GONDAR	GONDER/TOWN/	MARAKI	Town	243	233	398.3
74	AMHARA	NORTH GONDAR	GONDER/TOWN/	AZEZO AYER MAREFIYA	Town	190	275	601.3
75	AMHARA	SOUTH GONDAR	EBINAT	ADER SEG ABINA	Rural	178	179	1347.6

EA No	Region	Zone	Woreda	Kebele	Cluster	CSA EA HH Size	HH Size (Fresh Listing)	Final Weight
76	AMHARA	SOUTH GONDAR	EBINAT	DEBER TEKLEHAY-MANOT	Rural	176	183	1393.4
77	AMHARA	SOUTH GONDAR	EBINAT	ABEGELDI LUSINA	Rural	204	207	1359.8
78	AMHARA	SOUTH GONDAR	EBINAT	ZHIHA	Rural	249	211	1135.6
79	AMHARA	SOUTH GONDAR	EBINAT	SALAMAYA LANKO	Rural	223	231	1388.2
80	AMHARA	SOUTH GONDAR	EBINAT	GEDAYE	Rural	202	212	1406.4
81	AMHARA	SOUTH GONDAR	SIMADA	KEBELE 19	Rural	144	173	1491.7
82	AMHARA	SOUTH GONDAR	SIMADA	KEBELE 24	Rural	171	183	1328.8
83	AMHARA	SOUTH GONDAR	SIMADA	KEBELE 17	Rural	184	172	1160.6
84	AMHARA	SOUTH GONDAR	SIMADA	KEBELE 28	Rural	154	165	1330.3
85	AMHARA	SOUTH GONDAR	SIMADA	KEBELE 02	Rural	151	197	1619.9
86	AMHARA	SOUTH GONDAR	SIMADA	KEBELE 29	Rural	136	159	1451.6
87	AMHARA	SOUTH GONDAR	SIMADA	KEBELE 35	Rural	126	297	2926.7
88	AMHARA	NORTH WELLO	GIDAN	TATA	Rural	166	192	2093.3
89	AMHARA	NORTH WELLO	GIDAN	MEWAT	Rural	191	233	2207.8
90	AMHARA	NORTH WELLO	GIDAN	TUBBA	Rural	197	228	2094.6
91	AMHARA	NORTH WELLO	GIDAN	BEQULO MANEQIYA	Rural	208	312	2714.7
92	AMHARA	NORTH WELLO	GIDAN	AGEWUYE	Rural	161	177	1989.6
93	AMHARA	NORTH WELLO	LASTA	BILIBALA	Rural	200	215	2779.1
94	AMHARA	NORTH WELLO	LASTA	INJAFAT	Rural	454	248	1412.2
95	AMHARA	NORTH WELLO	LASTA	DEGOSACH	Rural	179	176	2541.9
96	AMHARA	NORTH WELLO	LASTA	GENET MARIYAM	Rural	196	234	3086.4
97	AMHARA	SOUTH WELLO	ALBUKO	FELANA MEDA	Rural	174	165	3679.3
98	AMHARA	SOUTH WELLO	ALBUKO	QALO	Rural	198	185	3625.3
99	AMHARA	SOUTH WELLO	WERE ILU	BATEL	Rural	181	171	2753.9
100	AMHARA	SOUTH WELLO	WERE ILU	DOLU	Rural	173	191	3218.3
101	AMHARA	SOUTH WELLO	WERE ILU	GESHOBER	Rural	212	228	3135.0

EA No	Region	Zone	Woreda	Kebele	Cluster	CSA EA HH Size	HH Size (Fresh Listing)	Final Weight
102	AMHARA	SOUTH WELLO	KOMBOLCHA/ TOWN/	KEBELE 03	Town	326	156	644.0
103	AMHARA	SOUTH WELLO	KOMBOLCHA/ TOWN/	KEBELE 08	Town	209	164	1056.1
104	AMHARA	SOUTH WELLO	KOMBOLCHA/ TOWN/	KEBELE 12	Town	262	196	1006.8
105	AMHARA	NORTH SHEWA	EFRATANA GIDIM	MIRAMIR SELELO	Rural	228	210	2713.6
106	AMHARA	NORTH SHEWA	EFRATANA GIDIM	LAGNAWATAYENA TACHIN	Rural	108	151	4119.2
107	AMHARA	NORTH SHEWA	EFRATANA GIDIM	ASHIQUAYE SHERIF	Rural	207	249	3544.0
108	AMHARA	EAST GOJAM	BIBUGN	MOSEBA SHIME ABO	Rural	136	206	5886.8
109	AMHARA	EAST GOJAM	BIBUGN	BIBUNYI GENETE MARIA	Rural	214	197	3577.7
110	AMHARA	EAST GOJAM	BIBUGN	WENBER KIDUS YO-HANES	Rural	198	208	4082.7
111	AMHARA	EAST GOJAM	DEBRE ELIAS	GIBITSAWITI	Rural	196	200	3939.3
112	AMHARA	EAST GOJAM	DEBRE ELIAS	DEJIBA	Rural	187	180	3716.0
113	AMHARA	EAST GOJAM	DEBERE MARKOS	KEBELE 03	Town	224	375	1926.1
114	AMHARA	EAST GOJAM	DEBERE MARKOS	KEBELE 05	Town	166	527	3652.5
115	AMHARA	WEST GOJAM	SEMEN ACHEFER	ESETUMITE	Rural	327	216	1179.1
116	AMHARA	WEST GOJAM	SEMEN ACHEFER	BIZIRA TUGIE	Rural	161	173	1918.0
117	AMHARA	WEST GOJAM	SEMEN ACHEFER	CHINBA	Rural	198	156	1406.4
118	AMHARA	WEST GOJAM	SEMEN ACHEFER	BELEN SANKURAWECH	Rural	463	191	736.4
119	AMHARA	WEST GOJAM	SEMEN ACHEFER	ANIBESHAN JOHANA	Rural	215	280	2324.6
120	AMHARA	WEST GOJAM	DEGA DAMOT	LIJE NIGUS CHAT WARK	Rural	181	182	2029.5
121	AMHARA	WEST GOJAM	DEGA DAMOT	SANTIME YESHOH	Rural	279	222	1606.0
122	AMHARA	WEST GOJAM	DEGA DAMOT	DAMOT TSEYION	Rural	219	179	1649.7
123	AMHARA	WEST GOJAM	DEGA DAMOT	AGEMI NIJAR	Rural	179	221	2492.0
124	AMHARA	WAG HIMRA	DEHANA	TSAMELA	Rural	195	198	2553.5
125	AMHARA	WAG HIMRA	DEHANA	DABETO	Rural	214	194	2279.8

EA No	Region	Zone	Woreda	Kebele	Cluster	CSA EA HH Size	HH Size (Fresh Listing)	Final Weight
126	AMHARA	WAG HIMRA	DEHANA	DIDA	Rural	185	276	3751.9
127	AMHARA	WAG HIMRA	DEHANA	AZILA	Rural	204	199	2453.2
128	AMHARA	AWI	GUAGUSA SHIKUDA	ASHEFA DAREWA BAHIRE	Rural	190	148	3081.5
129	AMHARA	AWI	GUAGUSA SHIKUDA	ABSELA WARDA	Rural	224	208	3673.4
130	OROMIYA	WEST WELLEGA	GIMBI	MELELO GACHI	Rural	233	239	4100.7
131	OROMIYA	WEST WELLEGA	GIMBI	MARICHE MIKAEL	Rural	196	182	3712.2
132	OROMIYA	EAST WELLEGA	BONEYA BUSHE	JAWIS	Rural	185	197	6988.6
133	OROMIYA	EAST WELLEGA	BONEYA BUSHE	CHEFE KONICHI	Rural	183	175	6276.0
134	OROMIYA	EAST WELLEGA	NEKEMTE TOWN	KESO	Town	204	171	910.6
135	OROMIYA	EAST WELLEGA	NEKEMTE TOWN	BKAKISA QELE	Town	157	165	1141.7
136	OROMIYA	EAST WELLEGA	NEKEMTE TOWN	BURKA JATO	Town	135	105	844.9
137	OROMIYA	EAST WELLEGA	NEKEMTE TOWN	DARGE	Town	206	199	1049.4
138	OROMIYA	ILU ABA BORA	GECHI	MUCHA	Rural	171	167	4513.5
139	OROMIYA	ILU ABA BORA	GECHI	ASENIDABO	Rural	258	213	3815.5
140	OROMIYA	JIMMA	SOKORU	KULATA	Rural	210	212	2349.2
141	OROMIYA	JIMMA	SOKORU	ERETO BEKE	Rural	178	211	2758.5
142	OROMIYA	JIMMA	SOKORU	GENGELETA	Rural	168	241	3338.2
143	OROMIYA	JIMMA	SOKORU	LIBEN	Rural	206	265	2993.5
144	OROMIYA	JIMMA	DEDO	OFOLE DAWE	Rural	179	203	1208.8
145	OROMIYA	JIMMA	DEDO	BUSA ESE ALEN	Rural	210	229	1162.3
146	OROMIYA	JIMMA	DEDO	BITO	Rural	196	190	1033.2
147	OROMIYA	JIMMA	DEDO	GESHE	Rural	171	162	1009.8
148	OROMIYA	JIMMA	DEDO	GARIRU KEDIDA	Rural	213	213	1065.9
149	OROMIYA	JIMMA	DEDO	ASA NUPE	Rural	161	168	1112.2
150	OROMIYA	JIMMA	DEDO	KAJA DLIBI	Rural	143	206	1535.5
151	OROMIYA	JIMMA	DEDO	METISO	Rural	170	206	1291.6
152	OROMIYA	JIMMA	DEDO	ASIKIRA	Rural	162	211	1388.3

EA No	Region	Zone	Woreda	Kebele	Cluster	CSA EA HH Size	HH Size (Fresh Listing)	Final Weight
153	OROMIYA	WEST SHEWA	AMBO	GENJINA GORO HORE	Rural	178	199	3064.3
154	OROMIYA	WEST SHEWA	AMBO	SENQELE FARSI	Rural	356	155	1193.4
155	OROMIYA	WEST SHEWA	AMBO	GOSU QORA	Rural	209	251	3291.8
156	OROMIYA	WEST SHEWA	ABUNA GINDEBE-RET	DEGOMA KIBI	Rural	170	208	3612.3
157	OROMIYA	WEST SHEWA	ABUNA GINDEBE-RET	WELENSU	Rural	180	237	3887.3
158	OROMIYA	WEST SHEWA	ABUNA GINDEBE-RET	OBORA	Rural	163	177	3206.0
159	OROMIYA	WEST SHEWA	ABUNA GINDEBE-RET	DEGA TINA	Rural	189	236	3686.6
160	OROMIYA	NORTH SHEWA	KIMBIBIT	WENTU	Rural	205	198	4499.0
161	OROMIYA	NORTH SHEWA	KIMBIBIT	TABOTANA MEHA-MEDE	Rural	222	224	4700.0
162	OROMIYA	NORTH SHEWA	KIMBIBIT	MENUSHANA LAYKOM-BOLC	Rural	234	226	4498.8
163	OROMIYA	EAST SHEWA	ADAMI TULU JIDO KOMB	ABUNE GERMAMA	Rural	131	199	3826.8
164	OROMIYA	EAST SHEWA	ADAMI TULU JIDO KOMB	KORME BUJURE	Rural	177	214	3045.8
165	OROMIYA	EAST SHEWA	ADAMI TULU JIDO KOMB	BARA HOBICHO	Rural	184	215	2943.6
166	OROMIYA	ARSI	CHOLE	MOYE GARADIMA	Rural	202	185	3397.2
167	OROMIYA	ARSI	CHOLE	GEMIBO DHAWE	Rural	174	203	4327.6
168	OROMIYA	ARSI	CHOLE	MAGNA WERQE DE-RARTU	Rural	274	162	2193.1
169	OROMIYA	ARSI	LODE HETOSA	GONIDE KORICHASA	Rural	187	191	3395.0
170	OROMIYA	ARSI	LODE HETOSA	SHAYA	Rural	166	125	2502.9
171	OROMIYA	ARSI	LODE HETOSA	GEBE	Rural	153	160	3476.0
172	OROMIYA	ARSI	ASELA	BOLE	Town	191	296	1674.9
173	OROMIYA	ARSI	ASELA	Welkesa	Town	261	241	997.9

EA No	Region	Zone	Woreda	Kebele	Cluster	CSA EA HH Size	HH Size (Fresh Listing)	Final Weight
174	OROMIYA	ARSI	ASELA	STADIUM	Town	359	244	734.6
175	OROMIYA	ARSI	ASELA	CHILALO	Town	214	127	641.4
176	OROMIYA	ARSI	ASELA	BURKITU	Town	342	215	679.4
177	OROMIYA	WEST HARARGE	DARO LEBU	KOTERA	Rural	238	242	1602.0
178	OROMIYA	WEST HARARGE	DARO LEBU	HAREBA FANO	Rural	154	172	1759.7
179	OROMIYA	WEST HARARGE	DARO LEBU	GELGELE	Rural	204	213	1645.1
180	OROMIYA	WEST HARARGE	DARO LEBU	HARORESE KILE	Rural	146	183	1974.8
181	OROMIYA	WEST HARARGE	DARO LEBU	EDOGELMA	Rural	118	168	2243.2
182	OROMIYA	WEST HARARGE	DARO LEBU	DAROGUDO	Rural	159	267	2645.8
183	OROMIYA	EAST HARARGE	QERSA	WICHIRO	Rural	183	172	1643.3
184	OROMIYA	EAST HARARGE	QERSA	EMERONA SODU	Rural	186	207	1945.7
185	OROMIYA	EAST HARARGE	QERSA	BULULO NEGEYA	Rural	197	205	1819.4
186	OROMIYA	EAST HARARGE	QERSA	WALITAHA BILISUMA	Rural	181	196	1893.2
187	OROMIYA	EAST HARARGE	QERSA	BURAK JENETA	Rural	152	228	2622.5
188	OROMIYA	EAST HARARGE	DEDER	OBI KU AREANAME 2	Rural	249	317	1655.7
189	OROMIYA	EAST HARARGE	DEDER	BIYO NEGAYA	Rural	176	165	1219.2
190	OROMIYA	EAST HARARGE	DEDER	KURE DEDER	Rural	204	189	1204.9
191	OROMIYA	EAST HARARGE	DEDER	WELTEHA GUDINA	Rural	218	209	1246.8
192	OROMIYA	EAST HARARGE	DEDER	BISHAN ADI	Rural	175	232	1724.1
193	OROMIYA	EAST HARARGE	DEDER	GOLU	Rural	240	212	1148.8
194	OROMIYA	EAST HARARGE	DEDER	HARENFEMA QUNI	Rural	176	203	1500.0
195	OROMIYA	EAST HARARGE	DEDER	GEGEWISA	Rural	205	207	1313.2
196	OROMIYA	BALE	GOLOLCHA	OURIGESA	Rural	98	106	3323.1
197	OROMIYA	BALE	GOLOLCHA	SELAM	Rural	167	214	3937.0
198	OROMIYA	BALE	GOLOLCHA	LEMILEM HALILA	Rural	155	193	3825.5
199	OROMIYA	BORENA	BULE HORA	SAKICHA	Rural	236	203	1327.4
200	OROMIYA	BORENA	BULE HORA	CHERE GULELICHA	Rural	201	199	1527.8
201	OROMIYA	BORENA	BULE HORA	BURIKA EBELA	Rural	185	200	1668.3

EA No	Region	Zone	Woreda	Kebele	Cluster	CSA EA HH Size	HH Size (Fresh Listing)	Final Weight
202	OROMIYA	BORENA	BULE HORA	KILENISO RESA	Rural	219	195	1374.1
203	OROMIYA	BORENA	BULE HORA	KELECHA MURITI	Rural	227	222	1509.2
204	OROMIYA	BORENA	BULE HORA	ROPI MEGADE	Rural	171	209	1886.1
205	OROMIYA	SOUTH WEST SHEWA	ILU	MULU SATEY	Rural	210	192	4928.8
206	OROMIYA	SOUTH WEST SHEWA	ILU	KETA	Rural	207	213	5547.1
207	OROMIYA	GUJI	QERCHA	SERE SEBA	Rural	207	188	1268.4
208	OROMIYA	GUJI	QERCHA	HEBO MOLICHA	Rural	179	209	1630.6
209	OROMIYA	GUJI	QERCHA	ELFERIDA	Rural	231	243	1469.1
210	OROMIYA	GUJI	QERCHA	ARUSE DERISA	Rural	204	219	1499.3
211	OROMIYA	GUJI	QERCHA	ELEDIMA	Rural	248	200	1126.3
212	OROMIYA	GUJI	QERCHA	GALESA DIBISA	Rural	248	217	1222.0
213	OROMIYA	WEST ARSI	QORE	JEMA SERDO	Rural	201	199	3335.9
214	OROMIYA	WEST ARSI	QORE	SHERE KOMOBOLCHA	Rural	169	176	3508.9
215	OROMIYA	WEST ARSI	QORE	LENCH ONESHA	Rural	228	200	2955.6
216	OROMIYA	WEST ARSI	SHASHEMENE	ARADA	Town	202	283	1309.6
217	OROMIYA	WEST ARSI	SHASHEMENE	ALELU	Town	147	241	1532.5
218	OROMIYA	WEST ARSI	SHASHEMENE	AWASH	Town	189	249	1231.5
219	OROMIYA	WEST ARSI	SHASHEMENE	ABOSTO	Town	218	360	1543.6
220	OROMIYA	WEST ARSI	SHASHEMENE	BULCHANA DENEBA	Town	166	171	962.9
221	OROMIYA	HORO GUDRU WELLEGA	GUDURU	ELAMU TEREKO	Rural	157	166	3589.3
222	OROMIYA	HORO GUDRU WELLEGA	GUDURU	GUDENE KOBO	Rural	218	279	4344.6
223	SOMALE	SHINILE	AYSHA	MERMEDEBIS	Rural	216	57	263.1
224	SOMALE	SHINILE	SHINILE	JEDENE	Rural	206	121	585.5
225	SOMALE	SHINILE	AFDEM	BEKOLI	Rural	78	84	1073.5
226	SOMALE	JIJIGA	GURSUM	SHEK ABDUSELAM	Town	186	145	777.1
227	SOMALE	JIJIGA	JIJIGA	ZERO AND	Town	200	228	398.6
228	SOMALE	JIJIGA	JIJIGA	ZERO AND	Town	173	418	844.9
229	SOMALE	JIJIGA	JIJIGA	ZERO AMIST	Town	188	228	424.1

EA No	Region	Zone	Woreda	Kebele	Cluster	CSA EA HH Size	HH Size (Fresh Listing)	Final Weight
230	SOMALE	JIJIGA	JIJIGA	ZERO SIDIST	Town	207	237	400.4
231	SOMALE	JIJIGA	JIJIGA	ZERO SIDIST	Town	223	749	1174.5
232	SOMALE	JIJIGA	JIJIGA	DEBUB KORLEY	Town	187	132	223.4
233	SOMALE	JIJIGA	JIJIGA	DIDHEDA 3RD	Town	89	94	334.2
234	SOMALE	JIJIGA	JIJIGA	JEMABEHAD	Town	159	128	254.8
235	SOMALE	JIJIGA	JIJIGA	KEBELE	Town	153	68	140.7
236	SOMALE	JIJIGA	JIJIGA	KABELE YUSULE	Town	44	34	244.5
237	SOMALE	JIJIGA	KEBRI BEYAH	SIYAREDA	Town	200	181	313.2
238	SOMALE	JIJIGA	KEBRI BEYAH	BUSHALE	Rural	160	140	302.9
239	SOMALE	JIJIGA	KEBRI BEYAH	DERWALE	Rural	201	111	191.1
240	SOMALE	JIJIGA	KEBRI BEYAH	DA'A WALE	Rural	182	125	237.7
241	SOMALE	JIJIGA	KEBRI BEYAH	GERBIHARE	Town	188	88	162.0
242	SOMALE	JIJIGA	HARSHIN	GARABEDEN	Town	151	146	369.7
243	SOMALE	JIJIGA	HARSHIN	BOLAD	Town	124	101	311.5
244	SOMALE	JIJIGA	HARSHIN	GARA LEMOD	Town	44	26	226.0
245	SOMALE	JIJIGA	HARSHIN	HAWHASEN	Town	82	31	144.6
246	SOMALE	LIBEN	FILTU	DIBI	Town	121	123	531.9
247	SOMALE	LIBEN	FILTU	TURAYLE	Town	124	102	430.4
248	SOMALE	LIBEN	FILTU	BIFTU	Rural	186	40	112.5
249	SOMALE	LIBEN	FILTU	GUNWAY	Rural	143	134	490.3
250	SOMALE	LIBEN	DOLO ADO	BIYOLE	Rural	197	115	345.6
251	SOMALE	LIBEN	DOLO ADO	BERDELE	Town	139	111	472.7
252	SOMALE	LIBEN	DOLO ADO	RAMA	Town	212	250	698.1
253	SOMALE	LIBEN	MOYALE	MUBAREK	Town	162	138	482.9
254	SOMALE	LIBEN	MOYALE	SURURO	Town	145	157	613.8
255	SOMALE	LIBEN	MOYALE	ELGOF	Town	170	187	623.6
256	SOMALE	LIBEN	MOYALE	ELQUR	Town	151	214	803.4
257	SOMALE	LIBEN	MOYALE	KETEMA	Town	156	60	218.0

EA No	Region	Zone	Woreda	Kebele	Cluster	CSA EA HH Size	HH Size (Fresh Listing)	Final Weight
258	SOMALE	LIBEN	MOYALE	ALULUKO	Rural	173	83	272.0
259	SOMALE	LIBEN	HUDET	BIMA	Rural	123	59	438.8
260	BENISHAN-GUL GUMZ	METEKEL	WENBERA	TERSHGA	Rural	186	121	265.7
261	BENISHAN-GUL GUMZ	METEKEL	WENBERA	ADIS ALEM	Rural	192	162	344.6
262	BENISHAN-GUL GUMZ	METEKEL	WENBERA	MINIJO	Rural	134	174	530.3
263	BENISHAN-GUL GUMZ	METEKEL	WENBERA	SENIKORA	Rural	255	286	458.0
264	BENISHAN-GUL GUMZ	METEKEL	WENBERA	ETARI GOCHER	Rural	156	170	445.0
265	BENISHAN-GUL GUMZ	ASOSA	ASOSA	GENIGEN	Town	196	163	219.6
266	BENISHAN-GUL GUMZ	ASOSA	ASOSA	AGOLE	Town	167	249	476.7
267	BENISHAN-GUL GUMZ	ASOSA	ASOSA	ALUBO	Town	158	363	800.4
268	BENISHAN-GUL GUMZ	ASOSA	BAMBASI	JEMATSA	Rural	135	180	621.4
269	BENISHAN-GUL GUMZ	ASOSA	BAMBASI	GARABICHE METEMA	Rural	139	85	285.0
270	BENISHAN-GUL GUMZ	ASOSA	BAMBASI	SONIKA	Rural	218	197	421.2
271	BENISHAN-GUL GUMZ	ASOSA	BAMBASI	MUTSA MADO	Rural	185	349	879.2
272	BENISHAN-GUL GUMZ	PAWE SPECIAL	PAWE SPECIAL	KETENA 2 MENIDER 17	Rural	130	247	903.0
273	BENISHAN-GUL GUMZ	PAWE SPECIAL	PAWE SPECIAL	KETENA 2 MENIDER 12	Rural	197	239	576.6
274	BENISHAN-GUL GUMZ	PAWE SPECIAL	PAWE SPECIAL	KETENA 1 MENIDER 7	Rural	185	196	503.5

EA No	Region	Zone	Woreda	Kebele	Cluster	CSA EA HH Size	HH Size (Fresh Listing)	Final Weight
275	BENISHAN-GUL GUMZ	PAWE SPECIAL	PAWE SPECIAL	KETENA 1 MENIDER 49	Rural	183	192	498.7
276	SNNPR	GURAGE	EZHA	WADIYE	Rural	378	179	1309.0
277	SNNPR	GURAGE	EZHA	WASIMARI	Rural	166	131	2181.5
278	SNNPR	GURAGE	EZHA	YASIHURANA WARI-WUYA	Rural	225	229	2813.5
279	SNNPR	GURAGE	MUHOR NA AKLIL-WERED	BATINA KERAS	Rural	202	182	2311.9
280	SNNPR	GURAGE	MUHOR NA AKLIL-WERED	ACHENE	Rural	203	199	2515.4
281	SNNPR	GURAGE	MUHOR NA AKLIL-WERED	CHEMOBI	Rural	197	169	2201.2
282	SNNPR	GURAGE	BUTAJIRA/TOWN/	KEBELE01	Town	233	248	1522.0
283	SNNPR	GURAGE	BUTAJIRA/TOWN/	KEBELE02	Town	177	135	1090.6
284	SNNPR	GURAGE	BUTAJIRA/TOWN/	KEBELE03	Town	217	300	1976.9
285	SNNPR	HADIYA	ANALIMO	HAQGELA SENFE	Rural	181	177	3640.7
286	SNNPR	HADIYA	ANALIMO	WGILA ABARA	Rural	145	128	3286.5
287	SNNPR	SIDAMA	HAWASSA ZURIYA	GALO ARIGISA	Rural	176	250	3025.8
288	SNNPR	SIDAMA	HAWASSA ZURIYA	SHAMENA GERIMAMA	Rural	195	199	2173.9
289	SNNPR	SIDAMA	HAWASSA ZURIYA	JARA KERARA	Rural	269	287	2272.7
290	SNNPR	SIDAMA	BENSA	BETURO TATESA	Rural	464	212	494.3
291	SNNPR	SIDAMA	BENSA	ALO	Rural	229	252	1190.5
292	SNNPR	SIDAMA	BENSA	SHENITAWENE	Rural	185	166	970.7
293	SNNPR	SIDAMA	BENSA	SHENTA GOLBA	Rural	210	293	1509.4
294	SNNPR	SIDAMA	BENSA	SADA WARE	Rural	212	174	887.9
295	SNNPR	SIDAMA	BENSA	GONIJABE	Rural	202	219	1172.9
296	SNNPR	SIDAMA	BENSA	KERISA BUDISA	Rural	223	224	1086.7
297	SNNPR	SIDAMA	BENSA	OSOLE	Rural	162	260	1736.2
298	SNNPR	SIDAMA	CHERE	SIDISA KEDADO	Rural	169	147	1913.5

EA No	Region	Zone	Woreda	Kebele	Cluster	CSA EA HH Size	HH Size (Fresh Listing)	Final Weight
299	SNNPR	SIDAMA	CHERE	HORA ELA	Rural	196	145	1627.4
300	SNNPR	SIDAMA	CHERE	TARATU	Rural	259	251	2131.9
301	SNNPR	GEDEO	BULE	BASURA	Rural	212	141	1560.4
302	SNNPR	GEDEO	BULE	AGAMESA	Rural	207	180	2040.1
303	SNNPR	GEDEO	BULE	WEKADI BITU	Rural	192	178	2175.1
304	SNNPR	GEDEO	BULE	LAYURASA	Rural	179	199	2608.3
305	SNNPR	WOLAYITA	KINDO KOYISHA	FECHENA	Rural	151	158	2484.1
306	SNNPR	WOLAYITA	KINDO KOYISHA	FAJENA MATA	Rural	161	183	2698.5
307	SNNPR	WOLAYITA	KINDO KOYISHA	TEPA	Rural	202	210	2468.1
308	SNNPR	SOUTH OMO	SEMEN ARI	BALIKISHOKAYISET	Rural	162	182	3680.1
309	SNNPR	SOUTH OMO	SEMEN ARI	AFINETIFERA	Rural	163	165	3315.9
310	SNNPR	KEFA	DECHA	MUTI	Rural	255	198	1391.7
311	SNNPR	KEFA	DECHA	AGAROBUSHI	Rural	202	176	1561.6
312	SNNPR	KEFA	DECHA	DUBIYO	Rural	215	205	1708.9
313	SNNPR	KEFA	DECHA	YOKA	Rural	219	218	1784.1
314	SNNPR	KEFA	DECHA	ANGELA	Rural	181	186	1841.8
315	SNNPR	KEFA	BONGA/TOWN/	ANDINET	Town	128	116	1996.1
316	SNNPR	KEFA	BONGA/TOWN/	SHETA KENTERI	Town	232	150	1424.1
317	SNNPR	GAMO GOFA	ARIBA MINICH ZURIA	KOLA SHERA	Rural	166	143	1277.0
318	SNNPR	GAMO GOFA	ARIBA MINICH ZURIA	ZIGITI BAKOLE	Rural	184	198	1595.1
319	SNNPR	GAMO GOFA	ARIBA MINICH ZURIA	GATSE	Rural	183	190	1539.0
320	SNNPR	GAMO GOFA	ARIBA MINICH ZURIA	GENITA KENICHEMA	Rural	267	179	993.8
321	SNNPR	GAMO GOFA	ARIBA MINICH ZURIA	ZEYISEDEMIBELE	Rural	186	185	1474.4
322	SNNPR	BENCH MAJI	DEBUB BENCH	ZEMIKA	Rural	150	127	1746.9

EA No	Region	Zone	Woreda	Kebele	Cluster	CSA EA HH Size	HH Size (Fresh Listing)	Final Weight
323	SNNPR	BENCH MAJI	DEBUB BENCH	ZOZO	Rural	173	185	2206.3
324	SNNPR	BENCH MAJI	DEBUB BENCH	SAYITU	Rural	205	222	2234.3
325	SNNPR	BENCH MAJI	DEBUB BENCH	GILETIN	Rural	228	185	1674.1
326	SNNPR	KONSO SPECIAL	KONSO SPECIAL	FUCHUCHA	Rural	167	213	1500.0
327	SNNPR	KONSO SPECIAL	KONSO SPECIAL	IYANA	Rural	134	187	1641.2
328	SNNPR	KONSO SPECIAL	KONSO SPECIAL	DORA	Rural	219	205	1100.9
329	SNNPR	KONSO SPECIAL	KONSO SPECIAL	DEBENO	Rural	239	192	944.8
330	SNNPR	KONSO SPECIAL	KONSO SPECIAL	GELGELENA QOLMALE	Rural	206	218	1244.6
331	SNNPR	KONSO SPECIAL	KONSO SPECIAL	MECHEQE	Rural	183	210	1349.6
332	SNNPR	SILTIE	SILTIE	ADBER WELIYA	Rural	184	184	1458.9
333	SNNPR	SILTIE	SILTIE	DANECH MUKERE	Rural	175	204	1700.6
334	SNNPR	SILTIE	SILTIE	GOFLOLA	Rural	160	138	1258.3
335	SNNPR	SILTIE	SILTIE	SEDA BARENGO	Rural	206	202	1430.5
336	SNNPR	SILTIE	SILTIE	ANSHOBESO	Rural	175	178	1483.9
337	SNNPR	SILTIE	SILTIE	GUTO WACHO	Rural	209	226	1577.5
338	SNNPR	HAWASSA CITY	HAWASSA CITY ADMINI	ADDIS KETEMA	Town	194	284	448.3
339	SNNPR	HAWASSA CITY	HAWASSA CITY ADMINI	HAYK DAR	Town	270	247	280.1
340	SNNPR	HAWASSA CITY	HAWASSA CITY ADMINI	MEHAL KETEMA	Town	207	197	291.4
341	SNNPR	HAWASSA CITY	HAWASSA CITY ADMINI	MISRAK	Town	159	156	300.5
342	SNNPR	HAWASSA CITY	HAWASSA CITY ADMINI	MENAHERIA	Town	163	135	253.6
343	SNNPR	HAWASSA CITY	HAWASSA CITY ADMINI	TABOR	Town	141	145	314.9
344	GAMBELLA	AGNEWAK	GAMBELLA ZURIYA	NYIKUWA	Rural	135	176	136.6
345	GAMBELLA	AGNEWAK	GAMBELLA ZURIYA	BONGA	Rural	210	459	229.1
346	GAMBELLA	AGNEWAK	GAMBELLA/TOWN/	KEBELE 02	Town	186	101	141.1

EA No	Region	Zone	Woreda	Kebele	Cluster	CSA EA HH Size	HH Size (Fresh Listing)	Final Weight
347	GAMBELLA	AGNEWAK	GAMBELLA/TOWN/	KEBELE 04	Town	187	214	297.5
348	GAMBELLA	AGNEWAK	GAMBELLA/TOWN/	KEBELE 05	Town	149	336	586.1
349	GAMBELLA	MEJENGER	GODARE	KABO	Rural	179	129	292.7
350	GAMBELLA	MEJENGER	GODARE	GUMARI	Rural	139	144	420.7
351	GAMBELLA	MEJENGER	GODARE	TOLINA TOKALI	Rural	215	169	319.2
352	GAMBELLA	MEJENGER	GODARE	AKASHI	Rural	195	284	591.5
353	GAMBELLA	MEJENGER	GODARE	DUNCHAYE	Rural	175	181	420.0
354	HARARI	HARARI-ALL	HARARI-ALL	KEBELE 02	Town	268	233	1169.4
355	HARARI	HARARI-ALL	HARARI-ALL	KEBELE 09	Town	136	174	972.2
356	HARARI	HARARI-ALL	HARARI-ALL	KEBELE 12	Town	199	169	455.5
357	HARARI	HARARI-ALL	HARARI-ALL	KEBELE 17	Town	179	172	1058.6
358	HARARI	HARARI-ALL	HARARI-ALL	HASENGAE	Rural	188	176	739.2
359	HARARI	HARARI-ALL	HARARI-ALL	MIYAY	Rural	233	216	866.0
360	HARARI	HARARI-ALL	HARARI-ALL	ERER DODOTA	Rural	190	202	790.4
361	ADDIS ABABA	AKAKI KALITY	AKAKI KALITY	KEBELE 01/03	Town	240	254	2229.2
362	ADDIS ABABA	AKAKI KALITY	AKAKI KALITY	KEBELE 01/03	Town	202	53	552.7
363	ADDIS ABABA	AKAKI KALITY	AKAKI KALITY	KEBELE 10/11	Town	173	272	3311.7
364	ADDIS ABABA	NEFAS SILK-LAFTO	NEFAS SILK-LAFTO	KEBELE 03/04/05	Town	123	105	1538.0
365	ADDIS ABABA	NEFAS SILK-LAFTO	NEFAS SILK-LAFTO	KEBELE 09/14	Town	93	41	794.3
366	ADDIS ABABA	NEFAS SILK-LAFTO	NEFAS SILK-LAFTO	KEBELE 12/13	Town	207	111	966.1
367	ADDIS ABABA	NEFAS SILK-LAFTO	NEFAS SILK-LAFTO	KEBELE 01(HANA,LEBU,	Town	256	115	809.4
368	ADDIS ABABA	NEFAS SILK-LAFTO	NEFAS SILK-LAFTO	KEBELE 11	Town	241	213	1592.4
369	ADDIS ABABA	KOLFE KERANIYO	KOLFE KERANIYO	KEBELE 01/05	Town	347	149	501.3
370	ADDIS ABABA	KOLFE KERANIYO	KOLFE KERANIYO	KEBELE 08/09	Town	203	185	1063.9
371	ADDIS ABABA	KOLFE KERANIYO	KOLFE KERANIYO	KEBELE 10/11	Town	157	380	2825.5
372	ADDIS ABABA	KOLFE KERANIYO	KOLFE KERANIYO	KEBELE 15/16	Town	186	137	859.9
373	ADDIS ABABA	KOLFE KERANIYO	KOLFE KERANIYO	KEBELE 07	Town	170	131	899.6
374	ADDIS ABABA	KOLFE KERANIYO	KOLFE KERANIYO	KEBELE 04	Town	211	188	1040.1

EA No	Region	Zone	Woreda	Kebele	Cluster	CSA EA HH Size	HH Size (Fresh Listing)	Final Weight
375	ADDIS ABABA	GULELE	GULELE	KEBELE 07/17	Town	215	171	2374.1
376	ADDIS ABABA	GULELE	GULELE	KEBELE 09/15	Town	160	61	1138.0
377	ADDIS ABABA	GULELE	GULELE	KEBELE 19/20/21	Town	446	135	903.5
378	ADDIS ABABA	GULELE	GULELE	KEBELE 10/18	Town	180	126	2089.5
379	ADDIS ABABA	KIRKOS	KIRKOS	KEBELE 05/06/07	Town	211	135	2512.3
380	ADDIS ABABA	KIRKOS	KIRKOS	KEBELE 13/14	Town	228	141	2428.3
381	ADDIS ABABA	KIRKOS	KIRKOS	KEBELE 04	Town	110	82	2927.2
382	ADDIS ABABA	ADDIS KETEMA	ADDIS KETEMA	KEBELE 04/05	Town	190	148	3010.2
383	ADDIS ABABA	ADDIS KETEMA	ADDIS KETEMA	KEBELE 10/11/12	Town	124	115	3583.9
384	ADDIS ABABA	ADDIS KETEMA	ADDIS KETEMA	KEBELE 19/20	Town	159	139	3378.3
385	ADDIS ABABA	YEKA	YEKA	KEBELE 03/04	Town	216	247	1290.4
386	ADDIS ABABA	YEKA	YEKA	KEBELE 08/15	Town	144	105	822.8
387	ADDIS ABABA	YEKA	YEKA	KEBELE 16/17/18	Town	237	452	2152.1
388	ADDIS ABABA	YEKA	YEKA	KEBELE 20/21	Town	233	237	1147.8
389	ADDIS ABABA	YEKA	YEKA	KEBELE 13/14	Town	192	142	834.6
390	DIRE DAWA	DIRE DAWA	DIRE DAWA-ALL	KEBELE 01	Town	177	194	1259.7
391	DIRE DAWA	DIRE DAWA	DIRE DAWA-ALL	KEBELE 02	Town	166	225	270.7
392	DIRE DAWA	DIRE DAWA	DIRE DAWA-ALL	KEBELE 03	Town	130	75	253.1
393	DIRE DAWA	DIRE DAWA	DIRE DAWA-ALL	KEBELE 04	Town	102	80	318.2
394	DIRE DAWA	DIRE DAWA	DIRE DAWA-ALL	KEBELE 06	Town	146	121	485.8
395	DIRE DAWA	DIRE DAWA	DIRE DAWA-ALL	KEBELE 08	Town	186	136	308.8
396	DIRE DAWA	DIRE DAWA	DIRE DAWA-ALL	KEBELE 09	Town	214	352	484.9
397	DIRE DAWA	DIRE DAWA	DIRE DAWA-ALL	HULAHULUL ASALISO	Rural	142	161	1175.2
398	DIRE DAWA	DIRE DAWA	DIRE DAWA-ALL	LEGA ODA MIRGA	Rural	168	151	879.8
399	DIRE DAWA	DIRE DAWA	DIRE DAWA-ALL	AWALE	Rural	201	203	835.5
400	DIRE DAWA	DIRE DAWA	DIRE DAWA-ALL	BELEWA	Rural	198	388	2782.8

ANNEX 8: HOUSEHOLD SURVEY INSTRUMENT

Identification #										

FMOH, FENOT and BIC

SECTION A: IDENTIFICATION INFORMATION

	NAME	Code
1. Region		____/___/_____
2. Zone		
3. Woreda/District		___/___/____
4. Name of Kebele/Peasant Association		
5. Cluster Number/EA		___/___/__/____
6. Household Number ____ Household Size___		___/___/__/____

7. Cluster Type (check as appropriate) 1. Urban ☐
Haala Garee
2. Rural ☐

8. Date of Interview: ____/____/2016

9. Name of Household respondent (Up to Grandfather):

10.Relationship of household respondent to household head:
(Check as appropriate)

1. Head of Household ☐
2. Wife/Husband/Partner ☐
3. Co-Wife ☐
4. Son or Daughter ☐
5. Sister/Brother ☐
6. Son or Daughter in-law ☐
7. Grandchild ☐
8. Parent ☐
9. Parent in-law ☐
10. Other Relatives ☐
11. Adopted/Foster/ Stepchild ☐
12. Guardian ☐
13. Not related ☐

11. Language of questionnaire ☐ Language of the interview ☐ Mother tounge of the respondent ☐

Language codes: 1=Amarigna 2. Oromifa 3. Tigrigna 4. Somali 5. Afar 6 Other (Specify)

12. Translator used 1. Yes 2. No

13. Sampling Interval

14. Total number of listed households in EA

15. Random Start

SECTION B: COMPOSITION OF HOUSEHOLD AND ITS CHARACTERISTICS

	Usual residents	**Sex**	**Religion**	**Relationship to Head**	**Age**	
01	**02**	**03**	**04**	**05**	**06**	
Line number	Please give me the names of the people who usually live in your household *(those who lived here for the last 3 months),* starting with the head of the household(including yourself)	**1** Male **2** Female	What is <name>'s religion? 1. Christian (Orthodox) 2. Christian (Catholic) 3. Christian (Protestant) 4. Christian (Other) 5. Muslim 6. Traditionalist/indeginious 7. Atheist 8. Others (specify)	What is the relationship of <name> to the household head? 1. Head of Household 2. Wife/Husband/Partner 3. Co-Wife 4. Son or Daughter 5. Sister/Brother 6. Son or Daughter in-law 7. Grandchild 8. Parent 9. Parent in-law 10. Other Relatives 11. Adopted/Foster/ Stepchild/orphan 12. Not related 13. Other (specify) 98. Don't Know	How old was <Name> at his / her last birthday. ***Interviewer:*** ***Under-1 = 0***	
		Write code	***Write code***	***Write code***	a. Date of birth (Month and year)	b. Age *(age in completed years)*
01					_ _ / _ _ / / _ _	
02					_ _ / _ _ _ _	
03					_ _ / _ _ _ _	
04					_ _ / _ _ _ _	
05					_ _ / _ _ _ _	
06					_ _ / _ _ _ _	
07					_ _ / _ _ _ _	
08					_ _ / _ _ _ _	
09					_ _ / _ _ _ _	
10					_ _ / _ _ _ _	

Note: Please make sure you have listed all members in column 01

		Educational Status *If age 5 Years or Older*			**Marital Status (if age>10?)**	**Employment Status of household in the last 12 months**			**Health Status**		
01	**07**	**08**	**09**	**10**	**11**	**12A**	**12B**	**13**	**17**	**18**	**19**
Line number	Is<name> able to read and write? 1. Yes (go to 8). 2. No (go to 11)	Has <NAME> ever been to school? 1. Yes go to 10. 2. No (go to 11) 3. DK(go to 11)	What is the highest grade <name> completed? ***Grade completed*** 1. Adult education 2. Church/mosque 3. Pre-primary 4. Primary education complete 5. Secondary education /grade 10 or 12 complete 6. Tech/Voc certificate 7. Univ/College/Technical diploma 8. Univ/college degree or higher **Do NOT ask if aged less than 5** ***Write code***	Number of years <NAME> completed *00= Less than 1 yr completed* *1-one year* *98= DK* *Note to interviewer: Please do NOT count gap years; Only number of years completed with 'pass' or 'fail' certificates are counted*	What is <name> Current marital Status? 1 Never married 2 Married/one wife 3. Married with two or more wives 4. Lives with a partner 5. Divorced 6.Widowed 7 Separated 8. Don't know ***Write code***	What is <name> employment status? ***1.Currently*** Working (formal/informal employment) **2**. Seeking work 3.Retired 4.Housewife/ housemaid 5.student 6.Others (Specify) ***Write Code***	If answer to 12A Was 1, what is <name>'s Main occupation?	What other activities does <name> do to generate additional income for the household? ***(Please select the code(s) from the list provided)***	How do you rate<NAME>'s health status compared to others of his/her age? 1)Very good 2)Good 3)moderate 4)bad 5) very bad 6)Don't know To Interviewer: You MUST READ the choices!	18.1 Does <name> smoke (cigarettes/pipe? 1. Yes 2. No 3. Don't Know 18.2 Does <name> chew khat1. **Yes** 3. No Don't Know	Does <name> have any of the following chronic health conditions? *(If yes indicate accordingly)* A) Hypertension B) Diabetes C) Cardiac disorders D) Arthritis/Gout E) HIV/AIDS F) Ulcers H) Other chronic (specify) (Interviewer: * At least 3 months and can recur) 1. Yes 2. No
											A / B / C
							Occupation	**Code**			
01											
02											
03											
04											
05											
06											
07											

08													
09													
10													

Codes for Q 12B and 13.

1. Farmer –
2. Housewife– (Not applicable to Q13)b
3. Shepherd –
4. Civil Servant –
5. Private sector –
6. Pastoralist –
7. Agro-pastoralist
8. Fishing –
9. Retail and wholesale trade –
10. Not declared –
11. Other (specify) - _____
12. (for #13) Don't have any secondary occucapation
13. Don't Know

01	20	21	22	23	24	25	26
Line number	Was <NAME> ill in the last four weeks? 1. Yes (go to 21) 2 .No (Go to 25) Don't know (go to 25) **Insert Code**	If Yes, to Q20 did <name> visit/consult a health provider (including hospital/ health center/ Health post/ Pharmacy/drug shop/ Birth Attendant &Traditional Healers) 1. Yes (go to 22) 2. No (go to 24) 3. Don't Know (go to 24) **Insert Code**	If Yes to Q21, did <Name> make all the visits that were required? 1. Yes go to Q25) 2. No (go to Q23) 3. Don't know (Go to 25) **Insert Code**	If No to Q22, what was <name>'s main reasons for not making all the visits? 1. Lacked Money 2. Self medication 3. Poor quality service 4. High Cost of Care 5. Religious /cultural reasons 6. Fear of discovering serious illness 7. Considered illness not serious 8. Long distance to provider 9. Others (_____specify) **Insert Code(s)**	If No to Q21, what was <name>'s main reasons for not seeking care? 1. Lacked Money 2. Self medication 3. Poor quality service 4. High Cost of Care 5. Religious /cultural reasons 6. Fear of discovering serious illness 7. Considered illness not serious 8. Long distance to provider 9. Others (_____specify) **Insert Code(s)**	Did <name> seek <u>preventive/promotive health</u> care in the last 4 weeks? 1. Yes 2. No 3. Don't know ***(List of services)*** • ***Family Planning*** • ***Immunization*** • ***Voluntary Counselling and Testing (VCT)*** • ***Ante/post natal care*** • ***Nutrition supplements*** **Insert Code** *Note to interviewer: Please read the examples listed above to remind respondent also refer to your field guide)*	Has [NAME] spent a night as a patient at a health care facility (HC or Hospital) in the past 12 months? 1. Yes (go to Q27) 2. No (go to Section C1) 3. Don't Know (go to Section C1) **Insert code**
01							
02							
03							
04							
05							
06							
07							
08							
09							
10							

01	27	28
Line number	If Yes to Q26, was <name> admitted? 1. Yes (go to section C3) 2. No (go to Q28) 3. Don't Know (go to section C1) **Insert code** **Note to interviewer: Admission refers to doctor's decision to keep patient in inpatient care**	If No to Q27, why was <name> not admitted? 1. Referred to higher facility 2. Not prescribed 3. Lacked Money 4. Self medication 5. Poor quality service 6. High Cost of Care 7. Religious /cultural reasons 8. Fear of discovering serious illness 9. Considered illness not serious 10. Long distance to provider 11. Others (_____specify) 98. Don't know Note to interviewer: Do NOT read the choices, (*Multiple responses allowed*) **Insert All Codes mentioned**
01		
02		
03		
04		
05		
06		
07		
08		
09		
10		

Note to interviewer: Repeat questions 20 to 28 to each member of household

Identification #										

FMOH, FENOT and BIC

SECTION C 1: UTILIZATION OF OUT PATIENT AND OTHER HEALTH RELATED SERVICES IN PAST FOUR WEEKS

This section is for <u>all household members</u> whose response was a "Yes" in Questions 20, 21, 22, 25 and 26 (section B)

Household membership number for the person who Consulted/sought /visited health provider for health care **(as appearing in Q2021, 22 Q25 and 26)** …… 29.1How many out patient visits did <Name>make in the last four weeks: _____ (number) *(Get information ONLY for last four visits*)	**VISIT 1**	**VISIT 2**	**VISIT 3**	**VISIT 4**

Household membership number for the person who Consulted/sought /visited health provider for health care **(as appearing in Q20 21, 22 Q25 and 26)** 29. 2 How many out patient visits did <name>make in the last four weeks: _____ (number) *(Get information ONLY for last four visits*)	**VISIT 1**	**VISIT 2**	**VISIT 3**	**VISIT 4**

Household membership number for the person who Consulted/sought /visited health provider for health care **(as appearing in Q2021, 22 Q25 and 26)** …… 29.1How many out patient visits did <Name>make in the last four weeks: _____ (number) *(Get information ONLY for last four visits)*	**VISIT 1**	**VISIT 2**	**VISIT 3**	**VISIT 4**
30.1What were the **MAIN reasons** for (name) seeking care: ***Enumerator probe to ensure no reason is missed]***	*Circle all that apply*	*Circle all that apply*	*Circle all that apply*	*Circle all that apply*
A**) ILLNESS**				
A.1 infectious parasitic Diseases				
1) Malaria	**1**	**1**	**1**	
2) Diseases of Respiratory including pneumonia	**2**	**2**	**2**	**1**
3) TB	**3**	**3**	**3**	**2**
4) HIV/AIDS	**4**	**4**	**4**	**3**
5) Diarrhoea	**5**	**5**	**5**	**4**
6) Intestinal worms	**6**	**6**	**6**	**5**
7) Vaccine preventable diseases	**7**	**7**	**7**	**6**
8) Neglected tropical diseases	**8**	**8**	**8**	**7**
9) Other infectious and parasitic diseases	**9**	**9**	**9**	**8**
	10	**10**	**10**	**9**
A..2 Nutritional deficiencies (severe malnutrition)				**10**
A.3. Non-communicable diseases	**12**	**12**	**12**	
1. Cancer				**12**
2. Diabetics	**13**	**13**	**13**	
3. kidney failure	**14**	**14**	**14**	**13**
4. Mental disorders	**15**	**15**	**15**	**14**
				15
A4. Injuries and other conditions				
	16	**16**	**16**	
B) ***Services -***	**1**	**1**	**1**	**16**
10) Physical check-up (prevention) -	**2**	**2**	**2**	**1**
11) Immunizations (prevention) -	**3**	**3**	**3**	**2**
12) Family planning (prevention) –	**4**	**4**	**4**	**3**
a) Oral contraceptives –	**5**	**5**	**5**	**4**
b) Condoms -	**6**	**6**	**6**	**5**
c) Intrauterine device -	**7**	**7**	**7**	**6**
d) Injectable–	**8**	**8**	**8**	**7**
e) Norplant –	**9**	**9**	**9**	**8**
f)Sterilization -	**10**	**10**	**10**	**9**
13) Prenatal or antenatal care				**10**
14) Delivery –	**12**	**12**	**12**	
15) Dental -				**12**
16) Circumcision –	**13**	**13**	**13**	
17) VCT –	**14**	**14**	**14**	**13**
18) Other forms of Counselling –	**15**	**15**	**15**	**14**
19) Physiotherapy -				**15**
20) Nutrition supplements –				
a) Vitamins/minerals –	**16**	**16**	**16**	
b) Micronutrient powder –				**16**
c) Baby formula –				
21) Other Services (specify) –				
	17	**17**	**17**	**17**
	18	**18**	**18**	**18**
	19	**19**	**19**	**19**
	20	**20**	**20**	**20**
	21	**21**	**21**	**21**

Household membership number for the person who Consulted/sought /visited health provider for health care **(as appearing in Q20 21, 22 Q25 and 26)** 29. 2 How many out patient visits did <name>make in the last four weeks: _____ (number) *(Get information ONLY for last four visits)*	**VISIT 1**	**VISIT 2**	**VISIT 3**	**VISIT 4**
30.2What were the **MAIN reasons** for (name) seeking care: **[*Enumerator to probe to ensure no reason is missed*)**	*Circle all that apply*	*Circle all that apply*	*Circle all that apply*	*Circle all that apply*
A**) ILLNESS -**				
A.1 infectious parasitic Diseases -			**1**	
1) Malaria -	**1**	**1**	**2**	**1**
2) Diseases of Respiratory including pneumonia -	**2**	**2**	**3**	**2**
3) TB - dhibee sombaa	**3**	**3**	**4**	**3**
4) HIV/AIDS -	**4**	**4**	**5**	**4**
5) NCDs (cancer hypertension, diabetes) -	**5**	**5**	**6**	**5**
6) Diarrhoea -	**6**	**6**	**7**	**6**
7) Intestinal worms -	**7**	**7**	**8**	**7**
8) Vaccine preventable diseases -	**8**	**8**	**9**	**8**
9) Neglected tropical diseases –	**9**	**9**	**10**	**9**
10) Other infectious and parasitic diseases -	**10**	**10**		**10**
A..2 Nutritional deficiencies			**12**	
A.3. Non-communicable diseases -	**12**	**12**		**12**
1. Cancer -			**13**	
2. Diabetics -	**13**	**13**	**14**	
3. kidney failured	**14**	**14**	**15**	**13**
4. Mental disorders -	**15**	**15**		**14**
				15
A4. Injuries and other conditions -			**16**	
	16	**16**		**16**
B) ***Services* - Tajaajilaaf**				
1) Physical check-up (prevention) -			**17**	
2) Immunizations (prevention) -	**17**	**17**	**18**	**17**
3) Family planning (prevention) –	**18**	**18**		**18**
a) Oral contraceptives –			**19**	
b) Condoms -	**19**	**19**	**20**	**19**
c) Intrauterine device -	**20**	**20**	**21**	**20**
d) Injectable -	**21**	**21**	**22**	**21**
e) Norplant –	**22**	**22**	**23**	**22**
f)Sterilization -	**23**	**23**	**23**	**23**
4) Prenatal/antenatal care –	**23**	**23**	**24**	**23**
5) Delivery –	**24**	**24**	**25**	**24**
6) Dental -	**25**	**25**	**26**	**25**
7) Circumcision –	**26**	**26**	**27**	**26**
8) VCT – qorannoo HIV	**27**	**27**	**28**	**27**
9) Other forms of Counselling –	**28**	**28**	**29**	**28**
10) Physiotherapy -	**29**	**29**	**30**	**29**
11) Nutrition supplements –	**30**	**30**		**30**
d) Vitamins/minerals –			**31**	
e) Micronutrient powder –	**31**	**31**	**32**	**31**
f) fudhatamu	**32**	**32**	**33**	**32**
g) Baby formula –	**33**	**33**	**34**	**33**
Other Services (specify) –	**34**	**34**		**34**

31.1What was the name of the health facility <name> visited? *(Including Chemists & Traditional Healers)*	***Name***	***Name***	***Name***	***Name***
32.1 What was the type of the health provider that <name> visited? ***(Including Chemists & Traditional Healers)***	***Circle code***	***Circle code***	***Circle code***	***Circle code***
1) Govt. Hospital –	1	1	1	
2) Private hospital –	2	2	2	1
3) Not for profit hospital –	3	3	3	2
4) Govt. Health Centre –	4	4	4	3
5) Gov't health post –	5	5	5	4
6) Not for profit health centre –	6	6	6	5
7) Private Clinic –	7	7	7	6
8) NGO Clinic –	8	8	8	7
9) Company/parastatal clinic –	9	9	9	8
10) Pharmacy/ Drugstore -	10	10	10	9
11) Traditional /religious healer –	11	11	11	10
12) TBA -	12	12	12	11
13) Other (specify)…….	13	13	13	12
				13
33.1Is this the nearest provider/facility to your home 1.Yes (go to Qs. 36.1) - 2. No (go to Qs. 34.1) – 3. Don't know (go to Q34.1) –	***Enter code***	***Enter code***	***Enter code***	***Enter code***
34.1 Who owns the facility nearest your home 1) Government - 2) Private (both formal & traditional) – 3) NGO/Faith Based Oorganization – 4) Other (specify) 5) Don't know Use 9 for DK –	***Enter code***	***Enter code***	***Enter code***	***Enter code***
35.1 What were the **main reasons** for <name> by passing the facility nearest to his/her home	*Circle code*	*Circle code*	*Circle code*	*Circle code*
1) Unfriendly staff –				1
2) Long waiting time –	1	1	1	2
3) Medicine unavailable –	2	2	2	3
4) Staff are unqualified –	3	3	3	4
5) More expensive services –	4	4	4	5
6) Dirty facility –	5	5	5	6
7) Would have paid (facility didn't sign agreement with insurance scheme) –	6	6	6	7
8) Would have paid (facility doesn't accept waiver system users)	7	7	7	8
9) Would have paid (facility doesn't provide exempted service)	8	8	8	9
10) No privacy–	9	9	9	10
11) Facility closed (at the time) –	10	10	10	11
12) Facility not in operation –	11	11	11	12
13) Other (specify) –	12	12	12	
Note to interviewer: Do NOT read the choices **(Multiple answers acceptable)**				

31.2What was the name of the health provider <name> visited? *(Including Chemists & Traditional Healers)*	***Name***	***Name***	***Name***	***Name***
30.2 What was the type of the health provider that <name> visited? ***(Including Chemists & Traditional Healers)***	***Circle code***	***Circle code***	***Circle code***	***Circle code***
14) Govt. Hospital –	1	1	1	1
15) Private hospital –	2	2	2	2
16) Not for profit hospital –	3	3	3	3
17) Govt. Health Centre –	4	4	4	4
18) Gov't health post –	5	5	5	5
19) Not for profit health centre –	6	6	6	6
20) Private Clinic –	7	7	7	7
21) NGO Clinic –	8	8	8	8
22) Company/parastatal clinic –	9	9	9	9
23) Pharmacy/ Drugstore -	10	10	10	10
24) Traditional healer –	11	11	11	11
25) TBA - Deessiftuu	12	12	12	12
1) Other (specify)…….	13	13	13	13
33.2 Is this the nearest facility to your home 1.Yes (go to Qs. 34.1) - 2. No (go to Qs. 35.1) – 3. Don't know (go to Q35.1) –	***Enter code***	***Enter code***	***Enter code***	***Enter code***
34. 2 Who owns the facility nearest your home 6) Government - 7) Private (both formal & traditional) – 8) NGO – 1) Don't know Use 9 for DK –	***Enter code***	***Enter code***	***Enter code***	***Enter code***
35.2 What were the **main reasons** for <name> by passing the facility nearest to his/her home35.1	*Circle code*	*Circle code*	*Circle code*	*Circle code*
	1	1		
14) Unfriendly staff –	2	2	1	1
15) Long waiting time –	3	3	2	2
16) Medicine unavailable –	4	4	3	3
17) Staff are unqualified –	5	5	4	4
18) More expensive services –	6	6	5	5
19) Dirty facility –	7	7	6	6
20) Would have paid (facility didn't sign agreement with insurance scheme) –	8	8	7	7
21) No privacy –	9	9	8	8
22) Facility closed (at the time) –	10	10	9	9
23) Facility not in operation –	*11*	*11*	10	10
24) Not covered by insurance (CBHI, SHI) –	*12*	*12*	*11*	*11*
25) Other (specify) –			*12*	*12*
(Multiple answers acceptable)				

36.1 What are the main reasons for <name> choosing the health provider that you visited?	*Circle code*	*Circle code*	*Circle code*	*Circle code*
1) Close to home –				
2) Staff give good advice –				1
3) Good staff attitude –	1	1	1	2
4) Knew someone in the facility –	2	2	2	3
5) Less waiting time –	3	3	3	4
6) Medicine available –	4	4	4	5
7) Staff are qualified -	5	5	5	6
8) Less costly –	6	6	6	7
9) Felt not seriously ill (minor ailment) –	7	7	7	8
10) Cleaner facility –	8	8	8	
11) More privacy –				9
12) Accept insurance (CBHI) –	9	9	9	1 0
13) Accept users of waiver system	1 0	1 0	1 0	1 1
14) Provide exempted services	1 1	1 1	1 1	1 2
15) Was referred -	1 2	1 2	1 2	
16) Other (specify) –				1 3
17) Don't know	1 3	1 3	1 3	14
Note to interviewer: Do NOT read choices	14	14	14	15
(Multiple answers acceptable)	15	15	15	

37.1.Did you obtain all medicine/drugs prescribed to youthere?	***Enter code***	***Enter code***	***Enter code***	***Enter code***
1) Yes (all)-Go to Q40.1				
2) Yes (some)-Go to Q38.1				
3) No –Go to Q39.1				
4) Don't know-Go to Q40.1				

38.1. If (2) Yes to Q37.1 (i.e. some of the needed drugs), what were the main reasons for not getting some?	***Enter code***	***Enter code***	***Enter code***	***Enter code***
1) Drugs not available –				
2) Used drugs available at home –				
3) Decided to do without drugs –				
4) Did not have enough money –				
5) Referred –				
6) Other				
Note to interviewer: Do NOT read choices				

39.1. If No to 37.1, what were the reasons?	***Circle code(s)***	***Circle code(s)***	***Circle code(s)***	***Circle code(s)***
1) Drugs not available –	**1**	**1**	**1**	**1**
2) Wanted to buy drugs from elsewhere –	**2**	**2**	**2**	**2**
3) Used drugs available at home -	**3**	**3**	**3**	**3**
4) Decided to do without drugs -	**4**	**4**	**4**	**4**
5) Did not have any money –	**5**	**5**	**5**	**5**
6) Other	**6**	**6**	**6**	**6**
Note to interviewer: Do NOT read choices				

36.2 What are the main reasons for <name>choosing the health provider that you visited?	*Circle code*	*Circle code*	*Circle code*	*Circle code*
	1	1	1	
	2	2	2	1
1) Close to home –	3	3	3	2
2) Staff give good advice –	4	4	4	3
3) Good staff attitude –	5	5	5	4
4) Knew someone in the facility –	6	6	6	5
5) Less waiting time –	7	7	7	6
6) Medicine available –	8	8	8	7
7) Staff are qualified -	9	9	9	8
8) Less costly –				9
9) Felt not seriously ill (minor ailment) –	1 0	1 0	1 0	
10) Do not have to pay –	1 1	1 1	1 1	1 0
11) Cleaner facility –	1 2	1 2	1 2	1 1
18) More privacy –	1 3	1 3	1 3	1 2
12) Employer/CBHIrequirement –	14	14	14	1 3
13) Accept insurance (CBHI, SHI) –	15	15	15	14
14) Was referred -				15
15) Other (specify) –				
(Multiple answers acceptable)				

37.2.Did you obtain all medicine/drugs prescribed to you there?	***Enter code***	***Enter code***	***Enter code***	***Enter code***
1) Yes (all)-Go to Q40.1				
2) Yes (some)-Go to Q38.1				
3) No –Go to Q39.1				
4) Don't know-Go to Q39.1				

38.2If Yes to Q37.1 (i.e. some of the needed drugs) what were the main reasons for not getting some? drugs), what were the main reasons for not getting some?	***Enter code***	***Enter code***	***Enter code***	***Enter code***
1) Drugs not available –				
2) Used drugs available at home –				
3) Decided to do without drugs –				
4) Did not have enough money –				
7) Referred –				

39.2 If No to 37.1, what were the reasons?	***Circle code(s)***	***Circle code(s)***	***Circle code(s)***	***Circle code(s)***
1) Drugs not available –		**1**	**1**	**1**
2) Wanted to buy drugs from elsewhere –	**1**	**2**	**2**	**2**
3) Used drugs available at home -	**2**	**3**	**3**	**3**
4) Decided to do without drugs -	**3**	**4**	**4**	**4**
5) Did not have any money -	**4**	**5**	**5**	**5**
	5	**6**	**6**	**6**
	6			

40.1. Did you pay money for the services you received? 1) Yes (go to Q41.1) 2) No (go to Q42.1) **3)** Don't know (Go to 46.1)	**1** **2** **8**	**1** **2** **8**	**1** **2** **8**	**1** **2** **8**
41.1. If yes, how much money was spent on <name's> treatment? 1) Registration/ Consultation - 2) Drugs/vaccines (including outside purchase) 3) Diagnosis/investigations (x-ray, lab etc.)– 4) Transport (round trip) including that of person accompanying, if any 5) Food and accommodation – including that of person accompanying, if any 6) Other (specify) – 7) Total – *8)* Don't know *(enter 9999)* – ***Enter overall estimate (8) only if detail not remembered.***	**Eth. Birr Birrii** 1…….. 2…….. 3……. 4……. 5……. 6…… 7……. …… _____	**Eth. Birr Birrii** 1…… . 2…… . 3……. 4……. 5……. 6…… 7……. …….. _____	**Eth. Birr Birrii** 1…….. 2…….. 3……. 4……. 5……. 6…… 7……. …….. _____	**Eth. Birr Birrii** 1…….. 2…….. 3……. 4……. 5……. 6…… 7……. …….. _____
42.1 If no to question 40.1, how was the cost of the services covered? 1) Fee Waivers – (Go to 46.1) 2) Exempted services – (Go to 46.1) 3) Insurance (CBHI) - (Go to 46.1) 4) Employer/private insurance - (Go to 46.1) 5) Other specify - (Go to 46.1) 6) Don't know (Go to 46.1)				

40.2.Did you pay money for the services you received? 1) Yes (go to Q41.1) 2) No (go to Q42.1) 3) Don't know (Go to 42.1)	**1** **2** **8**	**1** **2** **8**	**1** **2** **8**	**1** **2** **8**
41.2. If yes, how much money did <name> spend on treatment/ services received? 1) Registration/ Consultation - 2) Drugs/vaccines (including outside purchase) 3) Diagnosis/investigations (x-ray, labetc.)– 4) Medical Check up – 5) Transport (round trip) – 6) Food and accommodation – 7) Other (specify) – 8) Total – *9)* Don't know *(enter 9999)* – ***Enter overall estimate (7) only if detail not remembered.***	**Eth. Birr** 1…….. 2…….. 3……. 4……. 5……. 6…… 7……. 8…… 9…… 10……. ……	**Eth. Birr** 1…….. 2…….. 3……. 4……. 5……. 6…… 7……. 8…… 9…… 10…… . ……	**Eth. Birr** 1…….. 2…….. 3……. 4……. 5……. 6…… 7……. 8…… 9…… 10……. ……	**Eth. Birr** 1……... 2….... 3…… 4…… 5…… 6…… 7…… 8……. 9…… 10……. …….__
42.2 If no to question 40.1, how wasthe cost of the services covered? 1) Fee Waivers – 2) Exempted services – 3) Insurance (CBHI) - 4) Employer - 5. Other specify -				

43.1. How did <name> pay for the services received [C*ircle all that apply]*	**MODE OF PAYMENT**	***Visit 1*** ***Circle code(s) -***	***Visit 2*** ***Circle code(s)-***	***Visit 3*** ***Circle code(s) -***	***Visit 4*** ***Circle code(s) -***
	1.Cash–	***1***	***1***	***1***	***1***
	2.Given opportunity to pay later (credit) –	***2***	***2***	***2***	***2***
	3.Paid in kind–	5	***5***	***5***	***5***
	4. Other (specify)	***6***	***6***	***6***	***6***
	5. - Don't know –	***8***	***8***	***8***	***8***

43.2 How did <name> pay for the services received C*ircle all that apply]*	**Mode of payment**	***Visit 1*** ***Circle code(s)***	***Visit 2*** ***Circle code(s)***	***Visit 3*** ***Circle code(s)***	***Visit 4*** ***Circle code(s) marsaa***
	1.Cash -	***1***	***1***	***1***	***1***
	2.Given opportunity to pay later (credit) –	***2***	***2***	***2***	***2***
	5.Paid in kind (not clear??) –	***5***	***5***	***5***	***5***
	6. Don't know –	***6***	***6***	***6***	***6***
	7. Other specify -	***8***	***8***	***8***	***8***

		Visit 1	*Visit 2*	*Visit 3*	*Visit 4*
44.1. If you indicated in Q43.1 that <name>paid in kind, please list down the items and cost them using the prevailing market rates in that region. Item / Quantity / Unit of measure / Unit Pri ETB		***Total Value in* Eth. Birr** _____	***Total Value in* Eth. Birr** _____	***Total Value in* Eth. Birr** _____	***Total Value in* Eth. Birr** _____
45.1.Where did <NAME> get the funds to pay for the services and how much was paid from each source [*Circle all that apply]*	**Source of funds Madda kanfaltii**	**Amount in Eth. Birr**	**Amount in Eth. Birr**	**Amount in Eth. Birr**	**Amount in Eth. Birr**
	1 Had own cash available –				
	2. Friends, family members & relatives (assistance) –				
	3. Neighbourhood/edir contributions –				
	4. Borrowed money–				
	5. Sold household assets, livestock or cereals –				
	6. Sold /rented household land –				
	7. Don't Know–				
		Visit 1	***Visit 2***	***Visit 3***	***Visit 4***
46.1 .How long did <name> wait before being seen by a medical staff, after reaching the provder? **For those who don't know enter 99**		***Hs/Min*** ___/___	***Hrs/Min*** ____/____	***Hrs/Min*** ____/___	***Hrs/Min*** ___/____

		Visit 1	*Visit 2*	*Visit 3*	*Visit 4* -
44.2. If you indicated in Q43.2 that you paid in kind, please list down the items and cost them using the prevailing market rates in that region Item / Quantity / Unit of measure / Unit Price		***Total Value in* Eth. Birr** _____	***Total Value in* Eth. Birr** _____	***Total Value in* Eth. Birr** _____	***Total Value in* Eth. Birr** _____
45.2.Where did <NAME> get the funds to pay for the services[1] and how much was paid from each source [*Circle all that apply]*	**Source of funds**	**Amount in Eth. Birr**	**Amount in Eth. Birr**	**Amount in Eth. Birr**	**Amount in Eth. Birr**
	1 Had own cash available – kaashii ofii qabu				
	2. Friends, family members & relatives (assistance) –				
	3. Neighbourhood contributions –				
	4. Borrowed money - liqaa				
	7. Sold household assets –				
	8. Sold /rented household land –				
	98. Don't Know *(Enter 00)* –				
		Visit 1	***Visit 2***	***Visit 3***	***Visit 4***
46.2. How long did <name> wait before being seen by a medical staff? **For those who don't know enter 99**		***Hs/Min*** ___/___	***Hrs/Min*** ____/____	***Hrs/Min*** ____/____	***Hrs/Min*** ___/____

47.1. How long did <name> spend with the medical staff - **For those who don't know enter 99**	***Hs/Min*** ___/___ ……..	***Hs/Min*** ___/___ ……..	***Hs/Min*** ___/___ ……..	***Hs/Min*** ___/___ ……..	47.2. How long did <name> spend with the medical staff - **For those who don't know enter 99**	***Hs/Min*** ___/___ ……..	***Hrs/Min*** ___/___ ……..	***Hrs/Min*** ___/___ ……..	***Hrs/Min*** ___/___ ……..
48.1. How long did it take <name> to reach to the health provider and get back home? **Enter 99 = for those who don't know** ***Interviewer – Exclude time spend in the health facility***	***Hs/Min*** ___/___ ……..	***Hs/Min*** ___/___ ……..	***Hs/Min*** ___/___ ……..	***Hs/Min*** ___/___ ……..	48.2. How long did it take <name> to reach to the health provider and get back to home? **Enter 99 = for those who don't know** ***Interviewer – Exclude time spend in the health facility***	***Hrs/Min*** __/___ ……..	***Hrs/Min*** ___/___ ……..	***Hrs/Min*** ___/___ ……..	***Hrs/Min*** ___/___ ……..
49.1 What distance did <name> cover in KMs to get to the facility and back (two way round trip??)) **Enter 99 = for those who don't know**	***KMs*** _____ ……..	***KMs*** _____ ……..	***KMs*** _____ ……..	***KMs*** _____ ……..	49.2. What distance did <name> cover in KMs to get to the facility and back (two way) **Enter 99 = for those who don't know**	***KMs*** _____ ……..	***KMs*** _____ ……..	***KMs*** _____ ……..	***KMs*** _____ ……..
50.1 .What was <name>'s **MAIN METHOD** of transportation used to get to the health provider? 1) Woreda/HC/hospital Ambulance – ambulaansii mootummaa 2) Public transport (e.g. Bus, Minibus, taxi,truck) – 3) Private (own means) – 4) Taxi (private)/Bajaj/Gari – 5) Boat - 6) Walked - 7) Bicycle/motor cycle – 8) Animal (e.g. horse, mule, camel) – 9) Air – 10) Traditional ambulance 11) Other (specify) –	***Enter Code K***	***Enter Code***	***Enter***	***Enter Code***	50.2. What was <name>'s **MAIN METHOD** of transportation used to get to the health provider? 1) Woreda/HC/hospital Ambulance – 2) Public transport (e.g. Bus, Minibus, taxi,truck) – 3) Private (own means) – 4) Taxi (private)/Bajaj/Gari – 5) Boat - 6) Walked - Miilan 7) Bicycle/motor cycle – 8) Animal (e.g. horse, mule, camel) – 9) Air– xiyyaaran 10) Other (specify) –	***Enter Code***	***Enter Code***	***Enter Code***	***Enter Code***
51.1.Was <name> generally satisfied with the quality of care that he/she received from <name> health facility 1. Yes - 2. No - 3) Don't Know –	***Enter code***	***Enter code***	***Enter Code***	***Enter code***	51.2.Was <name> satisfied with the quality of care that he/she received from <name> health facility 1. Yes - 2. No – 3. Don't Know –	***Enter code***	***Enter code***	***Enter Code***	***Enter Code***

		Visit 1	***Visit 2***	***Visit 3***	***Visit 4***			***Visit 1***	***Visit 2***	***Visit 3***	***Visit 4***
		Enter code	***Enter code***	***Enter code***	***Enter code***			***Enter code***	***Enter code***	***Enter code***	***Enter code***
52.1.How would you rate the following aspects of quality of care in the <name > health facility visited? **1) Very Satisfied –** **2) Satisfied –** **3) Not satisfied –** 4) **Not at all satisfied** 5) **Don't know – hin**	a). Time spent with the Clinician					52.2. How would <name> assess the following aspects of quality care in the <name > health facility visited? itti quufe? 1. **Very Satisfied – sirritti itii quufan** **2.Satisfied – itti quufan** **3. Not satisfied –**	a). Time spent with the Clinician				
	b.) Waiting time after reaching facity						b.) Waiting time				
	c.) Courtesy of staff						c.) Courtesy of staff				
	d) Availability of drugs						d) Availability of drugs				
	e) Cleanliness of facility						e) Cleanliness of facility				
	f) Privacy during consultation						f) Privacy during consultation				

beeku **Note to interviewer: You MUST READ the above chices for each quality indicator**	g) Motivation of Staff						**itti hin quufne 4.Not at all satisfied – 5) Don't know –**	g) Motivation of Staff			
	h) Skill of providers							h) Skill of providers			
	i. Availability of diagnostic facility							i. Availability of diagnostic facility			

Start next column/visit, otherwise provide information for the next person as appropriate

IF THERE ARE MORE THAN TWO HOUSEHOLD MEMBERS, please use additional forms.

SECTION C2: ROUTINE HEALTH EXPENSES in the last four weeks (Apply to all Household Members)

53.1.Apart from the above health expenses, did any member of your household incur other expenses on health and health related commodities in the **last four weeks**(e.g. routine medication, FP commodities and services such as condoms, pills e.t.c, ORS, nutrition supplements e.g. Cod liver Oil, multivitamins, zinc, vitamin A, micronutrient powders, baby formulae.t.c? 1. Yes (go to Q54) – 2. No (go to Q57) - 3. Don't know (go to Q57) –	*Insert code -*			
54. If yes, indicate the household membership number of the person who incurred other expenses on health and health related commodities? (To be filled by interviewer)	ID No. _____	ID No. _____	ID No. _____	ID No. _____
55.How much did <name> spend on the following items/commodities? 1. Family planning commodities - 2. Bed/accommodation - 3. ORS *4.* Nutritional commodities (over-the-counter vitamin and mineral supplements (i.e., vitamin A, zinc, multivitamins), micronutrient powders, or even baby formulas) – *5.* Other commodities *6.* 5. Don't know *(Enter 99)* –	1.___**Eth. Birr** 2.___ **Eth. Birr** _____	1._____ **Eth. Birr** 2.____**Eth. Birr** _____	1.___**Eth. Birr** 2.___ **Eth. Birr** _____	1._____ **Eth. Birr** 2._____ **Eth. Birr** _____
57-Is one of the member of the<household > member of the health development Army or social mobilization committee? 1) Yes - 2) No - 3) I don't know – 58A- Is the household involved LLTIN (treated mosquito net) distribution, IRS operations (chemical spray) and in the environmental management to control malaria 1) Yes - 2) No - 3) I don't know –				

58B- If Yes to 58A, please indicate which members of the housrhold are involved in environmental management activities?

Household member	Month

59 How much time per week does the household spend each week in the following activities and what is its estimated value in ETB

	Health Development Army (one-to-five and one-to-thirty networks) or social mobilization related activities in the last four weeks				**Malaria control program in the last 12 months**			
	Regular meeting for experience sharing	Environmental control activities excluding malaria	Pregnant mothers' conference	Traditional Ambulance	LLTINs	IRS operations	Awareness creation	Pond draining & other environmental control activities
Time spent per week for 1-to-5 or social mobilization								
~~Estimated value in ETB~~								
Time spent per week for 1-to-30 network								
Estimated value in ETB								

Unit cost for daily labourer in ETB per day _____ ETB/Day

60.Did the household contribute in cash or in kind to the construction and maintenance of health posts, health centres, hospitals, HEWs homes, communal latrine in the last 12 months? 1) Yes – (Go to Q62) 2) No – 3) I don't know –				
61. Did the household contribute in cash, in kind or in labour towards enhancing utilization of services (for strengthening the health system, ambulance running cost, cultural food items and drinks to enhance delivery in the health centres) in the last 12 months? 1) Yes - 2) No – (Go to Section C3) 3) I don't know –				

62. If yes to questions 60 and 61, How much did the household spend on the above?

Type of Contribution		Estimated contribution			
	HP, HC, hospital construction/ maintenance	HEWs homes construction/maintenance	Construction of communal latrines	Ambulance running cost (contribution for fuel, driver or any related contribution)	Food and drinks contribution for promoting facility delivery
A. In Cash -					
B. Labour – (day)					
C. In Kind – (Y/N if Yes, fill the table below)					

62.1 - If Yes to 62.C, fill the box below :

U

nit cost for labour in the local community _____ETB per unit

Unit cost for in kind contribution _____ ETB per unit

Name of in-kind contribution	Quantity	Unit of measurement	Unit price ETB

Unit cost of labor in the local community: _____

Total cost for the in kind contribution: _____

SECTION C3: IN-PATIENT ADMISSION IN THE LAST 12 MONTHS

This section is for household members whose response was a "Yes" in Questions 27 (section B)

(Only the last two inpatient admission should be considered for a maximum of four household members)

Household membership number of the in-patient service user:	Household membership no.		Household membership No:		Household membership no.:		Household membership no.	
	Adm1/Ciisanii	**Adm2/Ciisanii**	**Adm1/Ciisanii**	**Adm2/Ciisanii**	**Adm1/Ciisanii**	**Adm2/Ciisanii**	**Adm1/Ciisanii**	**Adm2/Ciisanii**
63. How many times was <Name> admitted in the last 12 months?	_____times		_____times		_____times		_____times	
64. How long was <Name> admitted?	**Adm1**	**Adm2**	**Adm1**	**Adm2**	**Adm1**	**Adm2**	**Adm1**	**Adm2**
	_____***days***	_____***days***	_____***days***	_____***days***	_____***days***	_____***days***	_____***days***	_____***days***
65. What was the name of the health provider/facility that <Name> was admitted in?	*Name-* _____	*Name-* _____	*Name-* _____	*Name-* _____	*Name-* _____	*Name-* _____	*Name-* _____	*Name-* _____
66.What was the type and ownership of health provider that <name> was admitted in? 1) Govt. Hospitals 2) Private hospital	*Insert code*	*Insert code*	*Insert code*	*Insert code*	*Insert code*	*Insert code*	*Insert code*	*Insert code*

Household membership number of the in-patient service user:	Household membership no.		Household membership No:		Household membership no.:		Household membership no.	
	Adm1/Ciisanii	**Adm2/Ciisanii**	**Adm1/Ciisanii**	**Adm2/Ciisanii**	**Adm1/Ciisanii**	**Adm2/Ciisanii**	**Adm1/Ciisanii**	**Adm2/Ciisanii**
3) Not for profit Hospital 4) Govt. Health Centre 5) Private clinic 6) Not for profit health centre 7) Abroad (*care sought abroad)* 8) Traditional healer 9) Other (specify)								
67. Is this the nearest in-patient health facility to your home? 1. Yes (answer Qs. 70) 2. No (go to Qs. 68 and 69) 3.Don't Know (go to Qs.70)	*Insert code*	*Insert code*	*Insert code*	*Insert code*	*Insert code*	*Insert code*	*Insert code*	*Insert code*
68. Who owns the in-patient health facility nearest your home 1 Government - 2 Private - 3 NGO/faith-based organization - 4. Don't know –	*Insert code*	*Insert code*	*Insert code*	*Insert code*	*Insert code*	*Insert code*	*Insert code*	*Insert code*
69. What were the **main reasons** for bypassing the inpatient facility nearest to your home***(Multiple answers acceptable)*** 1) Unfriendly staff 2) Long waiting time 3) Medicine unavailable 4) Staff are unqualified 5) Services are expensive 6) Dirty facility 7) Would have paid (facility not signed contract agreement with insurance scheme) 8) Would have paid (facility doesn't accept waiver system users) 9) Would have paid (facility doesn't provide exempted service) 10) No privacy 11) Beds not available 12) Facility closed (at the time) 13) Facility not in operation 14) Other (specify)	**1 2 3 4 5 6 7 8 9 10 11**	**1 2 3 4 5 6 7 8 9 10 11**	**1 2 3 4 5 6 7 8 9 10 11**	**1 2 3 4 5 6 7 8 9 10 11**	**1 2 3 4 5 6 7 8 9 10 11**	**1 2 3 4 5 6 7 8 9 10 11**	**1 2 3 4 5 6 7 8 9 10 11**	**1 2 3 4 5 6 7 8 9 10 11**
70. What are the **main reasons** for choosing the health facility that you were admitted in? 1) Close to home 2) Staff give good advice 3) Good staff attitude 4) Knew someone in the facility 5) Less waiting time 6) Medicine available 7) Staff are qualified 8) Less costly 9) Do not have to pay (accept insurance/CBHI, etc.) 10) Accept users of waiver system 11) Provide exempted services 12) Cleaner facility	***Circle code*** **1 2 3 4 5 6 7 8 9 1 0 1 1 1 2**	***Circle code*** **1 2 3 4 5 6 7 8 9 1 0 1 1 1 2**	***Circle code*** **1 2 3 4 5 6 7 8 9 1 0 1 1 1 2**	***Circle code*** **1 2 3 4 5 6 7 8 9 1 0 1 1 1 2**	***Circle code*** **1 2 3 4 5 6 7 8 9 1 0 1 1 1 2**	***Circle code*** **1 2 3 4 5 6 7 8 9 1 0 1 1 1 2**	***Circle code*** **1 2 3 4 5 6 7 8 9 1 0 1 1 1 2**	***Circle code*** **1 2 3 4 5 6 7 8 9 1 0 1 1 1 2**

FMOH, FENOT and BIC

Household membership number of the in-patient service user:	Household membership no.		Household membership No:		Household membership no.:		Household membership no.	
	Adm1/Ciisanii	**Adm2/Ciisanii**	**Adm1/Ciisanii**	**Adm2/Ciisanii**	**Adm1/Ciisanii**	**Adm2/Ciisanii**	**Adm1/Ciisanii**	**Adm2/Ciisanii**
13) More privacy	**1 3**	**1 3**	**1 3**	**1 3**	**1 3**	**1 3**	**1 3**	**1 3**
14) Was referred	**14**	**14**	**14**	**14**	**14**	**14**	**14**	**14**
15) Don't know	**15**	**15**	**15**	**15**	**15**	**15**	**15**	**15**
16) Other (specify)								
Do NOT read options (Multiple answers acceptable)								
71.What were the **main reasons** for (name) seeking admission: (multiple choices allowed		***Circle code***	***Circle code***	***Circle code***	***Circle code***	***Circle code***	***Circle code***	***Circle code***
Enumerator probe to ensure no reason is missed]								
A)**Illness –**								
A1 infectious parasitic Diseases -								
1) Malaria -		**1**	**1**	**1**	**1**	**1**	**1**	**1**
2) Diseases of Respiratory including pneumonia -	**1**	**2**	**2**	**2**	**2**	**2**	**2**	**2**
3) TB -	**2**	**3**	**3**	**3**	**3**	**3**	**3**	**3**
4) HIV/AIDS -	**3**	**4**	**4**	**4**	**4**	**4**	**4**	**4**
5) Diarrhoea–	**4**	**5**	**5**	**5**	**5**	**5**	**5**	**5**
6) Intestinal worms -	**5**	**6**	**6**	**6**	**6**	**6**	**6**	**6**
7) Vaccine preventable diseases -	**6**	**7**	**7**	**7**	**7**	**7**	**7**	**7**
8) Neglected tropical diseases -	**7**	**8**	**8**	**8**	**8**	**8**	**8**	**8**
9) Other infectious and parasitic diseases -	**8**	**9**	**9**	**9**	**9**	**9**	**9**	**9**
	9	**10**	**10**	**10**	**10**	**10**	**10**	**10**
	10							
A.2 Nutritional deficiencies (severe malnutrition) –	**11**							**11**
A.3. Non-communicable diseases –		**11**	**11**	**11**	**11**	**11**	**11**	
1. Cancer -	**13**							**13**
2. Diabetics -	**14**	**13**	**13**	**13**	**13**	**13**	**13**	**14**
3. kidney failure -	**15**	**14**	**14**	**14**	**14**	**14**	**14**	**15**
4. Mental disorders -	**16**	**15**	**15**	**15**	**15**	**15**	**15**	**16**
		16	**16**	**16**	**16**	**16**	**16**	
A4. Injuries and other conditions -	**17**							**17**
b) ***Services -***		**17**	**17**	**17**	**17**	**17**	**17**	
1) Delivery -	**18**							**18**
2) Caesarean -	**19**	**18**	**18**	**18**	**18**	**18**	**18**	**19**
3) vaginal delivery -	**20**	**19**	**19**	**19**	**19**	**19**	**19**	**20**
4) Sterilization -	**21**	**20**	**20**	**20**	**20**	**20**	**20**	**21**
5) Treatment/surgeryfor reproductive health related cancers etc.–	**22**	**21**	**21**	**21**	**21**	**21**	**21**	**22**
6) Community management of Acute malnutrition –	**23**	**22**	**22**	**22**	**22**	**22**	**22**	**23**
7) Other Services (specify) –	**24**	**23**	**23**	**23**	**23**	**23**	**23**	**24**
		24	**24**	**24**	**24**	**24**	**24**	

72. Did <name> pay for the services received? 1. Yes- (go to Q73) 2. No-(go to Q 74A) 8. Don't Know (go to Q74A)		***Enter code***	***Enter code***	***Enter code***	***Enter code***	***Enter code***	***Enter code***	***Enter code***	***Enter code***
73.If yes to Q72, how much did <NAME> Spend on the following? ***Interviewer:-*** *Amounts paid by item should correspond to each admission*		**Enter Amt in EthBirr**	**Enter Amt in Eth. Birr**	**Enter Amt in Eth. Birr**	**Enter Amt in Eth. Birr**	**Enter Amt in Eth. Birr**	**Enter Amt in Eth. Birr**	**Enter Amt in Eth. Birr**	**Enter Amt in Eth. Birr**
	1. Registration/Consultation								
	2. Drugs (including outside purchase)								
	3. Surgical operation								
	4. Diagnosis and imaging (x-ray, lab etc)								
	5. Bed /accommodation								
	6. Transport (to and from the health provider) *7.* Other *(include cost incurred by the person accompanying the patient)*								
	8. Total ***Enter overall estimate only if detail not remembered***	_____	_____	_____	_____	_____	_____	_____	_____
	9) Don't know - (enter -99)	**Insert code**	**Insert code**	**Insert code**	**Insert code**	**Insert code**	**Insert code**	**Insert code**	**Insert code**
74B. How did <name> pay for the services? [*Enter the appropriate code by admission]*	***Mode of payment***	***Enter code***	***Enter code***	***Enter code***	***Enter code***	***Enter code***	***Enter code***	***Enter code***	***Enter code***
	1. Cash (go to 76)								
	2.Paid in kind (Go to 75)								
	3.Credit (go to 77) 4.Other (Specify) (go to 77)								
	5. Don't know (go to 77)								
74A- If No to question 72, how was the cost of services covered? 75. If you indicated in Q74, that you paid in kind, please list down the items and cost them using the prevailing market rates in that region Item | Quantity | Unit of measure | Unit Price ETB	1. fees waiver 2. exempted services **3.** insurance (CBHI) **4.** employer/private insurance **5.** Other (Specify)	***Total Value in* Eth. Birr** _____	***Total Value in* Eth. Birr** _____	***Total Value in* Eth. Birr** _____	***Total Value in* Eth. Birr** _____	***Total Value in* Eth. Birr** _____	***Total Value in* Eth. Birr** _____	***Total Value in* Eth. Birr** _____	***Total Value in* Eth. Birr** _____

76. Where did <NAME> get the funds to pay for the services and how much was paid from each source ***Interviewer:-*** *Amounts paid by source should correspond to each admission*	***Source of funds***	***Enter Amount*** **Eth. Birr**	***Enter Amount*** **Eth. Birr**	***Enter Amount*** **Eth. Birr**	***Enter Amount*** **Eth. Birr**	***Enter Amount*** **Eth. Birr**	***Enter Amount*** **Eth. Birr**	***Enter Amount*** **Eth. Birr**	***Enter Amount*** **Eth. Birr**
	1) Had cash available								
	2) Was given money (by friends, relatives & family members								
	3) Neighbourhood/Edir contributions								
	4) Borrowed money								
	5) Sold household assets/animals/farm products								
	6) Sold or rented land								
	7)Don't Know *(enter -99)* -								
77. Who provided drugs and pharmaceuticals? (*Multiple answers acceptable)* 1) By the health facility 2) Purchase from outside 3) Both (1 and 2) 4) Other (specify) 8) Don't know use 9 for DK		***Enter code(s)***	***Enter code(s)***	***Enter code(s)***	***Enter code(s)***	***Enter code(s)***	***Enter code(s)***	***Enter code(s)***	***Enter code(s)***
78. Was <name> satisfied with the quality of care that he/she received from <name> health facility? 1) Yes 2) No 3) Don't know		***Enter code***	***Enter code***	***Enter code***	***Enter code***	***Enter code***	***Enter code***	***Enter code***	***Enter code***

		Household number:		Household number:		Household number:		Household number:	
		Adm1 Enter code	***Adm2 Enter code***	***Adm1 Enter code***	***Adm2 Enter code***	***Adm1 Enter code***	***Adm2 Enter code***	***Adm1 Enter code***	***Adm2 Enter code***
79. How do you rate the following aspects of quality of care in the facility you visited? 1) Very Satisfied – 2) Satisfied – 3) Not satisfied – 4) Not at all satisfied – 5) Don't know – **Note to interviewer: You MUST READ the above chices for each quality indicator**	1) Time spent with the Clinician -								
	2) Waiting time after getting doctor's decision to be admitted -								
	3) Courtesy of staff -								
	4) Availability of drugs -								
	5) Availability of lab/diagnostics –								
	6) Cleanliness of facility/wards -								
	7) Bed linen –								
	8) Food quality –								
	9) Consultation Privacy – 10) Motivation of staff 11) Skill of providers								
80.A How long did it take <name> to get to the health provider and back (round trip)? **Enter -99 = for those who don't know**		***Hrs_____ Min_____*** _____	***Hrs_____ Min_____*** _____	***Hrs_____ Min_____*** _____	***Hrs_____ Min_____*** _____	***Hrs_____ Min_____*** _____	***Hrs_____ Min_____*** _____	***Hrs_____ Min_____*** _____	***Hrs_____ Min_____*** _____
80B). How long did it take <name> to be admitted (time between doctor's decision and admission)? **Enter -99 = for those who don't know 9**		***Hrs_____ Min_____*** _____	***Hrs_____ Min_____*** _____	***Hrs_____ Min_____*** _____	***Hrs_____ Min_____*** _____	***Hrs_____ Min_____*** _____	***Hrs_____ Min_____*** _____	***Hrs_____ Min_____*** _____	***Hrs_____ Min_____*** _____
81. What distance did <name> cover in KMs to get to the inpatient facility and back (Round trip) **Enter -99 = for those who don't know**		***_____ kms*** _____	***_____ kms*** _____	***_____ kms*** _____	***_____ kms*** _____	***_____ kms*** _____	***_____ kms*** _____	***_____ kms*** _____	***_____ kms*** _____
82. How much did <name> spend on transport (round trip), including transportation cost of person who accompanied <name>, if any **If don't know enter -99**		***Birr_____*** _____	***Birr_____*** _____	***Birr_____*** _____	***Birr_____*** _____	***Birr_____*** _____	***Birr_____*** _____	***Birr_____*** _____	***Birr_____*** _____
83. Did any member of your household /firend/neighbours accompany<NAME> during his/her hospital stay? 1. Yes (go to Q84) 2. No **(go to Section D)**		***Enter code***	***Enter code***	***Enter code***	***Enter code***	***Enter code***	***Enter code***	***Enter code***	***Enter code***
84. If yes in Q83, for how many days was <name> accompanied?		***Days***	***Days***	***Days***	***Days***	***Days***	***Days***	***Days***	***Days***
85. Indicate the household membership number for the person who accompanied <name> to the health provider (to be filled by interviewer) Fill Line number or "Not household member"		***Insert No.***	***Insert No.***	***Insert No.***	***Insert No.***	***Insert No.***	***Insert No.***	***Insert No.***	***Insert No.***

Note: Start next column/admission, otherwise provide information for the next person as appropriate

SECTION D: MORTALITY
Kutaa D: Lubbuun darbuu (Du'aa)

86 A. Is there a **Household member** who lived in this household and died in **the last 12 months** (do not include foetuses).

1. Yes (Go to 86B)
2. No (go to section E)

86B. If yes to Q 86A, how many have died?_____

M	87	88	89	90
Line number of Deceased Person	What was the relationship of (deceased) to head of household? 1 Wife/Husband/Partner – 2 Co-Wife – 3 Son or Daughter – 4 Sister/Brother – 5 Son or Daughter in-law – 6 Grandchild – 7 Parent– 8 Parent in-law – 9 Other Relatives – 10 Adopted/Foster/ Stepchild – 11 Not related – 12 Other (specify) – 13 Don't Know – ***Enter Code***	What was the sex of Deceased Person 1. Male - 2. Female - ***Enter Code***	Did the deceased receive health services before he/she died? 1 Yes (go to Q90) – 98. No(go to section E) – Enter Code	If yes to Q89, how much did the household spend on treatment for the deceased in the last 12 months? **Enter amount in Eth Birr.**
M1				
M2				
M3				
M4				
M5				
M6				
M7				
M8				
M9				
M10				
M11				
M12				

SECTION E: ACCESS TO HEALTH INSURANCE

Qs 91 – 93 to be answered for each household member

01	91A	91B	92	93
Line number	Is the Household member of health Insurance? 1) Yes 2) No 3) Don't know	Is <NAME> covered with a health insurance? 1) Yes (go to Q92) – 2) No (Go to section F) – Don't Know (Go to section F) – 3)	**Type of Insurance coverage –** 1) Community based health insurance – 2) Private insurance 3) Employer 4) Others (specify)_____ *(Multiple choices allowed)*	Who pays for insurance coverage? 1) Household head – 2) Government (for Indignet HHs) – 3) Employer – 4) Self - 5) Others (specify) - (Multiple answers allowed)
	Insert code		***Write code***	***Write Code***
01				
02				
03				
04				
05				
06				
07				
08				
09				
10				
11				
12				

94. How does your household pay for the health insurance coverage?*(Multiple choices allowed)* -
    1) Salary -
    2) Pension -
    3) Dependant(supported by family members)
    4) Cash – (including farm income)
    5) Others (specify) –
    6) Don't know –
95. How much does your household spend per month on the Community based/private/employer insurance premiums? Eth Birr _____
    (NB: If premiums are paid on annual basis, divide by 12)
96. What medical services are covered by your health insurance?
    1) In patient -
    2) Out patient -
    3) Both -
    4) Others (specify)_
    5) Don't Know –
    Note to interviewer: You will have to read this list
97. While having membership of CBHI/private insurance, was the household forced to pay from out of pocket during health service utilization?
1) Yes -

2) No -
3) I don't know –
98. If yes, to question 97, How much did the household spend (excess to reimbursement from your insurer) in the last 12 months? _____ETB

Note to interviewer: This question refers to the difference between what patient paid and what insurance paid

Section F: Housing Conditions and Household Assets (These questions to be asked to Household head)

99	In what type of dwelling does the household head live? *1) Permanent building – i* *2) Semi Permanent - i* 3) *Temporary –* 4) *4.Traditional –*	***Enter code*** ☐
100	Is the household a beneficiary of productive safety net program?	***1. Yes -*** ***2. No -*** ***3. I don't know –*** ☐
101	Do you have a domestic worker living with you?	1. Yes - 2. No -
102	Is your dwelling owned by your household or rented, or do you reside here without payments? *1) Owned by household or one of it's members –* *2) Rented -* *3) Occupied without payment –* 4) *Other (specify_____) –*	***Enter code*** ☐
103	What is the **main** type of material for the floor in your house?	*See box at right for codes* ☐
104	What is the **main** type of material are your walls made of?	*See box at right for codes* ☐
105	What is the **main** type of material is your roof made of?	*See box at right for codes* ☐
106	What is your main source of cooking fuel?	1.Firewood – 2.Charcoal - 3.Kerosine - 4. Gas - cylinder 5.Electricity - 6.Solar – 7.Other (specify) _____
107	What is your main source of lighting?	1.Electricity - 2.Kerosine – 3.Gas - biogas 4.Candle - 5.Firewood - 6.Solar – 7.Other (specify) _____

Codes for 102—104
1. Mud/crow dung –
2.Stone -
3.Cement/bricks -
4.Hollow Block
5.Wood -
6.Grass
7.Iron sheets -
8.Tiles -
9.Other (specify) –

FMOH, FENOT and BIC

109A	Does your household have any of the following items?	

Item	Qty
1. Radio	
2. Television	
3. Bicycle	
4. Motocycle	
5. Car	
6. Telephone/mobile	
7. Refrigerator	
8. Plough	
9. Animal drawn cart	

10. Ox	Qty
11. Cow	
12. Sheep	
13. Goat	
14. Horse	
15. Donkey	
16. Camel	

109B. Does the household have any cash crops/plants such as coffee plants, chat? Response items? 1. Yes 2. No 3. Don't know

109C. If Yes to 109B, please the types and quantities of cash crops/plants

Type	Unit of measure	Quantity

110	What is the main source of drinking water for the household?	Enter code 1.Piped into residence – 2.Piped into the compound or plot – 3.Public tap – 4. Well/borehole with pump in the compound/well in the residence or compound or plot – 5. Public well - 6.Rainwater collection; - 7.Well without hand pump - 8.Pond/River/Stream/Dam, - 9. protected spring - 10. Unprotected spring – 11. Rock catchment – 12.Others (specify) –
111	What type of toilet facility does the household use?	Enter code 1.Own flush toilet to sewage/septic tank– 2.Shared flush toilet in area – 3.Traditional pit latrine – 4.Ventilated Improved Pit Latrine– 5.Bush or field – (Go to 114) 6.Bucket Latrine - (Go to 114) 7.Other:____ (specify) –
112	Was the toilet constructed by the family?	***1. Yes -*** ***2. No -***
113	If yes, how much household spent on the construction of toilet (if constructed within the last 12 months)?	_____ ***in Eth Birr***
114	How many hectares of land under farming/gardening does the household own?	_____Hectares Please note: 4 timad=1 hectare. Therefore, 1 timad=0.25 hectare

SECTION G: HOUSEHOLD EXPENDITURE: Respondent: Wife, or woman responsible for purchasing, if not Household Head

I would like to ask you questions about your household expenses (include the contributions of the members of the household to the budget)

115	How much does your household spend per month on the following key foods and beverages, including your own produce? *1) Oil, butter and fats (include vegetable oils, etc) –* *2) Cereals (includingTeff, maize and wheat flour, rice etc) for injera –* *3) Pulses (lentils, beans, soy, shiro, etc) –* *4) Dairy produce e.g. Milk and eggs –* *5) Fish -* *6) Meat/liver -* *7) Sugar/ tea/coffee –* *8) Bread -* *9) Spices (berbere, mitmita, etc) –* *10) Vegetables (carrots, kale, tomatoes, etc) -*	Expenditure in Eth. Birr 1. …… 2. …… 3. …… 4. …… 5. …… 6. …… 7. …… 8. …… 9. …… 10. ……

	11) Fruits - Kuduraalee *12) Roots (potatoes, yams, beets, onions, garlicetc) –* *13) Soft drinks (soda, Juice etc) –* *14) Beer and Wines (includes Tella, Teji, Arakie, Bordie, etc.,) –* *15) Snacks/processed foods/sweets (biscuits, crackers, candies, etc.) –* *16) Nutrition commodities purchased to supplement diet –* *17) Meals consumed outside –* **[If you can't give a break down, please enter the total amount spent on food]**	11. …… 12. …… 13. …… Total amount _____ Eth. Birr

	Monthly household expenditures	
116	How much does your household spend per month on the following?	Amount (Eth. Birr)
	1) Cosmetics -	
	2) Soap and detergents –	
	3) Hair dressing –	
	4) Cigarettes/Pipes -	
	5) Chat/khat -	
	6) Rent (house rent? specify)-	
	7) Electricity -	
	8) Water -	
	9) Kerosene –	
	10) Telephone -	
	11) Transport -	
	12) Charcoal -	
	13) Fire wood –	
	14) Cooking gas –	
	15) Remittances (in cash and kind) -	
	16) Fuel (e.g. Petrol, diesel etc.) –	
	17) Others (Specify) –	
	17) TOTAL or estimate:	**Total amount _____ Eth. Birr**
	Annual household expenditures – Respondent: Preferably husband and wife together	
117	**How much did your household spend in the last 12 months on following?**	Amount (Eth. Birr)
	1) Education (registration, uniforms, books, tuition, exam fees)	
	2) Maintenance and repairs of buildings and vehicles	
	3) Holiday	
	4) Clothing and footwear	
	5) Wedding/dowry (give examples, gifts, food, drinks, money, clothes for going on wedding)	
	6) Funerals/Tezkar/Mahber can appear as a separate response item. (money, cereals, food, drinks, etc. incl. idir)	
	7) Major purchases/constructions (vehicles, land, house, furniture, ox, cow, horse, camel, fertilizer, improved seeds,etc). Adding machine required	

	8) Others (specify)	
	9) Total or estimate	
		Total amount _____ Eth. Birr

SECTION H: HOUSEHOLD INCOME: (This section is for HH members who are supporting HH budget)

118	How much income did this household receive during the **past 12 months (1 year)** from the following sources?	Income in Eth. Birr
	1. Public and parastatal salaries –	
	2. Private sector salary –	
	3. Business/enterprises -	
	4. Rent received (e.g. land rates, house/room rent) –	
	5. Remittances e.g. dowry –	
	6. Pensions -	
	7. Interest earned (dividend, interest from bank deposits etc) –	
	8. Sale of cash crops–	
	9. Sale of food crops –	
	10. Sale of livestock and livestock products	
	11. Other farming income (eg. Sale of woods, etc.)–	
	12. Consultancy –	
	13. Daily labour–	
	14. Others (specify)	
		Total amount _____ Eth. Birr

117. Survey administrator information: Ragaa nama walitti qabe

117.1: Name of Enumerator: _____

117.2: Signature of enumerator: _ _____

117.3: Name of Woreda/District Supervisor: _____

117.4: Signature of Woreda/District Supervisor: _____

THE END