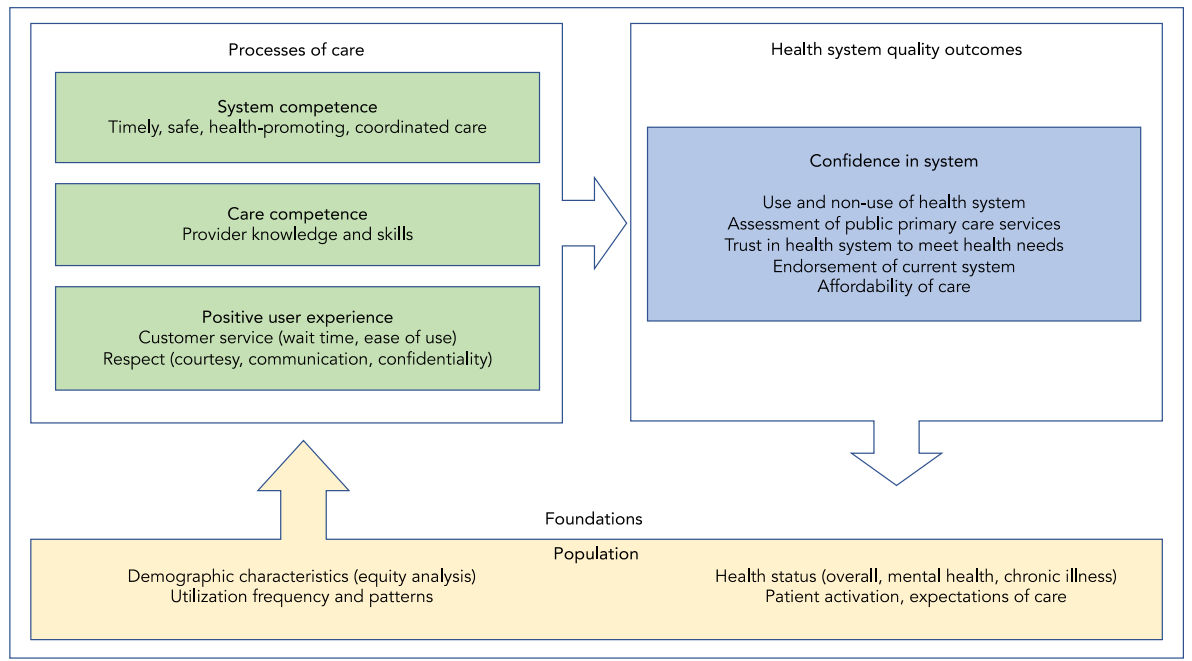


People's Voice Survey - Assessment of People's Perspective on Health System Performance in Ethiopia



Technical Report prepared by the QuEST Ethiopia and QuEST Harvard TH CHAN School of Public Health Team

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This report presents findings of the People’s Voice Survey - Assessment of People’s Perspective on Health System in Ethiopia which was implemented by the Ethiopian Public Health Institute in collaboration with the Ethiopian Ministry of Health and Harvard TH CHAN School of Public Health. The study was funded by Harvard TH CHAN School of Public Health.

Additional information about the People’s Voice Survey - Assessment of People’s Perspective on Health System in Ethiopia can be obtained from the Ethiopian Public Health Institute (EPHI), Gulele Arbegnoch Street, Gulele Sub-City, Addis Ababa, Ethiopia. Telephone: +251.11.275.4647; Fax: +251.11.275.4744; Website: <http://www.ephi.gov.et>. and from Harvard TH CHAN School of Public Health www.questnetwork.org

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Key findings

The people voice survey tool is a low cost, rapid survey, novel method of data collection tool through a mix of phone based and face to face interview can be used as a routine, integrated component of health system planning to bring a social voice to health system planning. The PVS measures how the health system's responsiveness to provide health services that addresses the needs and expectations of the individual and the communities.

The data generated by the PVS Survey will be used to answer key policy questions that can inform government practices and improve the performance of the health system. It can shed light on poorly understood concepts such as patient activation levels, service utilization patterns, unmet need for care, and population perceptions of health system performance, among others. The tool assists the health sector in improving health system responsiveness, thereby accelerating progress towards universal health coverage of essential health services. PVS tool will be a global public good, local researcher will be able to access and use it to answer sub-national or regional research questions and deepen future investigations into the performance of health systems.

Health care utilization pattern:

- In Ethiopia, every adult individual contact 2 times with health care contacts on average per year through in person, virtual or home.
- Seven percent of respondents get in-patient service per year.
- Nine percent of the population visited health care facilities frequently (more than four visits per year), while 55% visited only occasionally (1 to 4 visits per year). Sixty one percent of population visited one health care facility per year while 37% of population visited two to three health facilities per year.
- Nearly seven in ten Ethiopians rated their general health status as excellent or very good.
- Fifty –three percent of respondents rated they had very good or excellent mental health status.
- Six percent of respondents have received care for depression, anxiety, or other mental health issues.
- Thirty five percent of respondents fully vaccinated for COVID-19. Seven in ten of respondents had intention to take the COVID-19 vaccination recommended doses.
- One out of every ten people did not receive health care, even though they required it.
- The most common reasons for not using the needed health care were cost (38%), interpersonal skill such as long waiting time (22%), and service readiness-unavailability's of medicines and supplies (20%).
 - The distribution of unmet need varied across subpopulation subcategories, with rural residence (13%) being higher than urban residence (7%), and the uneducated subpopulation (14%) being higher than the higher educated subpopulation category.

Usual source of Health care use

- Seven in ten respondents had had usual source of care for their health care needs.
 - The main reasons for choosing the facility as their usual source of care are cost (low coat or covered by insurance) (31%), convenience or a short distance from their home or work area (30%), technical quality-provider skill (15%), service readiness (14%), interpersonal quality such as a short waiting time (7%), and the facility being the only facility available (four percent).

- Ninety three percent of these usual sources of care were from Primary health facilities (78% - public primary facilities and 15% -private primary health facilities).
- Most of the disadvantaged subpopulations had usual source of care:
 - 72% of old age respondents (60+) had usual source of care (76 % of them were from public health facilities).
 - 75 % of female respondents had usual source of care (85% of them are from Public health facilities).
 - 67% of rural respondents had usual source of care (89% are from public facilities).
 - 67% of illiterate respondents had usual source of care.
 - Thirteen percent of respondents had chronic diseases onset in the past one year prior to the survey, of which 84% had usual source of care.

Health system competency:

- The health system competency such as checking and testing their health status was low. Among all respondents, 36% of total respondents checked their blood pressure, 15% of respondents checked their eye health, 14% had checked their blood sugar level, and among women 13% screened for cervical cancer.

Quality of Health care Respondents rated):

- Quality of service from their usual source of care:
 - Forty percent of respondents reported they received an excellent or very good quality of care from their usual sources of health care.
 - 35% percent of old age peoples, 41% of female respondents, 37% of respondents in rural area rated the quality of services received from the usual source rate as very good or excellent.
 - Six percent of respondents who visited Ethiopian health care facilities experienced a medical mistakes, and
 - Thirteen percent of respondents had experienced unfair treatment or discrimination by health care providers. In rural area it was 15% and the younger subpopulation experienced the highest discrimination (21%).
- Quality of service at the last visit:
 - The median time spent for consultation by healthcare provider was 15 (IQR 10, 30) minutes. More than half of respondents (53%) reported that the consultation time was greater than 15 minutes.
 - The median wait time at the facility was 30 (IQR 20,60) minutes. Half of the respondents had a waiting time of 1 hour and more before seeing healthcare providers.
 - Forty-four percent of participants said the overall quality of care was very good or excellent.
 - Across the country, 55%, 48%, and 42% of respondents said they received good respect from the provider, competent care, and had good consultation time, respectively.
 - The overall quality of in rural residence was 42% which was lower than in urban residents (42%).
 - In all quality-measurement parameters, private-owned facilities provided better care than public-owned facilities. For example, in terms of overall service quality, private health facilities (55%) than public facilities (40%). Respect to

the patients were more practiced in private facilities (67%) than public facilities (51%), with a significant difference in consultation time (50% in private facilities vs. 39% in public facilities).

- Forty seven percent, 41%, 26% and 18 percent of respondents rated as excellent or very good the service provided by the public primary care to pregnant women, children, chronic conditions, and mental health status, respectively.

Confidence in the health system

- 80% of respondents were very confident in receiving high-quality healthcare if they become seriously ill.
- 55% of respondents were very confident in their ability to afford health care if they become very ill.
- 80% of respondents were very confident that the government takes public opinion into account when making decisions in the health system.
- 80% of respondents said that the government is properly managing the COVID-19 pandemic.

Promote the health facility to others and Health System need to Reform

- Half of respondents did not recommend their most recent visited health care facility to others.
- The findings revealed that older age groups, females, and respondents in urban area respondents in Ethiopia were more likely to recommend health facilities to their family or friends (56%, 48%, and 56%), respectively than their counterparts.
- Nearly eight in ten respondents confident that the health system getting better and better for the past two years.
- Majority (70%) of the respondents did not satisfied by the quality of the current health care services, they proposed the health system needs to rebuilt or change.
- Half of public facilities and 61% of private facilities require major renovations, while 15% and 12% of public and private facilities, respectively, must be rebuilt to meet the populations health-care needs.

Recommendations

- The PVS Survey is a global public good; it assists the health sector in improving health system responsiveness, accelerating progress towards universal health coverage of essential health services.
- Local researchers can access and use it to answer sub-national or regional research questions and deepen future investigations into the performance of health systems.
- The health-care system's competency was low and health facility visiting pattern is low. It needs to increase the awareness of the people and strengthen health facilities to improve the system competency for improving the health status of the population.
- The people perception on the discrimination (unfair treatment, unmet need) of services is a signal for the failed system. Policymakers should use PVS tools to promote health system accountability to the population and track the impact of reforms and policies over time at the national or subnational regional level.
- Half of the respondents did not recommend their last visited health facilities to family, friends, or other people in Ethiopia due to the perceived low quality of care (quality dimensions). This suggests that there is a lack of endorsement of healthcare facilities in Ethiopia, and which will influence trust and utilization of health care system. This needs to make the health system make the peoples centered approach to achieve the universal health coverage by improving the quality of services provided to the community.

- Three-quarters of the population believes the health-care system is improving, while 10% believes it is deteriorating, with 7percent of rural residents and 14% of urban residents believing it is worse and needs reform.
- Overall 15% of populations want to see major reform or complete overhaul; especially more educated, urban, higher income—implications for continued support for current UHC models.
- Indicators could be added to the HSIP and could be done after two years to see change
- By increasing sample size regional level analysis can be done

Implications (for an objective brief / information sharing)

- Access to a usual source of care is not universal and nearly eight in ten receive usual care from a public primary care facility.
- Having a usual source of care is associated with better access to key preventive services. Requires more to do on building awareness on the population to culture on the key preventive services. Extending access to primary care could improve take up of preventive care and increase user satisfaction.
- Public insurance coverage alone may be insufficient to increase access to high-quality health care services. The insurance coverage in Ethiopia is low, while large gaps in access to quality care continue to exist even among insured populations
- The PVS survey tool and methods can be applied as health system responsiveness assessment tools to maximize health care system quality and performance by timely generating evidence.
- The people's voice survey found that more than half of the respondents are not satisfied with the quality of care they received and had not recommended their last healthcare facility visits to family, friends, or other people in Ethiopia and need the health system reform to meet their health care needs.
- The people's voice survey pointed out that eight to ten respondent's confidence that the government considers peoples opinion when making decision on the health system and this is a great assets for the government to improve the health system. It needs to strengthen the confidence of the people on their health system to answer their health care needs by appropriately informing the policies, strategies through community ownership approach.
- New and more comprehensive, locally customized, approaches will likely be needed to reach the ambitious UHC targets- the use of PVS tool. PVS tool will assist the national monitoring of the health system responsiveness towards people's perspective towards health system and quality of health care services provisions –to build people's confidence and trust in their health care systems-which achieve universal health coverage targeted by SDG 2030.

1. Introduction

1.1 Background

Access to health care is expanding globally as countries pursue Universal Health Coverage (UHC). However, access does not always translate to better health: five million people die each year from treatable conditions despite seeking health care (1). These numbers will grow as more people seek care and as the burden of disease shifts to complex conditions. Newborn and maternal mortality rates are stalling in many countries at levels above global targets despite large investments, showing that doubling down on current strategies will not suffice. Current micro-level, incremental approaches to improving quality are inadequate (2), wholesale health system transformation is needed to further reduce mortality. These findings were outlined in the Lancet Global Health Commission on High Quality Health Systems and resonated widely across countries and among global development partners (3). Covid-19 has further highlighted the critical importance of well-functioning health systems, systems that must respond to the problem at hand but also maintain core operations. To create such systems for the future, large scale research and policy translation is needed. For example, it will be essential to learn from the current moment to develop and test a range of health care delivery models that a) work for the specific needs of patients with COVID and b) continue to provide reliable, high quality services for the remainder of the population safely.

The Ethiopian health sector has introduced a three-tier health care delivery system: level one is a Woreda/District health system comprised of a primary hospital (to cover 60,000-100,000 people), health centers (1/15,000-25,000 population) and their satellite Health Posts (1/3,000-5,000 population) connected to each other by a referral system. The primary hospital, health centre and health posts form a Primary Health Care Unit (PHCU). Level two is a General Hospital covering a population of 1-1.5 million people; and level three is a Specialized Hospital covering a population of 3.5-5 million people (4).

Over the last 20 years, Ethiopia has successfully implemented its strategy of expanding and rehabilitating primary health care. Though good trends are observed, the country is still facing a triple burden of diseases consisting of communicable diseases, non-communicable diseases and injuries. The Government of Ethiopia has been implementing Health Sector Transformation Plan (HSTP), which is part of the second Growth and Transformation Plan (GTP II) to improve the health of the population through the promotion of preventive, curative and rehabilitative health services by improving access to affordable and quality health services (4). It has four main objectives: 1) accelerate progress towards universal health coverage - accelerating the progress towards full coverage of essential health services and protecting people from financial hardship, including those in currently underserved populations; 2) protect people from health emergencies, 3) woreda transformation, and 4) improve health system responsiveness (4).

The extent to which health services respond to the needs and expectations of their people is referred to as health system responsiveness. The health system's responsiveness aims to provide health services that address the health needs of individuals and communities. It involves upholding dignity, privacy, non-discrimination, autonomy, confidentiality, and clear communication; and it includes a user-focused approach: provider selection, low wait times, respect for clients' voices and beliefs, cost, and simplicity of use. Meeting this goal will increase client and community satisfaction and trust, which will increase service uptake and referrals to others (4).

A comprehensive system of care allows people to access a continuum of care across their life course, comprising health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation, emotional and spiritual support, and palliative care. Three important considerations

should underlie the design of any health care system: services should be built to meet local needs; accessible and high quality primary care should be the bedrock for all other services; and individuals and communities should be engaged in the design, delivery, assessment, and improvement of each and every service (6). The WHO Framework on Integrated, People-centred Health Services, “all people have equal access to quality health services that are co-produced in a way that meets their life course needs”. It calls for the coordination of services across the continuum of care and for a supportive environment that helps caregivers practice with the skills and resources they need (6).

Involving people and communities in their own care and in the design of their health services is now recognized as a key determinant of better outcomes. People and the communities in which they are born, raised, live, work and play are at the heart of delivering quality health services. People who are actively engaged in their own health and care suffer fewer complications and enjoy better health and well-being. At the clinical level, this means enabling patients to partner in their care and in clinical decisions, and to actively manage their health. People-centeredness is the “doorway to all qualities” (Berwick). The People-centred care means that health systems ensures the community from illness prevention to palliation, between services and between levels of care throughout the life course; coordination across different care settings, in ways that meet the particular needs of the individuals and their careers; and comprehensiveness that broadens the portfolio of care (7).

The global data in 2016 estimated that 8.6 million lives lost in low and middle income countries due to low quality in the health care system (1). Non health outcomes such as confidence in the health system and cost of care also suffer in settings of low quality (8). The people’s low expectations about their health care system are problematic for several reasons. One, if people expect poor-quality care, either because they do not know what high-quality care is or because they have become accustomed to poor-quality care, they are less likely to hold health systems accountable for poor performance. In addition, people with low expectations are less effective in seeking better care. However, Health system expected to raise expectations which results in more people obtaining better care and provide feedback to health systems for improvement, better comparison of self-reported service quality and satisfaction across countries (9).

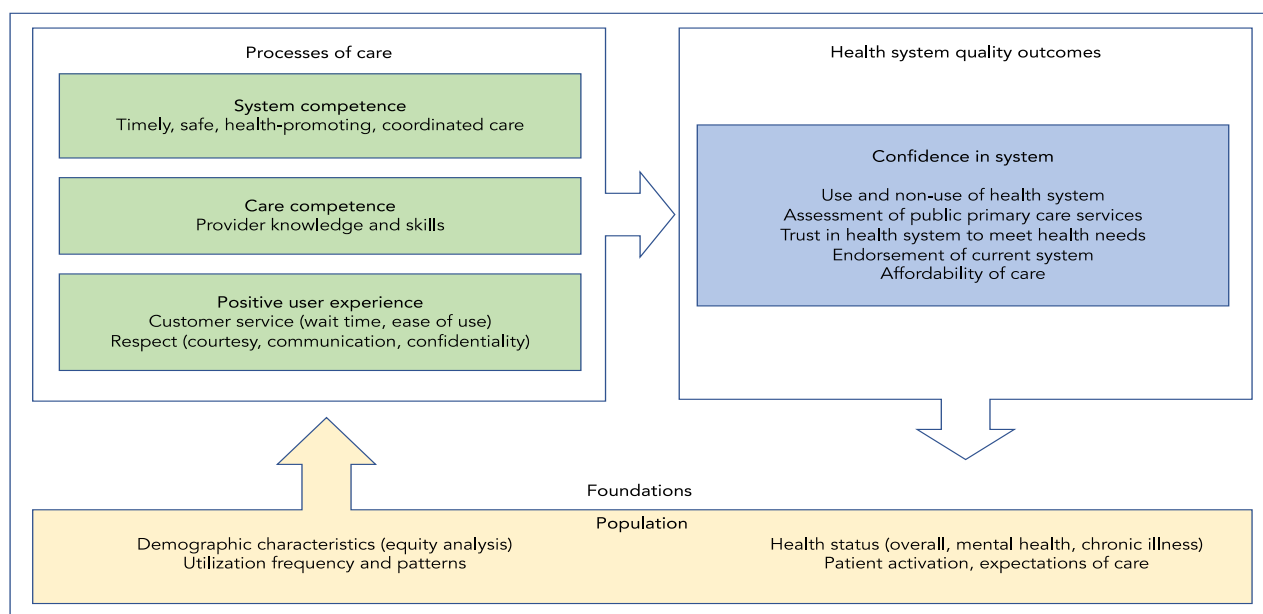
Expectations of healthcare quality are believed to influence how patients experience and rate healthcare; however, little is known about expectations in low- and middle-income countries (LMICS) including Ethiopia. There is a need for a population-based assessment of health system quality and health service preferences that can be delivered rapidly, repeated over time, and compared across regions, place of residence, education level and income status. In Ethiopia, there is lack of study that addresses the voices of the people in their health care system and health system performance measurement. The People’s Voice Survey (PVS) is intended to address this gap.

1.2 Significance of the research

The People’s Voice Survey (PVS) provide cross-national phone based survey tool to assess and measure people’s perspectives into health system performance. It enabled how care utilization compares to the intended purpose of each tier of the health system; assess the major reasons for non-use of care, and benchmarking of quality of care and confidence in the overall health system. The People’s Voice Survey tool will help to promote health system accountability to the population, and track impact of reforms and policies (e.g., UHC) over time. The survey findings and methods became global public goods to maximize impact on the health systems research community and policymakers worldwide. Improved understanding of population experiences of care, particularly in the wake of a global

pandemic, will inform investment in high-quality health systems globally. Furthermore, the PVS tool enables to generate evidence on the following framework (Figure 1):

Figure 1: People’s Voice Survey Framework



Notes: People care about outcomes beyond good health, which include trusting that the system can meet their needs, confidence that they can afford services, and endorsement of health system performance. These perceptions are informed by processes of care, including system competence (e.g., whether the health system provides coordinated, easy-to-use care integrated across platforms), care competence (e.g., provision of high-quality care from knowledgeable, high-skilled providers), and user experience (e.g., good customer service and respect). These processes and outcomes are underpinned by the foundations of the health system, including health status, demographic characteristics, patient activation, and expectations of care.

Domains and structure of the People’s Voice Survey

1. Health and demographics
 - 1.1. Demographic information
 - 1.2. Health status
 - 1.3. Patient activation
2. Utilization of care and system competence
 - 2.1. Usual source of healthcare
 - 2.2. Health service utilization patterns
 - 2.3. Health system competence in population health
 - 2.4. Non-use of healthcare
3. Care experience
 - 3.1. User experience and care competence
 - 3.2. Respondent endorsement of clinic
4. Health system confidence
 - 4.1. Assessment of public primary care
 - 4.2. Overall health system assessment
 - 4.3. Expectations for health system quality

2. Objectives of the study

2.1 General Objective

The aim of this study was to develop a rapid assessment tool to measure people's voices on utilization of care and system competence, to assess user care experience, and confidence in their health care system a focus on the quality of health care system.

2.2 Specific objectives:

- To assess the utilization of care and system competence and people's expectations from the health care system
- To assess the health care user experience
- To assess the confidence of the population on their Health care system
- To validate the tools used for the People's Voice Survey.

3. Research Methodology

3.1 Research setting design

Research area and setting: The research was a cross-sectional study in collaboration between the Ethiopian Public Health Institute (EPHI), Ministry of Health, School of Public Health – Addis Ababa University, and Harvard TH Chan School of Public Health. The people’s voice survey has been carried out concurrently in the 10 regions and two city administration of the country.

Study Design, Target populations and sample requirements:

It was a cross-sectional, a mixed phone-based and face to face survey particularly in low mobile coverage areas in the rural Ethiopia. The target population was all individuals aged 18 and older, whose usual place of residence was in the territory of the country. Random probability sampling was used to generate nationally representative samples.

PVS tool development and Data collection Tool: The People’s Voice Survey (PVS) was developed using international best practices for survey research^{1,2}. The content was guided by the *Lancet Global Health* Commission on High Quality Health Systems in the Sustainable Development Goals Era (HQSS Commission) conceptual framework with question wording, response options, and sequencing informed by reviews of prior surveys used in higher- and lower-income countries and by input from the PVS Global Development Group (GDG): health system academics, managers, policymakers, and health care users. Content validity was further tested through external peer review by health system experts in international organizations and survey methods specialists. The questionnaire was assessed for comprehension via cognitive interviews that included open-ended questions concerning key concepts. The instrument was translated into Amharic, Affan Oroomoo, Somali, and Tigrigna local languages by professional translators and pre-tests were conducted in all settings to refine question wording and local response options. The survey was piloted by the study contractor and corrections made by research teams prior to main stage data collection.

3.2 Survey mode, sampling, and weighting

The PVS was implemented with a stratified approach that included telephone surveys in areas that had higher mobile phone ownership and face-to-face surveys of people in lower-ownership areas.

Sample size: The sample size target was informed by best practice for nationally representative and cross-nationally comparable surveys. A total of 2779 respondents interviewed in this PVS wave survey.

Computer assisted Telephone interview (CATI): When conducted via telephone interviewing, PVS respondents were selected through a known-list sampling approach. We used a database of contacts (names and phone numbers) compiled by the Ethiopian statistical office (CSA) compiled from their surveys conducted over the past five years. The database contains nearly 350,000 contacts with sufficient contacts in all regions, except Tigray which is not covered, to deliver a nationally representative sample. Multi-stage cluster sampling, which included selection of rural primary sampling units (PSUs) and selection of households using random walk, was used to identify participants for FTF interviews.

¹ World Bank. (2023). *World Bank Open Data*. Available at: <https://data.worldbank.org/> (Accessed: 26 April 2023).

² Pew Research Center. (2016). *Smartphone ownership rates skyrocket in many emerging economies*. Pew Research Center’s Global Attitudes Project. Available at: <https://www.pewresearch.org/global/2016/02/22/smartphone-ownership-rates-skyrocket-in-many-emerging-economies-but-digital-divide-remains/> (Accessed: 26 April 2023).

To correct for design effects, inverse probability of selection weights for telephone samples (based on the number of telephone numbers available per respondent) and probability-proportional-to-size weights for FTF samples were constructed by country. Post-stratification weights based on external population statistics were used to adjust the sample on variables of importance to the survey, including age, gender, region, and education where possible to reduce sampling biases. Weights were constructed using an iterative proportional fitting (raking) approach. Ipsos was the data collection partners for QuEST Harvards. Data collection began on August 22, 2023 to November 2023

3.3 Data quality and monitoring:

- a) Training: Comprehensive training was provided to the data collectors on the objective of the study and phone based and face to face interview methods CATI and CAPI on 15& 16, August 2022. And refresher training for the main survey was provided 13, September 2022.
- b) Quality Control and monitoring: Before phone interview started, quality control checks by screen by screen checks of the survey scripted in English against the master questionnaire, screen by screen checks of the country-specific questions in English against the country specific versions of the questionnaire, screen by screen checks of the surveys in each of the additional languages scripted by a native speaker at the local agency, and pre-scripted hard and soft data logic checks.

For phone based, the quality assurance procedures was proceed, a minimum of 20% - 30%, of interviews via parallel listening or reviewing of recordings. The pointes checked include; quality of the audio recordings, whether the interviewer asks all the questions and probes correctly, whether the interview codes the correct response and overall levels of professionalism. For the face-to-face fieldwork the interviewers worked in teams to cover PSUs and were accompanied by a supervisor who was hand to monitor live fieldwork and answer any interviewer concerns.

- c) Quality Control on the interim database and Post-Fieldwork

The quality control on data was checked on the frequency checks on all questions – to re-check routing, checks to ensure only permitted values have been inputted, checked on response distribution, checks to ensure the dataset contains no duplicate or near-duplicate records, checks for either duplicate IDs or duplicate values across all variables, checked to identify any remaining impossible/implausible values, assessment of item non-response, and assessment of speeders and straight-lining.

3.4 Data/ Analysis:

The descriptive statistics on basic domain areas such as demographics, utilization of care, system competence, care experience, health system confidence and endorsement, and additional population characteristics with STATA V16. All the analysis based on weighted data unless otherwise specified. The findings were presented by using tables, bar charts and pie charts. The frequency and when necessary the mean and mode used. For this analysis, the 5-point likert scale based questions, in most of the analysis, the value considers very good and excellent as one category. The age of the respondents categorized as 18-24, 25-39, 40-59, and 60+ years based on the distribution of the data. The average annual income categorized as lowest income (average annual income less than or equal to 3000 Eth birr), middle income (greater than 3000 and less than or equal to 10,000 Eth birr), and highest income (greater than 20,000 Eth birr).

3.5 Ethical considerations and review process:

Ethical clearance was sought from EPHI IRB through protocol number EPHI-IRB-378-2021.

4. Result

4.1 Socio Demographic Characteristics of Population

Table 1 provides information on the socioeconomic characteristics of the respondents for the people's voice survey. The median age of the respondents was 32.0 [18.0-99.0] years. The majority (38%) of the study participants were in the age group 25 to 39, and 10% were in age group 60 and above. The respondents were with a male-to-female ratio of 1:1 with a nationally weighted sample. Of the total study respondents, 70% were from rural areas, 50% had no formal education, and only eight percent of the study population had post-secondary educational status in Ethiopia. Of the total study respondents, 62% had some form of health insurance, and out of this, 98% had insurance from the public sector, which means community-based health insurance. Income category was classified into three as lowest, middle and highest. Thirty-eight percent of the populations were in the lowest income group (Table 1).

Table 1: Socio-demographic characteristics of PVS-Respondents

Percentage of respondents by background characteristics, (n=2779), Ethiopia PVS, 2023

Characteristics	Category	Number	Per cent
Age	18 - 24	768	28
	25 - 39	1064	38
	40 - 59	668	24
	60+	279	10
Sex	Male	1391	50
	Female	1388	50
Residence	Rural	1953	70
	Urban	825	30
Education	None or no formal education	1,377	50
	Primary	851	31
	Secondary	332	12
	Post-secondary	219	8
Health insurance	No	1044	38
	Yes	1735	62
Income	Lowest income	1,068	38.4
	Middle income	679	24.4
	Highest income	803	28.9
	Don' t know	219	7.9
	Refused	9	0.3

Note:

4.2 Health status of respondents

In this section, respondents were asked how they rated their overall health and mental health, as well as whether they had a long-standing illness. They were asked had ever had COVID-19, taking or plan to receive vaccination, and how they rate the government's management of COVID-19. Four in ten populations were rated their general health status as excellent or very good. The youngest population rated as having an excellent or very good health status (47%) than the older age population (18%). The proportion of people who rated their health as excellent or very good increased as education level increased, from 27% for illiterate to 55% post-secondary education level. In terms of residence, 50% of urban and 38 % of rural residents rated their health status as excellent or very good, respectively.

According to how respondents rated their mental health conditions, 53% of the population rated they had an excellent or very good mental health status. Mental health conditions were rated differently depending on the background characteristics. The respondents who had an excellent or very good mental health status decreased with age increased, from 57% for the youngest age group (18 to 24 years old) to 27% for the oldest age groups (60+). When compared to 46% of the rural population, a slightly higher proportion (62%) of the urban population rated they had a good mental health status. One-thirds of the illiterate population rated their mental health as excellent /very good, while nearly three-fourths of the higher educated population rated their mental health as excellent /very good. Fourteen percent the population had one or more long-standing or chronic diseases. The proportion of this disease varies across the background characteristics (Table 2).

The proportion of the population who had COVID-19 was 2%, with 83% having it confirmed with a laboratory test. The COVID-19 vaccination status among the study population revealed that 35% were fully vaccinated, 36% in urban residence, and 38% of female respondents (Figure 2). Of the total unvaccinated or partially vaccinated who reported their intention to take the recommended COVID-19 doses, it was revealed that seven in ten populations intended to take the recommended doses, among which the younger age group, female population, and uneducated subpopulations were more likely to take the recommended doses than the other subpopulations (Table 2).

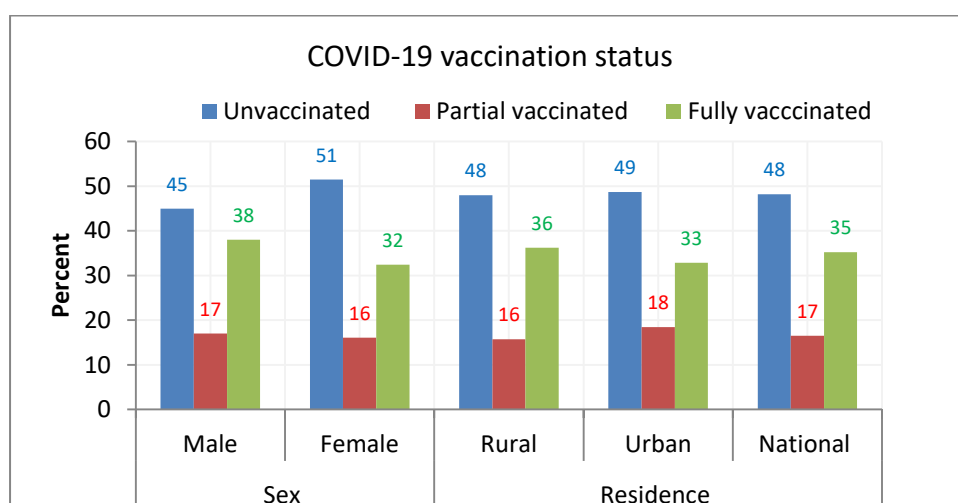


Figure 2: Percentage of non-vaccinated and Vaccinated against COVID-19

Table 2 shows that in Ethiopia, 58% of patients were active, which means that the patients can manage their overall health and tell a provider about concerns even when they do not ask at the national level. This patient activation level was varied by different background factors like insurance status, age, education, and residence of the study participants.

The population asked to rate the government's managements of COVID-19 pandemic, 54% of the populations rate as the governments management of the pandemic was excellent/very good (Table 2).

Table 2: Health status

Percentage of respondents who rate their general health and mental health as very good or excellent and percentage of respondents who had longstanding illness, percentage of respondents who rate the management of COVID -19 by the government is very good or excellent, by background characteristics, Ethiopia PVS, 2023 (n=2779)

		Health Status		Prevalence of longstanding diseases	Mental health status		Intent to take COVID-19 vaccination	Active Patients	Gov't COVID-19 Management	
		V good /Excellent	Good		vgood/excellent	Good			V good /Excellent	Good
Age	18-24	47	29	4	57	32	72	54	50	23
	25-39	49	25	10	58	24	74	61	57	32
	40-59	40	29	23	49	29	68	64	51	33
	60+	18	29	34	27	22	63	48	61	30
Sex	Male	49	24	13	57	24	69	61	55	28
	Female	37	32	14	48	30	73	55	53	31
Residence	Rural	38	29	11	46	29	72	52	54	31
	Urban	50	26	17	62	25	69	67	54	26
Insured	No	48	25	15	61	23	67	64	58	26
	Yes	39	30	13	45	31	74	54	52	32
Education	Illiterate	27	35	19	37	30	75	52	51	36
	Primary	44	24	12	50	28	72	54	59	23
	Secondary	48	24	12	54	30	66	64	53	26
	Secondary+	55	27	12	72	21	68	66	53	25
	National	43	28	14	53	27	71	58	54	30

4.3 Usual source of healthcare facility or healthcare provider's

The term "usual source of care" refers to a facility where an individual or family usually goes when they are sick, such as a doctor's office, clinic, or health care facility, but not an emergency department. It has been demonstrated that having a usual source of medical care improves care quality, increases access to preventative interventions, improves health outcomes, and lowers total health care expenditures³.

Seven in ten populations had usual source of care for their health care needs. Six to ten of the younger age groups (18-24 years) respondents had a usual source of care, whereas seven in ten and eight in ten respondents in rural and urban residents, respectively, had a usual source of care. The proportion of respondents who had usual source of care increased from 67% in illiterate subpopulation to 86% in population who had higher education level (Table 3).

Ninety three percent of these usual sources of care were from Primary health facilities (78% -public primary facilities and 15% -private primary health facilities). Only six and one percent of the

³ 1. Usual Source of Medical Care. Healthy Start EPIC Center. http://www.healthystartepic.org/wp-content/uploads/2018/03/usual_source_med508pdf2018.

respondents usual source were from public and private secondary or higher level health facilities (Figure 3).

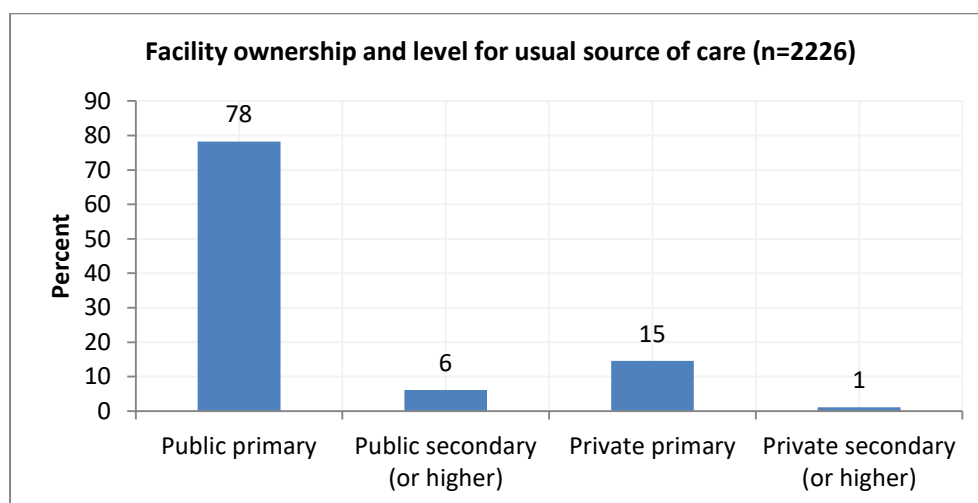


Figure 3: Facility ownership and level for usual source of care

The majority of respondents' typical sources of care were public health care facilities (84%), with private (for-profit) facilities accounting for 16%. Eighty-seven percent and three-fourth of the younger population (18-24) and elderly people (60+) got their usual source of care from public health care facilities, respectively. The usual source of care from public owned institutions dropped as age increased (87% for younger respondents to 76% for older age respondents). Respondents from rural and urban areas stated that 89% and 74% of their usual source of treatment were provided by publicly owned health facilities, respectively. As education level increased, the usual source of treatment from public health facilities decreased (from 89% uneducated to 69% higher education), whereas the usual source of care from private health facilities increased (from 9% uneducated respondents to 31% higher education) (Table 3).

The main reasons for choosing the facility for usual source of care were due to cost (low cost or covered by insurance) (31%), convenience or short distance to their home or working area (30%), technical quality- provider skill (15%), service readiness (14%), interpersonal quality such as short waiting time (seven percent), and the only facility available (four percent) (Figure 4).

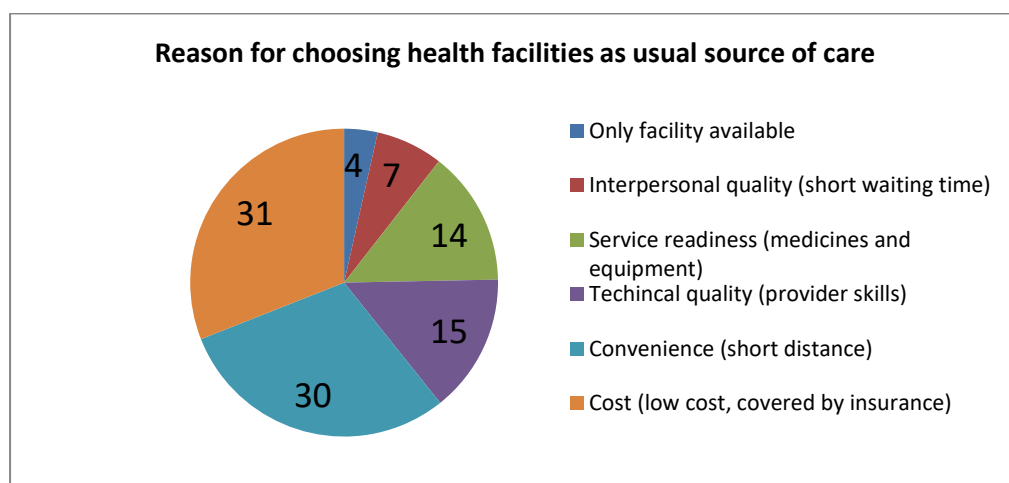


Figure 4: Main Reasons for choosing health facilities as usual source of care

Respondents also rated the quality of health care received from their usual source of care. Four in ten respondents rated excellent or very good services received from their usual source of healthcare. This self-reported quality rating varies by background characteristics. The younger respondents reported that they received good quality of health care services (41%) vs the old age respondents (35%). According to the findings of this study, excellent or very good quality of services received from the usual source rate more likely by the female respondents (41%) and urban respondents (43%)(Table 3).

Table 3: Usual Source of Care

Percentages of respondents who had usual source of care, type of health care facilities, percentage of respondents who rate the quality of services from the usual source of care as very good or excellent, by background characteristics, Ethiopia PVS, 2023

		Usual source of care (n=2779)	Ownership health facility (n=2236)			Overall quality at source of care (n=1832)	
			Public	Private	Other	v/good/excellent	Good
Age	18-24	62	87	12	0	41	33
	25-39	76	84	16	0	40	30
	40-59	76	82	18	0	39	32
	60+	72	76	18	6	35	32
Sex	Male	68	83	17	0	38	27
	Female	75	85	14	1	41	36
Residence	Rural	67	89	10	1	37	32
	Urban	82	74	26	0	43	30
Insured	No	70	74	25	1	43	31
	Yes	73	89	10	1	37	32
Education	Illiterate	67	89	9	1	27	43
	Primary	71	83	17	0	44	25
	Secondary	81	78	22	1	42	29
	Secondary+	86	69	31	0	44	32
National		72	84	16	1	40	31

4.4 Health care Utilization

Table 4 shows the health care utilization pattern 12 months prior to the survey. The respondents on average had 2.1 (95% CI 1.9, 2.4) (un-weighted) with health care either in-person at the facility, virtual home.

Table 4 Health care utilization

Average health care contacts, Percentages of respondents who had got fair or poor mental health care and percentage of respondents who had in-patient health care services, Ethiopia PVS, 2023

Health Care utilization in the past 12 months prior to the survey	
Total health care contacts (in-person, virtual, home), mean(95%CI)	2.1 (1.9, 2.4)
All visits made in-person to a facility, mean (95% CI)	1.7 (1.6, 1.9)
Visits made for COVID-19, mean (95% CI)	0.2 (0.1, 0.2)
Virtual or telemedicine contacts, mean (95% CI)	0.1 (0.1, 0.1)
Received mental health care (% of Respondents who reported poor or fair mental health)(95%CI)	8.4% (3.4%, 19.5%)
Had overnight hospital stay (% of respondents) (95% CI)	7.4% (5.1%, 10.6%)

The health care facility visiting pattern categorized as no visit per year, occasionally visiting (1 to 4 visits per year) and frequent visiting (more than four visits per year). The health care facility visiting pattern result showed that only nine present of the population visited health care facilities frequently (Figure 5).

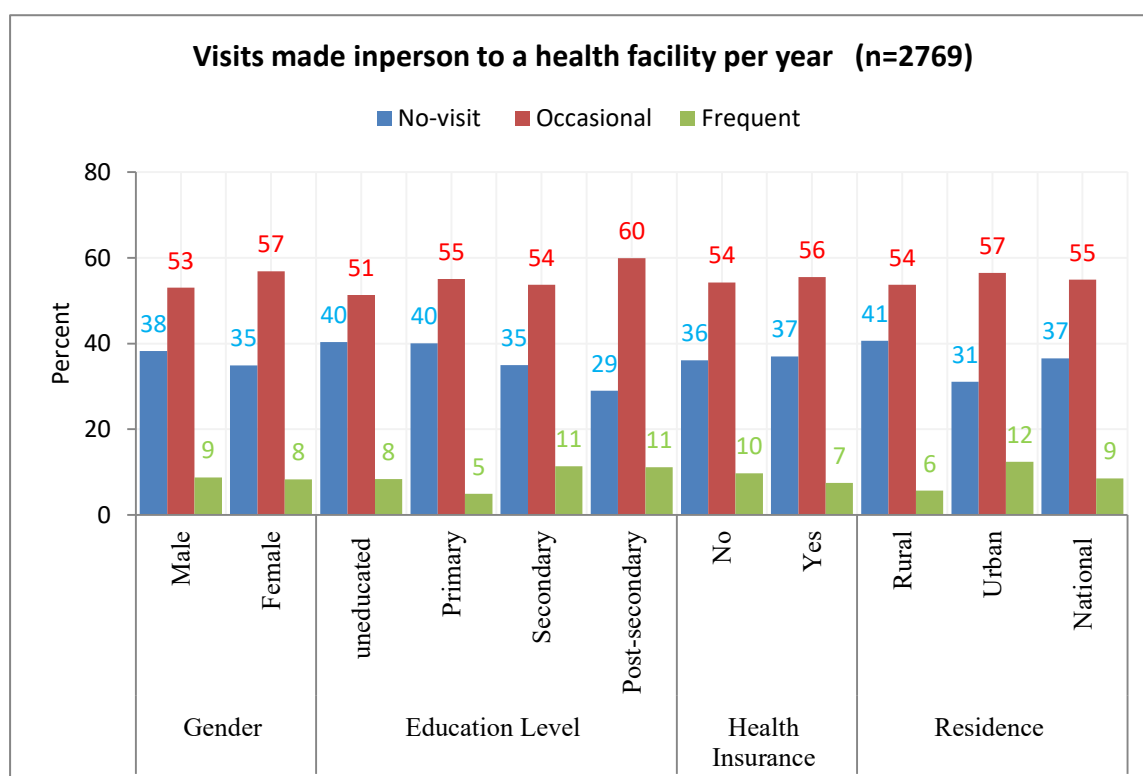


Figure 5: Health care utilization patterns in persons in terms of number of visiting health care facilities per year among adult population in Ethiopia 2023.

Most (61%) of the Ethiopians visited one health facility for their health care needs per year while 37% of population visited two to three health facilities per year. Among those health insurance holders, 71% of the populations visited one health facility while 28% visited more than one health facilities per year (Figure6).

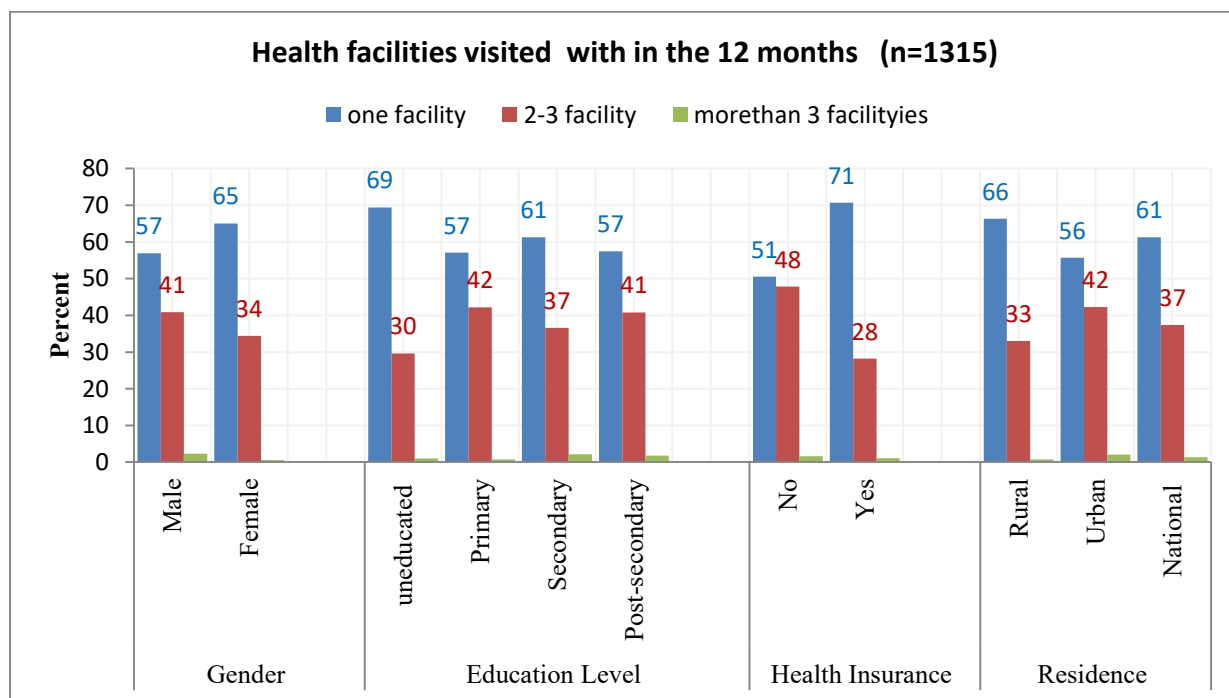


Figure 6: Number of health care facilities visited by respondents per year among adult population in Ethiopia 2023.

4.5 Health care System competence in population Health

4.5.1 Health system competence

As Figure 7 depicts, the health system competence through whether the respondents screened for cancer, checked their eye or vision, teeth, blood sugar, cholesterol levels, care for depression, anxiety, or another mental health condition during their most recent health system visit were very low. The study showed the health seeking behavior such as checking and testing their health status was low. For example among all respondents, 36% of total respondents checked their blood pressure, 15% checked their eye health, 14% checked their blood sugar level, and among women respondents 13% screened for cervical cancer (Figure 7). The findings showed that the practices of these services during their most recent health system visits were varying greatly by background characteristics, more or less good health seeking behavior observed in urban residence, as increased age, and education level, except care for any mental health conditions as education level increased getting of care for any mental health condition reduced.

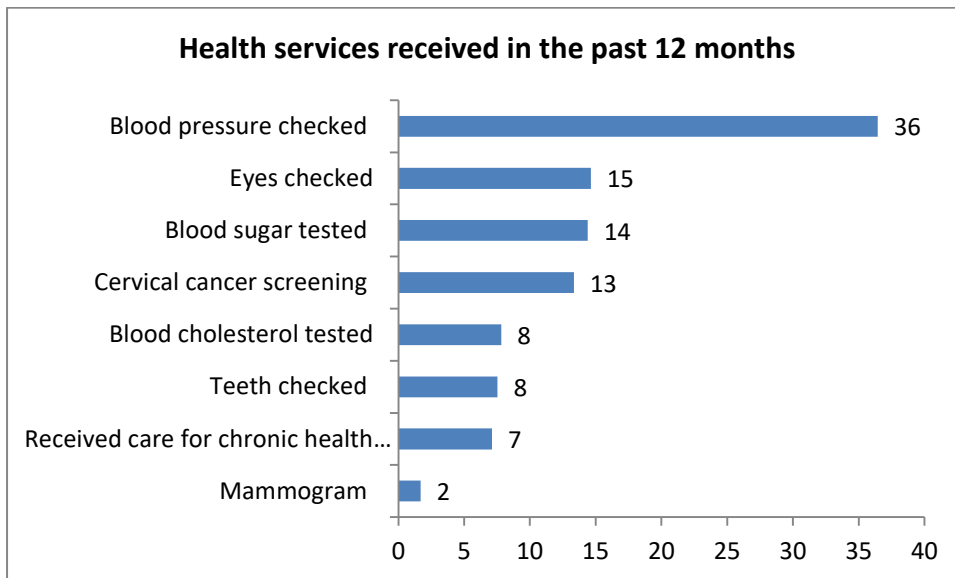


Figure 7: Percentages of health seeking behaviour in the past 12 months

4.5.2 Health system safety

During the visit to the health facilities, respondents feel they had medical mistake/error and unfair or discrimination during the health care process. The most important public health issue identified in this study revealed that six percent respondents reported that they perceived they had medical mistakes, and 13% had may have unfair treatment or discrimination by health care providers. Within each population subcategory, the distribution of failure in the health system varied the youngest subpopulation, male, primary or less educated, and rural dwellers faced unfair or discrimination during the health care process, 21%, 12%, 19%, and 15%, respectively (Figure 8).

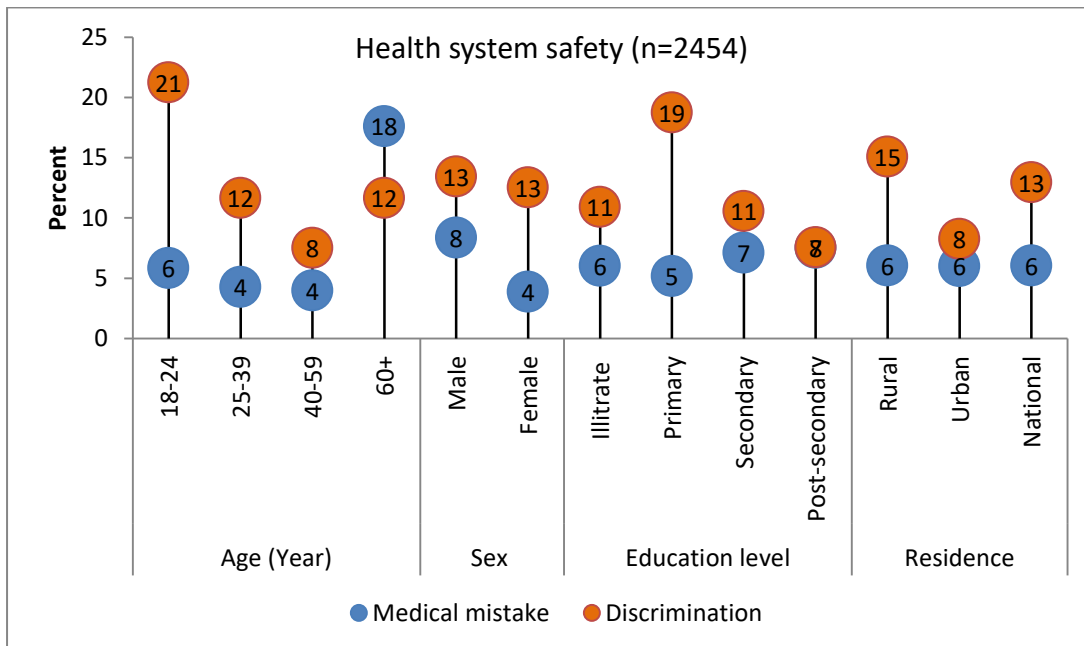


Figure 8: Medical mistakes and unfair treatment or discrimination by health care providers in the past 12 months

4.6 Non-use of health care system

Non-use of care in this survey means there is a needed medical attention but did not get health care. One in ten populations did not get health care even there was a needed medical attention. The distribution was varied across subpopulation subcategories, higher in rural residence (13%) than urban residence (seven percent), higher in uneducated subpopulation (14%) than higher educated subpopulation category (6%) (Figure 9). The main reason for the non-use of care where cost (38%), interpersonal skill (22%), and service readiness (20%) (Figure 10).

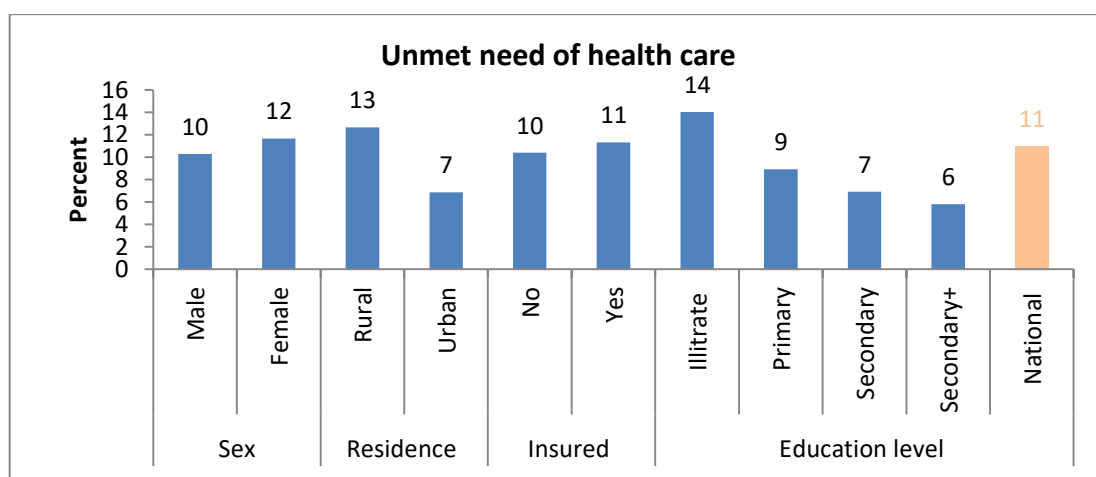


Figure 9: Needed medical attention but did not get health care

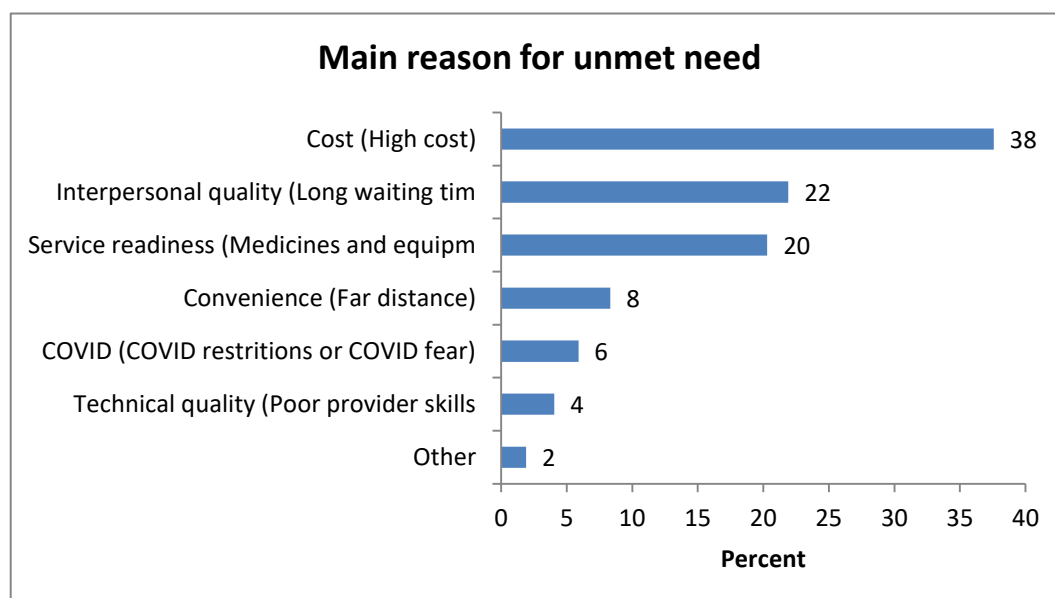


Figure 10: Reason for not getting health care when needed medical attention

4.7 User experience and care competence in last visit

The study assessed the waiting and consultation time of the respondents for the last visit. The median waiting (un weighted) time to get the provider for the most recent visit was 30 (IQR 20, 60) minutes. The majority of respondents waiting time were more than one hour (49%) while 20% of respondents had waiting time less than 15 minutes before seeing healthcare providers (Figure 12). The study revealed that, 57% of females, 55% of respondents from rural residents, and 60% of those with no formal education had waited more than an hour to see healthcare providers during their most recent health care visits.

The reported median for consultation time (un weighted) with a healthcare provider was 15 (IQR 10,30) minutes. Forty seven percent of respondents had less than or equal 15 minutes consultation time with their health care providers (Figure 11 and Table 4).

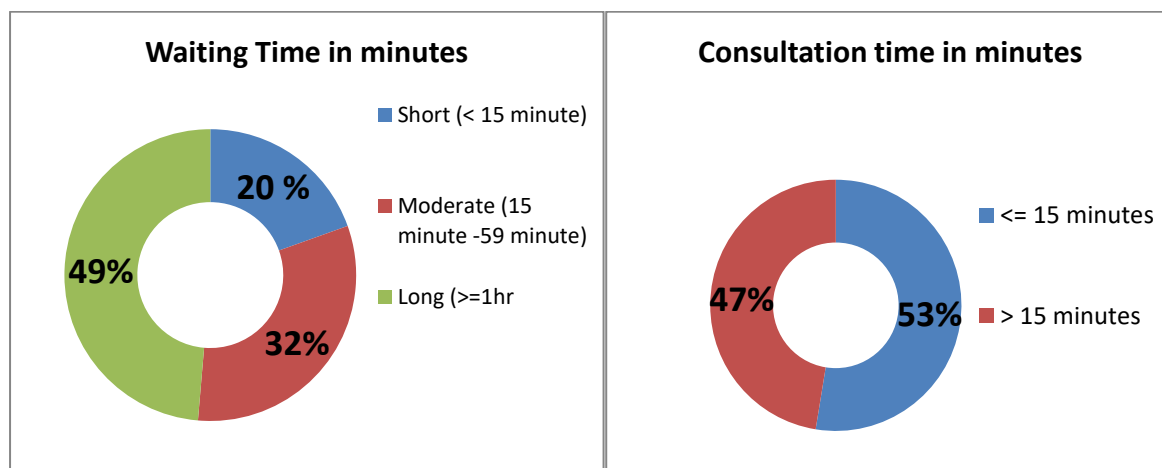


Figure 11: waiting time to see by provider and consultation time with providers in minutes

The waiting and consultation time in minutes showed variation between the public and private health facilities. Seventeen percent and 29 % in public and private facilities had a waiting time of less than 15 minutes, respectively. Half of the respondents had more than one hour waiting time in public health facilities.

Regarding to the consultation time, 54% of respondents had less than 15 minute consultation time in government health facilities and 53% of respondents in private facilities had more than 15 minutes consultation time (Table 5).

Table 5: User experience and care competence in last visit

Percentages of respondents who had get services by type of health care facilities, waiting time and consultation time, percentage of respondents who promoted the type of health facilities for others, by background characteristics, Ethiopia PVS, 2023

		Waiting time			Consultation time	
		Short (< 15 minute)	Moderate (15 minute -59 minute)	Long (>=1hr)	<= 15 minutes	> 15 minutes
Age						
	18-24	14	37	49	46	54
	25-39	22	26	52	53	47
	40-59	16	41	43	60	40
	60+	27	23	50	47	53
Sex						
	Male	24	36	39	57	43
	Female	15	28	57	49	51
Residence						
	Rural	15	30	55	52	48
	Urban	29	35	35	54	46
Insured						
	No	22	34	44	54	46
	Yes	18	31	51	52	48
Education						
	Illiterate	15	26	60	51	49
	Primary	20	39	41	54	46
	Secondary	28	35	38	52	48
	Post-secondary	33	37	30	58	42
Facility ownership						
	Public	17	32	51	54	46
	Private	29	33	38	47	53
National		20	32	49	53	47

4.8 Quality of Health care in the last visit

Table 6 shows respondents perspective on the quality of the health care they received in their last visits, such as the overall quality rating, the provider knowledge and skill, the availabilities of equipment and supplies, the level of respect from the provider, the provider knowledge on the prior visit, does the provider explain things clearly and participate in the decision and waiting time.

During the respondents last visit to the health facility, forty four percent of respondents reported that the overall quality of care was very good or excellent, 29 percent rated as good and 27% rated as fair or poor. 56 percent of respondents rated the Knowledge & skill of provider as excellent or very good and 28% as good and 15 % as fair or poor Forty percent of respondents rated the equipment's and supply that had available with the provider during their last visit were poor or fair (Figure 14).



Figure 12: Quality rating of the last visits in the past 12 months

Table 6: Quality of care in the last visit

Percentages of respondents who rated the quality of healthcare services as very good or excellent, by background characteristics, Ethiopia PVS, 2023

	Total Quality (n=1843)	Last visiting Rate:								
		Knowledge & Skill Provider (n=1832)	Equip & Supply (n=1818)	Respect (n=1844)	Knowledge prior visits & Test (n=1778)	Explain in Understandable way (n=1843)	Involved in decision (n=1839)	Consultation Time (n=1841)	Waiting Time (n=1839)	Curtsey and helpfulness (n=1835)
Age										
18-24	47	41	31	55	40	37	40	37	31	35
25-39	42	50	30	53	36	47	40	43	28	38
40-59	44	50	34	60	44	49	42	44	31	41
60+	46	51	30	53	42	46	45	42	30	38
Sex										

Male	44	48	30	57	41	47	40	41	30	39
Female	44	48	33	54	38	43	42	42	30	38
Residence										
Rural	42	43	27	48	35	37	38	35	25	36
Urban	47	54	36	63	45	54	44	49	36	41
Insured										
No	47	49	33	60	43	50	46	48	35	40
Yes	41	47	30	51	36	40	37	37	25	37
Education										
Illiterate	40	42	25	46	29	39	35	32	27	35
Primary	45	45	33	58	45	36	43	42	27	41
Secondary	42	48	33	52	36	49	36	41	28	38
secondary+	49	56	34	64	47	58	48	51	37	38
Facility ownership at last visit										
Public	40	44	27	51	36	42	39	39	27	36
Private	55	57	44	67	48	53	47	50	38	45
Others	31	63	32	63	31	63	63	63	63	100
National	44	48	31	55	39	45	41	42	30	38

4.9 Health System Assessment: Quality of Public health system

4.9.1 *Quality of services to pregnant women, child, chronic illness and mental health condition*

Participants were asked to rate the quality of health services provided by the public health system for the pregnant women children, chronic illness and mental health. Accordingly, 47%, 41%, 26%, and 18% of the respondents rated the quality of the health services provided to the pregnant women, children, chronic conditions and mental health status by the public health system as excellent or very good. Respondents from rural residence rated the quality of services to pregnancy and child health as excellent or very good was higher than respondents from urban area, 50% and 43%, respectively while the quality of service provided to chronic diseases rated in the rural residence 22% vs 30 percent in urban residence (Table 7).

Table 7: Health System Assessment: public health system quality rating

Percentages of respondents who rated the quality of healthcare services for pregnant women, child, chronic conditions and mental health as very good or excellent, by background characteristics, Ethiopia PVS, 2023

	How would you rate the quality of care provided for care:			
	Pregnancy (n=2704)	Children (n=2538)	Chronic Conditions (n=2387)	Mental Health (n=2149)
Age				
18 - 24	45	37	21	15
25-39	47	42	29	18
40-59	52	44	26	18
60+	47	42	26	24
Gender				
Male	46	36	24	19
Female	49	47	27	16
Residence				
Rural	50	43	22	18
Urban	44	39	30	17
Health Insurance				
No	47	41	27	16
Yes	48	41	24	19
Education level				
Illiterate	40	37	21	21
Primary	57	46	25	18
Secondary	48	44	29	17
Post-secondary	42	37	28	14
National	47	41	26	18
Note:				

4.10 Confidence in Health System

4.10.1 Confidence in the health system

This People Voice Survey (PVS) study assesses how peoples are confident in receiving good quality health care in the event of becoming very sick, confidence in being able to afford health care if becoming very sick, and confidence that the government considers people's opinions when making decisions. The confidence in receiving high-quality care was 80% while the confidence for affording the care was 55%. Eight in ten people was confident that the government considers the people’s opinion when taking decisions on the health system (Figure 13).

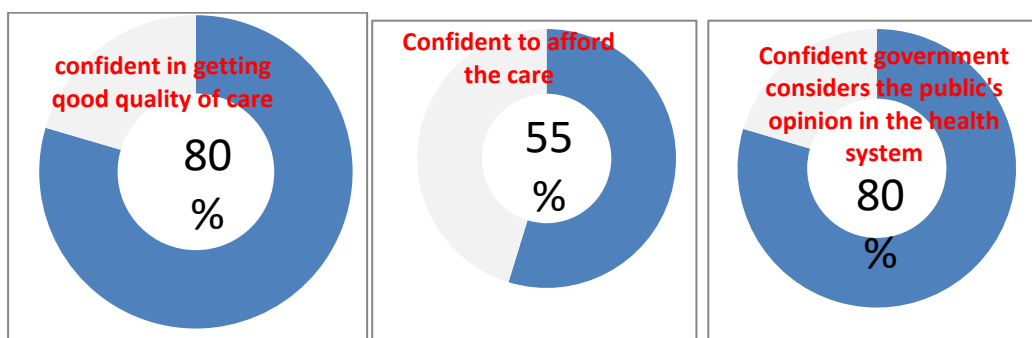


Figure 13: Confidence of receiving good quality of care and affording the services and the government considers public's opinion in the health system

The confidence of people in receiving and affording high-quality of care in case of very serious sick were assessed by the level of health care facilities. Considering their last visit, 82% of respondents were confident getting quality of care from the secondary or higher level facility and 52% can afford to get quality services from the same (Figure 14).

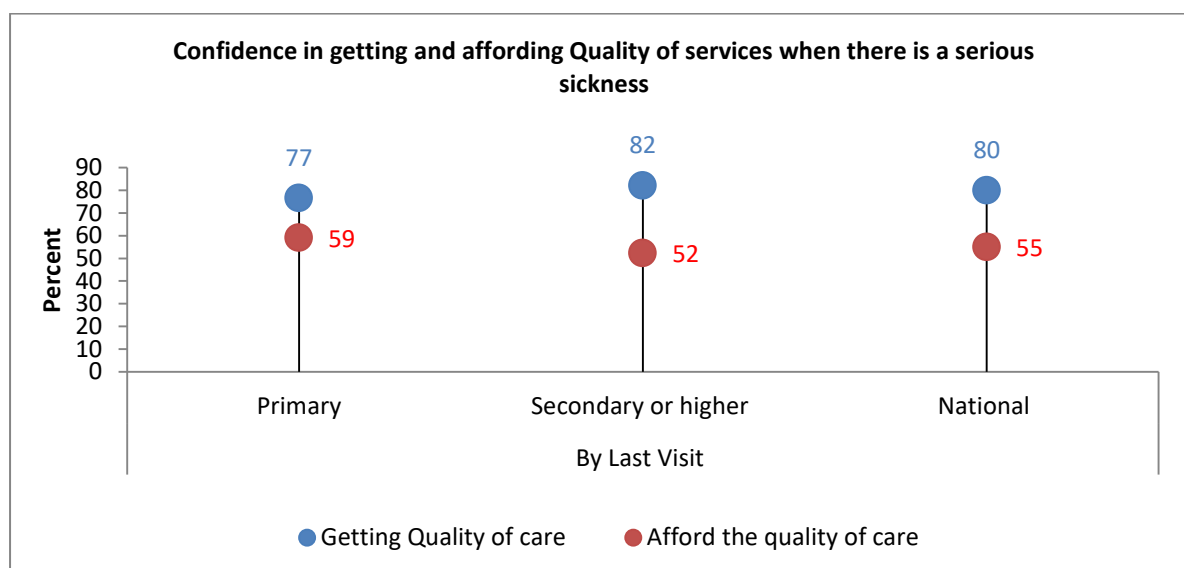


Figure 14: Confidence in getting and affording Quality of services when there is a serious sickness by sources of health care

The confidence in receiving high-quality care increased with age, 87% of older age people were confident in getting quality of care if they become seriously sick. Females and respondents from rural were more confident to get quality of care and the government considers people's opinion when taking decisions in the health care system than their counterparts. Compared to 73% of the urban population, 82% of rural residents were confident that the government considers public opinion when making health-care decisions (Table 8).

4.10.2 Promote the health facility to others

This People Voice Survey (PVS) study assesses how people recommend or promote the health facilities to other families or relatives, half of the respondents recommend their last visited health facility to others. More than half of the respondents did not recommend their last visited health care facility to others (Figure 19). The

findings showed that older age groups, females, and respondents in urban area recommends the health facilities 56%, 48%, and 56%, respectively to their family or friend than their counter parts (Table 8).

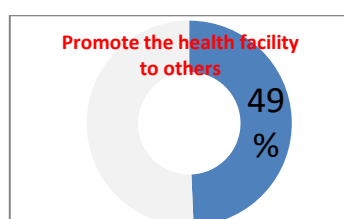


Figure 15: promote health care facilities by managing authority in Ethiopia

Table 8: Confidence in Health System

Percentages of respondent’s confidence on the overall health system and opinion on their health care system, by background characteristics, Ethiopia PVS, 2023

		Confident in getting good quality of care if you becomes very sick (n=2771)	Confident to afford the care you required (n=2772)	Confident government considers the public's opinion in the health system (n=2730)	Promote the health facility to others
Age	18-24	80	55	80	50
	25-39	76	56	79	48
	40-59	82	56	79	48
	60+	87	45	79	58
Sex	Male	83	55	79	46
	Female	76	54	80	52
Residence	Rural	81	55	82	44
	Urban	77	54	73	56
Insured	No	77	56	75	54
	Yes	81	54	82	45
Education	Illiterate	78	48	83	40
	Primary	84	63	78	55
	Secondary	79	61	74	47
	Post-secondary	75	55	70	54
National		80	55	80	49

4.11 Health System Reform

The population asked their opinion about how the health system functioned for the last two years. Nearly eight to ten respondents believes that the health-care system is getting worse, and eight out of ten respondents said that the health system getting improvement through time (Table 9).

The population asked their opinion about the need of reform in the health care system. Majority of the respondent did not satisfied by the current health care services, 70% of respondents need the health system needs rebuilt or major changes to address the health care demands of the population (Figure 16).

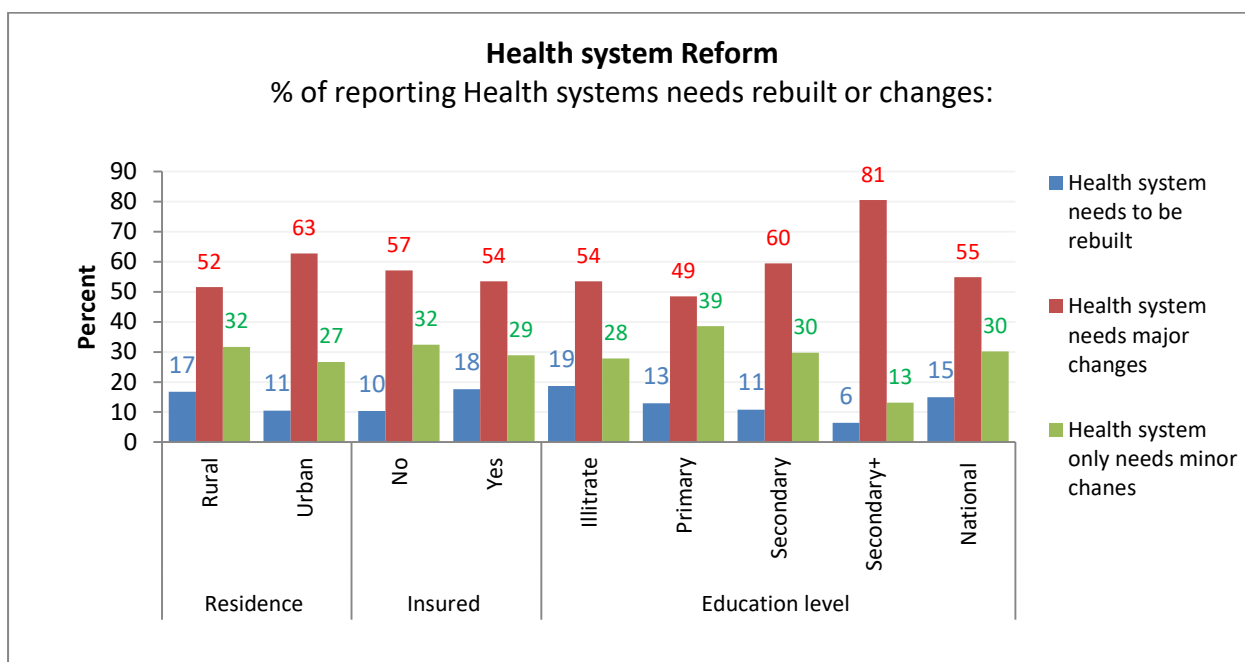


Figure 16: People’s opinion on the need of health system transformation by facility ownership and level

Even though health system shows improvement, six out of ten respondents believed that major changes are still required to meet the population's healthcare needs and 15% said the health system needs rebuilt. Six out of ten urban respondents believed the health-care system needs major overhaul and 11% said it needed to be rebuilt, with the figure rising to 17% in rural residence. Considering health insurance, 63% of those without health insurance said that the health system needs major change and 16% of non-health insurance users said that the health system needs rebuilt order to meet their health-care needs.

Table 9: Reform in Health System

Percentages of the overall health system and opinion on their health care system and reform, by background characteristics n=2763, Ethiopia PVS, 2023

		Health system functioning in the past 2 years			Health System Reform		
		Getting worse	Staying the same	Getting better	Health system needs to be rebuilt	Health system needs major changes	Health system only needs minor changes
Age	18-24	7	12	82	12	58	30
	25-39	7	17	76	13	58	29
	40-59	10	11	79	20	51	29
	60+	20	11	69	17	44	39
Sex	Male	10	16	74	16	54	30
	Female	8	11	81	14	56	30
Residence	Rural	7	14	79	17	52	32
	Urban	13	13	75	11	63	27
Insured	No	10	12	78	10	57	32
	Yes	8	15	77	18	54	29

Education	Illiterate	8	14	77	19	54	28
	Primary	7	13	80	13	49	39
	Secondary	14	10	76	11	60	30
	Secondary+	12	18	69	6	81	13
	National	9	14	78	15	55	30

4.12 Population perspective on the quality services provided by the provider

The quality of the health care services provided by the provider was rated based on the people's perspective. Accordingly, 93% of the people correctly identified the services provided by a health care provider as being of poor quality health care services, while 76% of the respondents correctly identified the health care provider as delivered good quality health care services based on a given case scenarios (Table 10). The ability to measure the quality of health care services provided was slightly higher, as evidenced by 95% of those with post-secondary education correctly identifying poor-quality services provided, and 97% of those with the highest income groups correctly identifying the poor-quality services provided.

Table 10: population perspective on the service quality

Percentages of respondents who rated the quality of the services provided by the provider as poor quality and good quality, by background characteristics, Ethiopia PVS, 2023

		Correctly identified as	
		Poor quality	Good quality
Age	18-24	88	74
	25-39	97	76
	40-59	93	77
	60+	94	77
Sex	Male	95	73
	Female	91	79
Residence	Rural	93	79
	Urban	93	70
Insured	No	93	74
	Yes	93	77
Education	Illiterate	91	79
	Primary	95	77
	Secondary	95	62
	Post-secondary	95	73
	National	93	76

5. Conclusion

The people survey tool is a novel method of data collection tool through a mix of phone based and face to face interview. The tool used to generate data on how the health system responds on the population needs by assessing the general and mental health status of the population, the usual sources of Health care for the needy population, the quality of care from the usual sources, the health care utilization pattern, the health system competency, care people need, the last visit health care quality, trust and confidence in the health system, promote the health facility to other, and the need of health system to reform.

The PVS measures how the health system's responsiveness to provide health services that addresses the needs and expectations of the individual and the communities. It pointed out how the health system approaching to upholding dignity, privacy, non-discrimination, autonomy, confidentiality, and clear communication; and it includes a user-focused approach: provider selection, low wait times, respect for clients' voices and beliefs, cost, and simplicity of use.

The People's Voice Survey can be used as a routine, integrated component of health system planning to bring a social voice to health system planning. As a low-cost, rapid survey, it can be used for both ad hoc assessment at critical moments of health system planning and longitudinal measurement of population sentiment. Program owners or implementers or governments (National or subnational) can use PVS to plan for and monitor implementation of universal health coverage, track reforms, and inform health system design to meet people's needs and preferences. Multinational organizations and global partners can use the tool to monitor effectiveness of investments and to help policymakers make smart investments that are responsive to people's needs.

The data generated by using the PVS Survey will be used to answer key policies questions that can inform government practices and strengthen health system performance. It can illuminate poorly understood concepts around levels of patient activation, service utilization patterns, unmet need for care, and population outlook on health system performance among others.

The survey will also provide optional data collection for the health systems research. The instrument includes novel items that can inform best practices for future health system measurement, such as whether adjusting for population expectations is essential for accurately gauging health care quality ratings. As PVS data will be a global public good, local researchers will be able to access and use the data to address sub-national or regional research questions and deepen future inquiry into health systems performance.

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