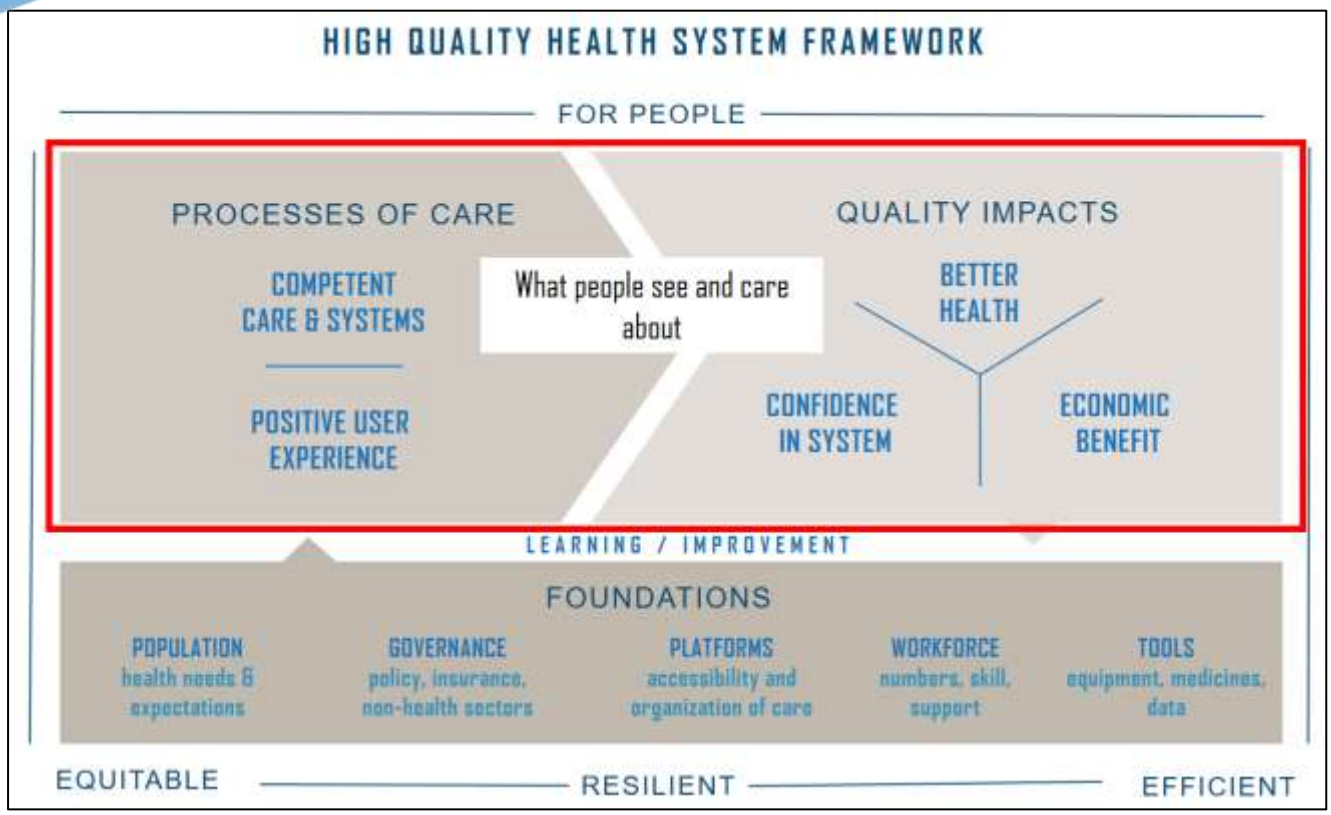

People's Voice Survey (Wave-II):

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

June 2025

This report presents findings of the People's Voice Survey (Wave II) - Assessment of People's Perspective on Health System performance in Ethiopia which was implemented by the Ethiopian Public Health Institute in collaboration with the Ethiopian Ministry of Health, the School of Public Health at Addis Ababa University, and Harvard TH CHAN School of Public Health. The study was funded by Harvard TH CHAN School of Public Health.

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Suggested citation:

Ethiopian Public Health Institute (EPHI), Ministry of Health, Harvard TH CHAN School of Public Health and Addis Ababa University, 2025. People's Voice Survey (Wave-II) - Assessment of People's Perspective on Health System Performance in Ethiopia. EPHI/MOH/Harvard/AAU, Addis Ababa, Ethiopia, June 2025

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QuEST Ethiopia would like to thank the QuEST Harvard team for the financial support and management of this study.

CONTENTS

LIST OF FIGURES

LIST OF TABLES

KEY MESSAGES

Health outcomes and self-perceptions of well-being in Ethiopia are closely linked to age, education, income, and residence; with younger, urban, and more educated individuals reporting better physical and mental health, fewer chronic conditions, and greater confidence in managing their health.

Health service utilization patterns in Ethiopia reveal age-related increases in healthcare engagement and care complexity, with disparities in access and modality of care—particularly telemedicine—shaped by socioeconomic status, education, and urban-rural divides.

The majority of Ethiopians have a usual source of care—predominantly in primary care facilities—with facility choice influenced by proximity, insurance, and provider competence; however, perceptions of care quality and satisfaction vary notably by age, gender, location, and socioeconomic status.

While access to preventive services has improved, significant gaps remain in screening coverage, with perceived medical errors, discrimination, and cost-related barriers disproportionately affecting younger adults, rural residents, and lower-income groups.

User experience with the health system varies by demographic group, with younger and urban populations reporting shorter waits and more diverse care types, while overall satisfaction and perceived care quality remain moderate and heavily influenced by continuity of care, socioeconomic factors, and facility ownership.

Perceptions of healthcare quality are mixed, with generally higher ratings for maternal and child services than for mental health or chronic disease care, and significant disparities influenced by age, gender, socioeconomic status, and continuity of care.

Despite high overall confidence in the quality of care, particularly among youth and lower-income groups, concerns about affordability and widespread demand for major system reform indicate that trust in the health system's sustainability and equity remains fragile across demographics.

KEY FINDINGS FROM THE ETHIOPIA PVS WAVE II

Indicator	%	Detailed Information
Health Status and Self-Reported Well-Being		
Reported Health Status	**53%**	Five to ten respondents rated their health status as excellent or very good, contrasting with a small 16% reporting poor or fair health
Mental Health status	**53%**	Five to ten respondents rated their mental health as excellent or very good while 15% rated as poor or fair mental health.
Prevalence of Longstanding Health Problems	**24%**	Nearly one-quarter of the respondents reported having a longstanding illness or health problems told by a health care provider.
Patient Activation and Confidence in Health Management:	**49%**	Half of the respondents felt very confident in their ability to manage their health including discussing about their health even when their health providers do not ask them.
Health service utilization patterns		
Healthcare Visits Frequency:	**25%**	one quarter of the respondents did not have any visit in the past one year,
	75%	Three fourth of respondents had at least one visit.
Modes of Healthcare Interaction:	**75%**	In-person visits remained the predominant mode of care, 15.5% are home visits, and virtual or telemedicine accounts 5.9%
Usual Source of Healthcare and Care Preferences		
Usual sources of care:	**85%**	The majority of the respondents reported having a usual source of care, predominantly at public facilities (76.7%) and primary-level facilities (91.1%).
Health system competence in population health		
Medical errors	**11%**	Perceived medical errors (such as wrong diagnosis, treatment, or prescribed drugs),
Discrimination	**12%**	Perceived discrimination.
Unmet need of health services:	**12%**	One in ten respondents reported needing medical care but not accessing it.
Barriers of health service utilization respect.		This was primarily due to high costs (43.3%) and issues related to provider or health facility interpersonal qualities, such as long waiting times, readiness of the facilities, and lack of staff respect.
User Experience and Care Competence		
Consultation Times:	**49%**	Reported waiting less than one hour for their last provider visit. Shorter waiting times were recorded in private facilities (39.6%), while public facilities had an optimum waiting time, (54% with 15-60 minute).

Consultation times	**53%**			Half of the respondents had consultation time less than 15 minutes. 47% for private health system while 54% for public health system.

Quality rating for their last visit

Items	Excellent/very good	Good	Fair/Poor	
Consultation time	**35%**	**42%**	**23%**	One third of the respondents are very satisfied with their consultation time with the provider.
Visit wait time	**28%**	**31%**	**41%**	Nearly three out of 10 respondents are very satisfied with the waiting time before seeing by a health provider.
Courtesy of facility staff	**36%**	**40%**	**24%**	36% respondents are very satisfied by the respect from the health facility.
Respect from provider	**46%**	**37%**	**17%**	Nearly half of the respondents are very satisfied by the respect from the provider.
Involvement in decisions	**37%**	**21%**	**22%**	37% respondents are very satisfied by their involvement in decision making about their health.
Care competence in last visit				
Provider skills	**36%**	**39%**	**25%**	36 % of the respondents are very satisfied by the provider skills.
Clarity of explanations	**42%**	**39%**	**19%**	Four out of ten respondents are very satisfied by the clarity of explanation provided by the provider.
Equipment and supplies	**29%**	**33%**	**38%**	Only three out of 10 the respondents are very satisfied by the availabilities of equipment and supplies of the health facilities.
Overall ratings of last visit				
Overall quality of last visit	**38%**	**38%**	**25%**	Nearly four out of 10 respondents are very satisfied by the overall quality of the provider/health facility.

Confidence in the health system

	Somewhat confident	Not to confident	
Can get good quality care if very sick	**81%**	**19%**	Eight out of ten respondents are confident to get good quality care if they became very sick.
Can afford good quality care if very sick	**54%**	**56%**	Half of the respondents are confident to afford the cost of good quality care if they became very sick.
Can get and afford good quality care if very sick	**48%**	**52%**	Half of the respondents are confident to get and afford the cost of good quality care if they became very sick.

Government considers the public's opinion in health system decision:	**72%**	**28%**	Seven out of 10 respondents are confident that the government considers the public opinion when making decision on the health system.

Perceptions of Health System Progress and Reform Expectations:

Health system trajectory over the past 2 years	**15%**	The health system getting worse
	18%	Staying the same, no change over the time.
	67%	Getting Better over the time.
Current health system	**73%**	Some good things but major changes needed.
	11%	So much wrong, need to completely rebuild.
	16%	Working pretty well, only minor changes needed.

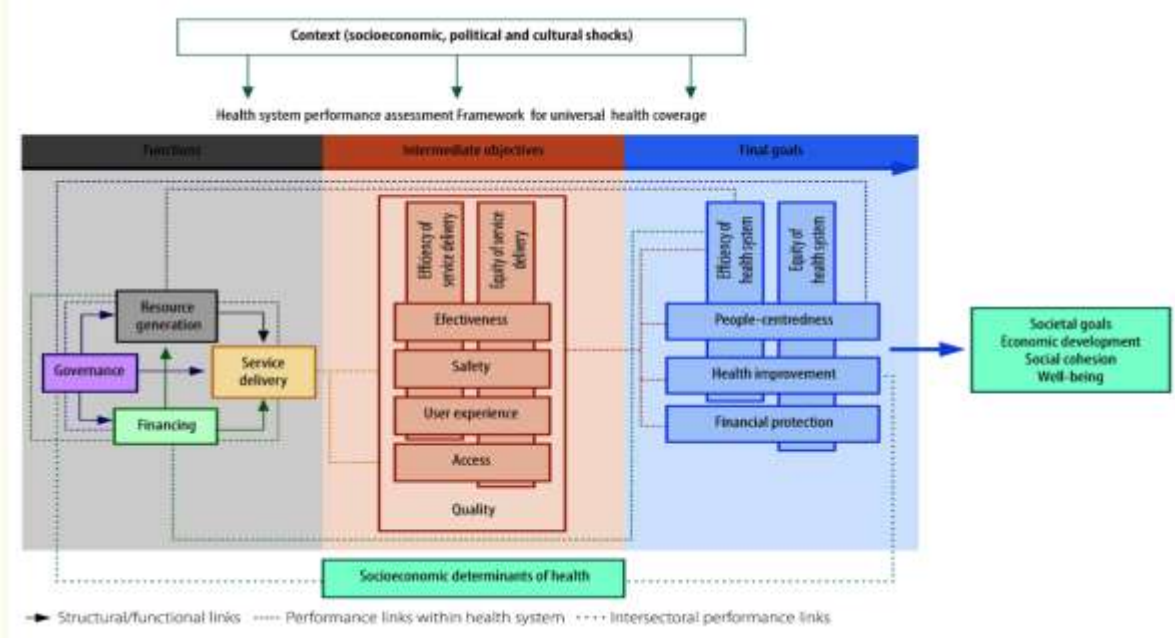
People's Voice Survey responses used to quantify domains of WHO framework for health system performance assessment, 2022–2025

		PVS 2022	PVS 2025	Total
Domain, indicator[a]	Total respondents included in the Survey	2779 **(55%)**	2314 **(45%)**	5093 (100%)
	Care Effectiveness			
Public health effectiveness[b]	% of people age 40 years and over with blood pressure and blood sugar test in the past 12 month	266 **(16%)**	363 **(26%)**	629 (21%)
Quality of own care[c]	% rating quality of care of last visit in past 12 months as very good or excellent	729 **(43%)**	653 **(38%)**	1381 (40%)
Quality of primary care services[d]	Average % of respondents rating 3 core primary care services (child, maternal, chronic disease) as very good or excellent"	**37%**	**33%**	35%
	User experience			
Respect[c]	% Respect provider showed you, courtesy of office staff, AND no discrimination	458 (16%)	437 (19%)	895 (18%)
Voice	% rating provider communication and being involved in decision making in a way you could understand as very good or excellent	432 (16%)	455 (20%)	887 (17%)
Customer service[e]	% of respondents rating wait time, time spent with provider, and time waiting for the provider Excellent or very good	298 **(18%)**	347 **(20%)**	645 (19%)
	Access			
Connection to health system	% Whether respondent has a usual source of care	1991 **(72%)**	1958 **(85%)**	3948 (78%)
Use of needed health care[f]	% with chronic disease who used care at least once in past 12 months	329 **(90%)**	499 **(89%)**	828 (90%)
No unmet need	% with Unmet need for care in past year	305 **(11%)**	291 **(13%)**	596 (12%)
	People-centeredness			
Quality of public health system	% rating quality of the country's public health system as very good or excellent	968 **(35%)**	729 **(32%)**	1697 (34%)
Quality of private health system	% rating the quality of the country's private health system as very good or excellent	891 **(33%)**	881 **(39%)**	1772 (36%)
Endorsement	% who say system needed Major changes/Rebuilt	1913 **(70%)**	1908 **(84%)**	3821 (76%)
	Works well needed only minor changes	829 **(30%)**	363 **(16%)**	1192 (24%)
Involvement in decision-making	% who are somewhat or very confident that government considers public's opinion	2180 **(80%)**	1609 **(72%)**	3789 (76%)
	Health improvement			

Self-rated health	% rating overall health as very good or excellent	1102 **(40%)**	1232 **(53%)**	2334 (46%)
Self-rated mental health	% rating mental health as very good or excellent	1351 **(49%)**	1235 **(53%)**	2586 (51%)
Absence of disease	% Does not have chronic illness /longstanding condition	2414 **(87%)**	1753 **(76%)**	4168 (82%)
	Financial protection			
Insurance	% of respondents with any health insurance (public, private, other)	1734 (62%)	1312 (57%)	3047 (60%)
Health security	% Somewhat confident/Very confident Confidence in ability to get and afford care healthcare if became very sick	1332 (48%)	1104 (48%)	2436 (48%)

a See Box 1 for definitions of survey indicators.
b The indicator only includes participants aged 40 years or older.
c The indicator includes questions only asked to participants who reported a visit to a health facility in the last 12 months.
d The indicator shows the average percentage of 3 questions. People were included if they had rated at least one of the questions as very good or excellent responses on the Likert scale.
e The indicator includes an additional question about the time spent and waiting for a provider.
f The indicator is only for participants with chronic disease.

WHO framework used to define indicators in a study on the use of People's Voice Survey indicators in a 16-country assessment of health system performance



Source: Adapted from

1. Papanicolas I, Rajan D, Karanikolos M, Soucat A, Figueras J, editors. Health system performance assessment: a framework for policy analysis. Geneva: World Health Organization; 2022. Available from: https://iris.who.int/handle/10665/352686 [cited 2024 Apr 5]. [PubMed] [Google Scholar]

2. Kruk ME, Sabwa S, Lewis TP, Aniebo I, Arsenault C, Carai S, Garcia PJ, Garcia-Elorrio E, Fink G, Kassa M, Mohan S, Moshabela M, Oh J, Pate MA, Nzinga J. Population assessment of health system performance in 16 countries. Bull World Health Organ. 2024 Jul 1;102(7):486-497B. doi: 10.2471/BLT.23.291184. Epub 2024 Apr 30. PMID: 38933481; PMCID: PMC11197641.

SUMMARY OF KEY FINDINGS

Health Status and Self-Reported Well-Being

- **Reported Health Status:** Overall, 53.3% of the respondents rated their health status is excellent or very good, contrasting with a small 15.5% reporting poor or fair health. Younger adults (30–39 years) rated the highest levels of excellent health (28.9%) and low levels of poor health (2.3%), while older adults (60+) exhibited the opposite pattern, with only 7.7% rating their health as excellent and 11.7% as poor. Men generally reported better overall health than women, and individuals with higher education and income levels, as well as urban residents, reported higher self-rated health.

- **Mental Health Insights:** Overall, 53.4% of the respondents rated their mental health as excellent or very good while 14.6% rated as poor or fair mental health. Younger age groups (18–39) rated they had better mental health status, with over 21% rating their mental health as excellent, whereas the 50+ age groups had rated their mental health as poor (17.4% for ages 50–59 and 6.6% for 60+). Women and rural residents rated their mental health as poor compared to men and urban dwellers, with higher percentages citing poor mental health and lower percentages citing excellent mental health. Better rates for the mental health were associated with higher education and income levels.

- **Prevalence of Longstanding Health Problems:** Nearly one-quarter (24.2%) of the respondents reported having a longstanding illness or health problems. The prevalence of such issues increased with age, affecting 42% of those aged 60 and above, compared to 20.4% of the 18–29 age group. Gender differences were also apparent, with men (28%) reporting a higher incidence of chronic conditions than women (20.5%). Additionally, rural residents experienced a higher prevalence (31.3%) compared to urban residents (18.7%). Furthermore, a strong inverse correlation exists between education level and chronic illness: only 13.3% of those with higher education reported such conditions, whereas this figure rose to 30.6% among individuals with no formal education.

- **Patient Activation and Confidence in Health Management:** Nearly half (49%) of the respondents felt very confident in their ability to manage their health including discussing about their health even when their health providers do not ask them. Confidence in managing personal health peaked among the 30–39 age group (62.1%) and decreased with age, with only 37.4% of those aged 60+ feeling very confident. Men and women displayed similar levels of confidence, with urban residents and individuals with higher education and income levels expressing greater self-efficacy.

Health service utilization patterns

- **Healthcare Visits Frequency:** one quarter of the respondents did not have any visit in the past one year, while 75% of respondents had at least one visit. Despite this, most respondents (over

75%) across all age groups had four or fewer healthcare interactions annually. The highest frequency of visits (over four) was observed in the 50–59 age group (26.6%). Interestingly, non-attendance was highest among younger adults (30–39), at 30%, a stark contrast to the lowest non-use rate of 19.9% seen in the 60+ age group. Rural residents reported more healthcare visits than urban residents. No significant differences in healthcare utilization were found between genders. Furthermore, individuals with higher education and income levels consistently showed greater engagement with healthcare services.

- **Modes of Healthcare Interaction:** In-person visits remained the predominant mode of care (75.3%), followed by home visits (15.5%) and virtual or telemedicine (5.9%). This varies by age groups, more in person visit especially among those aged 60+ (80.2%), while younger adults had higher rates of home visits and telemedicine use, with 22.9% of 18–29-year-olds receiving home visits and 8.1% engaging in tele-health services. Women, rural residents, and individuals with primary or no formal education showed higher proportions of in-person and home visits. Conversely, telemedicine visits were most common among higher-income groups, with urban residents also demonstrating greater engagement in virtual care.

- **Inpatient Care Utilization:** Approximately 15% of the respondents reported inpatient hospitalization in the past year, with the highest rates among the 18–29 age group (20.6%) and older adults (15.9%). Females and rural residents were slightly more likely to have inpatient admissions. Lower-income groups had higher inpatient utilization (up to 18%), indicating disparities related to socioeconomic status.

Usual Source of Healthcare and Care Preferences

- **Usual sources of care:** The majority of the respondents (84.9%) reported having a usual source of care, predominantly at public facilities (76.7%) and primary-level facilities (91.1%). As education level and income increased, urban residents were more likely to utilize private facilities and secondary levels of care.

- **Factors Influencing Facility Choice:** Respondents primarily value short distance, insurance coverage, and healthcare provider skills when selecting their usual source of care. Urban residents and higher-income groups prioritized convenience, with insurance coverage, low cost, and provider skills frequently cited as reasons across all demographics. Public facility users particularly emphasized insurance coverage, while private facility users focused on provider skills and the availability of medicines and equipment.

- **Perceptions of Care Quality:** Overall, approximately 38.0% of the respondents rated their usual source of care as very good or excellent, while 22.2% rated it as poor or fair. Among users, 36.1% public facility users rated their care as very good or excellent at 36.1%, compared to 44.7% for private facility users. Similarly, among users of primary-level facilities, 38.0% rated their care as excellent or very good, whereas 43.4% of those using secondary-level facilities

gave these high ratings. Ratings of poor quality were lowest among the highest income and education groups, and conversely, higher in rural areas and among public facility users.

Health system competence in population health

- **Preventive Health utilizations:** Overall, less than half of the respondents (45.9%) received blood pressure checks, with significantly lower rates for other screenings such as mammograms (17.2%) and cervical cancer screening (18.4%). Higher education and urban residence correlate with increased screening rates, but disparities persist.

- **Perceived Medical Errors and Discrimination:** In the past year, 10.9% of the respondents perceived medical errors (such as wrong diagnosis, treatment, or prescribed drugs), and 12.4% perceived discrimination. The 18–29 age group reported the highest rates for both types of experiences. Men perceived more errors and discrimination than women. Furthermore, lower education levels and rural residency were associated with a higher perceived incidence of medical errors and discrimination.

- **Unmet need of health services:** Approximately 12% of the respondents reported needing medical care but not accessing it. This was primarily due to high costs (43.3%) and issues related to provider or health facility interpersonal qualities, such as long waiting times, readiness of the facilities, and lack of staff respect. Younger adults (18–29) and rural residents exhibited the highest rates of non-utilization. Furthermore, lower-income groups and those without formal education were disproportionately affected by financial barriers, with over half citing high costs as the main obstacle.

User Experience and Care Competence

- **Facility Usage Patterns:** The majority of the respondents (71.5%) reported their last visit was to a public healthcare facility. The 40–49 age group had the highest rate of recent visits to public facilities, at 81.7%, while the 30–39 age group was more likely to favor private care, with 31.3%. Geographic disparities in service access were also evident, as rural residents primarily utilized health posts and health centers, compared to urban residents who more frequently visited medium clinics and hospitals.
- **Type of Care and Reasons for Visit:** Overall, health centers (47.9%) and health posts (2.8%) were the most commonly visited facilities. Younger adults (18–29) primarily visited for urgent or new health issues, accounting for 75% of their visits, while older adults (60+) mainly sought follow-up care for longstanding illnesses. Additionally, preventive care and chronic disease management were more prevalent among middle-aged groups and urban residents, reflecting diverse healthcare needs across different demographic segments.
- **Waiting and Consultation Times:** Nearly half (49%) of all the respondents reported waiting less than one hour for their last provider visit. Shorter waiting times were recorded in private facilities (39.6%), while public facilities had an optimum waiting time. Longer waiting times of an hour or more were more common among those aged 50–59 (35.4%) and 60+ (26.4%),

whereas younger respondents (18–29) typically experienced the shortest waits. On average, over half of respondents (53.1%) had consultations lasting less than 15 minutes, with women and higher-income individuals reporting marginally longer interactions. These findings highlight variations in wait and consultation durations across different demographic groups.

- **Perceived Quality of Care for the recent visit:** Overall, 37.6% of the respondents rated their last healthcare visit as "very good" or "excellent," with younger adults (18–29) expressing greater satisfaction at 42.1% compared to 25.6% among older adults. Women generally provided more positive ratings than men, and respondents with higher education and income levels also reported better perceptions of care. Key factors influencing positive evaluations included provider competence, hospital readiness, respectful communication, and patient involvement; however, disparities in perceptions persist across different age groups, genders, income levels, and geographic locations.

  Facility service Recommendations: About half (51.1%) of the respondents felt likely to recommend their healthcare facility to others, with younger individuals 18–29 age group being the most inclined (59.2%) and older adults (60+) the least (45.2%). Private facility users were more likely to recommend (60.9%) compared to public facility users (47.4%), underscoring a perception gap influenced by ownership and perceived quality of care.

- **Perceived Quality of Services by public primary facilities:** Respondents rated the quality of services as "excellent" or "very good" for various categories: 40.2% for pregnant women's care, 36.2% for child care, 23.5% for mental health care, and 16.0% for chronic illness care.
- Older age group respondents (60+) gave the highest ratings (excellent or very good quality of care) for services for pregnant women (46.1%) and children (47.1%). In contrast, younger adults (30–39) reported the lowest satisfaction for child (30.3%) and mental health services (14.7%).
- Men consistently rated the quality of care higher than women across all service categories, particularly for pregnant women and child care. Notably, respondents with a usual source of care reported significantly higher ratings for all services—pregnant women (41.9%), children (38%), chronic illnesses (24%), and mental health (16.8%)—compared to those without a usual source. This underscores the importance of ongoing provider relationships.

Health System Confidence

Confidence in Healthcare Access and Affordability: Overall, 80.6% of the respondents reported being somewhat or very confident in their ability to receive quality healthcare services if seriously ill. Confidence in affordability stood at 53.3%, and for both receiving and affording quality care, it was 48.2%. These confidence levels varied across demographics: the 18–29 age group showed the highest confidence in the health system, with 83.7% confident in receiving good care and 66% in affording it. In contrast, older adults (60+) also felt highly confident in receiving care (83%) but were significantly less so about affording it (40%),

pointing to potential financial barriers for seniors. While women and men shared comparable confidence in receiving quality health care (around 80%), men had slightly higher confidence in affordability (56.3%). Interestingly, respondents with no formal education expressed the highest confidence in both receiving quality care (82.8%) and government responsiveness (72.2%), whereas those with post-secondary education had lower confidence in care but higher confidence in its affordability. Similarly, the lowest income groups showed greater confidence in receiving quality care but the least in affording it, highlighting how economic constraints shape affordability perceptions.

- **Perceptions of Health System Progress and Reform Expectations:** Two-thirds (67%) of the respondents believed the health system had improved over the past two years. This positive perception was shared by 68.4% of the 18–29 age group and approximately 66–67% of older age brackets. However, the 50–59 age group stood out as notably more pessimistic, with 22.6% perceiving the system as worsening. Despite these improvements, nearly three-quarters of respondents felt the health system required major change or a complete rebuild to meet their needs, a view that varied by sociodemographic characteristics. Attitudes toward systemic reform indicated a substantial portion of middle-aged adults (76.3% of those aged 30–39) believed significant changes were necessary. Overall, confidence in the health system's future remained mixed, with certain groups expressing strong concerns about the need for fundamental overhauls.

POLICY RECOMMENDATIONS

Based on the comprehensive analysis of health status, service utilization, patient perceptions, and system confidence, the following policy recommendations are essential for policymakers to foster equitable, accessible, and responsive healthcare systems:

- First, targeted strategies are needed to address health disparities among older adults and rural populations, emphasizing chronic disease management, mental health support, and improved access to quality care, especially for older age groups and rural residents who report higher prevalence of longstanding illnesses, poorer health, and negative perceptions.
- Second, expanding preventive health services, including screenings and mental health initiatives, should be prioritized, with particular outreach to underserved groups such as those with lower education, low income, and rural dwellers, to bridge existing gaps in early detection and care engagement.
- Third, strengthening the continuity and quality of care through supporting patient-provider relationships—particularly for chronic disease and maternal/child health services—can enhance patient satisfaction and health outcomes, as positive perceptions and service ratings are markedly higher among those with a usual source of care.

- Fourth, addressing barriers to care—most notably financial constraints and perceived discrimination—is crucial; policies should focus on reducing out-of-pocket costs, expanding insurance coverage, and fostering culturally competent, respectful care environments that mitigate discrimination, especially for vulnerable groups like women, lower-income populations, and rural residents.
- Fifth, leveraging technology—such as telemedicine and mobile health—can improve access for younger populations and those in remote areas, complementing in-person services and reducing waiting times.
- Sixth, efforts should aim to improve systemic transparency and responsiveness, to maintain and build public confidence, given that perceptions of system improvement are generally positive but vary across demographics; targeted reforms should focus on issues raised by older adults and higher-income groups, including affordability and perceived quality.
-

Lastly, continuous monitoring and evaluation of healthcare quality and patient experiences across demographic groups are fundamental, ensuring that reforms effectively reduce disparities and meet evolving population needs, thus fostering an inclusive health system that promotes well-being at every life stage.

1. INTRODUCTION

1.1 BACKGROUND

Globally, in 2016 an estimated 8.5 million people die each year in low- and middle-income countries (LMICs) from treatable conditions, despite seeking care—highlighting a crisis in health system quality(1). As more individuals access health services and as the burden of disease shifts toward more complex conditions, these numbers are expected to rise. Maternal and newborn mortality rates are stagnating in many countries, remaining above global targets despite significant investment. This indicates that incremental, micro-level approaches to improving health care quality are insufficient, and comprehensive, system-wide transformation is required(2).

The 2018 LANCET GLOBAL HEALTH COMMISSION ON HIGH-QUALITY HEALTH SYSTEMS IN THE SUSTAINABLE DEVELOPMENT GOAL ERA (HQSS Commission) emphasized the urgent need for such large-scale transformations to improve care quality(3). According to the HQSS, a high-quality health system is one that "optimizes health care in a given context by consistently delivering care that improves or maintains health outcomes, is valued and trusted by people, and responds to evolving population needs." Central to this definition is the principle of people-centered care, which requires actively seeking and incorporating public feedback on health system performance(3) (4). Engaging people in their care leads to better health outcomes, including improved patient experience, greater adherence to treatment, and increased use of preventive services.

In Ethiopia, the health system is structured into a three-tier model: Primary level**:** District-level services including a primary hospital (serving 60,000–100,000 people), health centers (1 per 15,000–25,000 population), and satellite health posts (1 per 3,000–5,000 population), all linked by a referral system and grouped into Primary Health Care Units (PHCUs). Secondary level**:** General hospitals serving 1–1.5 million people. Tertiary level: Specialized hospitals serving 3.5–5 million people (5).

Over the past two decades, Ethiopia has made significant progress in expanding and rehabilitating its primary health care infrastructure. However, the country continues to face a triple burden of disease: communicable diseases, non-communicable diseases, and injuries. To address this, the Ethiopian government launched the Health Sector Transformation Plan (HSTP) as part of its broader Growth and Transformation Plan (GTP II), aiming to improve population health through accessible, affordable, and quality health services(5).

An essential aspect of a well-functioning health system is responsiveness—the ability to meet the needs and expectations of the population. Responsiveness encompasses respect for

dignity, autonomy, confidentiality, and clear communication, as well as considerations like provider choice, waiting times, and ease of use. High responsiveness increases trust and satisfaction, promoting service uptake and community referrals(5).

A comprehensive system of care provides continuous health services throughout the life course, covering prevention, diagnosis, treatment, rehabilitation, and palliative care. To be effective, health services must be locally tailored, grounded in strong primary care, and designed with the active engagement of individuals and communities. Evidence shows that involving communities leads to better outcomes, as people who participate in their care are healthier and more empowered(6).

Yet, despite global recognition of the importance of quality and people-centered care, health system failures persist. In 2016, poor quality of care accounted for an estimated 8.6 million deaths in LMICs(1). Beyond mortality, poor-quality care erodes public trust and increases the financial burden on patients(7). When expectations are low—either due to lack of awareness or normalization of poor-quality services—people are less likely to hold health systems accountable or to seek improved care. Raising public expectations is, therefore, key to driving quality improvement(8).

Understanding people's expectations and experiences is particularly critical in LMICs, including Ethiopia, where little data exists on public perceptions of health system quality. There is a pressing need for population-level assessments that can be rapidly deployed, repeated over time, and used to compare across regions, urban and rural areas, education levels, and income groups.

To address this gap, the People's Voice Survey (PVS) was developed. The PVS is a rapid, population-representative tool created by the Quality Evidence for Health System Transformation (QuEST) Network—a global initiative to measure and improve health system quality through multi-country collaboration. Unlike traditional patient experience surveys, the PVS captures the perspectives of the full adult population, including current, past, and potential future users of health services. It assesses key dimensions such as trust, confidence, and preferences, helping policymakers understand how well the health system is meeting the needs of all citizens(9)(10).

The PVS was co-developed by researchers, policymakers, and regional stakeholders in early implementing countries. It builds upon existing tools by enabling broad, cross-national comparisons of health system performance. The results can support evidence-based policy decisions, inform system reform efforts, and guide investments in quality improvement. Through the QuEST Network, the survey tools and findings will be openly shared to promote global learning and strengthen accountability in health systems worldwide.

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):

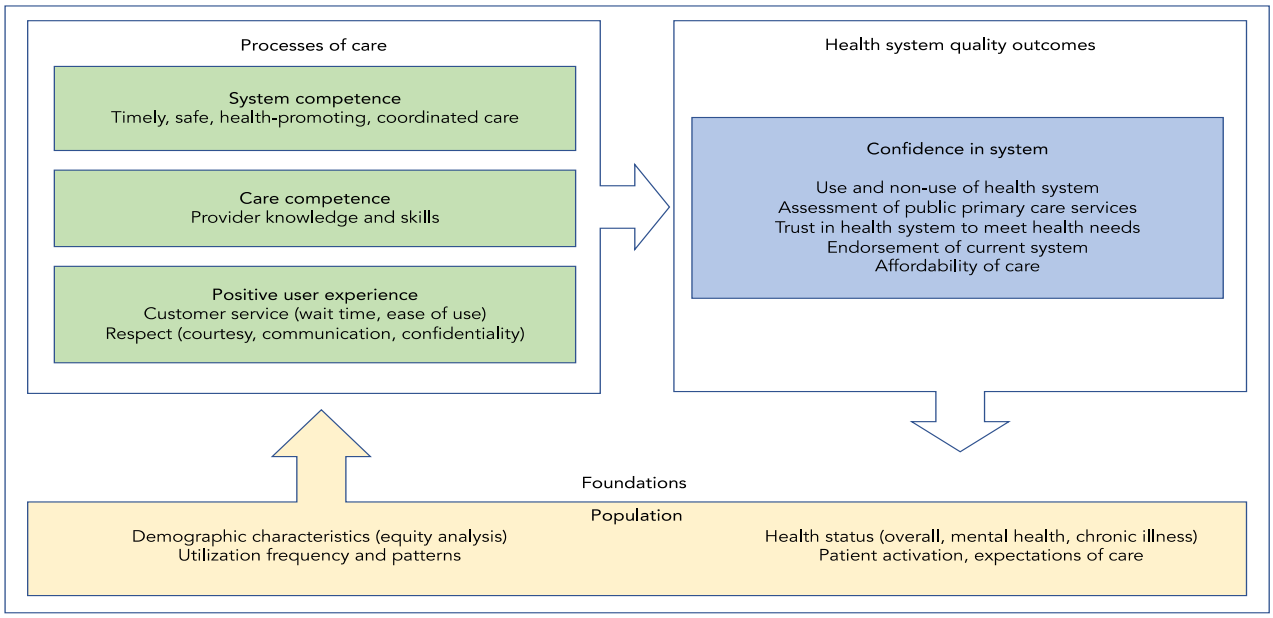


Figure 1.2-1 People's Voice Survey Framework

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.

Box-I: 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

1.3 OBJECTIVES OF THE STUDY

1.3.1 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.

1.3.2 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.

2. RESEARCH METHODOLOGY

2.1 RESEARCH SETTING DESIGN

The research methodology follows the PVS –wave-I (11)and briefly described below.

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 PVS-wave-II has been carried out concurrently in the 11 regions and two city administration of the country. Data collection was conducted from October 2024 to January 2025.

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.

PVS tool development and Data collection Tool: The current study uses the PVS-wave-I tool with a slight modification(9,10). In brief, 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.

2.2 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.

[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).

Sample size: The sample size target was informed by best practice for nationally representative and cross-nationally comparable surveys. A total of 2314 respondents interviewed in this PVS wave II survey (computer assisted Telephone Interviewing (CATI) 2002 and face to face interview (FTF) 312).

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 380,000 contacts with sufficient contacts in all regions. In PVS-wave –II Tigray also included but not in PVS-wave-I. Those with very low mobile phone penetration area were selected by selection of rural primary sampling units (PSUs) and selection of households using random walk was used to identify participants for face-to-face interviews.

Design weights (inverse probability of selection weights)

The sample was not selected using RDD sampling. The selection probabilities of the cases on the database, i.e. from their original household surveys, were unknown, and so it was not possible to calculate initial face-to-face survey design weights. Cases were also selected from the database disproportionally, so that they matched the wider Ethiopia population on gender and region. A correction was made for this in a single step at the calibration stage and therefore there was no design weight for the Ethiopia CATI sample.

Face-to-face samples

The rationale of PPS sampling is that the selection probabilities of the first two stages, when combined, deliver an equal probability sample, conferring the advantage of uniform fieldwork assignment sizes in spite of variable PSU sizes. Slight variations in selection probabilities arose given the sampling design. First, selection probabilities at the second sampling stage are based on the number of addresses contacted, which was allowed to vary, holding the number of interviews constant at 20 per PSU. However, given typically uniformly high response rates in rural areas this did not introduce much variation. Second, variation arose based on the number of eligible individuals in each household. The design weights for the face-to-face samples were calculated as follows.

The PSU selection weight dw_PSU was calculated as the inverse of the PSU selection probability, p_PSU:

$$dw\_PSU = 1/ p\_PSU$$

where:

p_PSU = Matrix (no. PSUs selection in region) * Size_PSUi / Sum_size_region (sum size PSUs in region)

Size_PSUi = size of PSU i

The address selection weight is calculated as:

dw_unit = 1/ p_unit

where:

p_unit = n_unit / Size_PSUi

n_unit = number of addresses selected in PSU i; this was available based on counts of the addresses added during the random walk by interviewers.

The individual respondent selection weight was calculated as:

dw_ind = 1/ p_ind

where:

p_ind = 1 / n_elig

n_elig = number of adult 18+ individuals in the household.

The full design weight (dw_overall) was calculated as the product of each of these stages (dw_PSU * dw_unit * dw_ind).

Combining telephone and face-to-face samples

Given the sampling procedures the telephone and face-to-face samples were non-overlapping. Weights were required to scale the size of each sample in proportion to the population it covered. The size of each covered population was calculated for the first wave of PVS (see below), and these blending factors were retained in order to maintain comparability of the samples. Broadly, the calculations adjusted the relative size of the CAPI/CATI samples to 50/50, reflecting the higher share of rural households without phones in Ethiopia.

During the first round of PVS the shares were calculated as follows:

The number of adults living in urban and rural areas was known from external statistics giving the total number of adults by urbanity.

The face-to-face contact sheet data was used to determine the proportion of adults in rural areas who owned a working mobile phone, meaning the number of such adults could be estimated, giving the size of the covered populations in rural areas for each mode.

The total phone coverage was known from external survey data although this was somewhat out of date. Nevertheless, combining this was the estimate from (2) above it was possible to estimate phone coverage for urban areas, and hence the total size of the covered phone population (urban + rural phone owners).

Weights were calculated to scale each sample to the total covered population size after applying the design weights up to this stage. The design weight for each mode sample was first scaled to an average of 1.

Calibration weights

External population statistics were then used to adjust the sample on variables of importance to the survey, to reduce sample biases that may arise from non-coverage and non-response. To be effective this adjustment should be done on variables which correlate with key survey estimates and where the sample profile differs to the external profile.

The data were weighted on age, gender, region and education, using the SPSS RAKE command (rim/calibration weighting). Small numbers of cases with missing values (refused) on the weighting variables were set to the mode value, and where necessary smaller categories were collapsed, affecting region and education. To improve weighting efficiency the weights were trimmed at the design weight stages (to 97.5th percentile). Trimming at each stage rather than simply at the end is good practice as it maintains the integrity/purpose of each stage. The final weight was not trimmed, in agreement with Harvard University, who planned to carry out additional inspection and trimming.

2.3 DATA QUALITY AND MONITORING

The research data quality and monitoring methodologies wave the same to that of the previous wave, briefly described below.

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 31 October and November 1, 2024. And refresher training for the main survey was provided 28, November 2024.
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 each 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 conducted with 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.

2.4 RESPONSE RATE AND INTERVIEW LENGTH

Table 2.4-1 Response Rate

Outcomes	Telephone fieldwork outcomes	Face-to-face fieldwork outcomes
Started (total)	13327	416
Open contacts	473	26
Closed contacts, of which:	12845	390
Interviews (before quality assurance)	2002	
Refusals	4007	18
Other non-response	2739	21
Non-Contact	303	1
Not eligible	4276	57
Unknown eligibility	6621	14
Yield rate (interviews/total leads)	15%	86%
Response rate	41%	89%

Interview length

The CATI survey takes 22.11 minutes on average while the face to face interview last 23.57 minutes on average. From experience, this is usually longer in native languages or during face-to-face interviewing.

Table 2.4-2 Interview lengths by mode

Mode	Median (HH:MM:SS)	Min (HH:MM:SS)	Max (HH:MM:SS)
CATI	00:23:11	00:08:13	01:27:14
CAPI	00:23:57	00:08:14	01:10:04

The research team also noted that interviews conducted in Somali will likely be shorter than interviews conducted in Amharic or Afan Oromo because the Somali interviewers were spoken faster than other languages. All interviews below 10 minutes were back checked. Interviews below 5 minutes were removed from the dataset. There are several interviews with long interview lengths > 1 hour. Whilst it is possible that some interviews took a long time it is more likely that interviews had to complete the interview in several parts but did not correctly record this in the system, so the interview length timer continued to count time. These interviews kept remained in the dataset.

2.5 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 V18. 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 2000 Eth birr), middle income (greater than 2000 and less than or equal to 5,000 Eth birr), and highest income (greater than 5,000 Eth birr).

2.6 ETHICAL CONSIDERATIONS AND REVIEW PROCESS:

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

Financial Support: It was financially supported by the Quality Evidence for Health System Transformation (QuEST) Network https://www.questnetwork.org/ through subcontract research agreement No: 263771-5120221

3. RESULTS

3.1 DEMOGRAPHICS AND GENERAL HEALTH STATUS

3.1.1 Demographic characteristics

Table 3.1.1 presents the distribution of demographic factors among the PVS respondents in Ethiopia. Most respondents were in younger age groups with 38.8% in the 18 to 29-year-old group and 26.9% in the 30 to 39-year-old group and decreased with each subsequent age group. Respondents were nearly equally represented across gender with 50.6% females and 49.4%% males. About 37.6% of respondents were from Oromia region, followed by 21.4% of respondents from the Amhara region. The most common level of educational attainment was none (or no formal education) (49.6%), with declining percentages in higher education level groups. The largest income level group was the lowest income bracket (33.6%) who made less than 2,000 Eth. Birr, and the next largest income group the middle income (32.8%) who made 2,000 to 5,000 Eth. Birr, and then the high-income group (25.6%) who made more than 5,001 Eth. Birr. Urban respondents (56.5%) more common than rural ones which represent 43.5% of respondents. About 56.5% of subjects were insured, and of these insured respondents, 89.9% had public insurance. The distribution of self-rated health peaked in the “Good” category (31.1%) followed by a "Very Good" category with 30.5% respondents ; 22.8% responding "excellent", 11.7% responding "fair" and 3.8% responding "Poor".

Table 1.3.2-1

Table 3.1-2Distribution of respondents by demographic characteristics, PVS 2025

		%	N
Age group (Year)	18-29	38.8	897
	30-39	26.9	623
	40-49	15.1	349
	50-59	8.5	197
	60+	10.7	247
Gender	Male	49.4	1,143
	Female	50.6	1,171
Region	Tigray	5.4	124
	Afar	1.9	44
	Amhara	21.4	495
	Oromia	37.6	870
	Somali	6.1	142
	SNNP	12.8	295
	Benshangul Gumuz	0.4	9
	Gambela	1.9	44

	Harari	0.1	1
	Sidama	4.9	113
	Dire Dawa	0.1	1
	Addis Ababa	3.6	84
	South West	3.9	89
Insurance status	No	43.3	1,002
	Yes	56.7	1,312
Type of insurance (for those who have insurance)			
	Public	89.9	1,180
	Private	10.1	132
Highest level of education completed	None (or no formal education)	49.6	1,147
	Primary	30.6	708
	Secondary	12.0	277
	Post-secondary	7.9	183
Self-rated health	Poor	3.8	88
	Fair	11.7	271
	Good	31.1	720
	Very Good	30.5	705
	Excellent	22.8	527
Income group	Lowest income	33.6	778
	Middle income	32.8	758
	Highest income	25.6	593
	Unknown	8.0	185
Place of Residence	Rural	43.5	1,007
	Urban	56.5	1,307
	Total	**100**	**2,314**

3.1.2 General health status

Table 3.1.2 shows the distribution of participant self-reported health status within each demographic category. Respondents aged 30 to 39 years reported the greatest percentage of "Excellent" health (28.9%) and the lowest relative percentage of "Poor" health (2.3%) compared to the rest of age categories. The oldest age group of 60+ year-olds reported the lowest percentage of "Excellent" health (7.7%) and the highest relative percentage of "Poor" health (11.7%). Men reported higher percentage in both the lowest two and the highest two health levels compared to women. About one third of women (34.3%) reported "good" health level while 27.9% of men reported "good" health level. Similarly, more respondents with post-secondary education reported the highest levels of health as compared to those with less

education. Better health status is associated with more education. Residents of urban areas and the highest income group also had greater self-reported health than rural residents and the lower income groups, respectively. Overall, 53.3% of participants rated their health status as “Excellent” or very good which a slightly increased from the previous PVS wave-I(11) study, which indicated that 39.7% of respondents rated their health status as excellent or very good in 2022, the rural area it was 35.5% while urban area rated as excellent or very good, at 49.5% (Figure 3.1.1).

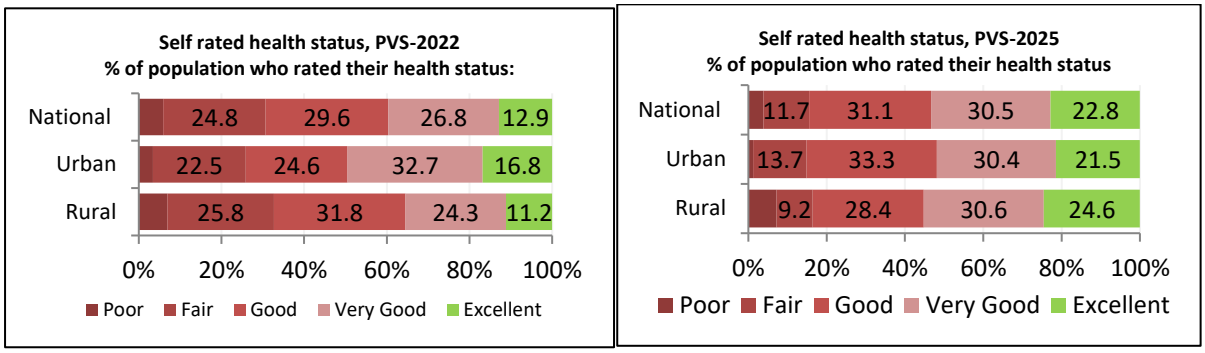


Figure 3.1-1 Distribution of participant self-reported health status by place of residence, PVS 2022 and 2025

Table 3.1-3 Proportion of respondent self-reported health status by demographic characteristics, PVS 2025

Self-rated health (%)						
	Poor	Fair	Good	Very Good	Excellent	N
Age group (Year)						
18-29	2.8	8.5	33.5	33.1	22.1	897
30-39	2.3	6.8	28.2	33.7	28.9	623
40-49	4.1	13.0	31.6	24.0	27.3	349
50-59	2.7	15.3	31.2	33.2	17.6	197
60+	11.7	30.9	29.4	20.3	7.7	247
Gender						
Male	3.2	14.1	27.9	33.5	21.3	1,143
Female	4.4	9.5	34.3	27.6	24.3	1,171
Highest level of education completed						
None (or no formal education)	6.3	13.1	30.4	30.8	19.4	1,147
Primary	1.5	11.2	34.8	27.5	25	708
Secondary	1.6	10.5	27.5	33.8	26.6	277
Post-secondary	0.4	7.1	26.9	35.2	30.3	183
Income group						
Lowest income	6.2	14.2	36.4	25.5	17.7	778
Middle income	3.7	8.8	27.6	32.5	27.3	756
Highest income	1.6	10.4	30.5	35.7	21.8	592
Place of Residence						
Rural	7.2	9.2	28.4	30.6	24.6	1,007

Urban	1.2	13.7	33.3	30.4	21.5	1,307
Total	**3.8**	**11.7**	**31.1**	**30.5**	**22.8**	**2,314**

3.1.3 Mental health status

Table 3.1.3 provides the distribution of self-reported mental health status within each demographic category. The last two older age categories reported the lowest better mental health , with 17.4% of 50 to 59-year-olds and 6.6% of 60+ year-olds reported "Excellent" mental health. While 21.9% of respondents aged 18 to 29 and 25.2% of respondents aged 30 to 39 reported "excellent" mental health. The inverse was also true: 2.1% of 30 to 39-year-olds and 7.5% of 60+ year-olds reported "Poor" mental health. Women and rural residents indicated worse mental health status than men and urban residents respectively; with 4.4% of women and 6% of rural residents reported "poor" mental health, while only 2.1% of men and 1.2% of urban residents reported "poor" mental health. In most cases, as education and income level increased, respondents reported better mental health outcomes. Overall, 21.7% of respondents reported "Excellent" health, while 3.3% reported "Poor" health.

Table 3.1-4 Distribution of self-reported mental health status by demographic characteristics, PVS 2025

	Self-rated mental health (%)					
	Poor	Fair	Good	Very Good	Excellent	N
Age group (Year)						
18-29	2.9	7.6	37.2	30.4	21.9	897
30-39	2.1	7.7	27.4	37.6	25.2	623
40-49	3.8	11.4	28.1	28.2	28.5	349
50-59	2.4	19.5	24.1	36.6	17.4	197
60+	7.5	27.4	36.0	22.5	6.6	247
Gender						
Male	2.1	13.3	29.0	34.8	20.8	1,143
Female	4.4	9.4	34.9	28.7	22.7	1,171
Highest level of education completed						
None (or no formal education)	5.3	13.2	29.9	32.5	19.1	1,147
Primary	1.5	10.7	36.8	29.4	21.7	708
Secondary	1.3	9.1	30.8	31.6	27.2	277
Post-secondary	0.3	5.3	28.3	35.7	30.3	183
Income group						
Lowest income	4.7	13.5	38.7	26.8	16.3	778
Middle income	3.7	7.7	26.6	35.6	26.5	756
Highest income	1.8	10.9	31.6	35.0	20.7	592
Place of Residence						
Rural	6.0	10.4	27.5	31.0	25.1	1,007
Urban	1.2	12.0	35.4	32.2	19.2	1,307
Total	**3.3**	**11.3**	**32.0**	**31.7**	**21.7**	**2,314**

3.1.4 Longstanding illness or health problem

Table 3.1.4 presents the percentage of individuals who reported having a longstanding illness or health problem in each demographic category. Age and percentage of respondents with a longstanding illness or health issue were positively correlated; with 20.4% of 18 to 29-year-olds as compared to 42% of 60+ year-olds indicating the problem. Higher percentage of men (28%) suffered from long standing health problems compared women; 20.5% of them reported to suffering from long standing health problems. Education status is inversely correlated with long standing health problems, as education status advance towards post-secondary, the percentage of longstanding health problem declined. About 30.6% of respondents with no education have suffered from long standing health problems, while only 13.3% of respondents with post-secondary education have suffered from long standing health problems. Rural residents (31.3%) have higher prevalence of lasting disease than urban residents (18.7%), this finding is in a reverse direction to the finding from wave1 (11) in which urban residents were disproportionately suffered from long lasting health problems (figure 3.1.2). Overall, 24.2% of respondents reported having a longstanding illness or health problems which increased from the previous report, 13.1%. This may be due to the conflicts and security issues in the recent years.

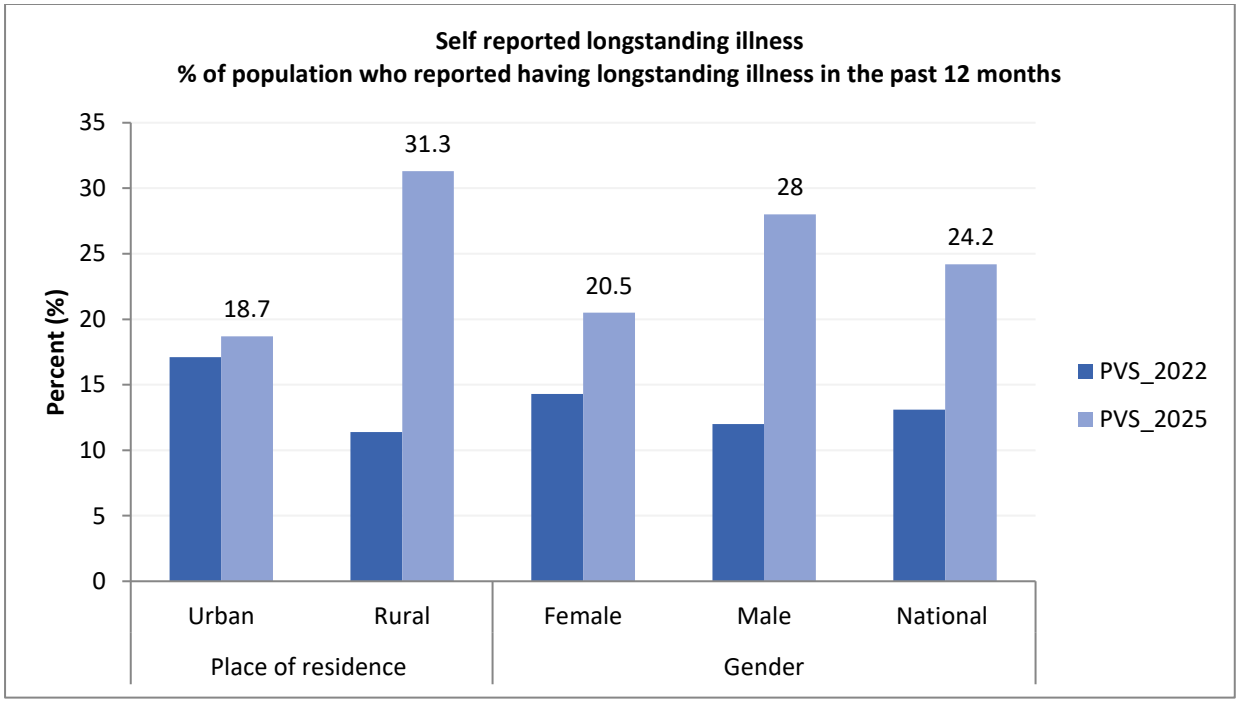


Figure 3.1-2 Percentage of individuals who reported having a longstanding illness by place of residence and gender

Table 3.1-5 Percentage of respondents who reported having a longstanding illness or health problem by background characteristics, PVS 2025

	Longstanding illness or health problem (chronic illness) (%)			
	No	Yes	Total	N
Age group (Year)				
18-29	79.6	20.4	100	897
30-39	86.2	13.8	100	623
40-49	69.4	30.6	100	349
50-59	59.2	40.8	100	197
60+	58.0	42.0	100	247
Gender				
Male	72.0	28.0	100	1,143
Female	79.5	20.5	100	1,171
Highest level of education completed				
None (or no formal education)	69.4	30.6	100	1,147
Primary	80.9	19.1	100	708
Secondary	82.1	17.9	100	276
Post-secondary	86.7	13.3	100	183
Income group				
Lowest income	70.0	30.0	100	778
Middle income	73.3	26.7	100	758
Highest income	88.1	11.9	100	593
Place of Residence				
Rural	68.7	31.3	100	1,007
Urban	81.3	18.7	100	1,306
Total	**75.8**	**24.2**	**100**	**2,314**

3.1.5 Patient activation

Table 3.1.5 shows the distribution of self-reported health management confidence in each demographic group. Confidence peaked in the 30-39 age group, with 62.1% of the group selecting “Very confident” and reached a minimum in the 60+ age group with only 37.4% of the group selecting “Very confident.” Both men (49.2%) and women (48.7%) are nearly equally confident in managing their health. Urban residents are more confident in managing their health than rural residents do, with 58.2% of urban residents selected “very confident”, while only 37% of rural residents selected “very confident”. Higher educational attainment was correlated with greater confidence with 63.5% of the post-secondary education group selecting “Very confident”, while only 39.7% of residents with no education were “very confident”. Respondents with the highest income category were more confident in managing

their health compared to the lower two income categories, with 54.3% of high income categories selecting “very confident”. Overall, 49% of respondents selected “Very confident,” while 1.4% selected “Not at all confident.”

Table 3.1-6 Distribution of self-reported health management confidence by background characteristics, PVS 2025

	Patient activation: manage overall health and tell a provider concerns		
	Not activated (%)	Activated (Very confident (%)	N
Age group (Year)			
18-29	54.7	45.3	897
30-39	37.9	62.1	623
40-49	52.1	47.9	349
50-59	59.5	40.5	197
60+	62.6	37.4	247
Gender			
Male	50.8	49.2	1,143
Female	51.3	48.7	1,170
Highest level of education completed			
None (or no formal education)	60.3	39.7	1,147
Primary	44.8	55.2	708
Secondary	38.4	61.6	276
Post-secondary	36.5	63.5	182
Income group			
Lowest income	51.9	48.1	778
Middle income	53.6	46.4	758
Highest income	45.7	54.3	593
Place of Residence			
Rural	63.0	37.0	1,007
Urban	41.8	58.2	1,306
Total	**51.0**	**49.0**	**2,313**

3.2 UTILIZATION OF CARE AND SYSTEM COMPETENCE

3.2.1 Number of health care visits

Table 3.2.1 Presents the distribution of the number of healthcare visits in the past 12 months within each demographic category. Majority of people in each age group had four or fewer healthcare visits in the past year. The 50-59 years age group had the highest percentage of individuals with more than four healthcare visits with 26.6% had more than four visit followed

by 40-49 years age group. The 60+ years age group are the least non-users, with only 19.9% of them had zero health facility visit in the last 12 months; on the other hand the 30-39 years represent the highest non-users with 30% of them had zero health care visit in the last 12 months. Urban residents had fewer healthcare visits than rural residents, while men and women have no any difference in the number of healthcare visit during the last 12 months. This finding is in reverse direction to the findings in wave1 (Figure 3.2.1). Majority of the individuals in every income group had between one and four healthcare visits. Respondents with no formal education and with primary education comprised the most frequent healthcare visit categories with 17.4% of the former group and 16.2% of the latter group reporting more than 4 visits in the past 12 months. Overall, 24.7% of respondents did not use the health system, it decreased from the previous report 39.2% in 2022. The non-user decreased in all age group and gender, however still high in 30-39 age group and female populations (Figure 3.2.1).

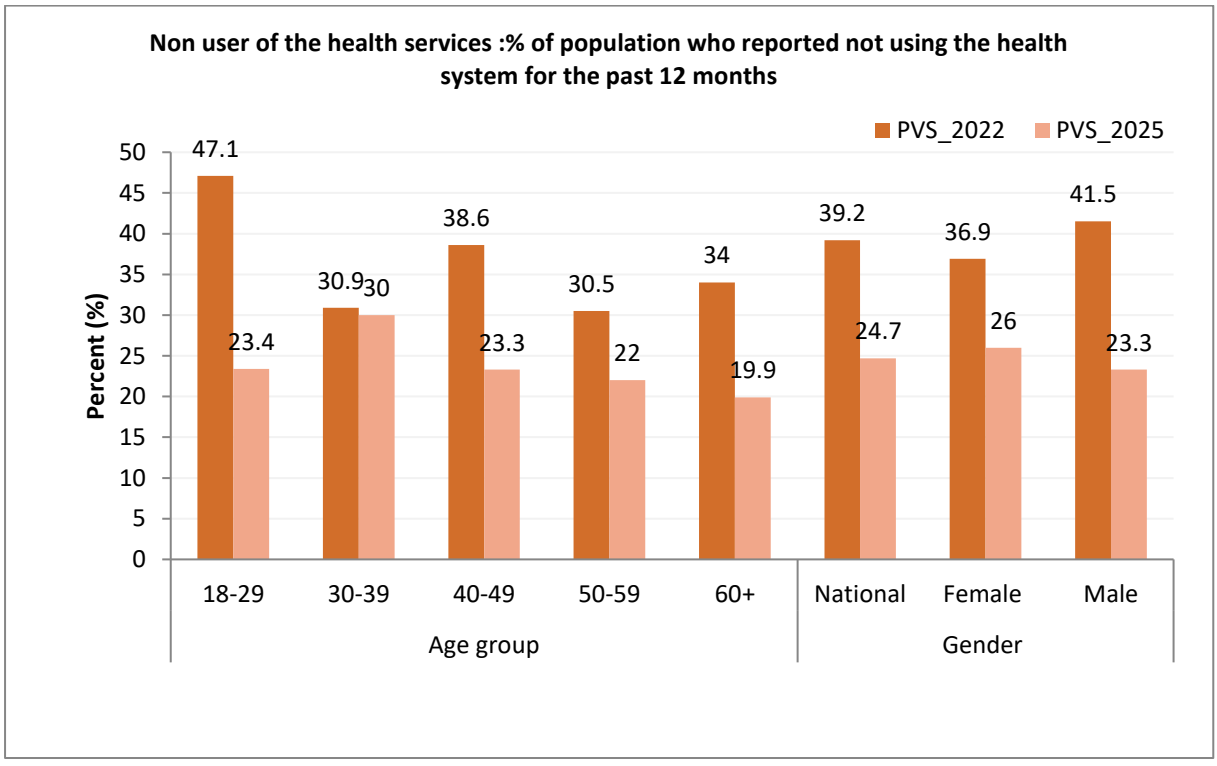


Figure 3.2-1 Distribution of the non-user of the health care by age group and gender.

Table 3.2-1 Percent distribution of the number of healthcare visits in the past 12 months by background characteristics, PVS 2025

	Visits (categorical) made in-person to a facility in past 12 months (%)			
	Non-user (0 visits)	Occasional user (1-4 visits)	Frequent user (more than 4)	N
Age group (Year)				
18-29	23.4	62.1	14.5	**897**
30-39	30.0	54.4	15.6	**623**
40-49	23.3	61.0	15.7	**346**
50-59	22.0	51.3	26.6	**195**
60+	19.9	68.3	11.9	**247**
Gender				
Male	23.3	60.3	16.4	**1,140**
Female	26	58.9	15.1	**1,168**
Highest level of education completed				
None (or no formal education)	28.9	53.7	17.4	**1,142**
Primary	17.8	65.9	16.2	**708**
Secondary	23.9	64.3	11.8	**276**
Post-secondary	25.6	65.1	9.3	**183**
Income group				
Lowest income	24.1	57.2	18.7	**777**
Middle income	25.5	58.7	15.8	**758**
Highest income	22.7	65.0	12.3	**593**
Place of Residence				
Rural	19.6	59.9	20.5	**1,004**
Urban	28.6	59.4	12	**1,304**
Total	**24.7**	**59.6**	**15.7**	**2,308**

3.2.2 Number of Health facility visited

Table 3.2.2 shows the distribution of the number of healthcare facilities visited in the past 12 months within each demographic category. The 50-59 age group had the highest percentage of individuals going to four or more facilities (9.6%), while the 30-39 age group had the highest percentage of individuals going to three or fewer facilities (99.5%). Women and urban residents visited a higher number of health facilities compared to men and rural residents, respectively .In the wave1 survey, men visited more health facilities than women, while the same direction of association observed across residence. Respondents with secondary school education most frequently reported three or fewer facilities (98.7%), while those with primary education most frequently reported four or more facilities (2.6%). Respondents in the middle income group had the highest percentage of visits to four or more different facilities (2.7%), while the highest income group have the highest percentage of visits to three or fewer

facilities (99.6%). Overall, 72.7% of respondents visited one health facility, while 2.2% of respondents visited four or more different facilities in the past 12 months.

Table 3.2-2 Distribution of the number of healthcare facilities visited in the past 12 months by background characteristics, PVS 2025

	Number of facilities visited during the past 12 months (%)			
	1 facility	2-3 facilities	More than 3 facilities	N
Age group (Year)				
18-29	79.5	18.7	1.9	556
30-39	62.9	36.6	0.5	293
40-49	70.4	27.2	2.4	221
50-59	71.0	19.4	9.6	125
60+	72.1	27.8	0.1	156
Gender				
Male	74.2	24.4	1.4	695
Female	71.2	25.8	3.0	656
Highest level of education completed				
None (or no formal education)	71.6	26.3	2.2	654
Primary	74.2	23.2	2.6	456
Secondary	73.2	25.5	1.3	151
Post-secondary	73.3	25.4	1.3	92
Income group				
Lowest income	69.6	28.4	2.0	483
Middle income	74.6	22.8	2.7	410
Highest income	77.4	22.3	0.4	371
Place of Residence				
Rural	73.5	24.9	1.6	673
Urban	72.0	25.3	2.7	678
Total	**72.7**	**25.1**	**2.2**	**1,351**

Table 3.2.3a presents the distribution of other healthcare interactions, including in-person visits at a healthcare facility, home visits by healthcare workers, and virtual or tele-medicine visits, within each demographic category. The 60+ age group had the highest percentage of in-person visits (80.2%). The 18-29 age group had the highest percentage of home visits (22.9%), while 50-59 age group had the highest percentage of telemedicine visits (8.1%). The 30-39 age group had the lowest percentage of in-person and home visits compared to all

other age groups. Women had a lower percentage of in-person visit (74%), home visits (11.8%) and telemedicine calls (4.6%) compared to men.

Respondents with primary education had the highest in person visit(with 82.1%, while respondents with no formal education had the highest home visit(19.4%). Respondents with post-secondary education had the highest percentage of tele-medicine calls (11.8%) followed by secondary education status (9.7%).

The highest income group also had the largest proportions of in-person visits (77.3%), while the middle income group had the highest telemedicine calls (8.6%) and home visits (19.9%), while the lowest income group had the least proportion of tele-medicine calls (3.1%). Rural residents have the highest percentage of in person visits and home visits with magnitudes of 80.4% and 18.8% respectively; while urban residents had a highest percentage of tele-medicine visits (9.4%). In aggregate, the healthcare interactions fell predominantly in-person visits (75.3%), followed by home visits (15.5%) and telemedicine calls (5.9%).

Table 3.2.3a Distribution of other healthcare interactions, including in-person, home virtual or tele-medicine visits, by background characteristics, PVS 2025.

Visits (categorical) made in past 12 months (%)								
		In-person			one or more home visits by health workers	N	one or more telemedicine calls	N
	N	Non-user (0 visits)	Occasional user (1-4 visits)	Frequent user (more than 4)				
Age group (Year)								
18-29	897	23.4	62.1	14.5	22.9	606	6.8	519
30-39	623	30.0	54.4	15.6	11.7	377	5.9	361
40-49	349	23.3	61.0	15.7	11.9	226	6.2	220
50-59	197	22.0	51.3	26.6	11.1	119	8.1	118
60+	247	19.9	68.3	11.9	5.0	157	0.7	154
Gender								
Male	1,143	23.3	60.3	16.4	19.5	723	7.4	646
Female	1,171	26.0	58.9	15.1	11.8	762	4.6	725
Highest level of education completed								
None*	1,147	28.9	53.7	17.4	19.4	697	5.4	605
Primary	708	17.8	65.9	16.2	11.5	500	3.8	484
Secondary	277	23.9	64.3	11.8	12.3	175	9.7	171
Post-secondary	183	25.6	65.1	9.3	14.7	113	11.8	112
Income group								
Lowest income	778	24.1	57.2	18.7	19.2	530	3.1	460
Middle income	758	25.5	58.7	15.8	19.9	478	8.6	438
Highest income	593	22.7	65.0	12.3	6.1	400	5.7	399
Place of Residence								
Rural	1,007	19.6	59.9	20.5	18.8	711	1.4	605
Urban	1,307	28.6	59.4	12.0	12.6	774	9.4	766
Total	**2,314**	**24.7**	**59.6**	**15.7**	**15.5**	**1,485**	**5.9**	**1,371**

*(or no formal education)

3.2.3 Inpatient visits

Table 3.2.3 presents the percentage of each demographic category that reported having an inpatient visit in the past 12 months. The 18-29 age group (20.6%) had the highest percentage of inpatient visits, followed by the 60+ age group (15.9%), while the 30-39 age group had the lowest percentage (8.8%). Women (15.7%) and rural residents (16.5%) had more inpatient visits as compared to men (14.2%) and urban residents (13.6%) respectively. Respondents with primary education had the highest percentage of inpatients visits (16.5%), followed by no formal education (14.7%). Respondents with secondary and post-secondary education groups had the lowest percentage of inpatient visits with magnitude of 12.5% and 13.1% respectively. Less income was correlated with a greater percentage of inpatient visits, with the highest percentage of reports in the lowest income bracket (18.0%) and declining percentages in each subsequent bracket. Overall, 14.9% of all respondents reported having an inpatient visit in the past 12 months prior to the survey.

Table 3.2-3 Percentage of respondents having inpatient visits by Background characteristics, PVS 2025

	N	%
Age group (Year)		
18-29	897	20.6
30-39	623	8.8
40-49	349	11.6
50-59	197	11.5
60+	247	15.9
Gender		
Male	1,143	14.2
Female	1,171	15.7
Highest level of education completed		
None (or no formal education)	1,147	14.7
Primary	708	16.5
Secondary	277	12.5
Post-secondary	183	13.1
Income group		
Lowest income	778	18.0
Middle income	758	14.7
Highest income	593	11.3
Place of Residence		
Rural	1,007	16.5
Urban	1,307	13.6
Total	**2,314**	**14.9**

3.2.4 Usual source of healthcare

Table 3.2.4 shows the percentage with a usual source of care and the distribution of care source by the type of health facility among these respondents, within each demographic group. The 50-59 age years group had the highest proportion of respondents with a usual source of care (90.3%), while the 30-39 age group had the lowest proportion (81%). The 60+ age group had the greatest use of public healthcare (83.2%), and the 18-29 age group had the greatest use of private healthcare (26.6%) compared to other age groups. Other care (0.4%) was most used by 30-39 age group compared to other age groups.

Women (87.5%) and urban residents (86.3%) had a usual source of care more often than men (82.3%) and rural residents (83.1%) respectively. Women used public (73.9%) and private (26.1%), while men used public (79.7%), private care (19.9%), and others (0.4%). Rural residents had greater usage of public (81%) than urban residents (73.5%), while urban residents had greater usage of private facility (26.1%) compared to rural residents (19.9%), and other facility categories was utilized by only urban respondents (0.3%). Secondary education level was associated with a greater likelihood of having a usual source of care (89.2%), while respondents with no formal education are the least to have usual source of care (83.2%). Compared to all other education levels, those without formal education most frequently used public facilities (79.4%), while the post-secondary group most frequently used private facilities (37.8%). Utilization of other facility categories is below 1%.

About 85% of all income groups had a usual source of care. The lowest income group used public care (80.9%) most frequently, while the private facility is utilized by 27.5 and 25.2% of middle and highest income groups respectively. Among usual source facilities, 91.1% are primary facilities and the remaining 8.1% were secondary facilities. The primary (84.3%) and secondary (84.6%) facilities had about an even distribution of public care. Overall, 84.9% of respondents had a usual source of care with 76.7% of these sources classified as public, 23.1% as private, and 0.2% as other.

The 50-59 years age group (94.5%) and 40-49 years age group (93.5%) used primary facilities more frequently than other age groups, while the 30-39 years age group (12.1%) used secondary or higher facilities more frequently than other age groups. Women (91.4%) and men (90.9%) used primary level health facilities with nearly the same proportion, while rural residents (96.3%) used primary facilities which are higher than urban resident's utilization (87.4%). Compared to other education levels, those without formal education used primary facilities the most (95.5%), while those with post-secondary education used secondary or higher facilities higher than all other education categories (20.2%). Respondents with the highest income category tend to use secondary or higher level facilities compared to the lowest and middle income groups. Overall, 91.1% of those with a usual source of care used primary facilities.

The respondent's usual source of predominantly public owned facility in both surveys. The highest income and dwellers from urban area used the private one. More primary health facility utilized by the respondents, while the secondary or specialized health facility less accessible even more utilized by the urban and high income respondents. No significant different between the two surveys regarding the usual sources of care (Figure 3.2.2).

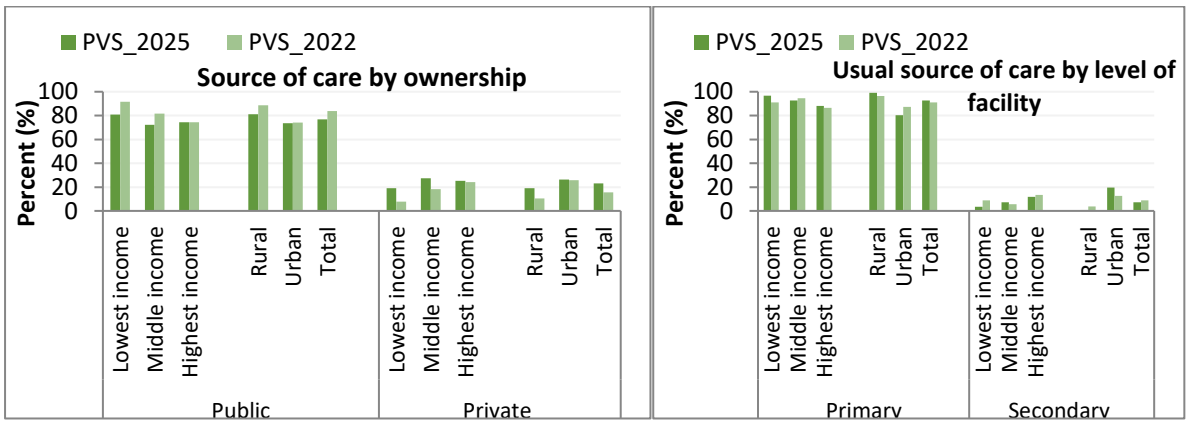


Figure 3.2-2 Distribution of respondents who had a usual source of care and of the type of healthcare facility by income and place of residence

Table 3.2-4 Percent distribution of respondents who had a usual source of care and of the type of healthcare facility by background characteristics, PVS 2025

		Usual source of care	Facility ownership for usual source of care			Facility level for usual source of care	
	N		Public	Private	Other	Primary	Secondary +
Age group (Year)							
18-29	897	85.8	73.2	26.6	0.2	92.3	7.7
30-39	623	81.4	75.8	23.8	0.4	87.9	12.1
40-49	349	85.0	82.2	17.8	0	93.5	6.5
50-59	197	90.3	77.4	22.6	0	94.5	5.5
60+	247	86.3	83.2	16.8	0	88.6	11.4
Gender							
Male	1,143	82.3	79.7	19.9	0.4	90.9	9.1
Female	1,171	87.5	73.9	26.1	0	91.4	8.6
Highest level of education completed							
None (or no formal education)	1,147	83.2	79.4	20.6	0	95.5	4.5
Primary	708	85.8	78.5	21.1	0.3	89.6	10.4
Secondary	277	89.2	70.8	28.4	0.8	84.0	16
Post-secondary	183	85.8	62.2	37.8	0	82.0	18
Income group							
Lowest income	778	84.2	80.9	19.1	0	91.1	8.9
Middle income	758	85.2	72.2	27.5	0.3	94.5	5.5
Highest income	593	84.7	74.4	25.2	0.4	86.5	13.5
Place of Residence							
Rural	1,007	83.1	81.0	19.0	0	96.3	3.7
Urban	1,307	86.3	73.5	26.2	0.3	87.4	12.6
Total	**2,314**	**84.9**	**76.7**	**23.1**	**0.2**	**91.1**	**8.9**

* Whether respondent has a usual source of care

3.2.5 Reasons for usual sources of care

Table 3.2.5 shows the distribution of reasons for choosing a specific healthcare facility type as their usual source of care within each demographic group. The proportion of the 60+ years age group that selected insurance coverage or low cost (48.1%) as their reason was the highest among all age groups followed by 40-49 years age group (42.5%), while the 50-59 age group prioritized good convenience/short distance (37.1%) as their predominant reason to select facilities, provider skill was most mentioned by 18-29 years (21%) and waiting time most mentioned by 30-39 years age group (6.6%). For all age groups, short distance to the provider, insurance coverage, health provider skill quality, and a availability of medicines and equipment were the most important factors in selecting a usual care source.

Women most mentioned short distance (33.7%) for reason of selecting source of care while men most cite low cost/insurance coverage (39.6%) as their reason for selecting their source of care. Short distance, insurance coverage and provider skills were the top three reasons for selecting source of care for both men and women. For those without formal education, insurance coverage followed by short distance were the top reasons for selecting a usual source of care, while secondary and post-secondary education groups mentioned short distance as their top reason for selecting source of care followed by insurance coverage. Respondents with higher education level most value convenience/short distance over insurance coverage in selecting source of care. Short distance, insurance coverage and health providers' skills are the top three reasons for selecting source of care for all the three of income groups. Decreasing value of short distance observed as income gradient increases.

As income increases, low cost, and provider skills are more frequently cited, while service readiness is most frequently cited by highest income groups compared to the other income groups. Respondents both from rural and urban areas prioritized insurance coverage, short distance and health providers' skill the most. Respondents who selected Public facilities cared most about insurance coverage (41.2%) followed by short distance (32.8%), while private primary users cared most about good healthcare provider skills (36%), short distance(23.2%), and medicine and equipment availability (16.8%). Respondents opt for secondary or higher level facilities cared most about providers skill(34.8%) followed by medicine and equipment availability (23.4%), and short distance(22.6%), while respondents opted for primary facilities cared most about insurance coverage (36.4%) followed by short distance (30.9%), and provider skills (15.5%). When selecting a usual source of care, respondents overall prioritized short distance (30.6%), insurance coverage (33.6%), good healthcare provider skills (17.2%), and medicine and equipment availability (8.2%), short waiting time and respect (5.8%) and only facility available(4.5%).

The figure below shows the major reason for selecting usual source of care between the surveys, No significant difference observed, the cost, short distance, and the provider skills are the major factors considered by the respondents when selecting usual sources of care (Figure 3.2.3).

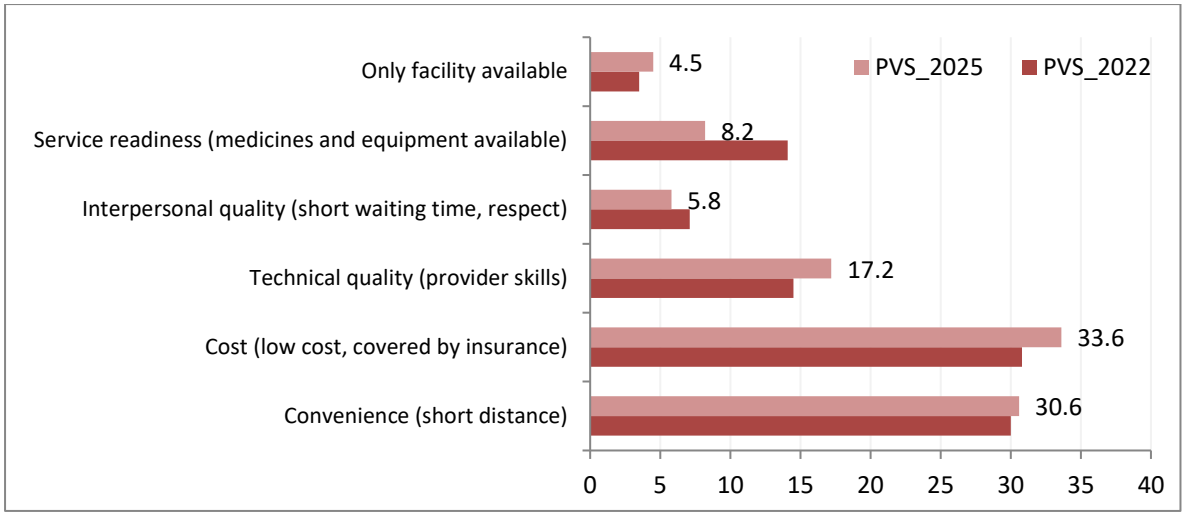


Figure 3.2-3 Percent Distribution of reasons for choosing a specific healthcare facility type as their usual source, PVS 2025.

Table 3.2-5 Percent distribution of reasons for choosing a specific healthcare facility type as their usual source of care by background characteristics, PVS 2025

	Main reason for choosing usual source of care facility						
	N	Convenience (short distance)	Cost (low cost, covered by insurance)	Technical quality (provider skills)	Interpersonal quality (short waiting time, respect)	Service readiness (medicines and equipment available)	Only facility available
Age group (Year)							
18-29	897	34.3	24.9	21.0	6.2	8.9	4.8
30-39	623	28.5	36.3	15.5	6.6	9.4	3.7
40-49	349	24.1	42.5	14.1	5.4	4.7	9.3
50-59	197	37.1	31.6	15.2	4.5	9.3	2.3
60+	247	26.1	48.3	14.1	3.8	6.9	0.9
Gender							
Male	1,143	27.3	39.6	12.8	5.6	7.9	6.9
Female	1,171	33.7	28.2	21.3	6.0	8.5	2.4
Highest level of education completed							
None (or no formal education)	1,147	29.6	39.8	16.9	3.2	6.1	4.4
Primary	708	31.4	32.7	14.8	7.1	8.3	5.7
Secondary	277	31.1	22.0	20.6	10.0	12.8	3.5
Post-secondary	183	33.2	18.3	23	9.6	13.4	2.6
Income group							
Lowest income	778	34.8	30.8	16.6	8.0	6.8	3.0
Middle income	758	29.5	37.6	19.1	4.1	6.6	3.1
Highest income	593	25.1	34.2	17.5	5.9	12.3	5.1

Place of Residence							
Rural	1,007	30.6	33.7	15.1	4.1	8.6	8.0
Urban	1,307	30.6	33.6	18.9	7.0	7.9	2.0
Facility ownership for usual source of care							
Public	1,499	32.8	41.2	11.6	3.6	5.5	5.2
Private	452	23.2	9.3	36.0	12.6	16.8	2.2
Other	4	0	0	0	52.2	47.8	0
Facility level for usual source of care							
Primary	1,756	30.9	36.4	15.5	5.7	6.8	4.7
Secondary (or higher)	171	22.6	10.9	34.8	7.6	23.4	0.6
Total	**2,314**	**30.6**	**33.6**	**17.2**	**5.8**	**8.2**	**4.5**

3.2.6 Quality rating for usual sources of care

Table 3.2.6 presents distribution of respondent quality rating of their usual place of healthcare within each demographic category. Within each age group, A minimum of one third of respondents rated their usual place of care as "Good." More than half (53%) of respondents from 60+ years age group rate the quality of their usual source of care as "good" which is more than any other age group, at the same time the 60+ age group had the most "poor" rating (13.2), followed by the 50-59 years age group(13%). The 18-29 years age group had the most "Excellent" ratings (12.1%). As age increases, the rate of reporting "poor" quality of the source of care increases. Women tended to provide more positive ratings. They have lower rating of "poor" and higher rating of "excellent" compared to men, but both men and women nearly equally report "good" rating of the source of care.

As education status increases, the probability of reporting "good" quality of source of care declined. Respondents with secondary education have the least (3.6%) reporting of "poor" and the highest (13.7%) reporting of "excellent" quality of source of care followed by post-secondary education in both cases. Respondents with no formal education have the highest (7.8%) "Poor" rating of their usual source of care, while those with primary education level have the lowest (6.9%) reporting of "Excellent" rating for their source of care followed by respondents with no formal education (7.8%).

As the income level increases, the chance of reporting "poor" quality of source of care decreases. The highest income group had the highest percentage of "good" ratings (47.5%) and the lowest percentage of "poor" rating (4.9%). Both urban and rural respondents more frequently rated their usual source of care as "good" with magnitudes of 45% and 33.2% respectively. Urban respondents had the lowest percentage of "poor" (5.5) and "excellent" (6%) rating of the quality of source of care. Both public and private facilities had a higher proportion of ratings in the "good" rating of source of care. Respondents whose source of care was public had the highest percentage of " poor"(7.7%) and "excellent " (8.9%) rating of the quality of their source of care, while respondents whose source of care was private had the higher percentage of " very good rating (37.3) compared to the public. Respondents whose source of care was secondary or higher level facility had the highest percentage of

"excellent" rating (16.2%). About 70% of respondents whose level of care was primary facility have rated the quality of source of care as either "good" or "very good". Respondents served at primary level facilities had reported the lowest percentage of "poor" and "excellent" rating of the quality of care.

Overall, 8.5% of respondents rated their usual source of care "Excellent," while 6.8% rated their usual source of care as "Poor." The most frequently selected service rating category was "Good"(39.8%).

Table 3.2-6 Distribution of respondent quality rating of their usual place of healthcare by background characteristics, PVS 2025.

	Overall quality rating of usual source of care (%)					
	Poor	Fair	Good	Very Good	Excellent	N
Age group (Year)						
18-29	3.5	11.8	36.5	36.0	12.1	722
30-39	5.4	17.2	41.8	28.5	7.1	469
40-49	9.3	21.0	38.3	26.5	5.0	281
50-59	13.0	17.4	34.3	30.5	4.8	169
60+	13.2	14.3	53.0	12.2	7.4	207
Gender						
Male	9.3	18.6	39.7	25.9	6.6	888
Female	4.5	12.4	39.9	32.9	10.3	960
Highest level of education completed						
None (or no formal education)	7.8	12.4	40.2	31.7	7.8	895
Primary	7.1	17.5	40.3	28.2	6.9	578
Secondary	3.6	21.7	39.1	22.0	13.7	229
Post-secondary	4.2	15.7	36.1	32.6	11.4	146
Income group						
Lowest income	6.9	18.8	38.3	23.6	12.4	622
Middle income	5.1	14.3	34.9	39.8	5.9	615
Highest income	4.9	12.8	47.5	26.3	8.6	460
Place of resident						
Rural	8.4	14.5	33.2	32.2	11.7	813
Urban	5.5	16.1	45.0	27.4	6.0	1,034
Place of Residence						
Public	7.7	15.4	40.7	27.2	8.9	1,428
Private	3.6	15.1	36.5	37.3	7.4	414
Other	0.0	0.0	47.8	52.2	0.0	4.0
Facility level for usual source of care						
Primary	6.5	15.4	40.2	30.1	7.9	1,667
Secondary (or higher)	7.7	16.3	32.7	27.2	16.2	160
Total	**6.8**	**15.4**	**39.8**	**29.5**	**8.5**	**1,848**

3.3 HEALTH SYSTEM COMPETENCE IN POPULATION HEALTH

3.3.1 Preventive care

Table 3.3.1 summarize the Proportion of respondents receiving specific health examinations in the past 12 months, by demographic category. Older women were more likely to receive a mammogram screening than their younger counterparts. The age increased higher likelihood of examination holds for the 30-39 to 60+ age groups for all tests. For blood pressure, blood glucose test, vision check and blood cholesterol tests, the 60+ age group had a highest likelihood of receiving the exam compared to all other age groups, and age group 18 -29 had the highest percentage of teeth checks. However, 50-59 age group had the highest percentage of blood pressure exams (46.9%), vision checks (21.5%), and blood glucose tests (22.5%) among all age groups.

For examinations conducted across both sexes, men had a higher percentage of tests received than women. Proportion of exams generally increased with education level, with some exceptions. Those with post-secondary education had the lowest percentage of cervical cancer screening (18.8%), and tooth checks (15.4%). Those with primary education had the lowest percentage of blood cholesterol tests (14.7 %). For cervical cancer screenings (24.5%) and mammogram (20.8%), the lowest income group had the highest proportion of tests received, but for blood pressure checks (51.9%%), blood glucose tests (29.5%), and blood cholesterol tests (22.2%), the highest income group had the highest proportion of their group receiving this examination. Urban residents generally had a higher percentage of examination, except for mammogram. Individuals with a usual source of care had higher percentage across most tests, except for tooth cheek.

Overall, the proportion of respondents receiving various examination was 45.9% had a blood pressure check, 17.2% had a mammogram, 18.4% had a cervical cancer screening, 20% had a vision check, 12.7% had a teeth check, 25% had a blood glucose test, 17.1% had a blood cholesterol test, and 8.2% had received care for depression or anxiety or other mental health condition.

A comparison of the proportions of health examination between in 2022 and 2025 reveals overall improvements across all examination. Notable increase in percentage change in mammograms (911.8%) percentage change, blood cholesterol (119.2%), blood glucose test (73%), tooth cheek (69.3%), cervical cancer (37.0%), vision cheek (37.0 %), blood pressure (25.5%) and Depression or anxiety or other mental care (15.5%). This shows improved access and utilizations of health care service over time.

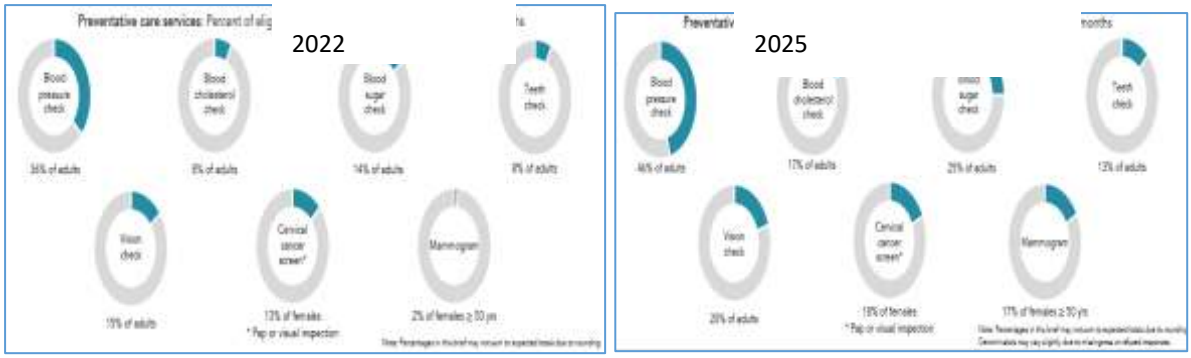


Figure 3.3-1 Proportion of respondents who received certain health examinations in the past 12 months PVS 2022 & PVS 2025.

Table 3.3-1 Proportion of respondents who received certain health examinations in the past 12 months by background characteristics, PVS 2025.

	N	Blood pressure	Mammogram	Cervical cancer	Vision check	Teeth check	Blood glucose	Blood cholesterol	Depression or anxiety or other mental care
Age group (Year)									
18-29	897	42.2	17.6	17.8	19	16.7	18.8	13.7	10.6
30-39	623	40.2	10.1	15.8	15.8	8.3	17.3	10.0	5.1
40-49	349	49.1	22.7	26.8	21.5	13.0	31.0	21.5	7.7
50-59	197	57.1	20.0	17.2	23.8	13.5	37.9	22.5	8.6
60+	247	59.2	29.9	16.9	27.8	8.2	47.1	37.3	7.9
Gender									
Male	1,143	46.4			21.9	13.1	25.5	18.6	8
Female	1,171	45.2	17.1	18.3	17.9	12.3	24.3	15.6	8.4
Highest level of education completed									
None (or no formal education)	1,147	43.1	17.2	15.2	17.8	8.9	23.3	17.9	8.7
Primary	708	46.9	17.5	21.8	19.4	16.7	23.0	14.7	6.2
Secondary	277	45.9	16.4	22.8	25.1	16.5	28.3	16.5	10
Post-secondary	183	58.2	16.7	18.8	27.1	15.4	37.3	22.2	10.4
Income group									
Lowest income	778	45.7	20.8	24.5	17.4	12.1	24.6	16.2	5.3
Middle income	758	44.2	12.8	14	22.7	18.7	21.8	15.8	12.8
Highest income	593	51.9	18.2	14.7	19.4	7.2	29.5	22.2	5.9
Place of Residence									
Rural	1,007	37.0	18.2	14.8	16.6	12.3	13.1	11.4	6.1
Urban	1,307	52.6	16.4	20.7	22.5	13.0	34.0	21.5	9.9
Whether respondent has a usual source of care									
No	348	35.2	21.2	12.5	12.2	14.6	9.4	5.1	3.6
Yes	1958	47.9	16.6	19.2	21.3	12.4	27.7	19.3	9.1
Total	**2314**	**45.9**	**17.2**	**18.4**	**20.0**	**12.7**	**25.0**	**17.1**	**8.2**

3.3.2 Medical mistakes and discrimination

Table 3.3.2 reveals that the percentage of people who experienced a medical mistake or discrimination in the past 12 months, by demographic category. The 18-29 age group reported the highest percentage of medical errors (17%) and discrimination (15.8%). Men reported medical error (12.2%) more than women (9.6%), while discrimination were higher among men (15.8%) compared to women (8.9%). Increased education was associated with a lower percentage of experiencing a medical mistake and discrimination. Those with primary education level group reported the highest percentage of discrimination (14.8%). The post-secondary education level group was reported the lowest percentage of discrimination (8.1%).

Individuals in highest income group had the lowest proportion of medical errors (5.2%) and discrimination (5.5%). Rural residents reported the highest percentage of medical errors (15.0%) and discrimination (16.2%). A larger proportion of people without a usual source of care experienced medical errors (12.0%), where as those with a usual source of care experienced higher discrimination (13.9%). Overall, the proportion of respondents reported medical errors was 10.9% and discrimination 12.4 %.

A comparison of the proportions of experienced a medical mistake or discrimination between in 2022 and 2025 reveals notable changes which are medical error reports increased significantly by 81.75%, indicating rise in reported health care mistakes, whereas discrimination slightly decreased by 3.9%, indicating a small improvement in equitable service delivery.

Table 3.3-2 Percentage of people who experienced a medical mistake or discrimination in the past 12 months by background characteristics, PVS 2025.

		A medical mistake was made in treatment or care in the past 12 months	
	N	Mistakes (%)	Discrimination (%)
Age group (Year)			
18-29	897	17.0	15.8
30-39	623	5.9	11.2
40-49	349	7.7	8.2
50-59	197	10.5	15.0
60+	247	4.9	6.5
Gender			
Male	1,143	12.2	15.8
Female	1,171	9.6	8.9
Highest level of education completed			
None (or no formal education)	1,147	12.7	14.8
Primary	708	10.5	11.3

Secondary	277	7.5	9.0
Post-secondary	183	7.1	8.1
Income group			
Lowest income	778	18.3	19.1
Middle income	758	8.1	11.7
Highest income	593	5.2	5.5
Place of Residence			
Rural	1,007	15.0	16.2
Urban	1,307	7.3	9.1
Whether respondent has a usual source of care			
No	348	13.4	7.7
Yes	1958	10.6	13.0
Total	**2314**	**10.9**	**12.4**

3.3.3 Non-use of healthcare

Table 3.3.3 presents the Proportion of respondents unable to access care when needed and reasons for non-use, by demographic category. The 18-29 age group had the highest percentage of non-users (13.9%), with high cost (39.0%) the primary reason for not accessing. Women (11.6%) were slightly more likely to be non-users than men (13.7%). Among women, the main reason for non-use includes high cost (44.6%), convenience (7.3%), and Interpersonal quality (Long waiting time, Respect) (17.3%). By education level, individuals without formal education had the highest percentage of non-users (14.4%), while higher education levels were associated with a lower percentage of non-users. By income level, lower income group had the highest percentage of non-users (12.5%) with reasons including high cost (32.4%), lack of respect from staff (5.6%), and Interpersonal quality (Long waiting time, Respect (21.4%). By residence type, rural residents had the highest percentage of non-users (19.0%), with high cost (52.0%) the most mentioned reason. Generally, 12.0% of individual needed medical care but did not get healthcare. The reason was high cost (43.3%), convenience (6.8%), Interpersonal quality (Long waiting time, Respect) (20.8%).

A comparison of the proportions of individual needed medical care but did not get healthcare between in 2022 and 2025 reveals 9.09 % increase over period.

Table 3.3-3 Proportion of respondents unable to access care when needed and reasons for non-use by background characteristics, PVS 2025

		Needed medical attention but did not get healthcare	Reason for not getting healthcare when needed medical attention (Q30)					
	N		Cost (High cost)	Convenience (Far distance)	Interpersonal quality (Long waiting time, Respect)	Technical quality (Poor provider skills)	Service readiness (Medicines and equipment not available)	Other
Age group (Year)								
18-29	897	13.9	39.0	2.6	25.5	11.4	20.5	1.0
30-39	623	10.0	27.6	7.3	8.0	31.0	20.8	5.3
40-49	349	11.5	52.5	4.8	27.3	14.2	1.3	0
50-59	197	10.8	43.9	30.7	22.5	1.3	1.6	0
60+	247	17.3	62.7	10.3	13.8	11.4	1.9	0
Gender								
Male	1,143	13.7	42.3	6.3	23.6	19.1	8.6	0
Female	1,171	11.6	44.6	7.3	17.3	8.7	19.2	2.9
Highest level of education completed								
None (or no formal education)	1,147	14.4	56.4	7.6	14.7	8.8	11.1	1.5
Primary	708	14.5	26.4	5.5	31	20.4	15.9	0.8
Secondary	277	5.3	33.3	8.1	14.8	32.7	11.2	0
Post-secondary	183	5.1	28.4	5.1	18.4	12.9	29	6.3
Income group								
Lowest income	778	12.5	32.4	5.6	21.4	23.6	13.3	3.8
Middle income	758	12.2	64.9	8.3	19.6	3.6	3.7	0
Highest income	593	12.1	30.2	9.1	16.3	18.1	26.1	0.2
Place of Residence								

Rural	1,007	19	52	2.8	17.3	15.3	11.2	1.4
Urban	1,307	7.7	26.2	14.6	27.7	12.7	17.7	1.1
Whether respondent has a usual source of care								
No	348	9.5	33.5	0.9	17.5	7.7	40.3	0
Yes	1958	13.2	44.8	7.6	21.2	15.4	9.5	1.5
Total	2314	12.6	43.3	6.8	20.8	14.4	13.4	1.3

3.4 USER EXPERIENCE AND CARE COMPETENCE

3.4.1 Last visit by facility ownership

Table 3.4.1 presents the proportion of each demographic category that visited each owner type of facility at their most recent healthcare visit. The 40 to 49-year-olds (81.7%) had the largest proportion of people who last visited a public facility compared to other age groups, although public facilities comprised the majority of last facility type visited for all age groups. The 30-39 age group had the highest proportion of private care as their last visit (31.3%). Men (72.5%) had a higher proportion of public care as their last visit compared to women (70.5%).

Those with primary education had the highest proportion of public care as their last visit (75.9%), and this proportion of public care use decreased as education level increased. The opposite was true of private care as last visit with 38.1% of post-secondary respondents using this care type. The same patterns of a decreasing proportion of respondents using public care as their last visit and an increasing proportion of respondents using private care as their last visit is observed as income level increases. Rural residents had a higher proportion of public care as their last visit (73.7%), but urban residents had a higher proportion of private care (29.7%). Primary and secondary or higher facility users had a similar distribution of last visit care types. Overall, 71.5% of respondents last visited a public facility, 27.5% last visited a private facility.

This figure had decreased from the previous wave1 survey, as 79.3% of respondents last visited a public facility, visiting private facilities increased from the previous findings. 27.5% last visited a private facility (Figure 3.4.1).

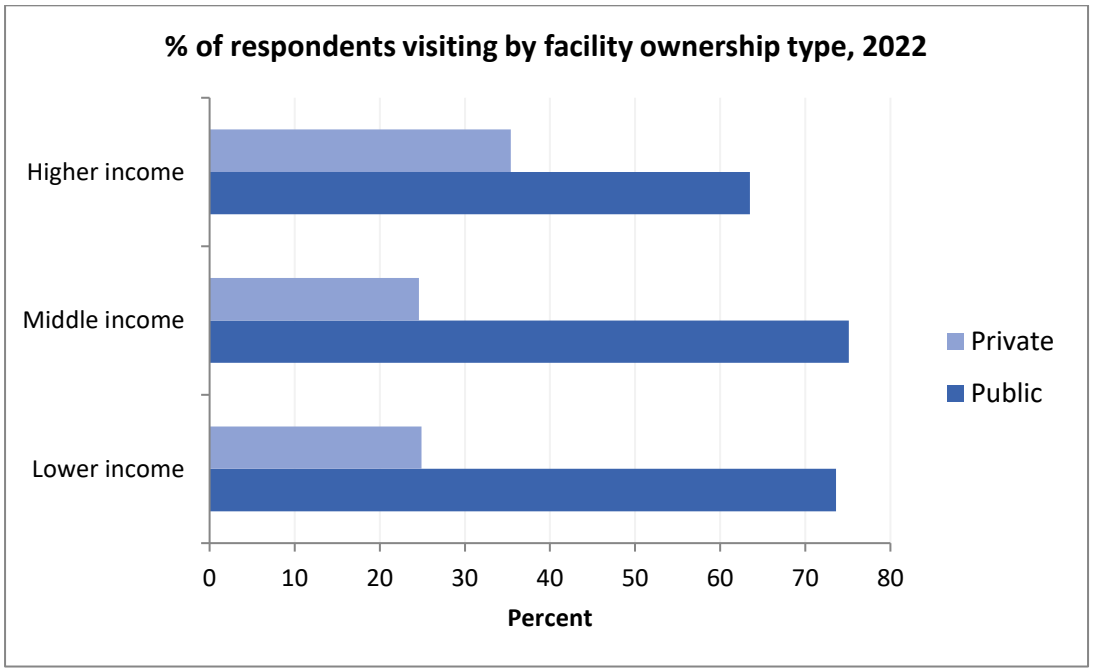


Figure 3.4-1 Proportion of respondents visited health care facility at their most recent healthcare, PVS 2025

Table 3.4-1 Proportion of respondents visited health care facility at their most recent healthcare visit by ownership and by background characteristics, PVS 2025

		Facility ownership for last visit to a healthcare provider		
	N	Public	Private	Other
Age group (Year)				
18-29	897	69.9	29.2	0.9
30-39	623	67.9	31.3	0.8
40-49	349	77.4	22.4	0.2
50-59	197	72.4	24.7	2.9
60+	247	76.5	22.3	1.2
Gender				
Male	1,143	72.5	26.3	1.2
Female	1,171	70.5	28.7	0.8
Highest level of education completed				
None (or no formal education)	1,147	72.6	26.8	0.7
Primary	708	75.9	23.1	1.0
Secondary	277	63.5	35.8	0.6
Post-secondary	183	58.8	38.1	3.0
Income group				
Lowest income	778	73.6	24.9	1.4
Middle income	758	75.1	24.6	0.3
Highest income	593	63.5	35.4	1.1
Place of Residence				
Rural	1,007	73.7	25.0	1.2
Urban	1,307	69.6	29.7	0.7
Whether respondent has a usual source of care				
No	348	71.7	27.5	0.8
Yes	1958	70.1	28.7	1.2
Total	**2314**	**71.5**	**27.5**	**1.0**

3.4.2 Last visit by facility type

Table 3.4.2 shows the distribution of each demographic category that used each type of healthcare facility at their last care visit. The 40-49 age group had the largest percentage of last visits to a health center (62.9%), and the 50-59 group had the lowest percentage (46.8%). The 50-59 age group was the most frequent users of the primary hospital (15.4%), while the 60+ age group was the most frequent users of general hospital (9.7%), and referral hospitals (2.8%) as their last visit. Men and women had a similar distribution of care type use as their last visit, except for health center, for which men (58.7%) had a higher percentage of use than

women (51.8%), and women had a higher percentage of use for referral hospital (2.9%) and speciality clinic 5.2% compared to men, 0.7% and 2.7%, respectively.

As education level increased, the proportion of the group that used health posts and health centers as their last visit decreased, and the proportion of the group that used a general hospital, referral hospital, medium clinic, and higher or specialty clinic. As income level increased, the proportion of the group that used a health post, health center, and primary hospital as their last visit decreased, while the proportion that used a, general hospital, referral hospital, and hospital/specialty center as their last visit increased. Rural residents had a larger proportion of respondents using a health post (3.6%) and health center (63.0%) than urban residents, while urban residents had a higher proportion of respondents using medium clinic and primary hospital types as their last visit. The most common types of care used as a last visit were a health center (47.9%), health post (2.8%) and medium clinic (15.2%) among all respondents.

Table 3.4-2 Distribution of respondents visited health facility type at their last care visit by background characteristics, PVS 2025

		What type of healthcare facility is this? (%)										
	N	Health Post	Health center	Primary hospital	General hospital	Referral hospital	Lower clinic	Medium clinic	Higher or specialty clinic	Speciality centre	NGO /Faith-based health center/clinic	NGO/faith-based hospital
Age group (Year)												
18-29	897	2.1	55.5	6.6	3.2	2.1	7.5	18	3.1	1.1	0.6	0.1
30-39	623	2.2	52.7	7.3	4.6	1.1	7.3	16.2	4.7	3.1	0.6	0.1
40-49	349	3.5	62.9	5.5	5.0	1.4	1.7	14.4	3.4	2.0	0.2	0
50-59	197	5.6	46.8	15.4	4.4	1.9	3.9	8.1	9.7	3.3	0.7	0.2
60+	247	3.6	56.6	7.1	6.7	2.8	5.8	9.5	1.5	6.4	0	0
Gender												
Male	1,143	3.5	58.7	6.0	3.7	0.7	5.3	15.6	2.7	3.o	0.8	0.1
Female	1,171	2.1	51.8	8.9	5.0	2.9	6.9	14.8	5.2	2.0	0.2	0.1
Highest level of education completed												
None (or no formal education)	1,147	2.5	60.4	7.0	2.7	0.5	7.4	14.3	3.5	1.8	0	0
Primary	708	3.5	58.3	7.3	4.2	2.6	5.4	11.4	4.5	2.0	0.8	0.1
Secondary	277	2.7	42.7	7.2	7.5	2.7	4.4	25.3	3.2	3.7	0.4	0.3
Post-secondary	183	1.4	31.9	11.0	9.6	5.2	4.1	21.2	5.5	7.3	2.5	0.2
Income group	778											
Lowest income	758	3.4	55.6	10.3	2.7	2.1	4.6	14.3	5.0	1.5	0.3	0.1
Middle income	593	1.8	61.9	6.2	3.6	1.6	3.9	14.8	4.4	1.5	0.3	0
Highest income	2,129	2.4	47.9	5.5	6.0	1.5	9.9	17.9	2.2	5.7	0.9	0.1
Place of Residence												
Rural	1,007	3.6	63	5.1	0.8	1.4	8.7	12.6	1.8	2.1	0.7	0.2
Urban	1,307	2.1	48.8	9.4	7.3	2.2	3.9	17.3	5.8	2.9	0.3	0
Total	**2314**	**2.8**	**55.3**	**7.4**	**4.3**	**1.8**	**6.1**	**15.2**	**3.9**	**2.5**	**0.5**	**0.1**

3.4.3 Reasons for choosing the facility for the last visit

Table 3.4.3 presents the distribution of reasons for selecting a particular facility for their last visit within each demographic group. The 18-29 age group had the highest percentage of respondents who chose care for an urgent or new health problem (75.0%), while the 60+ age group (42.4%) had the highest percentage of respondents who referenced follow-up care for a longstanding illness. The 30-39 age group had the highest percentage of respondents who cited preventive care (13.3%) compared to other age groups. Men referenced care for an urgent or new health problem (73.3%) more than women, but women referenced preventive care more (15.5%) than men. Increased education level was associated with a higher proportion of the group referencing urgent or new health problem as the reason for their last visit facility.

The group without formal education had the highest proportion of facility choice for follow-up care (70.4%). Higher income level was associated with a higher percentage of respondents citing an urgent or new health problem as the reason for their facility choice. The low-income (68.8%) and middle-income group (69.0%) had about the same proportion of the group making a choice due to an urgent or new health issue, while the highest income group had the highest percentage of preventive care reasoning (12.3%). Urban and rural residents had showed that rural area had a 76.2% for an urgent or new health issues, while the urban areas while the urban areas had a follow-up for chronic diseases and preventive or health check.

Public primary facility users had a lower percentage of respondents who chose their last visit facility based on an urgent or new health issue or follow-up care but a higher percentage who made the choice based on preventive care needs compared to private primary facility users. Public secondary or higher facility users had a higher percentage of respondents who made their choice based on an urgent or new health concern or preventive care and a lower percentage based on follow-up care compared to private secondary or higher facility users. Overall, 68.4% of respondents cited an urgent or new health issue, 21.4% cited follow-up care, and 10.0% cited preventive care as their reason for their most recent facility selection (Figure 3.4.2).

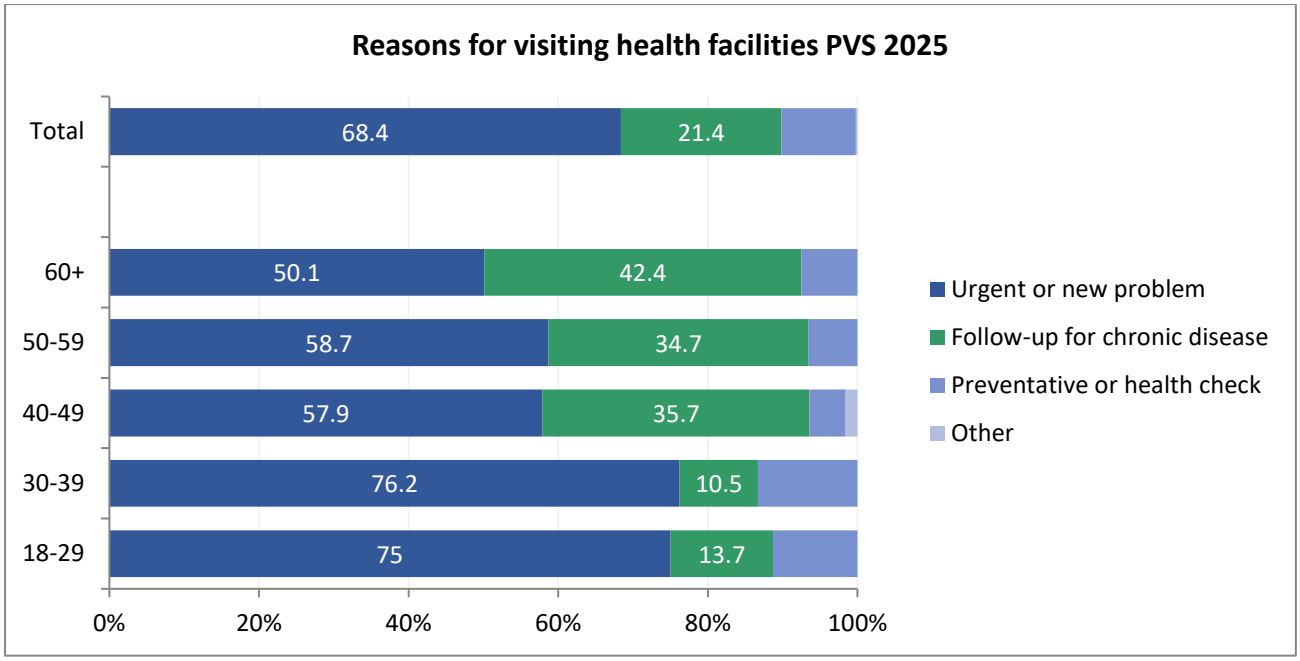


Figure 3.4-2 Percent distribution of respondent's reasons for selecting a particular facility for their last visit by age group, PVS 2025

Table 3.4-3 Percent distribution of respondent's reasons for selecting a particular facility for their last visit by demographic characteristics, PVS 2025

	N	Urgent or new problem	Follow-up for chronic disease	Preventative or health check	Other
Age group (Year)					
18-29	897	75.0	13.7	11.3	0.0
30-39	623	76.2	10.5	13.3	0.0
40-49	349	57.9	35.7	4.8	1.6
50-59	197	58.7	34.7	6.6	0.0
60+	247	50.1	42.4	7.5	0.0
Gender					
Male	1,143	73.3	21.7	4.5	0.5
Female	1,171	63.5	21.0	15.5	0.0
Highest level of education completed					
None (or no formal education)	1,147	70.4	24.1	5.0	0.5
Primary	708	67.8	19.3	12.9	0.0
Secondary	277	65.9	16.9	17.3	0.0
Post-secondary	183	63.4	20.6	16.0	0.0
Income group					

Lowest income	778	71.2	21.4	7.3	0.0
Middle income	758	64.1	24.9	10.2	0.8
Highest income	593	72.2	15.5	12.3	0.0
Place of Residence					
Rural	1,007	76.2	18.3	5.4	0.0
Urban	1,307	61.7	24.0	13.9	0.5
Facility ownership for last visit to a healthcare provider					
Public	1,499	69.4	19.4	10.8	0.3
Private	452	66.5	25.6	7.9	0.0
Other	4	46.4	47.2	6.4	0.0
Facility level for last visit to a healthcare provider					
Primary	1,756	70.7	19.9	9.2	0.3
Secondary (or higher)	171	171	33.3	18.7	0.0
Total	**2,314**	**68.4**	**21.4**	**10**	**0.2**

3.4.4 Waiting time for the last visit

Table 3.4.4 presents the distribution of waiting times at their last visit within each demographic group. Over 48% of all age groups had wait times of less than one hour. For the 18-29 age group (14.9%) and 30-39 age group (26.2%), 50-59 age group (35.4%) a wait time of one hour or more. The 60+ age group had the highest percentage (26.4%) in the short waiting time (<15 minutes). The 50-59 age group were most skewed to the moderate waiting time (less than 1hour) distribution with the highest percentages (53.4%). Half of Males and Females had moderate waiting time, 51.8% and 46.4%, respectively. As education level increased, the proportion of the group in the 0-15 minutes wait time category increased. Those without formal education had the highest percentage (53.4%) of respondents who waited less than one hour at their last visit, while the secondary education group had 52.4%. The highest -income group had the highest percentage of people who waited 0-15 minutes (29.1%) and less than one hour (51.3%). Rural residents had a higher percentage in short and moderate wait times as compared to urban residents. Among all ownership and levels of facilities, public secondary or higher facilities had the highest percentage in the short time waiting (26.3%).The public had the highest moderate waiting time (50.4%), while the private facilities had the highest short waiting time (39.6%) (Figure 3.3.3). Overall, 49.0% of respondents waited 0-60 minutes, while 28.2% waited 60+ minutes, and 22.7% of respondents waited for short minutes (<15 minutes).

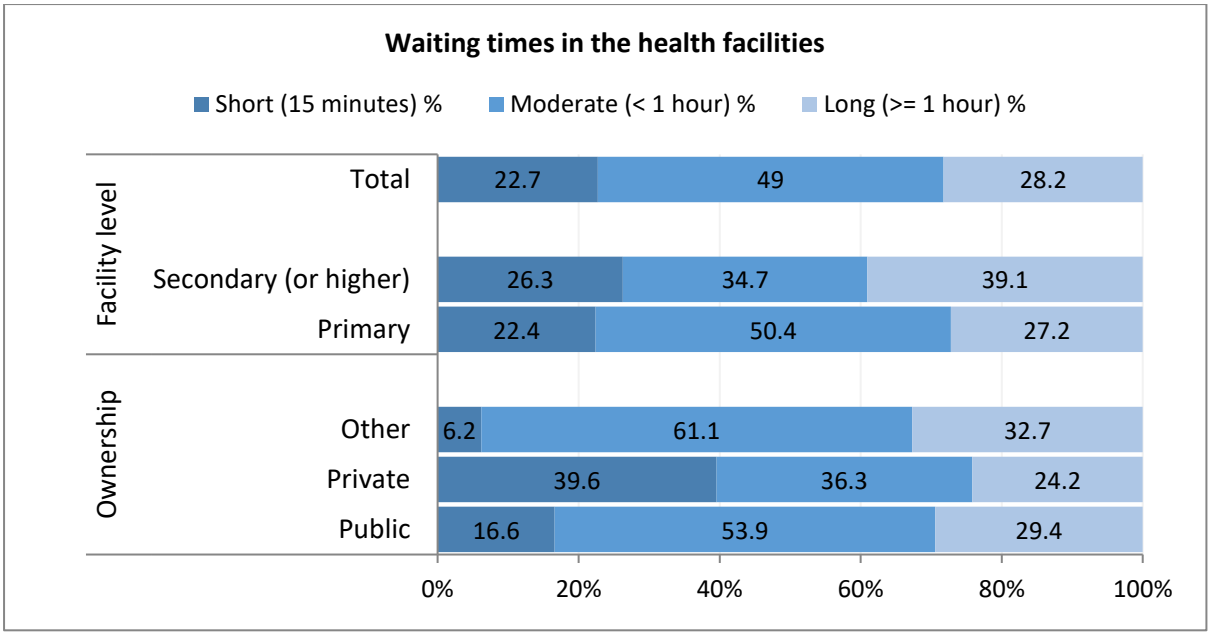


Figure 3.4-3 Waiting times at their last visit by facility ownership and level, PVS 2025

Table 3.4-4 Distribution of waiting times at their last visit by background characteristics, PVS 2025

		Length of time waited for last visit to a healthcare provider		
	N	Short (15 minutes) %	Moderate (15 - 60 minute) %	Long (>= 1 hour) %
Age group (Year)				
18-29	897	25.4	48.4	26.2
30-39	623	25.2	48.2	26.5
40-49	349	16.4	50.2	33.5
50-59	197	11.1	53.4	35.4
60+	247	26.4	49.2	24.4
Gender				
Male	1,143	22.0	51.8	26.2
Female	1,171	23.8	46.4	29.8
Highest level of education completed				
None (or no formal education)	1,147	21.0	53.4	25.6
Primary	708	24.5	41.8	33.7
Secondary	277	24.4	52.4	23.3
Post-secondary	183	24.6	50.1	25.3
Income group				
Lowest income	778	18.7	52.3	29
Middle income	758	23.4	48.2	28.4
Highest income	593	29.1	51.3	19.6

Place of Residence				
Rural	1,007	26.7	51.8	21.5
Urban	1,307	19.5	46.9	33.6
Facility ownership				
Public	1499	16.6	53.9	29.4
Private	452	39.6	36.3	24.2
Other	4	6.2	61.1	32.7
Facility level				
Primary	1,756	22.4	50.4	27.2
Secondary (or higher)	175	26.3	34.7	39.1
Total	**2314**	**22.7**	**49.0**	**28.2**

3.4.5 Consultation time for the last visit

Table 3.4.5 shows the distribution of consultation times with a healthcare provider during the respondent's most recent visit, within each demographic category. The 18-29 age group had the highest percentage of greater than 15-minute-long consultations (56.9%), while the 30-39 age group and 40-49 age group had the highest percentage of short consultation time (less than 15 minutes), 60.6% and 60.5%, respectively. Men tended to have shorter consultation times while women tended to have a longer consultation time. Higher level of education was correlated with an increased percentage of the group having a 0-15-minute-long consultation while the uneducated respondents had 15+ minutes long consultation times. The low-income group respondents had a short consultation time while the middle-income group had the longest consultation time compared to other income groups. Public health facilities provide the shortest consultation time (54.1%) while the private facilities providing the longest consultation time (52.7%). Public primary facilities had the shortest consultation time (53.4%) while the secondary facilities had long consultation time relative to the primary facilities. Overall, 53.1 % of respondents had short consultation time while the 46.9% of respondents had long consultation time.

Table 3.4-5 Distribution of consultation times with a healthcare provider during the respondent's most recent visit by background characteristics, PVS 2025

		Length of time spent with the provider during last healthcare visit	
	N	<= 15 minutes%	> 15 minutes %
Age group (Year)			
18-29	897	43.1	56.9
30-39	623	60.6	39.4
40-49	349	60.5	39.5
50-59	197	59.2	40.8

60+	247	46.7	53.3
Gender			
Male	1,143	56.9	43.1
Female	1,171	48.7	51.3
Highest level of education completed			
None (or no formal education)	1,147	50.6	49.4
Primary	708	54.3	45.7
Secondary	277	52.1	47.9
Post-secondary	183	58.4	41.6
Income group			
Lowest income	778	57.1	42.9
Middle income	758	41.9	58.1
Highest income	593	54.0	46.0
Place of Residence			
Rural	1,007	51.8	48.2
Urban	1,307	54.5	45.5
Facility ownership for last visit to a healthcare provider			
Public	1499	54.1	45.9
Private	452	47.3	52.7
Other	4	0	100
Facility level for last visit to a healthcare provider			
Primary	1,756	53.4	46.6
Secondary (or higher)	175	50.7	49.3
Total	**2314**	**53.1**	**46.9**

3.4.6 Quality of Health care in the last visit

Table 3.4.6 presents respondents' perceptions of the quality of care received during their most recent health facility visit, including ratings on overall quality, provider competence, facility readiness, communication, and client involvement. Overall, 37.6% of respondents rated the quality of their visit as "very good" or "excellent." Younger adults (18–29 years) gave the highest overall ratings (42.1%) compared to only 25.6% among those aged 60 and older. Women rated their care more positively (42.7%) than men (32.5%). Perceptions improved with education, ranging from 34.8% among those with primary education to 44.7% among those with post-secondary education. Similarly, middle-income respondents rated the quality higher (43%) than those in the lowest income group (34.2%).

The readiness of the facility which is availabilities of equipment and supplies also rated by respondents. The highest rate from the 30-39 age group 36.8% while the 60+ age group rate

the availabilities of equipment and supplies as 24.6%. As education level increased, rating the readiness of the facility also increased. Uneducated respondents rated as 27.3% while respondents with post secondary education level rated as 39.3%. as income level increased, rating the readiness of the facility also increased, ranged from 24.2% by the lowest income group to 35.8% by the highest income group. Respondents from rural areas, they rated the readiness of facility as very good or excellent was 25.5% while in the urban area as 32.5%.

Provider awareness of prior tests and visits was rated highest by the 60+ age group (40.6%) and men (38.3%). Involvement in decision-making was most positively rated by the 18–29 group (43.5%), and the rate increased with education, from 37.3% among those with no formal education to 52.2% among post-secondary graduates. Additional indicators include provider respect (46.1%), clarity in explaining health information (41.6%), consultation time (34.7%), waiting time (28.0%), and staff courtesy and helpfulness (36.1%). The overall rate on the quality of care during the last visit was rated excellent or very good 37.6%.

The respondents also rated the knowledge and skills of provider during their last visit, and the rate varied by socio-demographic characteristics. The 18-29 age groups and the 50-59 age group better rated (39.3%) and (38.0% while the lowest proportion was from the age 60+ age group, 30.0%. Respondents with the primary education level rated 30.4%, while 49.5% of the post secondary education level rated the knowledge and skills of the provider as excellent or very good. Respondents from the rural area also better rate the knowledge and skills of the provider 39.5% compared to the respondents from the urban area (33.5%).

The quality on the Provider knowledge about the prior test and visit also rated by the respondents. The 60+ age group rated it as very good or excellent (40.6%) followed by the 18-29 age group rated 39.4% . 38.3% of Male respondents rated the provider knowledge about prior test and visit as very good or excellent compared to the female respondents (31.2%). Does provider participate the respondents during decision making process also evaluated, accordingly the 18-29 age group rated the process as very good or excellent (43.5%) while the 60+ age group rated only 24.9% as very good or excellent. As education level increased, the participation in the decision-making process also increased, uneducated respondents rated the involvement in the decision-making process as very good or excellent 37.3% while 52.2% as very good or excellent by respondents with post-secondary education level.

Overall, the knowledge and skills of provider rated (36.3 %), availabilities of equipment and supplies provider had (29.2%), providers respect (46.1%), knowledge of prior tests and visits (34.8%), explaining things in understandable way (41.6%), provider involving in decision about the care (36.8%), consultation time (34.7%), waiting time (28.0%), and courtesy and helpfulness of the staff (36.1%). These findings point to notable disparities by age, gender, location, education, and income, highlighting the need to improve quality and equity of care (Figure 3.4.4). The comparison from the previous PVS 2022 also presented in figure 3.4.4a).

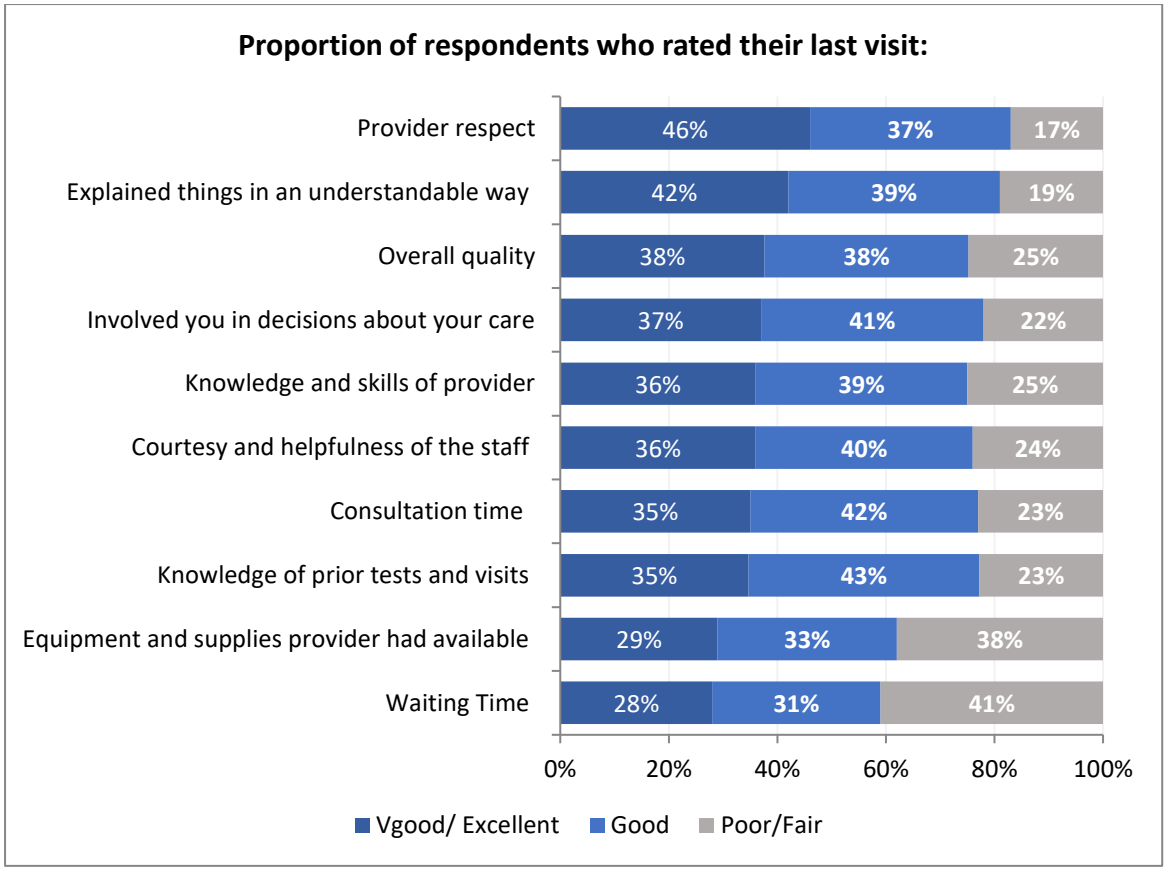


Figure 3.4-4 Perceived quality of care for the last visit, PVS 2025

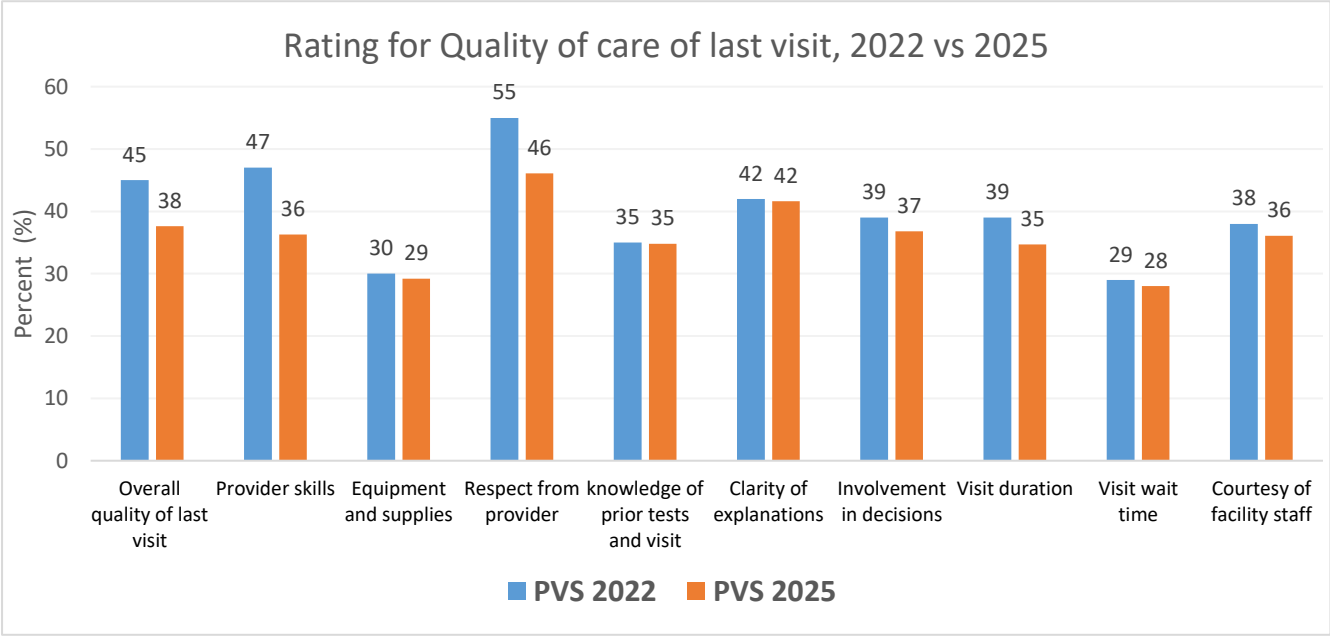


Figure 3.4-4 a Perceived quality of care for the last visit, PVS 2022 vs 2025

Table 3.4-6 Proportion of respondents that rated their last health facility visit "Excellent" or "Very Good" by background characteristics, PVS 2025.

	N	Last visit rating: overall quality	Last visit rating: knowledge and skills of provider (Care competence)	Last visit rating: equipment and supplies provider had available	Last visit rating: provider respect	Last visit rating: knowledge of prior tests and visits	Last visit rating: explained things in an understandable way	Last visit rating: involved you in decisions about your care	Last visit rating: amount of time provider spent with you	Last visit rating: waiting time	Last visit rating: courtesy and helpfulness of the staff
Age group (Year)											
18-29	687	42.1	39.3	26.4	42.5	39.4	43.6	43.5	38.5	29.4	41.8
30-39	436	40.1	33.7	36.8	49.2	29.9	42.6	32.9	31.3	25.8	29.1
40-49	265	31.3	38.0	25.4	43.8	28.5	42.8	32.7	30.1	28.6	33.2
50-59	152	36.4	36.1	33.1	49.3	31.5	39.0	40.6	30.4	23.7	28.1
60+	198	25.8	30.0	24.6	52.3	40.6	33.4	24.9	38.4	30.5	42.5
Gender											
Male	874	32.5	37.1	28.8	47.9	38.3	41.6	37.8	39.4	26.3	38.6
Female	864	42.7	35.6	29.6	44.2	31.2	41.6	35.9	30	29.5	33.7
Highest level of education completed											
None (or no formal education)	811	38.1	37.8	27.3	48.2	37.1	37.5	34.3	31.4	26.4	35.8
Primary	581	34.8	30.4	28.2	39.3	31.3	41.4	34.5	33.5	28.1	36.2
Secondary	210	38.8	39.0	32.8	47.9	31.6	45.6	42.7	40.7	28.5	32.4
Post-secondary	136	44.7	49.5	39.3	59.8	41.3	61.4	52.7	50.1	35.6	44.2
Income group											
Lowest income	590	34.2	35.1	24.2	35.0	27.7	39.4	35.3	26.8	19.1	26.0
Middle income	565	43.8	41.2	30.8	51.2	39.4	44.2	43.3	38.7	38.1	42.8
Highest income	459	38.8	34.6	35.8	54.7	43.0	43.0	33.1	41.7	33.8	45.0

Place of Residence											
Rural	807	38.6	39.8	25.5	40.9	35.6	42.0	36.5	31.2	25.2	41.1
Urban	931	36.6	33.5	32.5	50.6	34.1	41.3	37.1	37.8	33.9	32.0
Whether respondent has a usual source of care											
No	169	28.8	22.1	22.8	50.7	28.9	41.8	25.9	24.7	29.6	34.0
Yes	1,570	38.5	37.9	29.9	45.6	35.4	41.6	38	35.8	27.8	36.4
Total	**1,738**	**37.6**	**36.3**	**29.2**	**46.1**	**34.8**	**41.6**	**36.8**	**34.7**	**28.0**	**36.1**

3.4.7 Recommendation of the facility to other users

Table 3.4.7 shows the likelihood of respondents recommending the health facility they most recently visited, broken down by demographic characteristics. The highest percentage of respondents who were *VERY LIKELY* to recommend the facility was among the 18–29 age group (59.2%), while the 60+ age group had the highest share of those *LEAST LIKELY* to recommend (detractor) their last visited facility (55.8%). Women were more likely to recommend their last facility (54.8%) compared to men (47.6%). Respondents from rural areas were also more likely to recommend their facility (53.9%) than those from urban areas (48.8%). Users of private facilities were significantly more likely to recommend their visit (60.9%) than users of public facilities (47.4%). Overall, just over half of all respondents (51.1%) reported being likely to recommend the facility they visited.

Table 3.4-7 Distribution of the respondent's likelihood of recommending their last visited facility by background characteristics, PVS 2025

	Net promoter score for facility visited for last visit		
	Detractor (%)	Promoter (%)	N
Age group (Year)			
18-29	40.8	59.2	445
30-39	54.1	45.9	593
40-49	53.2	46.8	379
50-59	55.8	44.2	200
60+	54.8	45.2	142
Gender			
Male	52.4	47.6	927
Female	45.2	54.8	832
Highest level of education completed			
None (or no formal education)	48.5	51.5	199
Primary	51.7	48.3	397
Secondary	42.5	57.5	475
Post-secondary	48.4	51.6	688
Income group			
Lowest income	46.6	53.4	465
Middle income	48.0	52.0	505
Highest income	47.1	52.9	683
Place of Residence			
Rural	46.1	53.9	412
Urban	51.2	48.8	1,347
Facility ownership for last visit to a healthcare provider			
Public	52.6	47.4	1,155

Private	39.1	60.9	565
Other	59.8	40.2	37
Facility level for last visit to a healthcare provider			
Primary	49.8	50.2	1,450
Secondary (or higher)	39.0	61.0	298
Total	**48.9**	**51.1**	**1,748**

3.4.8 Quality of Public primary health care: pregnant women, child, chronic illness and mental health condition

Table 3.4.8 shows the proportion of respondents' perception rated as excellent or very good on the quality of services provided by public primary healthcare facilities to pregnant women, children, chronic conditions and mental health which dis aggregated by demographic characteristics. Respondents aged 60+ gave the highest ratings, with 46.1% for pregnant women, 47.1% for children, 32.8% for chronic illness, and 16.6% for mental health. In contrast, the 30–39 age group generally reported the lowest ratings for child (30.3%) and mental health services (14.7%). Men consistently rated higher than women across all categories for pregnant women service 43.4% vs 37.0%, for child care (40.3% vs. 32.3%), chronic conditions (24.8% vs. 22.0%), and mental health (17.2% vs. 14.9%).

Respondents with primary education reported the highest perceived quality for pregnant women care (45.5%) and chronic conditions care (29.7%). Those with no formal education had the lowest rating for chronic illness care (18.6%) and mental health 16.5%. The lowest income group had perceived lower quality compared to Middle income group across all services, with 37.4% vs.43.8% for pregnant women, 32.6% vs.37.3% for child care, 22.4% vs.24 for chronic conditions and 15.4% vs 17.6 % for mental health. Urban respondents (41.0%) rated pregnant women services slightly more than rural respondents (39.1%). This urban and rural difference was more noticeable in ratings for chronic conditions 25.9% in urban vs. 20.1% in rural. Having a usual source of care was ratings higher than those without a usual source across all categories i,e 41.9% vs. 30.7% for pregnant women, 38.0% vs 26% for child care, 24.0% vs.19.7% for chronic illness, and 16.8% vs. 11.1% for mental health services. Overall, perceptions of quality varied across demographic groups and service areas. Care for pregnant women and children received higher ratings compared to services for chronic illness and mental health. Respondents aged 60+, men, middle income groups, urban residents, and those with a usual source of care were generally more likely to view services as good, while mental health services received the lowest quality ratings across nearly all groups. Figure 3.4.5 illustrates the perceived quality of care for the advantageous subpopulations.

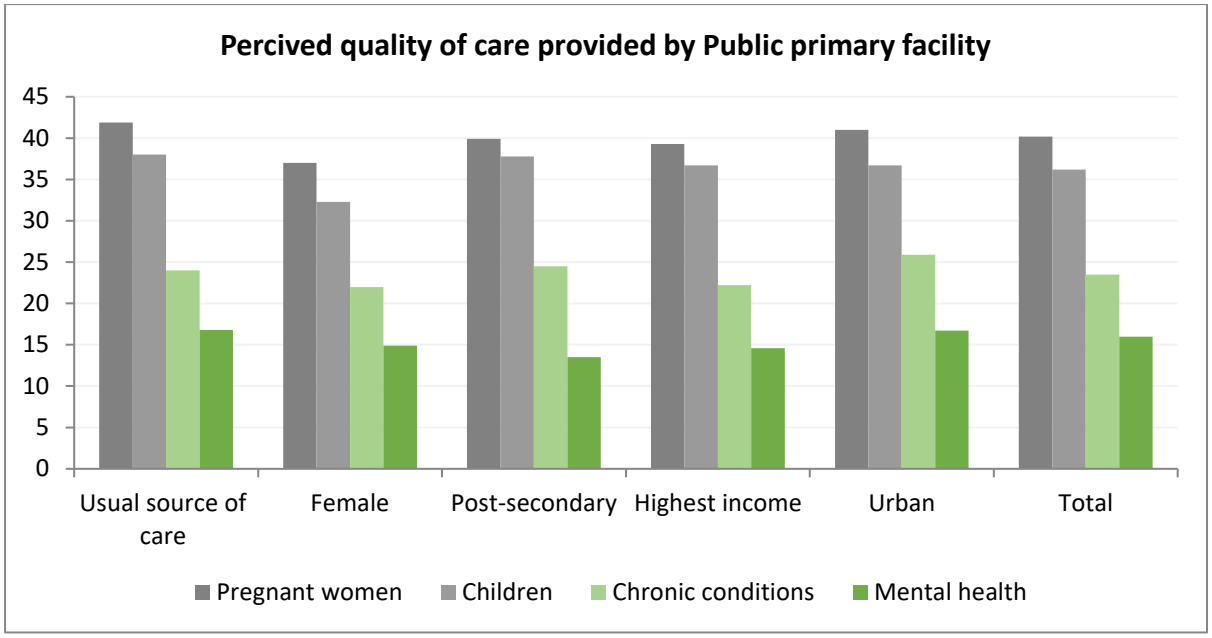


Figure 3.4-5 Proportion of respondents Perception on Quality of Public Primary Health Services rated as excellent or very good, PVS 2025

Table 3.4-8 Proportion of respondents Perception on Quality of Public Primary Health Services rated as excellent or very good by Demographic Characteristics, PVS 2025

	N	Public primary care system rating for: pregnant women	Public primary care system rating for: children	Public primary care system rating for: chronic conditions	Public primary care system rating for: mental health
Age group (Year)					
18-29	897	39.7	34.2	19.7	18.0
30-39	623	35.2	30.3	20.4	14.7
40-49	349	44.9	39.7	28.7	11.9
50-59	197	42.4	44.8	30.4	17.6
60+	247	46.1	47.1	32.8	16.6
Gender					
Male	1,143	43.4	40.3	24.8	17.2
Female	1,171	37.0	32.3	22.0	14.9
Highest level of education completed					
None (or no formal education)	1,147	37.4	37.1	18.6	16.5
Primary	708	45.5	35.4	29.7	14.6
Secondary	277	38.4	34.0	25.3	19.7
Post-secondary	183	39.9	37.8	24.5	13.5

Income group					
Lowest income	778	37.4	32.6	22.4	15.4
Middle income	758	43.8	37.3	24.0	17.6
Highest income	593	39.3	36.7	22.2	14.6
Place of Residence					
Rural	1,007	39.1	35.7	20.1	15.2
Urban	1,307	41.0	36.7	25.9	16.7
Whether respondent has a usual source of care					
No	1499	30.7	26.0	19.7	11.1
Yes	452	41.9	38.0	24.0	16.8
Total	**2314**	**40.2**	**36.2**	**23.5**	**16.0**

3.5 HEALTH SYSTEM CONFIDENCE

Table 3.5.1 presents the proportion of respondents of each demographic categories who reported confidence receiving good quality care, affording healthcare if they became very sick and the government's consideration of public opinion in healthcare decision-making. Respondents aged 18–29 reported the highest confidence in receiving good quality care (83.7%) and the ability to afford care (66%).Among those aged 60+, with 83% confident in receiving good care and the lowest confidence in affordability (40%).

Men and women reported similar confidence in receiving good care (80.6% vs. 80.4%). However, men were slightly more confident in their ability to afford care (56.3% vs. 50.5%). Confidence in their government’s consideration of public opinion was also slightly higher among men (72.3%) than women (71.1%). These patterns are consistent with previous findings, which also indicated that about half of the respondents who felt confident in affordability and public participation were men.

Respondents with no formal education had the highest confidence in receiving quality care (82.8%) and in government responsiveness (72.2%). Those with post-secondary education had the lowest confidence in receiving care (75.2%), though they reported the highest confidence in affording care (57.9%). The lowest income group reported the highest confidence in receiving quality care (84.2%) and in government consideration of public opinion (70.2%) compared to highest income group (77.9%) and (69.4%) respectively, but the lowest confidence in affording care (44.3%) compared to 54.7% in highest income group. These are consistent with previous findings, which also noted that the lowest income group had the lowest confidence in affordability but highest confidence in receiving quality care.

Rural respondents showed slightly lower confidence in receiving quality care (79.4% vs 81.4%) but higher confidence in affordability (55.2% vs 51.9%) compared to urban respondents. Confidence in government consideration of public opinion was also slightly higher in rural areas (72.2%) than urban (71.3%). This is inconsistent with previous findings which suggested that rural respondents had the highest confidence in all three categories. Respondents who had a usual source of care reported higher confidence in receiving quality care (80.9% vs. 78.9), but lower confidence in affording care (52.5% vs. 58.1%) compared to those without a usual source of care.

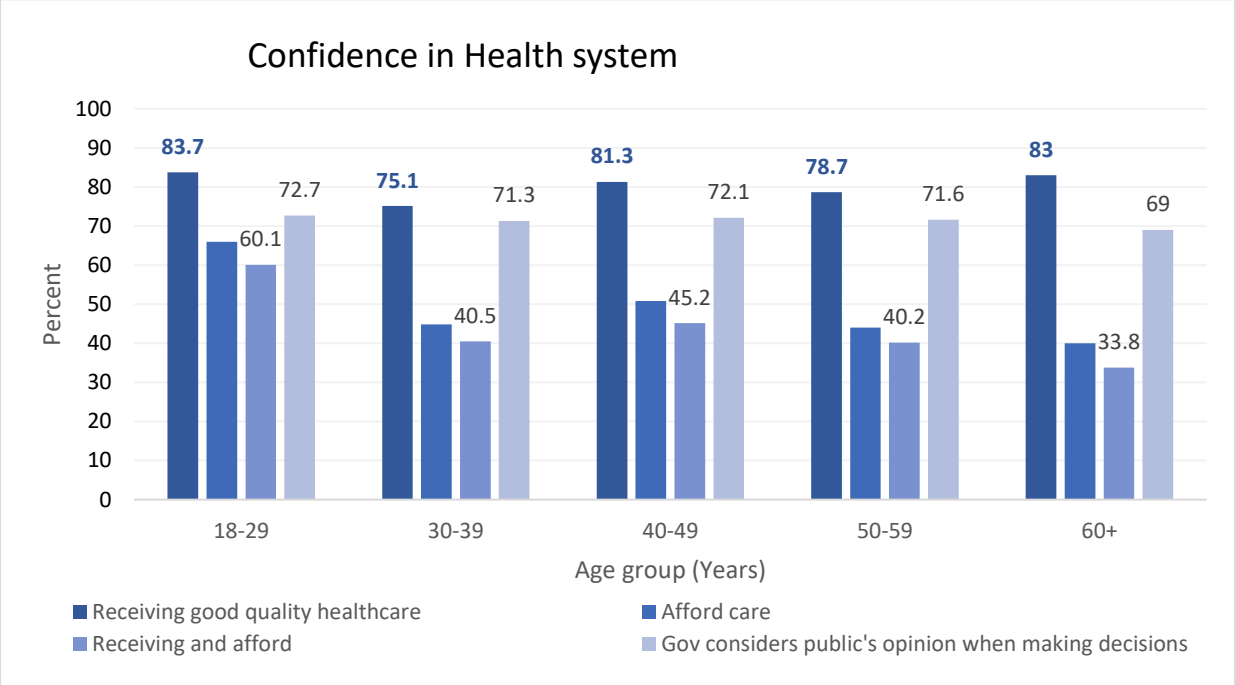


Figure 3.5-1 Proportion of respondents' confidence in health system by age group, PVS 2025

Table 3.5-1 Percent of respondents that reported confidence in receiving good quality care, in their ability to afford health care, in the government's consideration of public opinion during healthcare decision-making by background characteristics, PVs 2025

		Confidence in receiving good quality healthcare if became very sick	Confidence in ability to afford care healthcare if became very sick	Confidence in receiving and affording healthcare if became very sick	Confidence that the gov considers public's opinion when making decisions
	N	Somewhat confident/Very confident	Somewhat confident/Very confident	Somewhat confident/Very confident	
Age group (Year)					
18-29	687	83.7	66.0	60.1	72.7
30-39	436	75.1	44.8	40.5	71.3
40-49	265	81.3	50.8	45.2	72.1
50-59	152	78.7	44.0	40.2	71.6
60+	198	83.0	40.0	33.8	69.0

Gender					
Male	874	80.6	56.3	49.8	72.3
Female	864	80.4	50.5	46.5	71.1
Highest level of education completed					
None (or no formal education)	811	82.8	52.8	48.9	72.2
Primary	581	79.8	51.5	46.5	70.7
Secondary	210	76.4	57.3	49.9	72.3
Post-secondary	136	75.2	57.9	47	71.4
Income group (Q51)					
Lowest income	590	84.2	44.3	41.8	70.2
Middle income	565	81.2	64.4	58.5	74.9
Highest income	459	77.9	54.7	47.0	69.4
Place of Residence					
Rural	807	79.4	55.2	49.7	72.2
Urban	931	81.4	51.9	46.9	71.3
Whether respondent has a usual source of care					
No	169	78.9	58.1	52.3	73.5
Yes	1,570	80.9	52.5	47.5	71.5
Total	**1,738**	**80.6**	**53.3**	**48.2**	**71.8**

3.6 ENDORSEMENT: HEALTH SYSTEM TRAJECTORY OVER PAST 2 YEARS

Table 3.6.1 presents how respondents across various demographic categories perceive the performance of their health system over time, categorized into three options: getting better, staying the same and getting worse. Respondents aged 18–29 were reporting the system is getting better 68.4%, followed closely by the 30–39 (66.8%) and 60+ (67.4%) age groups. Respondents aged 50–59 expressed the most concern, with the highest proportion reporting getting worse 22.6% and the lowest rating for getting better 59%. These findings are in contrast with the previous findings which indicated the 50–59 age group had the highest getting better perception (83%), while the 60+ group had the highest getting worse rating (19.7%). Women 70.6% were more likely than men 62.6% to say the health system is getting better. In contrast, 17.8% of men believed the system is getting worse compared to only 12.8% of women. These findings are consistent with previous (Figure 3.6.1).

Respondents with secondary education 71.6% and post-secondary education 64.7% were saying the system is getting better in contrast 15% and 19.1% believing it is getting worse respectively. The current finding shows secondary education respondents had the highest

getting better perception, while the previous findings showed primary education respondent as the most positive (80.3%). Both the current and previous findings indicated secondary education as having the highest getting worse perception (15% vs.14%) respectively.

The middle- and high-income groups were more positive about health system getting better, with 67.4% and 67.8%, respectively. The lowest income group was with the lowest proportion reporting getting better 61.9% and higher perceptions of getting worse 17.5%. these finding is inconsistent with previous where higher income was associated with a smaller proportion of the group perceiving their health system as "Getting better" and a larger proportion of the group perceiving their health system as "Getting worse''. Both urban 67.1% and rural 66.1% respondents were reporting the health system is getting better which is almost similar. However, urban respondents reported, with 17% indicating the heath system is getting worse compared to 13.1% of rural residents. Previously, rural respondents were more likely to say the system is getting better (78.6%) than urban respondents (74.9%). Overall, regarding changes in the health system over time youth, women, and individuals with secondary education were reported the health system was getting better while older adults, men, and low-income groups expressed as the health system getting worse.

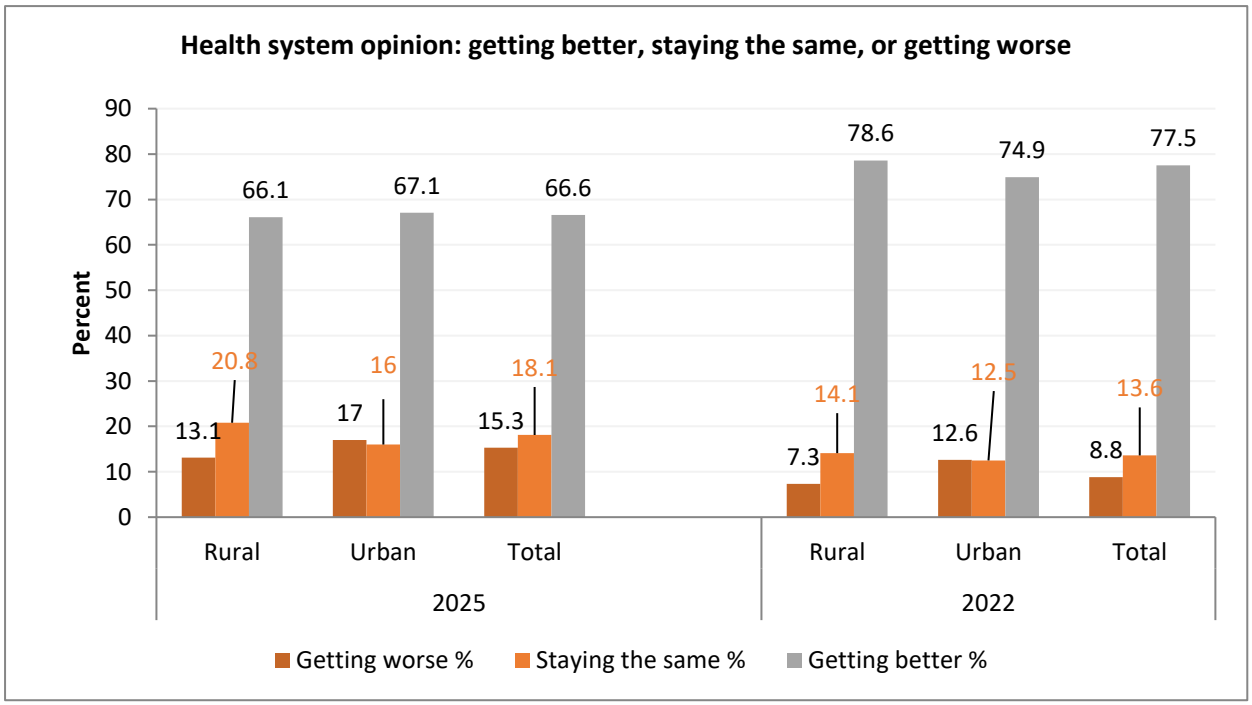


Figure 3.6-1 Respondents Health system opinion during the past two years by place of residence, PVS 2022 and 2025

Table 3.6-1 Distribution of respondent's perception of their health system over time by background characteristics, PVS 2025

	Health system opinion: getting better, staying the same, or getting worse			
	Getting worse %	Staying the same %	Getting better %	N
Age group (Year)				
18-29	12.5	19.1	68.4	565
30-39	14.5	18.8	66.8	782
40-49	19	15.5	65.5	501
50-59	22.6	18.4	59	259
60+	16.6	16.0	67.4	173
Gender				
Male	17.8	19.6	62.6	1,214
Female	12.8	16.6	70.6	1,066
Highest level of education completed				
None (or no formal education)	13.9	20.0	66.1	279
Primary	16.7	17.3	66.1	502
Secondary	15.0	13.4	71.6	624
Post-secondary	19.1	16.1	64.7	875
Income group				
Lowest income	17.5	20.6	61.9	604
Middle income	12.1	20.5	67.4	646
Highest income	17.4	14.8	67.8	882
Place of Residence				
Rural	13.1	20.8	66.1	510
Urban	17.0	16.0	67.1	1,770
Total	**15.3**	**18.1**	**66.6**	**2,280**

3.7 ENDORSEMENT: CURRENT HEALTH SYSTEM

Table 3.7.1 reveals that the highest percentage of respondents in the 40-49 age group believed that the health system needed a complete overhaul to be fixed (15.1%). The 30-39 age group had the highest percentage of respondents who believed that major changes were needed (76.3%), and the 18-29 age group with the most positive view of health system performance and the highest percentage of respondents who believed that only minor changes were needed to fix the health system (18.9%). These findings differ from those in the wave 1 assessment. The percentage of people in the 50–59 age range who said that the health

system needed a total overhaul to be improved was 27.0% during the wave 1 evaluation. These indicate that, in comparison to the wave 1 evaluation, a declining percentage of respondents believed that the health system required a comprehensive reform in order to be improved. Compared to women (9.2%), a significantly larger percentage of men (12.3%) believed the system needed a total overhaul, and a little higher percentage of men (75.4%) believed the system needed significant reforms (71.2%).

The percentage of respondents who said the system needed major adjustments has increased and varied by sex when compared to the previous assessment. Post-secondary education was linked to a lower percentage of respondents who believed the health system needed to be rebuilt entirely (6.7%) and had the highest proportion of respondents with a moderate performance evaluation (81.5%), while the primary education group had the highest percentage of positive performance evaluations (19.3). Nonetheless, the percentage of respondents from wave 1 evaluation, which was 38.6%, has decreased. In contrast to wave 1 assessment, which was the highest income group (29.6%), the middle income group had the highest percentage of respondents who had a positive evaluation of the health system's performance (17.2%). Though opinions were distributed fairly similarly across all income levels, the middle income group had a somewhat larger percentage of respondents who had favourable judgments about the performance of the health system. Compared to urban residents, who were more likely to have moderate and very favourable opinions of the health system's performance, rural residents were more likely to have very negative opinions. Overall, 73.3% of respondents rated the performance of the health system as moderate, 10.7% as unfavourable, and 16% as positive (Figure 3.7.1).

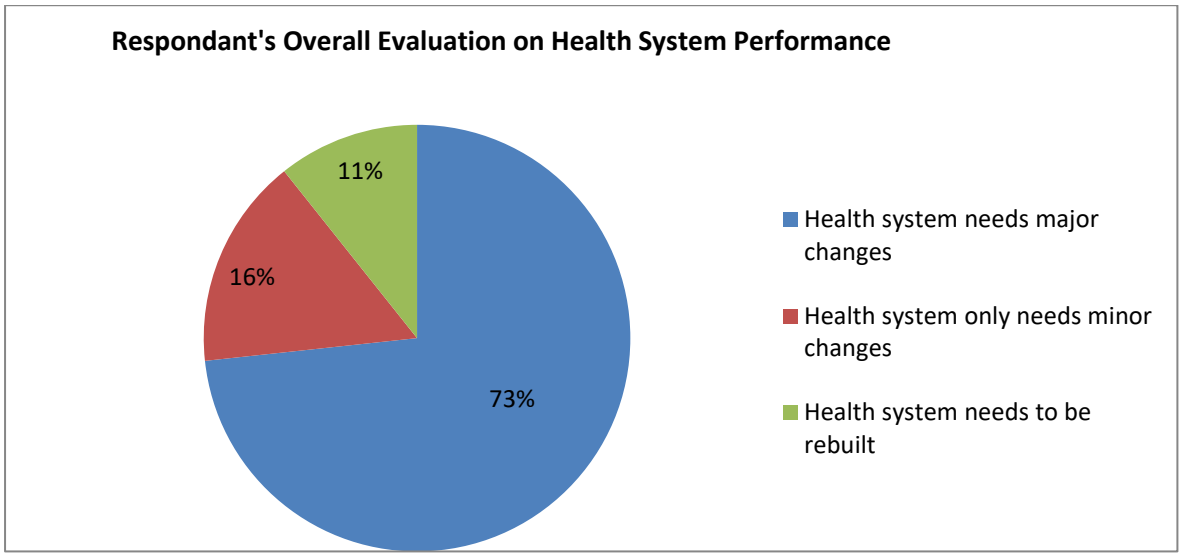


Figure 3.7-1 Percent distribution of respondents' overall assessment on the performance of the health system, PVS 2025

Table 3.7-1 Percent distribution of respondents' overall health system performance evaluation by background characteristics, PVS 2025

	Health system opinion: minor, major changes, or must be completely rebuilt			
	Health system needs to be rebuilt	Health system needs major changes	Health system only needs minor changes	N
Age group (Year)				
18-29	8.2	73.0	18.9	569
30-39	10.9	76.3	12.8	786
40-49	15.1	71.2	13.7	503
50-59	9.7	72.4	17.8	259
60+	14.4	70.5	15.1	171
Gender				
Male	12.3	75.4	12.3	1,220
Female	9.2	71.2	19.6	1,068
Highest level of education completed				
None (or no formal education)	10.8	74.3	14.9	272
Primary	11.9	68.8	19.3	504
Secondary	10.2	75.3	14.5	631
Post-secondary	6.7	81.5	11.9	881
Income group				
Lowest income	11.3	73.2	15.5	609
Middle income	9.6	73.2	17.2	649
Highest income	11.5	74.2	14.4	882
Place of Residence				
Rural	12.8	71.6	15.6	511
Urban	9.1	74.6	16.3	1,777
Total	**10.7**	**73.3**	**16.0**	**2,288**

3.8 EXPECTATIONS FOR HEALTH SYSTEM QUALITY

Table 3.8.1 shows that, in contrast to wave 1 assessment, which was in the 60+ age group (91.7%), the 30-39 age group had the largest percentage of respondents rating the quality as "Poor" (82.5%), while the 50-59 age group had the lowest percentage of respondents rating the quality as "Poor" (71.9%). The largest percentage of respondents who rated the quality as "Good" or "Excellent" were in the 50–99 age range. Compared to male respondents (74.6%), female respondents had a somewhat greater percentage of "Poor" judgments (78.3%). With

the largest percentage of "Poor" ratings (80.7%), the post-secondary education group had the most unfavourable evaluations of quality. The distribution of assessments at every educational level is close to that of wave 1. The distributions of quality assessment scores were most negatively skewed for the groups with no formal education and primary education, respectively. The middle-income group had the highest number of "Poor" assessments (80.1%). In contrast to the wave 1 assessment, which was given to the high-income group, the low-income group had the highest percentage of "Excellent" assessment (2.7%).Rural respondents were more likely than urban respondents to rate the low-quality vignette negatively, with a larger percentage of respondents selecting the "Poor" grade (78.9%). It does, however, indicate a little shift from the 84.6% found in the prior evaluation. 76.4% of respondents said the low-quality scenario was "poor," 9.6% thought it was "fair," 5.2% thought it was "good," 6.9% thought it was "very good," and 1.9% thought it was "excellent." According to the current findings, there has been a discernible change since the last quality assessment.

Table 3.8-1 Percent distribution of quality assessment ratings for a low-quality care description (vignette) by Background characteristics, PVS 2025

	Rating of vignette (poor care)					
	Poor	Fair	Good	Very Good	Excellent	N
Age group (Year)						
18-29	75.1	9.9	3.4	8.9	2.6	896
30-39	82.5	8.7	5.2	2.6	1.0	611
40-49	74	8.5	7.3	9.1	1.0	345
50-59	71.9	11.9	8.7	4.6	2.9	192
60+	73	10.6	5.7	8.4	2.4	246
Gender						
Male	74.6	10.2	5.3	7.2	2.8	1,125
Female	78.3	9.1	5.1	6.5	1.1	1,165
Highest level of education completed						
None (or no formal education)	77.1	7.2	5.4	7.9	2.4	1,129
Primary	74.3	12.6	4.7	6.6	1.8	703
Secondary	76.4	12.6	5.6	4.1	1.3	275
Post-secondary	80.7	8.7	4.6	5.2	0.8	182
Income group						
Lowest income	70.7	9.2	6.6	10.8	2.7	774
Middle income	80.1	6.9	3.9	7.4	1.8	757
Highest income	79.6	14.1	3.0	2.2	1.1	580
Place of Residence						
Rural	78.9	8.7	3.0	7.8	1.6	1,001
Urban	74.5	10.3	6.8	6.1	2.2	1,289
Total	**76.4**	**9.6**	**5.2**	**6.9**	**1.9**	**2,290**

As seen in Table 3.8.2 the 60+ age group had the largest percentage of "poor" ratings (8.1%), while the 18–29 age group had the highest percentage of "Excellent" or "Very Good" evaluations (23.2% & 37.5%, respectively). The rating distributions for men and women were similar, with somewhat more men selecting "Fair" (13.4%) and "Good" (28.2%) than women. However, women selected "Very Good" (33.7%) and "Excellent" (20.6%) slightly more frequently than men. The highest percentage of "Excellent" assessments (22.4%) and "Very Good" assessments (37.9%) were seen among people with only a primary school education and those without any formal education, respectively. The largest percentage of "Poor" assessments (8.2%) was seen in the post-secondary education group. Additionally, the "Very Good" rating was most frequently chosen by all income categories. The highest percentage of "Very Good" and "Excellent" ratings were found in the middle income group (42.7% and 20.3%, respectively), whereas the highest percentage of "Poor" and "Fair" assessments were found in the lowest income group (8.9% and 14.5%, respectively). The vignette quality was most frequently rated as "Very Good" (37.8%) and "Excellent" (27.9%) by rural residents and as "Good" (32.7%) by urban respondents. Overall, "Very Good" (33.6%) was the most often given evaluation, followed by "Good" (27.0%) and "Excellent" (19.5%).

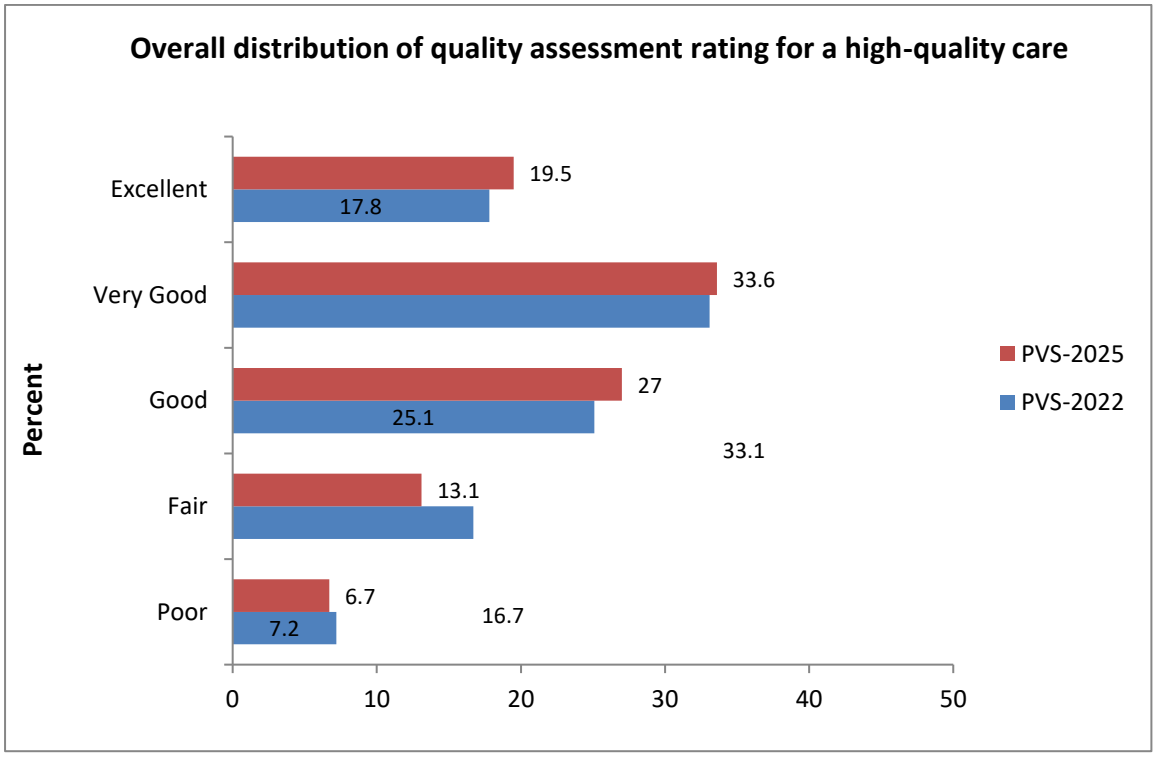


Figure 3.8-1 Overall distribution of quality assessment ratings for a high-quality care during phase 1 and phase 2 assessments

Table 3.8-2 Distribution of quality assessment ratings for a high-quality care description (vignette) by background characteristics, PVS 2025

	Rating of vignette (good care)					
	Poor	Fair	Good	Very Good	Excellent	N
Age group (Year)						
18-29	6.5	10.4	22.3	37.5	23.2	896
30-39	6.8	13.2	30.2	31.4	18.5	619
40-49	7.3	13.4	25.3	34.9	19.1	345
50-59	5.1	13.7	39.3	27.8	14.0	194
60+	8.1	21.7	28.9	27.8	13.5	242
Gender						
Male	6.4	13.4	28.2	33.5	18.5	1,132
Female	7.1	12.8	25.8	33.7	20.6	1,163
Highest level of education completed						
None (or no formal education)	6.6	11.6	25.3	37.9	18.6	1,133
Primary	7.8	14.9	27.7	27.2	22.4	706
Secondary	3.7	12.6	31.8	34.5	17.4	275
Post-secondary	8.2	15.9	28.1	30.6	17.2	182
Income group						
Lowest income	8.9	14.5	29.9	29.4	17.2	775
Middle income	4.3	8.7	24.0	42.7	20.3	757
Highest income	8.2	18.0	24.5	31.2	18.0	586
Place of Residence						
Rural	5.8	8.8	19.6	37.8	27.9	1,001
Urban	7.5	16.4	32.7	30.4	13.0	1,294
Total	**6.7**	**13.1**	**27.0**	**33.6**	**19.5**	**2,295**

4. CONCLUSION

The study paints a nuanced picture of the current health landscape, highlighting significant disparities across demographic groups. Younger adults (30–39 years) tend to report higher levels of both physical and mental health, paired with greater confidence in managing their health and a preference for private care options. Conversely, older populations, especially those over 60, report poorer health outcomes, increased longstanding health issues, and more reliance on inpatient services. These patterns underscore the natural decline in health status with age, but also point to socioeconomic influences, such as lower education and income levels, being associated with worse health and limited access to quality care. Urban residents generally report better health outcomes and higher satisfaction with healthcare

experiences, though disparities persist, particularly in perceptions of care for vulnerable groups like pregnant women, children, and individuals with mental health needs.

Mental health and chronic illness management reveal stark differences in service perception and access. Women and rural residents tend to report poorer mental health, emphasizing the need for targeted mental health infrastructure and community-based support services. Despite improvements in preventive care participation—such as mammograms and blood pressure screenings—disparities remain, especially among younger, less educated, and rural populations who face barriers like cost and limited facility availability. Moreover, reports of medical errors and discrimination, although showing mixed trends, raise concerns about patient safety and equity, particularly among younger adults, men, and rural residents. These issues highlight the importance of strengthening healthcare quality and fostering respectful, stigma-free environments to improve patient trust and satisfaction.

An encouraging trend from the data is the shift toward private healthcare, with a decline in reliance on public facilities, especially among middle-aged groups and urban dwellers who prioritize convenience and perceived quality. Patients generally rate their care positively, with private providers receiving higher satisfaction scores, which correlates with perceptions of better provider competence and hospital readiness. However, challenges remain, notably longer wait times and lower satisfaction among older adults and low-income groups, indicating ongoing barriers to equitable access. Perceptions of the health system's progress are mixed; younger populations and women are more optimistic, while older adults and lower-income groups perceive little improvement or stagnation. Efforts to address these gaps—through enhancing mental health services, reducing financial barriers, and ensuring equitable resource distribution—are essential to advancing a more inclusive, patient-centered health system.

5. REFERENCES

1. Kruk ME, Gage AD, Joseph NT, Danaei G, García-Saisó S, Salomon JA. Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries. Lancet. 2018;392(10160):2203–12.

2. Rowe AK, Rowe SY, Peters DH, Holloway KA, Chalker J, Ross-Degnan D. Effectiveness of strategies to improve health-care provider practices in low-income and middle-income countries: a systematic review. Lancet Glob Heal [Internet]. 2018;6(11):e1163–75. Available from: http://dx.doi.org/10.1016/S2214-109X(18)30398-X

3. Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, Roder-DeWan S, et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. Lancet Glob Heal. 2018;6(11):e1196–252.

4. Doyle C, Lennox L, Bell D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. BMJ Open. 2013 Jan;3(1).

5. Ministry of Health (MoH). Health Sector Transformation Plan II 2020/2021-2024/2025. Addis Ababa, Ethiopia: MoH, Addis Ababa, Ethiopia; 2021. 1–128 p.

6. World Health Organization (WHO). Framework on integrated people-centred health services. Report by the Secretariat. World Health Organization. Sixty-ninth World Health Assembly.WHA69.39. Sixty-Ninth World Heal Assem. 2016;Provisiona(April):1–12.

7. Rockers PC, Kruk ME, Laugesen MJ. Perceptions of the health system and public trust in government in low- and middle-income countries: evidence from the World Health Surveys. J Health Polit Policy Law. 2012 Jun;37(3):405–37.

8. Valentine N, Verdes-Tennant E, Bonsel G. Health systems' responsiveness and reporting behaviour: Multilevel analysis of the influence of individual-level factors in 64 countries. Soc Sci Med. 2015 Aug;138:152–60.

9. Lewis TP, Kapoor NR, Aryal A, Bazua-Lobato R, Carai S, Clarke-Deelder E, et al. Measuring people's views on health system performance: Design and development of the People's Voice Survey. PLoS Med. 2023 Oct;20(10):e1004294.

10. Kruk ME, Kapoor NR, Lewis TP, Arsenault C, Boutsikari EC, Breda J, et al. Population confidence in the health system in 15 countries: results from the first round of the People's Voice Survey. Lancet Glob Heal [Internet]. 2024;12(1):e100–11. Available from: https://www.sciencedirect.com/science/article/pii/S2214109X23004990

11. EPHI/MOH/AAU/HARVARD. People ' s Voice Survey - Assessment of People ' s Perspective on Health System Performance in Ethiopia. 2023;(May).

6. BOX 1. WHO HEALTH SYSTEM PERFORMANCE ASSESSMENT FRAMEWORK DOMAINS AND CORRESPONDING PEOPLE'S VOICE SURVEY INDICATORS.

Intermediate objectives Care effectiveness: (i) public health effectiveness: percentage of respondents aged ≥ 40 years who had both a blood pressure and blood sugar test in the past year; (ii) quality of own care: percentage of respondents rating quality of care of most recent visit in past 12 months as very good or excellent; and (iii) quality of primary care services: average percentage of respondents rating three core primary care services (child, maternal, chronic disease) as very good or excellent.

User experience: (i) respect: percentage of respondents rating respect that provider showed them and courtesy of office staff in most recent visit as very good or excellent, and who experienced no discrimination in health care; (ii) voice: percentage of respondents rating their desired level of involvement in their health care and their health-care provider's explanation as very good or excellent; and (iii) customer service: percentage of respondents rating wait time and time spent with provider (as well as time waiting for appointment in six countries with appointment systems) as very good or excellent.

Access: (i) connection to health system: percentage of respondents with usual source of care; (ii) use of needed health care: percentage of respondents with chronic disease who used care at least once in past year; and (iii) no unmet need: percentage of respondents with no unmet health care needs in past year.

Final goals People-centredness: (i) quality of public health system: percentage of respondents rating quality of the country's public health system as very good or excellent; (ii) quality of private health system: percentage of respondents rating quality of the country's private health system as very good or excellent; (iii) endorsement: percentage of respondents reporting that the health system works well as it is/needs only minor change; and (iv) involvement in decision-making: percentage of respondents rating that government considers public opinion as very good or excellent.

Health improvement: (i) self-rated health: percentage of respondents reporting their overall health as very good or excellent; (ii) self-rated mental health: percentage of respondents reporting their mental health as very good or excellent; and (iii) absence of disease: percentage of respondents who do not have a chronic/longstanding condition.

Financial protection: (i) insurance: percentage of respondents with any health insurance (public, private, other); and (ii) health security (affordability): percentage of respondents who are somewhat or very confident they can get and afford good care if they are sick.

7. ANNEX TOOL

People's Voice Survey

Introduction

Good morning/afternoon/evening. My name is [YOUR NAME] and I work for [ADD COMPANY NAME]. We are carrying out research on people's use of health services and their opinions about healthcare in different countries. Your answers will be used to assess the performance of the health system in your country and to inform health system planning in the future. There are no right or wrong answers, and please be assured that the information collected from you will be treated completely confidentially. Your answers will be combined with information from other participants and only the total results will be used for reporting. Taking part is voluntary and you can change your mind at any time. The interview will last approximately 20 minutes. [CATI ONLY: For quality assurance, this phone call may be monitored and recorded.]

[COUNTRY-SPECIFIC ETHICAL APPROVAL REQUIREMENTS]

Are you happy to proceed with the interview?

DO NOT READ ANSWER OPTIONS.
Yes

No
INTERVIEWER: ADD IF ASKED BY THE RESPONDENT.

DATA PRIVACY/ DATA PROTECTION: If you would like to read the Data Protection Notice, you can access it at (ADD WEBSITE). This explains the purposes for processing your personal data as well as your rights under data protection law.

WHAT PERSONAL DATA WILL BE COLLECTED: Your gender, area where you live and age will be collected, as well as personal data from your replies to the interview questions. All of the information you provide will remain confidential, and no personal data will be shared in any way

WHO IS OUR CLIENT: Our client is the QuEST Network, a research collaboration between [INSERT ORGANIZATION HERE (eg, KEMRI)] and Harvard University, a university and non-profit institution based in the United States of America.

If CATI: HOW DID YOU GET MY NUMBER: Your telephone number has been randomly generated by a computer, like all numbers we dial for this research. Our aim is to interview a representative sample of [COUNTRY'S] population.

IF CAPI: HOW DID YOU GET MY ADDRESS: Your address has been randomly selected from a list of locations available from the census data. Our aim is to interview a representative sample of the [COUNTRY'S] population

SECTION 1: DEMOGRAPHICS AND HEALTH STATUS

1.1 BASIC DEMOGRAPHICS

Item	Response option	Notes
1.1 Basic demographics		
Q1. What is your age?	_ _ _ _ 998 (DO NOT READ) DON'T KNOW 999 (DO NOT READ) REFUSED	
IF Q1 UNKNOWN OR REFUSED: continue to Q2 Otherwise, skip Q2		
Q2. Could you please tell me if your age is being …? (Years)	0 Under 18 1 18 to 29 2 30 to 39 3 40 to 49 4 50 to 59 5 60 to 69 6 70 to 79 7 80 or older 999 (DO NOT READ) REFUSED	
Q3. What is your **gender**?	1. Male 2. Female 999 (DO NOT READ) REFUSED	
Q4. What REGION do you live in?	1 Tigray 2 Afar 3 Amhara 4 Oromia 5 Somali 6 South Ethiopia 7 Benshangul Gumuz 8 Gambella 9 Harari 10 Addis Ababa 11 Dire Dawa 12 Sidama 13 South West Ethiopia 14 Central Ethiopia 999 (DO NOT READ) REFUSED	
Q5. Permanent residential /Location?	1 City	

	2 Small town 3 Rural area 999 (DO NOT READ) REFUSED	
Q6.Do you have health insurance?	0 Yes 1. No 999 (DO NOT READ) REFUSED	
Q7.What type of health insurance do you have?	1 Health insurance through your or someone else's employer or union 2 Community-based health insurance 3 Private health insurance 4 Other (specify) 999 (DO NOT READ) REFUSED	
Q8. What is the highest level of education that you have completed?	1. Never attended school or only kindergarten 2. Grades 1 through 8 (elementary) 3 Secondary School (GRADES 9-12) 4 Above secondary school (such as College diploma/TVET) 999 (DO NOT READ) REFUSED	
1.2 Health Status		
Q9. In general, would you say your health is:	1. Excellent 2. Very good 3. Good 4. Fair 5. Poor 999 (DO NOT READ) REFUSED	
Q10. In general, would you say your mental health, including your mood and your ability to think, is:	1. Excellent 2. Very good 3. Good 4. Fair 5. Poor 999 (DO NOT READ) REFUSED	
Q11. Do you have any longstanding illness or health problem (by longstanding I mean illness or health problem which have lasted or are expected to last for 6 months or more)	1 Yes 0 No 999 (DO NOT READ) REFUSED	
1.3 Patient Activation		

Q12. SHOW FOR FIRST ITEM: When you think about your health, how confident are you that (INSERT ITEM)? READ LIST AS NECESSARY. a. you are the person who is responsible for managing your overall health? b. you can tell a healthcare provider concerns you have even when he or she does not ask?	3 Very confident 2 Somewhat confident 1 Not too confident 0 Not at all confident 999 (DO NOT READ) REFUSED	

SECTION 2: UTILIZATION OF CARE AND SYSTEM COMPETENCE

Item	Response options	Notes
2.1 Usual source of care		
Interviewer READ: would now like to know about your recent experiences with obtaining healthcare from the healthcare system.		
Q13. Is there one healthcare provider's group, health center or clinic you usually go to for most of your medical care?	1 Yes 0 No 999 (DO NOT READ) REFUSED 999 (DO NOT READ) REFUSED	
Q14. Is this a public, private, social security, NGO, or faith-based facility?	1. Public 2. Private 3. NGO or faith-based 4. Other (specify) 999 (DO NOT READ) REFUSED	
Q15. What type of healthcare facility is this? Interviewer: allow respondent to answer, do not read response options. Use response card for assigning responses to category. If response does not fit into options below as listed, probe: suggest possible type from list, ask is this health facility run by the government? Are the providers general care providers? Specialists?	SHOW IF Q14 = 1 1 Health post 2 Health center 3 Hospital SHOW IF Q 14 = 2 1. Lower clinic 2. Medium clinic 3. Higher clinic/specialty clinic 4. Hospital/specialty center SHOW IF Q14 = 3 1 NGO/Faith-based health center/clinic 2 NGO/Faith-based hospital 3 Other, specify	

	999 (DO NOT READ) REFUSED	
Q16. Why did you choose this healthcare facility? Please [IF CATI/CAPI: tell us; IF WEB: indicate] the main reason.	1 Low cost 2 Short distance 3 Short waiting time 4 Good healthcare provider skills 5 Staff shows respect 6 Medicines and equipment are available 7 Only facility available 8 Covered or assigned by insurance 9 Other (specify) 999 (DO NOT READ) REFUSED	
Q17. Overall, how would you rate the quality of medical care you received in the past 12 months from this healthcare provider/facility	4 Excellent 3 Very good 2 Good 1 Fair 0 Poor 5 I did not receive healthcare from this provider in the past 12 months 999 (DO NOT READ) REFUSED	
2.2 Utilization		
Interviewer READ: We are interested to hear about your use of health services in the past 12 months. Please answer about your own experience only. First, we will talk about only in-person visits (where you went to see a provider at a facility).		
Q18. How many healthcare visits in total have you made in the past 12 months? This includes in-person visits with health providers including dental visits. Do not include any overnight stays in hospital or virtual visits. Do not include self-testing or treatment at home or in pharmacies or shops.	1 ___ [ENTER NUMBER 0-365] 998 DO NOT READ) DON'T KNOW 999 (DO NOT READ) REFUSED	
(ASK IF Q18=998,999; DON'T KNOW OR REFUSED) **Q19. Could you please [IF CATI/CAPI: tell me; IF WEB: indicate] if the total number of healthcare visits you have made in the past 12 months is:**	1 0 2 1-4 3 5-9 4 10 or more 999 (DO NOT READ) REFUSED	
(ASK IF Q18>1 VISIT OR Q19=2,3,4; HAD AT LEAST TWO VISITS IN THE PAST 12 MONTHS)	1 Yes 0 No 999 (DO NOT READ) REFUSED	

Q20. You said you made [ENTER RESPONSE FROM Q18 OR Q19] visits. Were they all to the same healthcare facility?		
(ASK IF Q20=0; ALL VISITS WERE NOT TO THE SAME FACILITY) (IF Q18>1 VISIT: DO NOT ALLOW NUMBER GREATER THAN Q18; IF Q19=2: DO NOT ALLOW NUMBER GREATER THAN 4; IF Q19=3: DO NOT ALLOW NUMBER GREATER THAN 9) (DO NOT ALLOW NUMBER LESS THAN 2) Now we would like to ask you about home visits and virtual visits you had with healthcare providers. **Q21. How many different healthcare facilities did you go to in total?**	1 ___ [ENTER NUMBER 2-30] 998 (DO NOT READ) DON'T KNOW 999 (DO NOT READ) REFUSED	
Q22. How many visits did you have with a healthcare provider at your home in the past 12 months?	1 ___ [ENTER NUMBER 0-365] 998 (DO NOT READ) DON'T KNOW 999 (DO NOT READ) REFUSED	
Q23. How many virtual or telemedicine visits did you have in the past 12 months? READ IF NECESSARY: A telemedicine visit is when you use a phone or computer to have a visit with a healthcare provider rather than going to the healthcare facility in person. This could be for physical or mental health. It does not include scheduling visits by phone or computer if you then go in person to the healthcare facility to meet with the provider.	1 ___ [ENTER NUMBER 0-365] 998 (DO NOT READ) DON'T KNOW 999 (DO NOT READ) REFUSED	
(ASK IF Q23>0 VISITS; AT LEAST 1 VIRTUAL VISIT IN PAST 12 MONTHS) **Q24. What was the main reason for your last virtual or telemedicine visit?** IF CATI/CAPI: READ LIST.	1 Care for an urgent or new health problem such as an accident or injury or a new symptom like fever, pain, diarrhea, or depression. 2 Follow-up care for a longstanding illness or chronic disease such as hypertension or diabetes. This may include mental health conditions. 3 Preventive care or a visit to check on your health, such as an annual check-up, antenatal care, or vaccination. 4 Other (specify) 999 (DO NOT READ) REFUSED	
(ASK IF Q23>0 VISITS; AT LEAST 1 VIRTUAL VISIT IN PAST 12 MONTHS) **Q25. Thinking about your last virtual or telemedicine visit, how would you rate the overall quality of care you received?**	IF NECESSARY: Is that excellent, very good, good, fair, or poor? 4 Excellent 3 Very good 2 Good 1 Fair 0 Poor 999 (DO NOT READ) REFUSED	

Q26. In the past 12 months did you stay overnight at a healthcare facility as a patient?	1 Yes 0 No 999 (DO NOT READ) REFUSED	
	2.3 SYSTEM COMPETENCE IN POPULATION HEALTH	
(ASK ALL A,D,E,F,G,H; ASK B AND C IF Q3=1; FEMALE) **Q27. SHOW FOR FIRST ITEM: Please [IF CATI/CAPI: tell me, IF WEB: indicate] if you have received any of the following health services in the past 12 months from any healthcare provider. First, have you [INSERT ITEM]?** SHOW FOR SUBSEQUENT ITEMS Next, have you [INSERT ITEM]? IF NECESSARY: Have you had this service in the past 12 months from any healthcare provider? a. had your blood pressure tested b. received a mammogram (this is a special X-ray of the breast) c. received cervical cancer screening, like a pap test or visual inspection (this is checking for cancer of the cervix through a vaginal exam) d. had your eyes or vision checked e. had your teeth checked f. had a blood sugar test g. had a blood cholesterol test (this is checking for fat in the blood) h. received care for depression, anxiety, or another mental health condition (which may include feeling sad or worried a lot of the time)	1 Yes 0 No 998 (DO NOT READ) DON'T KNOW 999 (DO NOT READ) REFUSED	
Q28. SHOW FOR FIRST ITEM: Thinking about the last 12 months, have any of the following events happened to you personally? First, have you [INSERT ITEM]? Next, have you [INSERT ITEM]? a. thought a medical mistake was made in your treatment or care (this could include a wrong diagnosis, incorrect type or amount of medication, or inappropriate sharing of private health information) b. been treated unfairly or discriminated against by a doctor, nurse, or another healthcare provider	1 Yes 0 No 999 (DO NOT READ) REFUSED	
2.4 Non-use of care		
Q29. In the past 12 months, did you have a health problem and needed medical attention, but you did not get health care?	1 Yes 0 No 999 (DO NOT READ) REFUSED	

Q30. The last time this happened, what were the reasons you did not seek care? [INTERVIEWER NOTE: DO NOT READ OUT. PROBE TO CODE. SELECT ONLY ONE ANSWER. THIS IS THE MAIN REASON THE RESPONDENT DID NOT GET HEALTHCARE, NOT THE MAIN REASON THEY NEEDED MEDICAL ATTENTION.]	1 High cost (e.g., high out of pocket payment, not covered by insurance) 2 Far distance (e.g., too far to walk or drive, transport not readily available) 3 Long wait time (e.g., long line to access facility, long wait for the provider) 4 Poor healthcare provider skills (e.g., spent too little time with patient, did not conduct a thorough exam) 5 Staff don't show respect (e.g., staff is rude, impolite, dismissive) 6 Medicines and equipment are not available (e.g., medicines regularly out of stock, equipment like X-ray machines broken or unavailable) 7 Illness not serious enough 8 Other (specify) 999 (DO NOT READ) REFUSED 999 BLANK	
Q31. SHOW FOR FIRST ITEM: Sometimes people have difficulty affording healthcare. First, in the past 12 months, have you ever [INSERT ITEM]? SHOW FOR NEXT ITEM: Next, have you ever needed to [INSERT ITEM]? a. borrow money from family, friends, banks, or other moneylenders to pay for healthcare b. sell items such as furniture or jewelry to pay for healthcare	1 Yes 0 No 999 (DO NOT READ) REFUSED	

SECTION 3: CARE AT THE LAST VISIT

Item	Response options	Notes
3.1 CARE COMPETENCE AND USER EXPERIENCE		
IF Q18>0 VISITS OR Q19=2,3,4 HAD AT LEAST ONE VISIT IN THE PAST 12 MONTHS)		

Interviewer READ: The following questions are about your experiences in your last health care visit for a new or ongoing health problem or a regular checkup (please do not include emergencies or hospital admissions) Interviewer: In-person care only. Includes preventive care, routine care, chronic care, antenatal care *Excludes: surgery, accident, trauma, emergency room visits,*		
(ASK IF Q18>0 VISITS OR Q19=2,3,4; HAD AT LEAST ONE VISIT IN THE PAST 12 MONTHS) **Q32. Was this a public, private, social security, NGO, or faith-based facility?** *Do not read response options.* PROBE TO CODE.	1 Public 2 Private 3 NGO or faith-based 4 Other (specify)	
(ASK IF Q18>0 VISITS OR Q19=2,3,4; HAD AT LEAST ONE VISIT IN THE PAST 12 MONTHS) **Q33. What type of healthcare facility was this?** READ LIST AS NECESSARY.	SHOW IF Q32= 1 1 Health post 2 Health center 3 Hospital SHOW IF Q 32 = 2 1 Lower clinic 2 Medium clinic 3 Higher clinic/specialty clinic 4 Hospital/specialty center SHOW IF Q32 = 3 1 NGO/Faith-based health center/clinic 2 NGO/Faith-based hospital 3 Other, specify	
(ASK IF Q18>0 VISITS OR Q19=2,3,4; HAD AT LEAST ONE VISIT IN THE PAST 12 MONTHS) **Q34. What was the main reason you went?** READ LIST.	1 Care for an urgent or new health problem such as an accident or injury or a new symptom like fever, pain, diarrhea, or depression. 2 Follow-up care for a longstanding illness or chronic disease	

	such as hypertension or diabetes. This may include mental health conditions. 3 Preventive care or a visit to check on your health, such as an annual check-up, antenatal care, or vaccination. 4 Other (specify) 999 (DO NOT READ) REFUSED	
(ASK IF Q18>0 VISITS OR Q19=2,3,4; HAD AT LEAST ONE VISIT IN THE PAST 12 MONTHS) **Q35. Did you go to the facility without an appointment, or did you need to make an appointment in advance?**	1 I made an appointment 0 I went without an appointment 999 (DO NOT READ) REFUSED	
(ASK IF Q35=1; HAD AN APPOINTMENT IN THE PAST 12 MONTHS) **Q36. How long did you wait in days, weeks, or months between making the appointment and seeing the health care provider?** INTERVIEWER: DO NOT READ. PROBE TO CODE.	1 Same or next day 2 2 days to less than one week 3 1 week to less than 2 weeks 4 2 weeks to less than 1 month 5 1 month to less than 2 months 6 2 months to less than 3 months 7 3 months to less than 6 months 8 6 months or more 999 (DO NOT READ) REFUSED	
(ASK IF Q18>0 VISITS OR Q19=2,3,4; HAD AT LEAST ONE VISIT IN THE PAST 12 MONTHS) **Q37. At this most recent visit, once you arrived at the facility, approximately how long did you wait before seeing the provider?** Please do not include wait time for other parts of the visit such as lab tests, X-rays, or trips to the pharmacy. IF CODE 7>8 hours READ/DISPLAY: Are you sure it was [enter number] hours? IF CATI/CAPI: INTERVIEWER: DO NOT READ. PROBE TO CODE	1 Less than 15 minutes 2 15 minutes to less than 30 minutes 3 30 minutes to less than 1 hour 4 1 hour to less than 2 hours 5 2 hours to less than 3 hours 6 3 hours to less than 4 hours 7 More than 4 hours (specify) 999 (DO NOT READ) REFUSED	
(ASK IF Q18>0 VISITS OR Q19=2,3,4; ASK ITEM K IF Q35=1; HAD AT LEAST ONE VISIT IN THE PAST 12 MONTHS) **Q38. SHOW FOR FIRST ITEM: Thinking about this last visit, how would you rate the following? First, [INSERT ITEM]. IF CATI/CAPI: Is that excellent, very good, good, fair, or poor?**	4 Excellent 3 Very good 2 Good 1 Fair 0 Poor	

READ IF NECESSARY: Is that excellent, very good, good, fair, or poor? a. the overall quality of care you received b. the knowledge and skills of your provider c. the equipment and supplies that the provider had available, such as medical equipment or lab tests d. the level of respect your provider showed you e. whether your provider knew about your prior visits and test results f. whether your provider explained things in a way you could understand g. whether your provider involved you as much as you wanted to be in decisions about your care h. the amount of time your provider spent with you i. the amount of time you waited before being seen j. the courtesy and helpfulness of the healthcare facility staff, other than your provider k. how long it took for you to get this appointment	5 I have not had prior visits or tests 6 The clinic had no other staff 999 (DO NOT READ) REFUSED	
3.2 FACILITY ENDORSEMENT		
(ASK IF Q18>0 VISITS OR Q19=2,3,4; HAD AT LEAST ONE VISIT IN THE PAST 12 MONTHS) **Q39. Using a scale from zero to ten, where zero means you definitely would not recommend and ten means you definitely would recommend, how likely is it that you would recommend this healthcare provider or facility to a friend or family member?**	1 ___ [INSERT SCALE 0-10] 999 (DO NOT READ) REFUSED	

SECTION 4: HEALTH SYSTEM CONFIDENCE

Item	Response	Notes
4.1 ASSESSMENT OF THE PUBLIC HEALTH SYSTEM		
(ASK ALL) **Q40. For the next set of questions, we are interested in your views on public primary care services in [COUNTRY]. In your opinion, how would you rate the quality of care provided for the following services?** Please answer even if you have not used these services. We are interested in your opinions and perceptions from anything you may have seen or heard, even if you have not experienced these services yourself.	4 Excellent 3 Very good 2 Good 1 Fair 0 Poor 5 I am unable to judge (DO NOT READ) 999 (DO NOT READ) REFUSED	

First, [INSERT ITEM]. IF CATI/CAPI: Is that excellent, very good, good, fair, or poor? How about [INSERT ITEM]? READ IF Is that excellent, very good, good, fair, or poor? How would you rate the quality of [INSERT ITEM]? a. care for pregnant women, like antenatal care or prenatal care b. care for children, like well-child care and care for sick children c. care for ongoing or chronic conditions, like hypertension or diabetes d. care for mental health conditions, like depression or anxiety		
4.2 OVERALL HEALTH SYSTEM ASSESSMENT		
Q41. SHOW FOR FIRST ITEM: Now we would like to hear your thoughts on the healthcare system in your country as a whole, including public, private, and other healthcare facilities and providers. How confident are you that [INSERT ITEM]? IF CATI/CAPI: Is that very confident, somewhat confident, not too confident, or not at all confident? What about that [INSERT ITEM]? READ IF NECESSARY: Is that very confident, somewhat confident, not too confident, or not at all confident? a. you would receive good quality healthcare if you became very sick b. you would be able to afford the healthcare you needed if you became very sick c. the government considers the public's opinion when making decisions about the healthcare system	3 Very confident 2 Somewhat confident 1 Not too confident 0 Not at all confident 999 (DO NOT READ) REFUSED	
(ASK ALL) **Q42. SHOW FOR FIRST ITEM: Overall, how would you rate the quality of the government or public healthcare system in your country? Please answer even if you have not used these services.** READ IF NESSECARY: Is that excellent, very good, good, fair, or poor?	4 Excellent 3 Very good 2 Good 1 Fair 0 Poor 999 (DO NOT READ) REFUSED	
(ASK ALL) **Q43. Overall, how would you rate the quality of the private for-profit healthcare system in your country? Please answer even if you have not used these services.**	4 Excellent 3 Very good 2 Good 1 Fair	

READ IF NESSECARY: Is that excellent, very good, good, fair, or poor?	0 Poor 999 (DO NOT READ) REFUSED	
(ASK ALL) **Q44. Overall, how would you rate the quality of the NGO or faith-based healthcare system in your country? Please answer even if you have not used these services.** READ IF NESSECARY: Is that excellent, very good, good, fair, or poor?	4 Excellent 3 Very good 2 Good 1 Fair 0 Poor 999 (DO NOT READ) REFUSED	
Q45. Thinking about the past two years, would you say your country's health system is getting better, staying the same, or getting worse? READ IF NECESSARY: The health system includes all healthcare facilities and providers, including public, private, and other facilities and providers.	1 Getting better 2 Staying the same 3 Getting worse 999 (DO NOT READ) REFUSED	
(ASK ALL) **Q46. Which of the following statements do you agree with most?** READ LIST.	1 Number 1: Our healthcare system has so much wrong with it that we need to completely rebuild it. 2 Number 2: There are some good things in our healthcare system, but major changes are needed to make it work better. 3 Number 3: On the whole, the system works pretty well and only minor changes are necessary to make it work better. 999 (DO NOT READ) REFUSED	
(ASK ALL) **Q47. How would you rate the government's management of the COVID-19 pandemic (like COVID -19) epidemic such as Malaria overall?** **Is that excellent, very good, good, fair, or poor?**	4 Excellent 3 Very good 2 Good 1 Fair 0 Poor 999 (DO NOT READ) REFUSED	
4.3 EXPECTATIONS FOR HEALTH SYSTEM QUALITY		

READ I would like to read you; IF WEB: here is] a story to get an understanding of how you rate the quality of care that some people get. [Mamo] has been feeling increasing stomach pain for the past three days and decides to go to the health facility. (ASK ALL) **Q48. At the health facility, the doctor does not ask about his symptoms or examine his body; she gives him pain medication and does not give him the diagnosis. How would you rate the quality of care provided?** **Is that excellent, very good, good, fair, or poor?**	4 Excellent 3 Very good 2 Good 1 Fair 0 Poor 999 (DO NOT READ) REFUSED	
(ASK ALL) **Q49. Now, [Mamo] goes to another clinic. There the doctor examines him and orders a blood test. She tells him it is not serious, gives him pain medication, advises a light diet, and asks him to come back if it gets worse. How would you rate the quality of care provided?** **Is that excellent, very good, good, fair, or poor?**	4 Excellent 3 Very good 2 Good 1 Fair 0 Poor 999 (DO NOT READ) REFUSED	
CONCLUDING QUESTIONS		
READ: We have a few more questions before we conclude. Your answers will be confidential. They will be put together with thousands of other people we are talking to for an overall picture. It will be impossible to pick you out from what you say, so please feel free to answer honestly. (ASK ALL) **Q50. What is your native language or mother tongue?** IF NECESSARY: This is the language you spoke at home growing up.	1 Oromo 2 Amharic 3 Somali 4 Tigrinya 5 Sidamo 6 Wolaytta 7 Gurage 8 Afar 9 Hadiya 10 Gamo 11 Gedeo 12 Silt'e 13 Kafa 14 Harari 15 Agew 16 Argoba 17 Other (specify) 999 (DO NOT READ) REFUSED	
(ASK ALL)	1 Lesthan 1000 Eth.Birr	

Q51. If you think about your total monthly household income, which of these categories does it fit into? READ LIST.	2 1000 - 3000 Eth.Birr 3 3001 – 5000 Eth.Birr 4 5001 – 10000 Eth.Birr 5 10001 - 20000 Eth.Birr 6 20000+ Eth.Birr 998 (DO NOT READ) DON'T KNOW 999 (DO NOT READ) REFUSED	
(ASK IF MOBILE CATI) **CELL1. Do you have another mobile phone number besides the one I am calling you on?**	1 Yes 0 No, no other numbers 998 (DO NOT READ) DON'T KNOW 999 (DO NOT READ) REFUSED	
(ASK IF CELL1=1; HAS MORE THAN ONE MOBILE PHONE NUMBER) **CELL2. How many other mobile phone numbers do you have?**	0 ___ [ALLOW NUMBERS 1-10] 998 (DO NOT READ) DON'T KNOW 999 (DO NOT READ) REFUSED	

(ALL)

Thank you for taking part in this study. Your responses will help us to better understand the healthcare system in your country. Once again, the answers given by you are confidential and will not be linked back to you. We appreciate your time.