HARAMAYA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

Perceptions' of Patient-Centered Care and Associated Factors among Adult Patients Admitted to West Hararge Public Hospitals, Oromia Regional State, Ethiopia : Mixed Study.

MSc Thesis

Kedir Umer

January, 2025

Harar, Ethiopia

Perceptions of Patient-Centered Care and Associated Factors among Adult Patients Admitted to West Hararge Public Hospitals, Oromia Regional State, Ethiopia, 2025.

A Research Thesis to be Submitted to Haramaya University, College of Health and Medical Science, School of Nursing in Partial Fulfilment of The Requirement of a Master of Science in Adult Health Nursing.

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January, 2025

Harar, Ethiopia

APPROVAL SHEET

HARAMAYA UNIVERSITY

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I hereby certify that I have read and evaluated this thesis entitled "Perceptions of Patient-Centered Care and Associated Factors among Adult Patients Admitted to West Hararge Public Hospitals" prepared under my guidance by Kedir Umer. I recommend that it can be submitted as fulfilling the thesis requirement.

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As a member of the board of examiners of the MSc Open Thesis Defense Examination, I certify that I have read and evaluated the Thesis prepared by Kedir Umer and examined the candidate. I recommend that the Thesis be accepted as fulfilling the thesis requirement for the degree of Masters of Science in Adult Health Nursing.

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BIOGRAPHICAL SKETCH

My name is Kedir Umer Boru. I was born on September 2, 1994, in Egu (12) Kebele, Anchar Woreda, West Hararge zone, Oromia National Regional State, Ethiopia. I attended my primary education at Dindin primary school (1999-2007), and secondary and preparatory school at mechora (2008-2012). I joined the University of Jimma in, 2013 and graduated with a BSc degree in Nursing in 2016, After working as a Senior nursing professional at Chiro General Hospital for 5 years, I joined Haramaya University to attend my master's degree in Adult Health Nursing in November, 2021.

ACKNOWLEDGEMENTS

First off, I would like to thanks Haramaya University, College of Health and Medical Science to provide me this chance to develop this research thesis. Next, I would like to forward my heartfelt gratitude to my advisors; Dr. Aboma Motuma (PhD, Assistant Professor) and Mr. Deribe Bekele (MSc, Assistant Professor) who tirelessly guide me, through critical review, constructive and timely comments through this thesis development. Finally, I would like to thanks, Data collectors, supervisors, study participants, my family, friends and all others who supported me.

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ACRONYMS AND ABBREVIATIONS

AOR	Adjusted Odds Ratio
BSc	Bachelor Science
CI	Confidence Interval
COR	Crude Odds Ratio
FGD	Focused Group Discussion
DC	Data Collectors
FMOH:	Federal Ministry of Health
IHRERC	Institutional Health Research Ethics Review Committee

IOM	Institute of Medicine
HSTP	Health Sectors Transformation Plan
LMIC	Low Middle-income Country
PCC	Patient-Centered Care
PI	Principal Investigator's
PPCC	Perception of Patient-Centered Care
PPPCC	Poor perception of patient-centered care
QI	Quality Improvement

ABSTRACT

Background: Patient-centered care is poorly implemented in clinical practice in Ethiopia, which leads to Poor patients' outcome. However, there is no published mixed study on 'patients` perception of patient-centered care and associated factors at public hospitals in Ethiopia. Particularly there is no research on the perception of patient centered care at the eastern part of Ethiopia.

Objective: To assess perceptions of patient-centered care and associated factors among admitted adult patients to West Hararge Zone Public Hospitals, Oromia Regional State, Ethiopia from September 20, to October 20, 2024.

Methods: A multicenter sequential explanatory mixed methods study was conducted among adult patients admitted to West Hararge public hospitals. Multi-stage sampling procedure and structured interviewer-administered questionnaires were used for Quantitative data collection. Data were

entered into Epidata 3.1 and exported to STATA 17 for analysis. Binary logistic regression was applied to assess the relationship between the perception of patients and associated factors. Those variables with a p-value < 0.25 in bivariate analysis were transferred to multivariate analysis and were taken as significantly associated variables with a p-value < 0.05 at a 95% confidence interval. An explanatory qualitative study was employed. Purposively 24 participants that grouped into four Focused Group discussions were selected. Semi-structured open-ended guide line questions, Radio tape recorder and field note taker were used for data collection. Data collection were conducted after the quantitative data analysis to complement and clarify the quantitative results, facilitating integrate through a connecting approach. The qualitative data was examined to find meaning full patterns using codebook thematic analysis.

Results: A total of 508 participants were included in the study, which resulted in a responses rate of 99.6%. The overall poor perceptions of patient-centered care among study participants was found to be 62.8%. urban residence (AOR: 2.15; 95% CI: 1.31-3.53); length of hospitalization (AOR: 2.98; 95% CI: 1.19-7.47), unavailability of prescribed medication (AOR: 2.53; 95% CI: 1.57-4.07); difficulty of access to hospital service (AOR: 2.49; 95% CI: 1.58-3.92);lack of information about treatment options (AOR:1.98; 95% CI: 1.23-3.18);lack of participants involvement in their management decisions (AOR: 1.80; 95% CI: 1.19-2.85); and poor intimacy with healthcare providers (AOR: 1.93; 95% CI: 1.23-3.01) were the factors significantly associated with poor patients perception of patient centered care. The codebook thematic analysis generates two major themes, dimension of patient centered care and associative factors. The findings of the qualitative data complemented the result of the quantitative data.

Conclusion: The study revealed a high magnitude of poor perceptions of patient-centered care among participants. Urban residence, prolonged hospitalization, unavailability of prescribed medications, difficulty of access to hospital service and lack of information about treatment options, lack of involvement in their management decisions making process and patients'weak intimacy with healthcare providers were factors significantly associated with poor patients' perception of patient centered care. To enhance patient-centered care, hospitals should Ensure that

availability of prescribed medications, adequate numbers of qualified health care providers, safe Environment for patients and easy access to hospitals service.

Key words: Perception of patient centered care, patient centered care, public hospitals, Ethiopia

1. INTRODUCTION

1.1. Back ground

Patients Perception to patient-centered care (PPPCC)is patients view of point or experience to Patient Centered care (Gishu T. *et al.*, 2019, Al-Jabri F.Y.M. *et al.*, 2021). Perception (from Latin perception 'gathering, receiving') is the identification, organization and interpretation of sensory information in order to understand and represent the presented information or environment (Schacter D., 2011). Patients perceptions include personal experiences with healthcare professionals, the setup and facilities, communication level and responsiveness, and care management processes; these perspectives could provide important insights into: the level of quality care as a function of their overall satisfaction, readiness to access the health facilities in the future, adherence to provider's instruction, the requirements for international accreditation and monitoring programs for hospital services, and the financial performance and profitability of healthcare institutions (Abbasi-Moghaddam M.A. *et al.*, 2019, Barnett H. *et al.*, 2018, Gishu T. *et al.*, 2019).

PCC is a care that is planned with the patient in mind, with practitioners working in harmony with patients and families to recognize and meet the patient's complete range of needs and preferences defined by American Institute of Medicine (AIOM); but, it did not widely accepted until the Institute of Medicine (IOM) in the United States identified the six essential dimensions of quality care along with safety, timeliness, effectiveness, efficiency, equity, and patient-centered care (Baker A., 2001). The others eight categories were established by the Picker Institute and Harvard University to quantify patient-centered care (PCC): Patient preferences, Information and education, Physical comfort, Emotional support, Accesses to care, Involvement of family and friends, Continuity and transition, and care coordination (Cramm J.M. and Nieboer A.P., 2018, Flitcroft K. *et al.*, 2020, Liang H., 2022). These concepts consider PCC at all stages of the patient's journey and their care environment (Alkhaibari R.A. *et al.*, 2023b).

PCC is a strategy that practically every healthcare delivery system should support in order to achieve significant benefits, such as improved access to care, improved health knowledge, increased adherence to the agreed-upon care plan and treatment, increased survival/healing process, increased satisfaction with care, decreased patient distress, shorter hospital stays, lower overall costs, increases patient empowerment, advocacy, participation, and physical well-being which leads to good patients perception to PCC (Zhou L.M. *et al.*, 2021). It promotes collaborative goal-setting and pushes

healthcare professionals to evaluate their practice choices and delivery, improve staff satisfaction, lower medical error rates, improve employee recruitment and retention, improve health outcomes, leading to professional advancement and cut down on pointless testing and referrals (Alkhaibari R.A. *et al.*, 2023b). Furthermore, good practice of PCC improve organizational effectiveness (Grover S. *et al.*, 2022).

PCC is crucial component of high-quality healthcare services (WHO, 2016). Encouraging patients to take a more active part in sustaining and promoting their treatment is a crucial way that health care organizations, experts, and patients can all work together to offer high-quality care (Ewunetu M. *et al.*, 2023). Quality of health care system are measured by patients perception (Al-Jabri F.Y.M. *et al.*, 2021, Gishu T. *et al.*, 2019). The perspective of the patient might offer crucial information on how accommodating and sensitive the healthcare system is to their needs and expectations (Members W.C. *et al.*, 2020). Patient perception is an important indicator which gives an idea about the quality of health care services. It also provides feedback to determine quality and evaluation of health care providers performance because of this, using patients perception as a proxy in measuring of PCC is recommended (Gishu T. *et al.*, 2019).

1.2. Statements of Problem

Despite the mobilization of enormous resources and the advancement of technological sophistication in medical equipment, the global health system is unable to meet the needs of patients which indicate poor practice of PCC that result in Poor patient Perception to patient-centered care (PPPCC) (Alkhaibari R.A. *et al.*, 2023b). PCC is poorly implemented in clinical practice, particularly in Africa this lead to Poor patients perception to patients centered care (PPPCC) (Bogale T., 2021). According to a survey conducted in Uganda, Addis Ababa, and Bahardar more than half of hospitalized patients perceived poor patient- centered care (Waweru E. *et al.*, 2020, Birhanu F. *et al.*, 2021, Ewunetu M. *et al.*, 2023).

A qualitative Study in Chine found that lack of PCC lead to: surgical dalliance, peri-operative complication, increasing length of stay, operation site infection, increase cost of hospitalization, decreased patients satisfaction, increased readmission, increased patients morbidity and mortality this out come with PPPCC (Liu Y. *et al.,* 2022).Cross sectional survey done in low- and middle-income nations, inadequate medical care results in 8.6 million fatalities annually which indicate poor practice of PCC (Kruk M.E. *et al.,* 2018).

Previous research from a variety of sources demonstrates that patients' perceptions of patient-centered healthcare were influenced by a number of factors including:- residency, closeness to healthcare providers, awareness of the disease, medication information, access to health care services, involvement in decision-making, privacy during treatment, hospital appearance and information on care plans, service expansion, national policy, team spirit, shortage of resource, inadequate space of working environment, numbers of hospitalization, length of stay in hospital, distance of hospital, lack of transportation, organizational structure and culture, health care providers attitude, health education and communication and lack of patients empowerment factors (Al-Sahli B. *et al.,* 2021, Birhanu F. *et al.,* 2021, Chiwire P. *et al.,* 2022, G/egziabher R. *et al.,* 2022, Ewunetu M. *et al.,* 2023, Bogale T., 2021).

PCC integration in clinical practice is often found inconsistent across the globe due to great challenge to Implement it into practice (Bogale T., 2021).Traditionally, provision of health care in developing countries has been organized around the needs and desires of health care professional rather than patients centered this is also hindered the practice of PCC (Bogale T., 2021). Particularly in the sub-Saharan region of Africa, the health system's organizational elements, provider practices, and the diverse socioeconomic context in which healthcare professionals operate are all poorly implemented that hinder the practice of PCC, which result in poor patients perception to PCC (Alkhaibari R.A. *et al.,* 2023b, Ewunetu M. *et al.,* 2023).

PPCC is critical component of health police worldwide, that integrates ethical norm with medicine (Liu Y. *et al.,* 2022). The health system in Ethiopia has been prioritized by the Health Sectors Transformation Plan (HSTP) and has been the subject of quality improvement (QI); nonetheless, a provider-centered approach is mostly being used in its implementation (Birhanu F. *et al.,* 2021). The PPCC among patients in Ethiopia is generally poor, and not well understood, particularly in public hospitals due to poor practice of PCC (Birhanu F. *et al.,* 2021, Ewunetu M. *et al.,* 2023).It seems

sense that patient perceptions is the best technique to quantify PCC since they are the most significant predictors' factors PCC (Kamimura A. *et al.*, 2019).

Most of the previous study missed important variables like, patient's characteristics such as, substance used and does not include all dimension of PCC, this leads to information gaps in Ethiopia as well as in my study area. Also, there is no published mixed study on patient's perception of patient-centered care and associated factors at public hospitals in Ethiopia. Therefore, the purpose of this study was to assess perceptions of patient-centered care and associated factors among admitted adult patients to West Hararge public hospitals from September 20, to October 20, 2024.

1.3. Significance of Study

The findings from this study will have significant importance for different stakeholders to know patient's perception of patients centered care. It provides basic information on patient's perception of patients centered care and their related factors for health service providers and all hospital management body of an involved hospital in the study zone and Oromia Regional state health Bureau, Federal Ministry of Health (FMOH), this will be improve the practice of PCC that result in increased the health outcome of participants. Academic community also used as a base line information for a future researcher. The local institutions or organizations who will be used from this study results are: Chiro, Gelamso, Hirna and west Hararge zone health bureau for the purpose of providing basic information on perception of patient's to patient centered care to increasing quality of health service in different health facility science PCC is core component of quality health service.

1.4. Objectives of study

1.4.1. General objective

To assess perceptions of patient-centered care and associated factors among adult patients admitted to west Hararge public hospitals from September 20, to October 20, 2024.

1.4.2. Specific objectives

1. To assess perceptions of patient-centered care.

2. To identify factors associated with perceptions of patient-centered care.

2. LITERATURE REVIEW

2.1. Magnitude of Patient's Perception of PCC

Magnitude of patients' perception of patient-centered care worldwide varies, with studies indicating both positive and negative perceptions to PCC (Alkhaibari R.A. *et al.*, 2023b).

Cross sectional study conducted in Europe showed that perception of patient-centered care varies across different countries and healthcare systems. The magnitude of patients Perception of patient-centered care in the United Kingdom (n=481, 40.3%), Sweden (n=231,(19.3%), the Netherlands (n=80, 6.7%), Northern Ireland (n=79, 6.6%) and Norway (n=61, 5.1%) (Rosengren K. *et al.*, 2021). Cross sectional studies conducted in Africa specifically in Uganda (n=300, 21.7%),Bahar dar(n=300, 66.3%), Addis Ababa(n=285, 72.2%), Tigray(n=436, 45%), and South wallo(n=618, 39.1%) showed that poor patients Perception of patient-centered care(Waweru E. *et al.*, 2020, Ewunetu M. *et al.*, 2023, Birhanu F. *et al.*, 2021, Berhe H. and Gigar G., 2017, G/egziabher R. *et al.*, 2022).

2.2. Factors associated with patient's perception of PCC

Variations in contexts and geographical areas can influence PPCC care in Africa. Different studies conducted in African show that different factors impacting patient-centered care include things like: the significance of cultural sensitivity, religious influences, communication difficulties, inappropriate work environments, lack coordinated care, staff shortages, insufficient funding, and the requirement for ongoing training programs for healthcare professionals. These variables are critical in influencing the standard of treatment given to patients and their overall experience to PCC this affect poor PCC (Lateef A. and Mhlongo E.M., 2022, Alkhaibari R.A. *et al.*, 2023b, Janerka C. *et al.*, 2023, Albougami A.S. *et al.*, 2019, Akkafi M. *et al.*, 2019, Svavarsdottir E.K. *et al.*, 2022).

2.2.1. Sociodemographic characteristic factors

Cross-sectional study conducted at Gahanna show that high educational level (0.722, 1.509, $p< 0.05$) positively affect PPCC in which the educated patients were more likely to cope and remain satisfied with the health care provided to them than encounter one. In this study participants those have high monthly income level (0.790, 1.410, $p<0.001$) perceived good PCC than the low income level respondents this is due to health care providers frequently have empathy for and spend a lot of time with patients from wealthy backgrounds, either as a result of behavioral motivational factors or the health care providers being drawn in by the patients this result in discriminated patient-centered care by income show that significant associated with PPCC (Atinga R.A. *et al.*, 2016). The study conducted at

Tanzania Higher socioeconomic status women are probably going to demand more from their caregivers, this study found that more educated women cared more about the medical knowledge of the health worker than women without any secondary school education this affect PPCC (Larson E. *et al.,* 2015).

On the study conducted at Emek medical center in Israel Married patients had higher perceived PCC scores than all other family statuses (married vs. divorce, single or widow < 0.05), and accompanied patients had higher perceived PCC scores than unaccompanied patients ($p < 0.05$) this affect PPCC (Tsvitman I. *et al.,* 2021).

Cross sectional study conduct at south wallo show that older age (AOR: 0.39, 95% CI: 0.32–0.64) patients perceived higher PCC than youngers patients due to they have different level of expectation and patients with higher social well-being (AOR: 2.34, 95% CI: 1.45–3.78) perceived more PCC than patients with low social well-being this is due to patients with higher social well-being create close relationship with their health care providers and express their preference more than the low social well-being this improve their health outcome that have positive effect on PPCC (G/egziabher R. *et al.,* 2022). The cross sectional study conducted at Bahar dar and south wall show that odd of perceiving PCC is higher among people living in a rural area than urban this is due to lack of information and low expectation among people live in rural area this make them to have higher PPCC (Ewunetu M. *et al.,* 2023, G/egziabher R. *et al.,* 2022). Cross sectional study conducted at Tigray show that 76.3% of farmers reported having positive experiences with PCC when compared to self-employed (70%) of individuals who had negative experiences to PCC this is due to they have different expectation and knowledge that affect their PPCC (Berhe H. and Gigar G., 2017).

2.2.2. Health care Providers related factors

Expletory descriptive study at Germany found that, health care providers with high professional skill practice PCC than those with low professional skills this affect PPCC (Vennedey V. *et al.,* 2020).

A cross sectional study conduct at Singapore found that Doctors and nurse communication to patients ($r=0.348$, p-value<0.001), ($r=0.318$, $P<0.01$) has significant association with PCC respectively, which also support expletory descriptive study at Germany found that good communication between health care providers and patients increase the health outcome of patients this leads to good PPCC (Vasanwala Dr R.F. *et al.,* 2022, Vennedey V. *et al.,* 2020). The others cross sectional study conducted at public hospitals in Harare Ethiopia, show that poor patients perception to word nursing

communication, specifically language difference (AOR: 0.61, 95% CI: 0.40-0.94) hindered the nurse to practice PCC which result in poor patients out comes that negatively affect PPCC (Bekele Y. *et al.*, 2022).

Cross sectional Study at Singapore found that Caring for patients emotional need ($r = 0.303$, $p < 0.01$), discharge and transition ($r=0.347$, $p<0.001$) result in good clinical outcome of patients which positively affect PPCC (Vasanwala Dr R.F. *et al.*, 2022). Cross sectional study conducted at Tanzanian populations show that women who reported dis -respect treatment and abused were less likely report the quality of the care they received this make the women to perceive poor to PPCC (Larson E. *et al.*, 2015). Cross sectional study conducted at south wall show that the odds of PCC is higher among patients Perceived high quality of care (AOR: 3.69, 95% CI: 2.07–6.04), and routine check-ups (AOR: 1.92, 95% CI: 1.15–3.13) than those did not, this is due to the patients Perceived high quality of care and routine checkup established more relationship with their health care providers and enhanced their involvement in decision-making regarding their health this associated with good PPCC (G/egziabher R. *et al.*, 2022). Information on the plan of care (AOR: 2.3; 95% CI: 1.1-4.6), and medication (AOR: 3.1; 95% CI: 1.5-6.3) have significant association with PPCC (Birhanu F. *et al.*, 2021). Cross sectional study conducted at Bahar dar show that 196 patients (65.3%) receiving care, did not participate in decision-making during their treatment this show poor practice of PCC which leads to PPPCC (Ewunetu M. *et al.*, 2023).

A systematic review conducted at Indonesia show that length of stay in the hospital is affected by practice of PCC, in which poor practice of PCC increase length of stay in the hospitals that result in poor PPCC (Rivai F. *et al.*, 2022). Cross sectional study Conducted at south wallo show that length of hospital stay (AOR: 0.13, 95% CI: 0.02–0.79) have significant association with PPCC (G/egziabher R. *et al.*, 2022).

A cross sectional study conducted at Addis Ababa, Pawie and Bahar dar show that Privacy to access care (AOR: 2.0; 95% CI: 1.1-4.1), (AOR: 12.5; 95% CI: 2.89-54.1), 107 (35.7%) has significant association with PPCC respectively (Birhanu F. *et al.*, 2021, Aga T.B. *et al.*, 2021, Ewunetu M. *et al.*, 2023).

2.2.3. Institutional related factors

Expletory descriptive study conducted at Germany show that Organization structure, informational technology, special service are factors associated with PCC, In which good structural building, service directory (clear information) and numbers of specialist in the hospitals affect PPCC (Vennedey V. *et al.,* 2020). Cross sectional study conducted at Indonesia show that among study participants, "easy access to services" was positively perceived 118 (39.5%) that associated with PPCC (Nugroho H.S.W. *et al.,* 2023). Cross sectional study conducted at Bahar dar show that " Thirty-five percent104 (34.7%) individuals thought that hospitals had a "good external appearance "associated with PPCC, which support the study at Addis Ababa good hospital appearance increase patient satisfaction and hospital service (AOR: 3.3; 95% CI: 2.0–5.8) which affect PPCC (Ewunetu M. *et al.,* 2023, Birhanu F. *et al.,* 2021).

On the cross-sectional study conducted at Zambia show that (n=104, 64.3%) of patients does not satisfied with hospital food and the other study at Wolaita zone only (n=423, 33.6%) of patient satisfied with regular hospital food service this lead to poor PPCC (Miyoba N. and Ogada I., 2019, Teka M. *et al.,* 2022).

The study conducted at Tanzania discovered that women who had previously given birth in a medical setting preferred cleanliness more than other women whose give birth at others wards this affect PPCC (Larson E. *et al.,* 2015). Mixed cross sectional study conducted on 86 health facility in Addis Ababa show that 100% had limited access to sanitation in health facility specifically; (88.4%) had limited hand hygiene service, (97.7%) did not had cleaning environment, (29%) had no waste management service, and the toilet is not clean and inoperable due to poor design this indicate poor sanitation in the health facility that result in PPCC (Derso A. *et al.,* 2023). Cross- sectional study conducted at Pawie west Ethiopia show that (56%) of patients were not satisfied with cleanness of hospital toilet this decreased level of patients satisfaction to hospital environment that affect PPCC (Aga T.B. *et al.,* 2021).

2.2.4. Patients related factors

Cross sectional comparative study conducted at Bahar dar city, Nekemte and Addis Ababa show that perceived closeness with the health care providers (n=170, 56.7%), (AOR: 3.19, 95%CI: 1.87-5.43), (AOR: 0.4; 95% CI: 0.2-0.8) were associated with PPCC respectively (Ewunetu M. *et al.*, 2023, Garedew M. *et al.*, 2019, Birhanu F. *et al.*, 2021).

Cross sectional study conducted at Bahar dar city show that (n=234, 78%) of study participants did not have "awareness on their disease or diagnosis this show poor practice of PCC that affect PPCC (Ewunetu M. *et al.*, 2023). A Cross sectional study conducted at Addis Ababa show that admitted patients at medical ward awareness of their prognosis (AOR: 0.11; 95%CI: 0.05-0.27, p<0.001), Surgical ward awareness of treatment (AOR: 0.34; 95% CI: 0.14-0.84, p<0,019) and prognosis (AOR: 0.34; 95% CI: 0.14-0.84, P<0.020) and gyn ward awareness of diagnosis (AOR: 0.29; 95% CI: 0.12-0.73, P<0.009) and treatment (AOR: 0.30; 95% CI: 0.12-0.77, P<0,013) are factors that affect PPCC (Teklu A.M. *et al.*, 2022).

2.3. Conceptual Framework

This Conceptual framework was developed by the principal investigator after reviewing different literatures related to the topic (Zhou L.M. *et al.*, 2021, Tsvitman I. *et al.*, 2021, Larson E. *et al.*, 2015, G/egziabher R. *et al.*, 2022, Berhe H. and Gigar G., 2017, Ewunetu M. *et al.*, 2023, Vennedey V. *et al.*, 2020, Vasanwala Dr R.F. *et al.*, 2022, Bekele Y. *et al.*, 2022, Rivai F. *et al.*, 2022, Birhanu F. *et al.*, 2021, Nugroho H.S.W. *et al.*, 2023). It describes factors associated with patient's perception of patient centered care. These factors include socio-demographic, organizational, health workers, and patient-related factors.

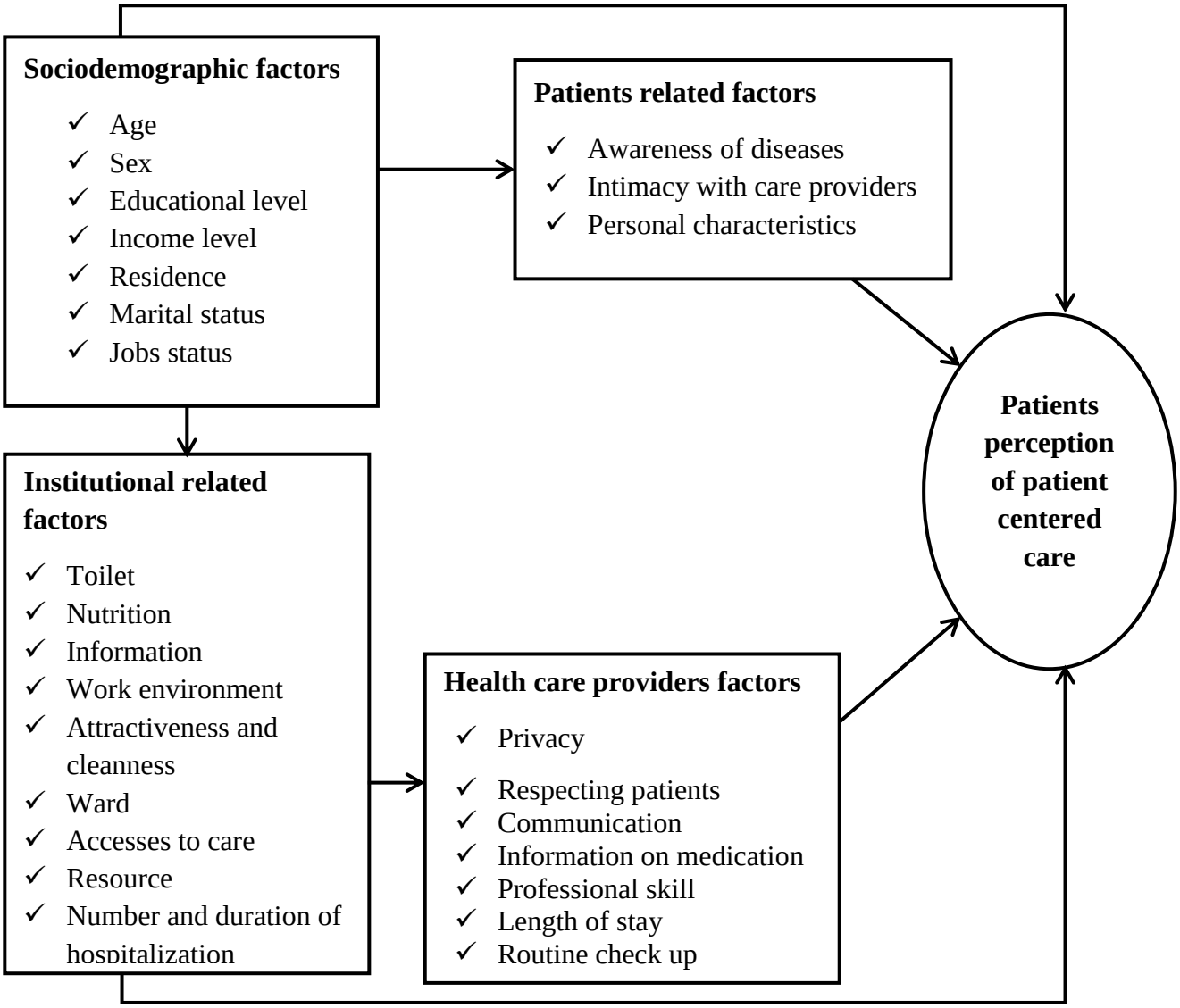

Figure 1: Conceptual framework on perception of patient centered care and associated factors among admitted adult patients to west Hararge public hospitals, Oromia regional state, Ethiopia from September 20, to October 20, 2024 (developed from review of different literatures).

3. METHODS AND MATERIALS

3.1. Study Area and Period

The study was conducted in public hospitals of West Hararge Zone. West Hararge Zone is one of the 20 Zones in the Oromia Regional State. Chiro town; the capital of the zone is located 321km from Addis Ababa; the capital city of the country in the eastern direction. By 2020, the Zone has a total population of 2,728,836. The zone has 15 districts and 2 city administrations. There are a total of seven public hospitals (2 general hospitals and five primary hospitals), 84 public health centers, and 482 health posts in the zone (Wake A.D., 2023). All hospitals are providing inpatient, out-patient, emergence, and delivery services. Therefore, three hospitals mean Chiro, Gelamso and Hirna hospitals are where the study was conducted from September 20, to October 20, 2024.

3.2. Study Design

3.2.1. Quantitative

An institution-based cross-sectional study design was conducted.

3.2.2. Qualitative

Explanatory qualitative study was employed to explain patient's perception of patient centered care and associated factors.

3.3. Population

3.3.1. Source Population

All adult patients who were admitted to Chiro, Gelamso and Hirna hospitals were source of population.

3.3.2. Study Population

All adult patients admitted to Medical, Surgical and Gyn-obs case team units of the hospitals, who were available during data collection were the study population.

3.4. Inclusion and Exclusion Criteria

3.4.1. Inclusion criteria

All adult patients who were admitted to surgical, medical, and gyn wards and those who were stayed in hospitals for 24 hours or more were included in the study.

3.4.2. Exclusion criteria

All severely ill patients who were unable to give information at the time of data collection and patients with mental illness /psychiatric disorders were excluded from interviews.

3.5. Sample size determination

3.5.1. Quantitative

To determine the sample size for this study, the outcome variable and several factors significantly associated with the outcome variable were considered. Thus, the sample size was calculated for each specific objective separately and the largest sample size was used for this study.

Sample size calculation for the first objective: The minimum sample size required for the study was determined by using a single population proportion formula.

The best estimate expected population proportion is:$n = \frac{\left(z\frac{a}{2}\right)^2 p(1-P)}{d^2}$

Where, n = required sample size, nf= fianal required sample size

Z(a/2)= 1.96 (95% confidence interval)

p= 0.278 magnltude of perception of patient's to patient centered care in public hospital in Adis Ababa (Birhanu F. *et al.*, 2021). d= is the margin of sampling error tolerated (5%) = 0.05

For possible non response rate, 10% was added to simple size. Total numbers of patients who were admitted to Chiro, Gelamso and Hirna Hospitals were 820 (Chiro=300, Gelamso=291, and Hirna=229)

n = $\underline{(1.96)^2 * 0.278(1-0.278)}$ = $\underline{3.84 * 0.201}$ = 308.8=309

$(0.05)^2$0.0025

So, n = 309, nf= 309 by adding 10% non - respondent rate 309+30.9= 339.9 =340 patients

By considering designed effect. nf=1.5*340=510.

For the second specific objective: -

The sample size for the second specific objective of this study was determined by double population proportion:$n = \frac{(Z_{\alpha/2} + Z_{\beta})^2 \times P_1(1-P_1) + P_2(1-P_2)}{(P_1 - P_2)^2}$. By considering factors that were significantly

associated with patient's perception of patient centered care by using Epi-Info version 7.2.4.6 Stat Calc. computer software and summarized in table 1: below**.**

Table 1: Sample size determination of associated factors to perception of patient centered care among adult patients admitted to West Hararge Zone public hospitals, 2024.

Factors	Assumptions	Sample size with 10% none respondent.	Reference
Intimacy with care providers	Yes (exposed) = 43.3% No (unexposed) = 56.7% CI = 95%, Power = 80%, Ratio = 1:1, AOR = 2.4	237	(Ewunetu M. *et al.*, 2023)
Ease access to care	Good (exposed) = 39.3% Poor (unexposed) = 60.7% CI = 95%, Power = 80%, Ratio = 1:1, AOR = 2.76	205	(Ewunetu M. *et al.*, 2023)
Hospital attractiveness	Yes (exposed) = 34.7% No (unexposed) = 65.3% CI = 95%, Power = 80%, Ratio = 1:1, AOR = 2.27	337	(Ewunetu M. *et al.*, 2023)

After comparing different sample sizes, the largest one was selected. Thus, the final sample size needed for this study was **510.**

3.5.2. Qualitative

Sample size had 24 patietns from two Hospitals; 12 patients from Chiro and 12 from Hirna Hospitals.

3.6. Sampling Procedure and technique

3.6.1. Quantitative

Out of seven public hospitals randomly three were selected:- Chiro, Gelamso and Hirna public hospitals. A total of 820 patients admitted per month in these public hospitals were identified. Accordingly, the sampling frame was developed, and the total sample size (n=510) was proportionally allocated to those hospitals and three wards were purposively selected. Then, the study

participants were selected using simple random sampling technique from the sample frame. Finally, the data were collected until the required sample size was obtained.

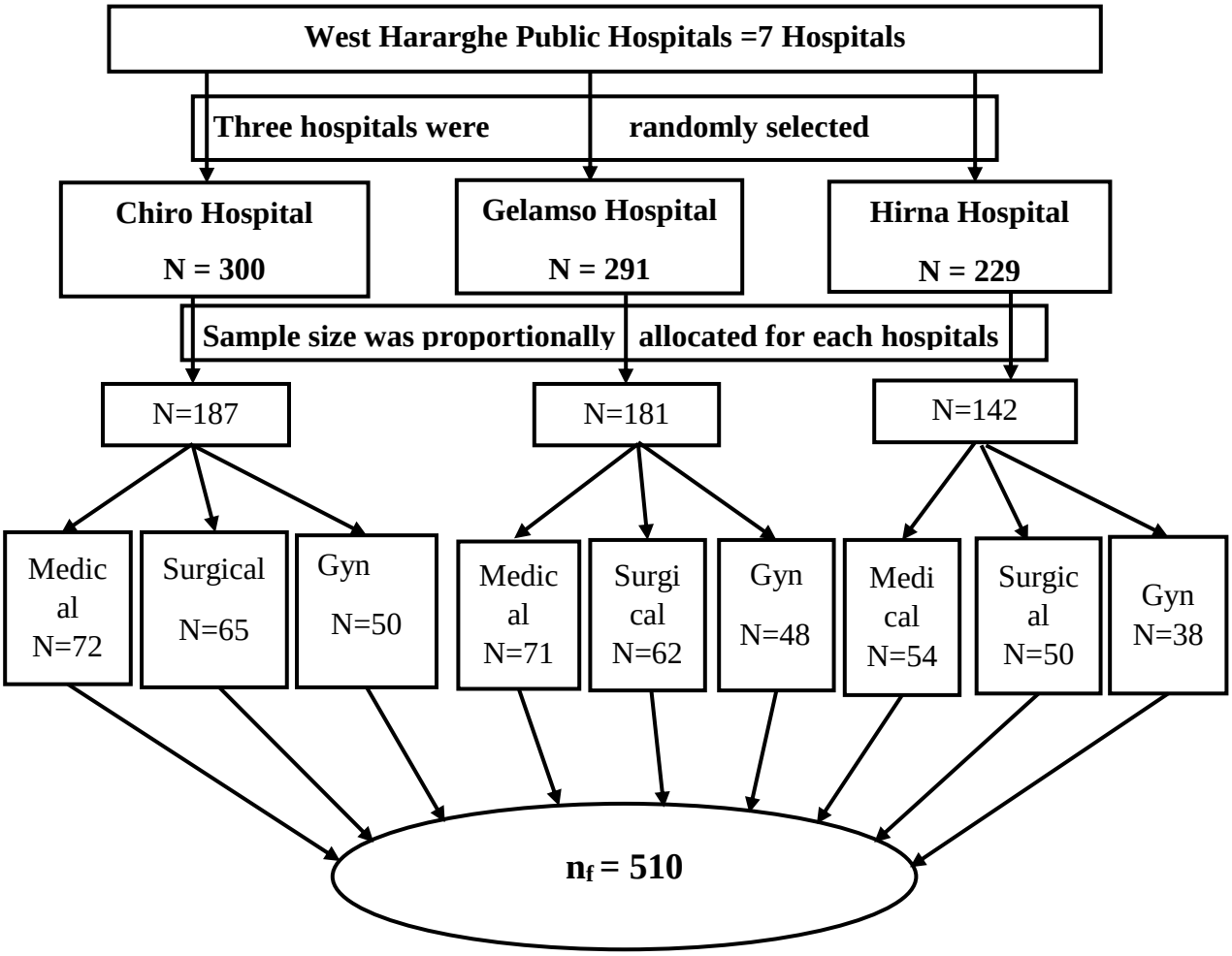

Figure 2: Schematic representation of sampling procedure for perception of patient centered care and associated factors among adult patients admitted to West Hararge public hospitals from September 20, to October 20, 2024.

3.6.2. Qualitative

Randomly two hospitals (Chiro and Hirna) and 24 patients were selected by considering 12 patients (6 males and 6 females) from one hospital, finally four FGDs were the study participants to address the question not answered by quantitative study. Males and females' groups were discussed separately to get balanced information from both males and females' groups. The discussion was continued until the information is saturated. Radio tape recorder and field note taker were used for data collection.

3.7. Data Collection Methods

3.7.1. Data collection instruments

3.7.1.1. Data collection instruments for quantitative

Structured English language questionnaire was adapted after reviewing of different study (Cramm J.M. and Nieboer A.P., 2018, Birhanu F. *et al.*, 2021, Ewunetu M. *et al.*, 2023, G/egziabher R. *et al.*, 2022). Then it was translated into local language (Afan Oromo) by the expert of both language and re translated back to English language to check internal consistence. Cronbach alpha test was done to check reliability (internal consistence) of questionnaires, which was 0.799. It consists five sections :the first section is questions on socio-demographic characteristic of respondents which contain eight questions, 2nd section is Institutional related factors which contain 15 question measured by Yes or No question, 3rd section is Health care providers related factors (10 question) which is measured by Yes or No, 4th section is patients related factors (5 question) measured by Yes or No, 5th section is PPCC question which is standardized question developed by Cramm and Nierberto measure 8 dimension of PCC and contain 36 questions measured by 5 point of Likert scale (1= Strongly Disagree, 2= Disagree, 3= Neutral, 4 = Agree, 5= Strongly Agree) (Cramm J.M. and Nieboer A.P., 2018).

3.7.1.2. Data collection instruments for qualitative

Semi-structured FGD interview guiding questions were used to address unaddressed questions by quantitative. Interviews was conducted by the PI on different days for each of the two hospitals by used field notes taker and an audio recorder. FGDs were conducted in Afan Oromo language.

3.7.2. Data collectors and supervisors

Eight Bachelor of Science (BSC) nurses were assigned for data collectors and two MPH holders were assigned for supervisors, both of them were recruited out of the study area. Three data collectors were assigned to Chiro, three to Gelamso and two Hirna hospitals.one supervisor was assigned to chiro and Hirna Hospitals, while one was assigned for Gelamso Hospital.

3.7.3. Data collection procedure

3.7.3.1. Data collection procedure for quantitative study

After the approval of the proposal, the investigator visited the hospital administrator’s office and explain the aims and methods of the study to obtain permission to carry out the study. Two days of training was given to data collectors and supervisors by principal investigator prior to data collection

on study instrument and data collection procedure including; objective of the study, importance of this study, about confidentiality of information and informed consent. The purpose of the study was clearly explained to the participants and written voluntary consent was obtained prior to data collection. The structured questionnaire regarding to assess patients' perceptions of patient centered care and associated factors was conducted by interviewer administered questionaries' and finally attached to each respective respondent's questionnaire for data entry. Supervision were done regularly. The data collection was conducted for four consecutive weeks from September 20, to October 20, 2024.

3.7.3.2. Data collection procedure for qualitative study

After the approval of the proposal, the investigator visited the hospital administrator's office and explain the aims and methods of the study to obtain permission to carry out the study. Two days training was given to data collectors on data collection procedures. Purpose of the study was clearly explained to the participants and written voluntary consent was obtained prior to held focus group discussion. Findings from quantitative analysis, were used to collect qualitative data. Data was collected through FGD guiding question. FGDs were conducted in Afan Oromo language. Interviews was conducted by principal investigator (PI) on different days for each of the two hospitals, and was recorded by two trained data collectors. Field notes taker and an audio recorder were used for data collection among selected patients to explain PPCC. Data collection ceased after the information gathered was deemed sufficient to answer the research questions (information saturated). Finally, the audio-visual recorded tape during discussion was transcribed and thematically analyzed manually. The data collection was conducted for two consecutive days from November 20, to November 21, 2024.

3.8. Study Variables

3.8.1. Dependent Variable

Patient's perception of patient- centered care.

3.8.2. Independent Variables

Sociodemographic status: Age, sex, place of residence, religion, marital status, job status, educational level, monthly income level.

Institutional related factors: Information, Work environment, Attractiveness and cleanness, Reception, Wards, Easy accesses to care, Resource, numbers of hospitalization, duration of hospitalization, nutritional service, Travel time to hospital and service types.

Health care providers related factors: Respecting patients, Communication, Information on medication, Professional skill**,** participant's involvement in their management decisions, Availability of healthcare providers and providing holistic care.

Patients related factors: Awareness of their diseases, Intimacy with care providers, Personal characteristics.

3.9. Operational Definitions

Perception **of Patient-centered care** is the views points of patients to the involvement of themselves, family and friends in clinical care with health care providers and it was measured with standard tools consists of eight dimensions of PCC and 35 items: which is 35 items each having five-point Likert scale from strongly disagree (1) to strongly agree (5) were used. Then, client was labeled as "good perception to patient-centered health care practice" if their participants is ≥ mean score of perception of patient centered questions, otherwise they are labeled as "poor perception to patient-centered health care practice". The tool for measuring patient perception to patient-centered care and method of measurement was taken from previous similar studies (Alkhaibari R.A. *et al.*, 2023b, Birhanu F. *et al.*, 2021, Bohart S. *et al.*, 2023, Cramm J.M. and Nieboer A.P., 2018). Internal consistency of the thirty-five items was checked by using Cronbach's alpha was found (0.799). The points obtained from the thirty-five items by each participant were computed to get the total score of each participant and participants scored a minimum of (65) and a maximum of (86) points with a mean score of 75.1. Thus, participants who has score ≥75.1 were labeled as "perceived Good" those who has scored <75.1 were labeled as "perceived poor" Perceptions of patient centered care.

Access to care: The presence of timely health service available in the institution without difficulty. Patients have "good" perception if they are score above or equal to the mean and "poor" perception, if they are score below the mean (Alkhaibari R.A. *et al.*, 2023b, Birhanu F. *et al.*, 2021, Ewunetu M. *et al.*, 2023, Cramm J.M. and Nieboer A.P., 2018).

Information and education: The view point of patient regarding clear information on treatment plan during hospital stay. Patients have "good" perception, if they are score above or equal to the mean and "poor" perception, if they are score below the mean (Alkhaibari R.A. *et al.*, 2023b, Birhanu F. *et al.*, 2021, Ewunetu M. *et al.*, 2023, Cramm J.M. and Nieboer A.P., 2018).

Privacy during care: Perception of the respondents whether there is privacy during care. Patients have "good" perception, if they are score above or equal to the mean and "poor" perception, if they are score below the mean (Alkhaibari R.A. *et al.*, 2023b, Birhanu F. *et al.*, 2021, Ewunetu M. *et al.*, 2023, Cramm J.M. and Nieboer A.P., 2018).

Intimacy with providers: Respondents' perception regarding whether they are knowing their health care providers or care givers. I t will be measured by "Yes" or "No" (Birhanu F. *et al.*, 2021, Ewunetu M. *et al.*, 2023).

Decision involvement regarding treatment: Perception of patients' regarding their involvement with healthcare providers in the choice of treatments or procedure, It will be measured by "Yes" or "No" (Birhanu F. *et al.*, 2021, Ewunetu M. *et al.*, 2023).

Information on medication: Patients' perception regarding the medication, how/when he/she is informed by health care providers, It will be measured by "Yes" or No" (Birhanu F. *et al.*, 2021, Ewunetu M. *et al.*, 2023).

3.10. Data quality control

To declare the quality of data, appropriately designed and validated data collection tools was used. The data collection tool (questionnaire) was prepared first in English and then translated to a local language (Afan Oromo), and re-translated back to English by experts who are familiar with the field of area to verify the consistency and content of the questionnaires.

Training was given to data collectors and supervisors for two days regarding the objective of the study, data collection tool, and ways of data collection. A pre-test was made on 5% (26) of the sample

size at A sabot primary hospital one week before the actual data collection period and any ambiguity, confusion, and difficulty words was revised and verified the appropriateness of the tool based on pre-test experience. Throughout the data collection, interviewers were supervised and regular meetings was held between the data collectors, supervisor, and the principal investigator together in which problematic issues arising from interviews was discussed and addressed. Each questionnaire was coded with a unique identification number. All identified perception of patient -centered care and associated factors was confirmed by the principal investigator.

Additionally, the collected data was examined by supervisors and the principal investigator subsequently; any doubt or problem identified was get an immediate solution. Data was kept in the form of a file in a secure place where no one can access it, except the principal investigator, and confidentiality of the data was insured by not recording names or any personal identity. Finally, after checking for data completeness, Epi-Data was utilized for data entry as it has a controlling mechanism for error detection. Any missing value and outliers were done by running descriptive frequency. Data was cleaned before Analysis.

3.11. Methods of Data Processing and Analysis

3.11.1. Data Processing and Analysis for quantitative

The data were manually checked for completeness, cleaned, coded, and entered using Epi-Data 3.1, and then finally exported to STATA 17.0 for analysis. Variables were recoded and computed through the transform function of the STATA and then both descriptive statistics and logistic regression analyses were computed. Descriptive statistical analysis such as simple frequencies and cross-tabulations were done to look for missing values and outliers; measures of central tendencies and measures of variations were computed to summarize and describe the characteristics of study participants and presented using frequencies, summary measures, graphs, and tables.

Multicollinearity was checked to see the linear correlation among the associated independent variables by using the variance inflation factor (VIF) and standard error (SE). VIF of >10 or standard error of >2 or tolerance test < 0.1 were considered suggestive of the existence of multicollinearity. For that reason, variables with VIF > 10 or standard error > 2 or tolerance test < 0.1 were checked to be dropped from the multivariable analysis. No Multicollinearity was detected during the analysis accordingly. Bi-variable analysis (COR with 95%CI:), was used primarily to check which variables had associated with the dependent variable (perception of PCC). To control possible confounding

factors, variables with a p- value of < 0.25 in the bivariable analysis were taken to the multivariable analysis. Hosmer Leme-show goodness-of-fit test was done to check for model fitness and it was found to be insignificant (at p-value = 0.2353); which indicates the model was good-fitted. The adjusted odds ratio (AOR), with 95%CI, was used to identify the independent variables associated with the dependent variable (perception to PCC). Statistical significance was declared at a p-value of < 0.05 and which does not include the null value in the 95% CI:

3.11.2. Data Processing and Analysis for qualitative

To explain the perceptions of patient-centered care that not addressed by quantitative study the FGDs were used. The audio data was transcribed immediately after the close of interview with each hospital by PI and trained data collectors. Transcribed audio data and typed field notes was compared to identify omissions and was finally merged into a single transcript.

Following the transcription of the interviews, the verbatim transcripts were cross referenced with the audio recordings, and subsequently translated into English by principal investigator. To ensure consistency and accuracy, the English transcript was then blindly back translated to Afan Oromo by a bilingual expert. the transcripts were meticulously reviewed multiple times by investigator and data collectors to become form fully immersed in to the data.

A code book thematic analysis, guided by the recommendation of Braun and Clarke, (Braun V. *et al.*, 2023), was then employed to deductively identify meaning full pattern. This approach is one of several variation of thematic analysis design to uncover pattern of meaning within a qualitative dataset, as categorized by Braun and Clarke in to coding reliability, code book and reflexive approaches. In quantitative analysis factors such as urban residence, length of hospital stays, Easy access to hospital service, absence of medication from hospitals, lack involvement in management decision making process, patients' intimacy with health care providers were founded to be associated with the oval of poor perception of patient centered care (score of patients). These quantitative findings were then utilized to create a structured coding framework for developing and documenting qualitative analysis.

Additionally, these evolving themes underwent further discussion and refinement by principal investigator, finally the narrative was structured according to the research objectives, and the qualitative finding were triangulated with quantitative results during the interpretation phase of the mixed-methods analysis. Finally, data was analyzed manually

3.12. Ethical consideration

The proposal was reviewed by the institutional health research ethics review committee (IHRERC) of Haramaya University, a college of health and medical science, and a formal letter of ethical clearance and approval was obtained from the IHRERC (Ref.No: IHRERC/238/2024). After obtaining ethical clearance, the official letter of cooperation was written to each of three hospitals (Chiro, Gelamso and Hirna) to allow execution of the research. All the study participants were informed about the purpose, the risk, benefit, and confidentiality of the study and their right to refuse, and informed written and signed voluntary consent was obtained prior to the interview. The participants were assured that the information obtained from them were kept with confidentiality and do not cause any harm to them. All the interviews were taking place in separate rooms or areas to keep the privacy of participants and cultural norms were respected. Besides, all personal identifiers were omitted from the data collection tool to ensure the confidentiality of the participants.

4. RESULTS

4.1. Socio-demographic characteristic of respondents

In this study, out of 510 participants, 508 patients participated yielding a response rate of 99.6 %. Two hundred eight nine (N=289, 56.89%) participants were male. The age of participants ranged from 18-79 with mean and standard deviation (SD) 40.44 ± 14.2 years respectively. Majority of participants, 427 (84.1%) were married and 303 (59.65%) were living in rural areas. More than half (52.56%) of participants earn 10001-15000ETB a month (Table 2).

Table 2: Socio-demographic Characteristics of patients' in public hospitals of West Hararge Zone, Oromia Regional State, Ethiopia**,** 2024 (n = 508).

Variables	Categories	Frequency (N)	Percentage (%)
Sex	Male	289	56.89
	Female	219	43.11
Age in years	18-34	166	32.68
	35-64	300	59.05
	65 and above	42	8.27
Marital status	Single	66	12.99
	Married	427	84.06
	Widowed	6	1.77
	Divorced	9	1.18
Religion	Muslim	240	47.24
	Orthodox	178	35.04
	Protestant	80	15.75
	Other specify	10	1.97
Place of residence	Urban	205	40.35
	Rural	303	59.65
Educational status	Cannot read and write	194	38.19
	Can read and write	54	10.63
	Primary School	97	19.09

	Secondary school and above	163	32.09
Job status	Farmer	191	37.60
	Government employed	66	12.99
	Non-Government employed	19	3.74
	Merchants	92	18.11
	House wife	114	22.44
	Others specify	26	5.12
Monthly income levels	<5000	166	32.68
	5001-10000	267	52.56
	10001-15000	64	12.60
	>15000	11	2.17

Other religious =catholic, other jobs = students, daily labors

4.2. Perceived institutional related factors

Out of the study participants, 270 (53.15%) had no history of previous hospital admissions. Majority (n=454, 89.57%) of them stayed in the study hospitals for 3-10 days, with the mean length of stay 5.4 days (±SD 3.2). More than half (n=338, 66.54%) perceived the hospital structure as unattractive, and 346 (68.11%) found their admission rooms have inadequate space and cleanliness. Majority (n=435, 85.63%) of respondents perceived that hospital toilets were not clean, and 319 (62.8%) experienced difficulty of accessing hospital services. Over half (n=304, 59.84%) of respondents used community-based health insurance (CBHI) for hospitals services, but among the 134 who paid for services, 104 (77.4%) felt the costs were unaffordable. Additionally, 386 (75.98%) perceived that the food and drinks in hospitals did not meet their preferences, and 371 (73.03%) did not receive prescribed medication from the hospitals. More than half (n=310, 62.02%) also reported inadequate service access in the pharmacy and diagnostic areas (Table 3).

Table 3: Perceived Institutional related factors of patients' in public hospitals of West Hararge Zone, Oromia Regional State, Ethiopia**,** 2024 (n = 508).

Variables	Categories	Frequency (N)	Percentage (%)
Previous history of admissions	For the 1st time	270	53.15
	Twice	163	32.09
	Three times	51	10.04
	Four and above	24	4.72
Duration of hospitalization.	3-10 days	454	89.37
	11-20 days	54	10.63
Wards	Medical	196	38.58
	Surgical	176	34.65
	Gyn	136	26.77
Hospitals reception room.	Yes	236	46.46
	No	272	53.54
Hospitals structure attractiveness	Yes	170	33.46
	No	338	66.54
Adequate space and cleanness of admission room	Yes	162	31.89
	No	346	68.11
Cleanness of hospitals toilet.	Yes	73	14.37
	No	435	85.63
Travel time to hospitals	15-60 minutes	200	39.37
	61-120 minutes	230	45.28
	>=121 minutes	78	15.35
Easy access to service in hospitals.	Yes	189	37.2
	No	319	62.8
Types of hospitals service	Payments	150	29.53
	Free	54	10.63
	Insurances	304	59.84
Affordability of hospitals service cost	Yes	27	18.00

	No	123	82.00
Patient preference of food and drinking	Yes	122	24.02
	No	386	75.98
Enough medical equipment in hospitals	Yes	212	41.73
	No	296	58.27
Availability of prescribed medication from hospitals	Yes	137	26.97
	No	371	73.03
Availability service in pharmacy and other diagnostic center at any time.	Yes	198	38.98
	No	310	61.02

4.3. Perceived health care providers related factors

More than half (n=303, 59.65%) of participants felt disrespected by healthcare providers and 299 (58.86%) did not get their diseases specialist during consultations. Most (n=323, 63.58%) of respondents lacked safety alert information, and 299 (58.86 %,) did not receive full information on treatment options. Additionally, 276 (52.56%) stated providers were unfamiliar with their conditions, while a significant majority (n=331, 65.16%) felt excluded from their management decisions. Moreover, 351(66.09%) reported not receiving holistic care, with, 207 (40.75% receiving care only twice a day (Table 4).

Table 4: Health care providers related factors of patients' in public hospitals of West Hararge Zone, Oromia Regional State, Ethiopia**,** 2024 (n = 508).

Variables	Categories	Frequency (N)	Percentage (%)
Speak politely and respecting the patients	Yes	205	40.35
	No	303	59.65
Availability of specialists at any consultation time.	Yes	209	41.14
	No	299	58.86
Availability health care providers on time during care.	Yes	222	43.70
	No	286	56.30
Provided safety alert information to patients	Yes	185	36.42
	No	323	63.58
Skill during patient care.	Yes	204	40.16
	No	95	18.70
	I don't Know	209	41.14
Providing full information to patients on treatment options.	Yes	209	41.14
	No	299	58.86
Familiarity with patient's disease.	Yes	241	47.44
	No	267	52.56
Involving patient's in management decision.	Yes	177	34.84
	No	331	65.16
Providing holistic care to patients	Yes	157	30.91
	No	351	69.09
Providing care to patient's per day	Once	36	7.09
	Two time	207	40.75
	Three times	80	15.75
	Four and above	185	36.42

4.4. Perceived patients related factors

According to this study finding more than half, 281(55.31%) of the study participants had no good health perception for themselves. More than half, 274 (53.94%) respondents had history of substance used, in which, chat 137 (26.97%) was the most common substance used by the respondents. More than half ,278 (54.72%) respondents had no awareness about their diseases. Regarding intimacy with health care providers 295 (58.07%) respondents had no intimacy with their health care providers (Table 5).

Table 5: Patients related factors of patients' in public hospitals of West Hararge Zone, Oromia Regional State, Ethiopia**,** 2024 (n = 508).

Variables	Categories	Frequency (N)	Percentage (%)
Good health perception.	Yes	227	44.69
	No	281	55.31
Substance used	Yes	234	46.06
	No	274	53.94
Types of substance	Alcohol, Khat and Smoking	21	4.13
	Khat and Smoking	58	11.42
	Khat only	137	26.97
	Others specify	64	12.6
Awareness about their diseases / diagnosis	Yes	230	45.28
	No	278	54.72
Intimacy with health care providers.	Yes	213	41.93
	No	295	58.07

Other=Coffee

4.5. Patient's perception of Patient–centered care

The assessment of PPCC involved eight dimensions of PCC through 35 items. Participants' mean scores were used to classify both the overall and individual dimensions of PCC as either poor or good, depending on whether their scores were below or above the mean. Accordingly, out of the total 62.8% (n=319) of the participants score < 75.1(SD ±4.14), which was below the mean values and labeled as poor perception whereas the remaining 37.2% (n=189) scored ≥ 75.1 (SD±4.14), which was above the mean values and labeled as good perception. Based on this finding, 62.8% of participants were perceived the overall PCC were poor, while 37.2% of participants were perceived good. Regarding perception to each dimension of PCC: - More than half (66.9) of participants had poor perception on their preference. Additionally, 65.6% experienced inadequate physical comfort, and a significant 74.6% felt that coordination of care was lacking. Continuity and transition of care were also perceived poor by 65.7% of participants. Emotional support was another critical issue, with 69.3% expressing dissatisfaction. Access to care posed challenges, as 62.4% reported difficulties, and 64.6% felt they lacked adequate information and education about their care. Furthermore, support from family and friends was perceived as poor by 61% of the participants. (Figure 3).

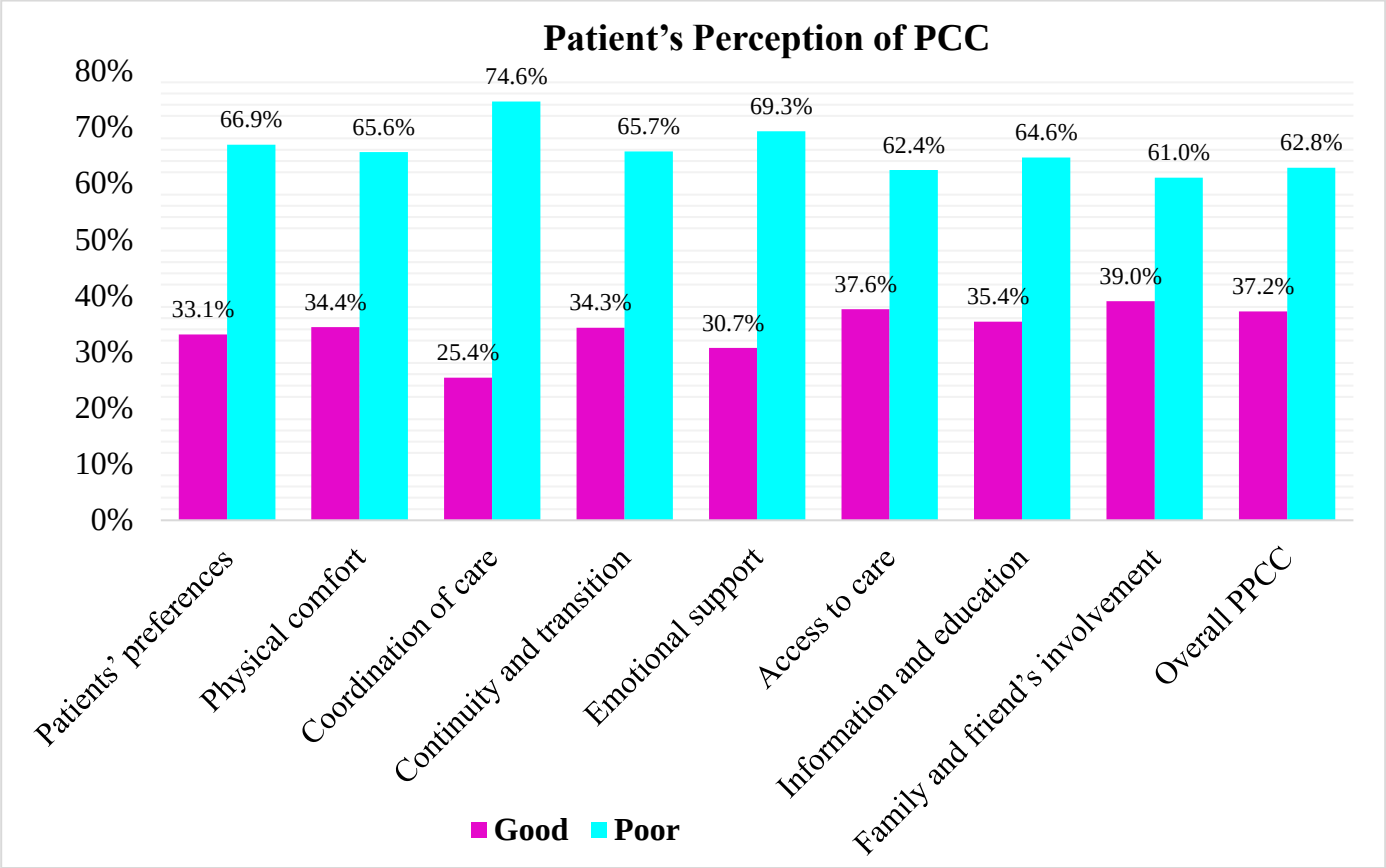

Figure 3: Patient's perception of PCC at public hospitals of West Hararge Zone, Oromia Regional State, Eastern Ethiopia, 2024 (n = 508).

4.6. Factors associated with perception of patient centered care

In the binary logistic regression analysis factors such as place of residence, hospital attractiveness length of hospitalization, prescribed medication from hospital, easy access to hospital service , information about treatment options, healthcare provider involvement in management decisions, getting specialist consultation, healthcare providers politeness and respect, patients' awareness about disease and patients' intimacy with healthcare were significantly associated with perception of patient centered care at $p < 0.25$.

Accordingly, patients residing in urban areas exhibited a poorer perception of care compared to those in rural areas (AOR: 2.15; 95% CI: 1.31-3.53). Those hospitalized for 11-20 days had a significantly higher proportion of poor perception compared to patients hospitalized for 3-10 days (AOR: 2.98; 95% CI: 1.19-7.47). A higher percentage of patients who did not receive prescribed medication

reported poor perceptions, compared to those who did (AOR: 2.53; 95% CI: 1.57-4.07). Difficulties of access to hospital service led to poorer perceptions compared to patients who reported easy access to hospital service (AOR: 2.49; 95% CI: 1.58-3.92).

Patients who did not receive information about treatment options had a poor perception when compared to those who did (AOR: 1.98; 95% CI: 1.23-3.18). Those who felt excluded from management decisions exhibited a poor perception compared to those involved (AOR: 1.80; 95% CI: 1.14-2.85). Lastly, patients who reported limited intimacy with healthcare providers showed significantly poorer perceptions compared to those with greater intimacy (AOR: 1.93; 95% CI: 1.23-3.01) (Table 6).

Table 6: Bivariable and Multi-variable logistic regression analysis for factors associated with Patient's perception of PCC at public hospitals of West Hararge Zone, Oromia Regional State, Ethiopia, 2024 (n = 508).

Variables	**Perception of patient centered care**		**COR (95% CI:)**	**AOR (95% CI:)**
	Poor Perception (%)	**Good Perception (%)**		
Place of residence				
Urban	159 (77.56)	46 (22.44)	3.09 (2.08-4.60)	**2.15 (1.31-3.53) ****
Rural	160 (52.81)	143 (47.19)	**1**	**1**
Hospital structure attractiveness				
Yes	96 (51.34)	91 (48.66)	**1**	**1**
No	223 (69.47)	98 (30.53)	2.16 (1.49-3.13)	1.03 (0.65-1.63)
Length of hospitalization				
3-10 days	271 (59.69)	183 (40.31)	**1**	**1**
11-20 days	48 (88.89)	6 (11.11)	5.40 (2.27-12.88)	**2.98 (1.19-7.47) ***
Prescribed medication from hospital				
Yes	52 (37.96)	85 (62.04)	**1**	**1**
No	267 (71.97)	104 (28.03)	4.20 (2.78-6.34)	**2.53 (1.57-4.07) *****
Easy access to hospital service				
Yes	83 (43.92)	106 (56.08)	**1**	**1**

No	236 (73.98)	83 (26.02)	3.63 (2.48-5.31)	**2.49 (1.58-3.92) *** **
Information about treatment options				
Yes	89 (42.58)	120 (57.42)	**1**	**1**
No	230 (76.92)	69 (23.08)	4.49 (3.06-6.60)	**1.98 (1.23-3.18) ** **
Patient involvement in management				
Yes	78 (44.07)	99 (55.93)	**1**	**1**
No	241 (72.81)	90 (27.19)	3.40 (2.32-4.98)	**1.80 (1.14-2.85) * **
Get specialist consultation				
Yes	110 (59.46)	99 (40.54)	**1**	**1**
No	209 (64.71)	90 (35.29)	2.09 (1.45-3.02)	1.14 (0.72-1.80)
HCP politeness and respect				
Yes	118 (57.56)	87 (42.44)	**1**	**1**
No	201 (66.34)	102 (33.66)	1.45 (1.01-2.09)	1.22 (0.78-1.91)
Patients' awareness about disease				
Yes	126 (54.78)	104 (45.22)	**1**	**1**
No	193 (69.4)	85 (30.6)	1.87 (1.30-2.70)	1.31 (0.84-2.04)
Patients' intimacy with healthcare				
Yes	102 (47.89)	111 (52.11)	**1**	**1**
No	217 (73.56)	78 (26.44)	3.03 (2.08-4.40)	**1.93 (1.23-3.01) ** **

Statistically significant at P<0.001= ***, P<0.01= ** and at P<0.05= *, 1: reference, AOR: Adjusted odds ratio, COR: Crude odds ratio, and HCP: Health care provider.

4.7. Qualitative findings

4.7.1. Perception of patients to patient centered care

Theme 1: Perception to Dimension of patient-centered care.

Code 1: Patients Preference

Majority of FGDs participants perceived that lack of preferences.

> *One participant said, "When you ask a question or assert that I have a right to know, the health worker will not want to deal with you; they say you can find another facility."* ***(FGD 3, p (participant)2, 41 years old, Female)***
>
> *Another participant noted, "I need to know about the ordered medications, but the doctor became silent and just handed me the medication."* ***(FGD 1, p3, 35 years old, Male)***

Some FGD participants noted that certain healthcare providers do prioritize patients' needs.

> *One participant said, "There is a nurse in my ward whom all the patients like. He stays with us, even overnight, and asks about my illness/feelings. I talked freely with him, unlike the other healthcare providers."* ***(FGD 2, P5, 49 years old, Female)***

Code 2: Physical comfort

Majority of participants perceived that some of health care providers were not give attention to their pain.

> *One participant noted, "Since I was admitted, most healthcare providers have not been active in ensuring I am okay." (**FGD 1, P4, 37 years old, Male).***
>
> *Another said, "I experienced pain at night, and no one checked on me. I suffered with severe pain until morning." (**FGD 3, P6, 27 years old, Female).***

Majority of participants perceived lack of hospital environment hygiene.

> *One participant commented, "Our ward is not neat since I have been here." (**FGD 4, P2, 34 years old, Male).***
>
> *Another participant said, "The hospital toilet was unclean and smelly, I even developed a cough after using it." (**FGD 1, P3, 35 years old, Male).***
>
> *Moreover, one noted, "The bathroom and toilet facilities are communal and not well-maintained at optimum level of hygiene."* ***(FGD 3, P5, 42 years old, Female)***

The most of participants expressed that their rest and sleep were significantly disturbed**.**

One participant said, "I didn't have enough pillows," "my mattress didn't fit," "my bed was too small," and "the bed was hard and covered in plastic." ***(FGD 2, P1, 28 years old, Female).***

Another noted, "At night, it was quite noisy, and I couldn't sleep because of other patients' disturbance." ***(FGD 4, P3, 38 years old, Male).***

Code 3: Coordination of care

Majority of health care provider not listen to the participant's concern.

One participant stated, "Healthcare providers cut me off as I was expressing my concerns." ***(FGD 3, P1, 25 years old, Female).***

Another said, "The doctor ordered an x-ray at night, but there was no radiographer available. We waited over an hour for him, until he came from his home. This hospital is disorganized." ***(FGD 1, p4, 37 years old, Male).***

Code 4: Continuity and transition

The majority of participants identified a lack of interdepartmental relationships, and noted the absence of assigned healthcare providers in their designated areas.

One participant said, "The doctor admitted me to the in patients ' ward when I arrived at this ward, there was no bed there, so I returned to the emergency room and I was stayed outside of the emergency room at corridor during that night." ***(FGD2, P4,26years old, Female).***

Some of FGDs participants perceived that absence of health care providers from assigned area.

One participant said, "I had medication scheduled for 9:30 am but took it at 11:30 am due to the absence of health care providers. It felt like my treatment wasn't getting attention." ***(FGD 4, p4, 37 years old, Male).***

*Another noted, "I was referred from a health center for bleeding, and when I arrived, there was no health care provider in the ward. I waited over an hour without treatment; this hospital management is poor." (****FGD 3, p6, 26 years old, Female).***

Code 5: Emotional support

Most participants commented that there was a lack of emotional support from healthcare providers, particularly regarding attention to patients' fears and anxieties. They noted issues such as a lack of respect, dignity, and empathy, as well as the use of inappropriate words by staff. Some participants believed that providing emotional support is not the responsibility of healthcare providers and mentioned that certain patients exhibited bad behavior.

> *One participant said, "Health care providers never consult me on anything, they just come, say hi with an angry face, and continue with their things, and go back, even I need their counseling on my fear and anxiety."* ***(FGD1, P6, 41 years Old, Male).***
>
> *Another noted "I have a lot on my mind from staying long in the hospital and being away from my family, yet none of the providers asked me how I feel." (****FGD 3, p3, 32 years, Female).***

Some of participants experienced lack of respect and dignity.

> *One participant noted that, "Some health care providers used inappropriate words and showed no interest. It's not my choice to be here with a disease."* ***(FGD 4, p1, 46 years old, Male).***
>
> *Another noted, "When I said I was stressed, the health worker laughed and told me not to disturb them. I'm very irritated by their attitude."* ***(FGD 2, p6, 36 years old, Female).***

Some FGDs participants believe that providing emotional support is not the responsibility of healthcare providers**.**

> *One participant noted, "I need the words of health care providers, but I fear asking about my feelings, as I don't think emotional support is their role."* ***(FGD 2, p2, 33 years old, Female).***
>
> *Another one said, "I would never discuss my emotional problems with health care providers. Those are my issues to handle, and I prefer talking to family or elders, not health workers."* ***(FGD 4, p1, 46 years old, Male)***

Some participants perceived the behavior of some participants were as inappropriate.

> *One participant commented, "We cannot always blame health care providers; some patients are extremely unpleasant or irate around them." (****FGD 3, p5, 42 years old, Female).***
>
> *Another one said, "Some patients and attendants insult health care providers. How can they give compassionate care in such situations?" (****FGD 1, p2, 48 years old, Male).***

Code 6: Information and education

Patients reported inadequate communication and health education about their care, especially regarding medication and safety, which made them feel marginalized. They linked this to staff shortages, and lack of interest.

> *One participant said, "I've been in this hospital for five days, and none of the healthcare providers told me about the safety alert."* ***(FGDs4, P3, 38 years old, Male****).*

Shortage of staff (work over loads);

> *One participant noted, "... They had no time to communicate with me, they're rushing to give medication and routine care rather than discussing my concerns." (****FGDs 2, P5, 49 years old, Female).***
>
> *Another one also commented that, "the day was on a Sunday, there are only two nurses for a large number of patients. We all had different questions; how can they stay with us****?" (FGDs 1, p 2, 48 years old, Male).***

Lack interesting;

Most participants feel that healthcare providers lack interest in their work.

> *One participant commented that, "Most health care providers won't tell you anything because they assume you don't understand and think your questions are unimportant." (****FGDs 3, p 2, 41 years old, Female)***
>
> *Another one noted, "I think health care providers were not satisfied with their work because most of them didn't smile or engage with us."* ***(FGDs 2, P2, 33 years old, Female)****.*
>
> *Moreover, a participant noted "I think health care providers weren't happy with their pay****. (FGDs 4, P4, 37 years old, Male).***

4.7.2. Associated factors

Theme 2: Factors associated with perception of PCC.

Code 7: Residence

Participants from rural and urban areas raised their concerns regarding the service they received at the hospitals.

Urban residence;

The majority of urban participants were not happy with their care.

*One participant expressed her frustration, 'To speak frankly, I am not happy with the inpatient services in this hospital. Even though patients' rights are posted, the healthcare providers do not adhere to them. For example, after my surgery three days ago, I experienced severe pain. When I called a healthcare provider for medication, she told me her shift was over and that I would have to wait for the next provider to arrive. Is it possible …?" (**FGDs 2, p3, 26 years old, Female, Urban).***

*Another participant commented, "I am generally less satisfied with this hospital services, particularly regarding the admission room, beds, food, and the availability of specialists and medication. I recommend that the hospital administrators to improve these areas." **(FGDs 4, P6, 34 years old, Male, Urban).***

In contrast, some participants of FGDs from the urban areas perceived that they received good service during their follow-up visits at the hospital.

*One participant commented that, "I am happy with the service I've received at this hospital. Since I've been following up here, I know most of the healthcare providers, and they respond promptly to me. The quality of service has been improving compared to my previous experiences." **(FGD 1, P6, 41 years old, Male, Urban).***

Rural residence;

The majority of FGDs participants from rural areas expressed satisfaction with the healthcare services provided, especially when compared to their previous experiences at health centers.

*One participant expressed gratitude, stating, "...I want to thank the hospital staff. I came here with a bone fracture and was treated with compassion. They changed my bed sheets daily and provided timely medication. Even if some peoples were worried about the service for admitted patients, I am very pleased with the care I received here compared to the health center near to our community." **(FGDs3, p2, 41 years old, Female, Rural).***

*Another participant noted, "Apart from concerns about toilet and ward hygiene, almost every aspect of the services I received in this hospital was good. **(FGDs1, p3, 35years old, Male, Rural.).***

Code8: Length of the hospital stay

Some participants who stayed in the hospital for over a week reported financial loss and work disruption;

> *One participant stated, "I have stayed in this hospital for more than 10 days, and now I have no money to buy medication, so I decided to go home." (**FGD 1, P3, 35 years old, Male).***
>
> *Another participant noted, "...I have been here for more than two weeks, and I am worried about the potential loss of income." (**FGD 3, p5, 42 years old, Female**).*
>
> *Furthermore, one participant stated, "I am here more than 15 days, all my family is with me; no one is at the workplace. I think it's better to discharge me." **(FGD 2, p3, 26 years old, Female).***

Code 9: Absence of prescribed medication from the hospitals

Most FGDs participants noted the lack of prescribed medication in hospitals, expressing the following comments:

> *One participant stated, "The government asks us to pay for CBHI, but when we come to the hospital, there is no medication. I'm sorry! Why do we come here if there is no medication?" **(FGD 1, p2, 48 years old, Male).***
>
> *Another participant commented, "Since medication is highly expensive at private pharmacies, I'm constantly worried about missing it from this hospital as it may affect my recovery." **(FGD 3, P4, 34 years old, Female).***
>
> *Furthermore, a participant stated, "Since I came here for delivery, my family has bought almost all the medications from outside private pharmacy, including gloves. Can we say this hospital is a public hospital?" **(FGD 2, P4, 32 years old, Female).***

Code 10 :Difficulty of hospital service access .

Most participants noted that accessing services in the hospital is challenging.

> *One of participant noted that,"I visit this hospital to obtain further treatment and testing, but what I expected and get is vary; sometimes you will get what you want, and other times you won't." (**FGD 4; P6, 34years old, Male)**.*
>
> *Another one also commented that, "This hospital does not live up to its name; you did not receive the laboratory tests that you would have received at a private clinic." **(FGD 2, P2, 33 years old, Female).***

*Moreover one participant said "Unless you have been followed at their private clinic, you were not get the specialist doctor you wanted." **(FGD 3, P6, 27 Years old, Female).***

Code 11: Lack of information on treatment.

Majority of FGDs participants perceived that lack of information on their treatment**.**

*A Participant noted, "I spent two weeks in this hospital and had no awareness of my treatment plan." **(FGD 4, P5, 28 years old, Male).***

*Another participant remarked, "I asked many questions, but none of the healthcare providers showed interest in discussing my condition or treatment." **(FGD 1, P1, 38 years old, Male).***

Code 12: Lack of involvements in management decision-making process.

Most participants felt they were not involved in the decision-making process regarding their management.

*One participant expressed, "Health providers ask their own questions, and even when I have many questions about my disease, they only tell me their decisions, which confuses me." **(FGD 3, P3, 32 years old, Female).***

*Another participant stated, "Patient involvement in their treatment is marginalized." **(FGD 1, P5, 37 years old, Male).***

Code13: Intimacy of patients with health care providers.

Most participants believed that a close relationship with health professionals was essential for receiving quality hospital services.

*One of the participants said that, "There is a big difference; hospital services are easily accessible to those who have good relationships with healthcare providers." **(FGD 2, P6, 36 years old, Female).***

*Another one commented that, "It is preferable to visit the private clinic if you do not know anyone at the hospital, everything is done by knowing each other's." **(FGD 4, p 2, 34 years old, Male).***

5. DISCUSSION

This study aimed to assess the perception of patient centered care among admitted adults' patients at Public hospitals of, West Hararge zone, Ethiopia. The study was found that magnitude of poor PPCC was 62.8% (with 95% CI: 58.58%-67.01%) and factors such as urban residence, length of hospitalization, unavailability prescribed medication from hospital, difficulty of accesses to hospital service, lack of information about treatment options, lack of participants involvement in their management decisions making , and poor patients' intimacy with healthcare provider were found to have a statistically significant association with poor perception of patient centered care at $p < 0.05$.

This study finding was comparable with previous study conduct in Bahar Dar Ethiopia (66.3%) (Ewunetu M. *et al.*, 2023).However, the finding of this study was higher than study conducted in Canada 37.8% (King A. and Piccinini-Vallis H., 2023), South Africa (16.8%) (Maseko L. and Harris B., 2018), Eastern Uganda (42.46%) (Waweru E. *et al.*, 2020), North Western Uganda 35.2% (Aleni M. *et al.*, 2024), South Wallo, Ethiopia (39%) (G/egziabher R. *et al.*, 2022) and Tigray, Ethiopia (45 %) (Berhe H. and Gigar G., 2017). This discrepancy might be due to study setting, sociodemographic characteristics and tools used to assess PPCC (Zhou L.M. *et al.*, 2021).

On other hands, the finding of this study was lower than the study conducted in Addis Ababa, Ethiopia (72.2 %) (Birhanu F. *et al.*, 2021). This deference was may be due to socio-demographic characteristic, tools used to assess PPCC and health care system. In this study ,the majority of participants comes from a rural catchment area, whereas study in Addis Ababa primarily involved urban populations .This study encompassed all dimension of patient centered care ,unlike the former study was not. Furthermore, the current health system has improved when compare to previous one particularly by providing patients with access to health care workers who speak the local language of patients.

Qualitative findings showed that, most felt that healthcare providers were not meeting their preferences for effective care. They reported inadequate physical comfort and care coordination. Additionally, many of them emphasized a lack of emotional support, continuity of care, and effective communication regarding their health status and management. This study was supported by previous study conducted in Eastern Uganda (Waweru E. *et al.*, 2019) and Nigeria (Lateef M.A. and Mhlongo E.M., 2022). However, in contrast with the previous study conducted in Kenya (Ahmed B.D., 2023), in which majority of participants highlighted that health care providers provided effective care. This

discrepancy suggests that while some regions face significant challenges in meeting patient expectations for PCC, others may be making strides in improving care delivery.

The triangulation of quantitative and qualitative findings revealed a clear and coherent association between patient's poor perception of patient centered care and factors such as length of hospital stay, information on treatment plan, and patient involvement in their management decision-making process, patient intimacy with health care providers, and availability of medication with the qualitative findings complementing the quantitative results.

The odds that being urban residence were 2.15 times more likely perceived poor perception of patient centered care than those being rural residence. The finding of this study is supported by the previous study conducted in Ethiopia (Birhanu F. *et al.*, 2021, Ewunetu M. *et al.*, 2023, G/egziabher R. *et al.*, 2022). It might be due to Urban residents had more access to health care and health education, resulting in higher expectations from health care providers. When these expectations are unmet, it can lead to dissatisfaction and disengagement from care. As a result, urban participants may view patient-centered care (PCC) practices as poorer compared to those experienced by rural residents.

Majority of focus group discussions (FGDs) participants from urban areas perceived hospital services as not good enough. However, some urban participants who have regularly follow up at the hospital expressed satisfaction with the services. In contrast, many FGDs participants from rural areas viewed hospital services positively, especially when compared to their previous experiences with local health centers. This stud was supported by the previous study conducted in south Nigeria (Nwankwo O.N. *et al.*, 2022), Seven Community of East and West Africa (Ameh S. *et al.*, 2021), China (Liu Y. *et al.*, 2018).

Patients who were admitted at hospitals for 11-20 days were 2.98 more likely perceived poor patient-centered care practice than the encounter part. This finding is in line with previous study conducted in Ethiopia (Birhanu F. *et al.*, 2021, Ewunetu M. *et al.*, 2023, G/egziabher R. *et al.*, 2022). This is due to long time hospital stay leads participants to develop hospital acquired infection, increasing anxiety and economic burden this affect the health outcome of participants which result ln perceived poor PCC (Han T.S. *et al.*, 2022, Siddique S.M. *et al.*, 2021).

Some of FGDs participants those stayed more than 2 weeks in the hospitals perceived that lack of good health care practice that leads them to potential financial and works loss, even they commented that, as health care providers responsiveness were decrease. This study was supported by the study conducted in Benishangul Gumuz, Regional State , North West Ethiopia (Kewi S. *et al.*, 2018) and South Africa (Bosire E.N. *et al.*, 2020).

Patients who did not knew their health care providers were 1.93 times more likely perceived poor patient-centered care practice than those didn't know their health care providers, this study is supported by previous study conducted in Ethiopia (Birhanu F. *et al.*, 2021, Ewunetu M. *et al.*, 2023, G/egziabher R. *et al.*, 2022). This might be due lack of weak patient to health professional relationship leads to miss trust, poor communication, miss diagnosis, and lack of holistic care this increased health care cost and decreasing participants health outcome which leads the participants to had poor PPCC than those have good intimacy with health care providers (Wang K. *et al.*, 2017, Lindau S.T. *et al.*, 2011, Arends S.A.M. *et al.*, 2024).

Majority of FGDs participants commented that patients that had no good relationship with health care providers were not get hospital service easily, this study was supported by previous study conducted in Jeddah Saudi Arabia (Webair H.H. *et al.*, 2021, Alkhaibari R.A. *et al.*, 2023a).(Molina-Mula J. and Gallo-Estrada J., 2020) (Rutz M. *et al.*, 2017).

Patients who didn't received information on medication were 1.98 times more likely perceived poor patient-centered care practice than the informed one, this is supported by previous study conducted in Ethiopia (Birhanu F. *et al.*, 2021, Ewunetu M. *et al.*, 2023, G/egziabher R. *et al.*, 2022). This may due to participants who had no information on medication may develop poor adherence to treatment, poor compliance and risk for medication error this result in poor health outcome, which leads participants to perceived poor PCC than the informed participants (Brown M.T. and Bussell J.K., 2011, van Herpen-Meeuwissen L.J.M. *et al.*, 2022, Moges T.A. *et al.*, 2024, Mekonnen G.B. and Gelayee D.A., 2020).

Qualitative findings showed that, majority of FGDs participants perceived lack of information on their treatment plan, this study was supported by previous study conducted in Eastern Uganda (Waweru E. *et al.*, 2019), South Africa (Bosire E.N. *et al.*, 2020), Jeddah Saudi Arabia (Webair H.H. *et al.*, 2021), Nigeria (Lateef M.A. and Mhlongo E.M., 2022), Netherland (Lateef M.A. and Mhlongo

E.M., 2022)(Lateef M.A. and Mhlongo E.M., 2022)(Lateef M.A. and Mhlongo E.M., 2022) (Lateef M.A. and Mhlongo E.M., 2022) (Lateef M.A. and Mhlongo E.M., 2022), (Bekker C.L. *et al.*, 2020), Tanzania (Okeny P.K. *et al.*, 2024).

Participants who did not involve in their management decision-making process were 1.80 times more likely perceived poor PCC practice than involved one. This is supported by previous study conducted in Ethiopia (Birhanu F. *et al.*, 2021, Ewunetu M. *et al.*, 2023, G/egziabher R. *et al.*, 2022). This might be due to Lack of patient involvement in their management decision-making process this leads participants to reduce adherence to treatments, increase anxiety, and stress, ineffective communication, misalignments of goals, increased hospital readmissions, rising healthcare costs, worsened health literacy and missed opportunities for share decision making this result poor participants satisfaction and health outcome this leads respondents to perceive poor PPCC than involved one (Marzban S. *et al.*, 2022, Kemp K.A. *et al.*, 2017, Van der Voorden M. *et al.*, 2023, Valderas Martinez J. *et al.*, 2016).

FGDs findings showed that, majority of participants perceived that lack of involvement in their management decision making process .This findings was supported by the previous study conducted in Saudi Arabia (Alkhaibari R.A. *et al.*, 2023a), South Africa (Bosire E.N. *et al.*, 2020), Israel (Lipovetski O. and Cojocaru D., 2020), Malawi (Makwero M. *et al.*, 2021).

Participants who perceived hospitals access to service were not easy were 2.49 times more likely to perceive poor PCC practice than those perceive hospital had easy access to service. This is supported by previous study conducted in Ethiopia (Birhanu F. *et al.*, 2021, Ewunetu M. *et al.*, 2023, G/egziabher R. *et al.*, 2022). This might be due to lack of access to hospital service causes delayed treatment (worsening conditions, increased complications), increased mortality rates, preventive care shortfalls (missed screenings, health education),economic burden, increased stress and inadequate follow-up care (poor chronic disease management) this result in poor health outcome which leads the participants to perceive poor PCC than those who were easily access to service of the hospitals (Vecchio N. *et al.*, 2018, Clay S.L. *et al.*, 2021).

Most of FGDs participants noted that, accessing services in the hospitals were challenging. This study was supported by previous study conducted in Eastern Uganda (Waweru E. *et al.*, 2019).

Participants who were not received prescribed medication from hospitals were 2.53 times more likely to perceive poor PCC when compared to those who were receive the prescribed drugs. This study is supported by previous study conducted in Ethiopia (Birhanu F. *et al.*, 2021, Ewunetu M. *et al.*, 2023, G/egziabher R. *et al.*, 2022). This is due to the absence of prescribed medication from a hospital can leads to treatment delays, increased complications, Increased costs, lose trust and confidence (patient perception that their care is inadequate or that the hospital is disorganized), increase anxiety and stress levels among patients, perceived poor quality of care (believe that the hospital does not prioritize their health needs), and increase emotional response (trigger feelings of frustration or helplessness) this leads the participants who were not get prescribed medication from hospitals to perceive poor PCC than the encounter part (Hussien M.A. *et al.*, 2021, Atif M. *et al.*, 2021, Phuong J.M. *et al.*, 2019).

Majority of FGDs participants commented that, absence of prescribed drugs from the hospitals, this leads them to financial loss and increase their anxiety and stress .This study was supported by previous study conducted in Eastern Uganda (Waweru E. *et al.*, 2019), South Africa (Bosire E.N. *et al.*, 2020).

5.1. Strengths and limitations

5.1.1. Strengths of the study

The mixed methods approach used for this study will provided valuable information to the stake holders to get deep insight into factors affection patients perceptions to patient centered care.

Used multi-sectoral study with large sample size.

5.1.2 Limitations of the study

Self-report data likely introduce social desirability bias.

6. CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

The study revealed a high magnitude of poor perceptions of patient-centered care among participants, Urban residence, prolonged hospitalization, unavailability of prescribed medications, difficulty of access to hospital services, and lack of information about treatment options. Furthermore, patients' poor intimacy with healthcare providers and lack of involvement in their management decisions making process were factors significantly associated with poor perception of patient centered care.

6.2. Recommendations

For Health Bureaus

⇒ Regularly assess the availability of essential medicine in health facilities and take corrective access as needed.

⇒ Developing target hiring initiative to reduce shortage of health care provides.

⇒ Equipment the hospitals with necessary supplies and resources to maintain clean line and comfort.

⇒ Establish regular assessments of patient's perceptions of care to identify areas for improvement.

For Hospital Administrators

⇒ Employment care coordination strategies to minimize unnecessary prolonged hospital stays.

⇒ Ensure safe Environment for patients.

⇒ Ensure that adequate numbers of qualified health care providers are available at all times.

⇒ Ensure that prescribed medications are readily available and communicate clearly about any changes to medication plans.

⇒ Streamline processes to improve access to hospital services, ensuring patients can easily obtain the care they need.

⇒ Provide educational materials that empower patients to take an active role in their care.

⇒ Develop programs that recognize and reward staff who exemplify patient-centered care principles.

⇒ Establish metrics to regularly evaluate the effectiveness of patient-centered care initiatives.

⇒ Use evaluation data to inform ongoing improvements and adjustments to patients centered care practices.

For Healthcare Providers

⇒ Offer emotional support that address patients concern and fear.

⇒ Prioritized patient needs, preference, and values in all interactions.

⇒ Foster open communication with patients regarding their conditions and treatment options.

⇒ Regularly check for understanding and address any questions patients may have.

⇒ Involve patients in decision-making processes about their care to improve their sense of agency and satisfaction.

⇒ Provide targeted educational resources that cater to the specific needs of patients, especially those with limited intimacy with health care providers.

For Future Researchers

⇒ Conduct longitudinal studies to assess changes in patient perceptions over time and the long-term effects of implemented interventions.

⇒ Investigate patient-centered care practice across health care providers to identify unique challenges and effective strategies.

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8. ANNEXES

8.1. Information Sheet and Informed voluntary consent form for the Heads of the Hospitals

My name is Kedir Umer Boru, I am working as a principal investigator of the study being conducted in this institution. I am Master's student at Haramaya University, College of Health and Medical Sciences. I kindly request you to lend me your attention to explain to you about the study and your institution being selected as the study setting.

. **1. The study title:**

Perceptions of patient-centered care and associated factors among adult patients admitted to West Hararge public hospitals from September 20, to October 20, 2024.

2. Purpose/aim of the study:

The findings of this study can be of a paramount importance for the West Hararge zone health bureau, Chiro, Gelamso and Hirna hospitals. Administrative department, for the study facilities and Stockholders to describe perception of patient centered care and to plan intervention programs by addressing the gaps. Moreover, the aim of this study is to write a thesis as a partial requirement for the fulfillment of a Master's of Adult health nursing program for the principal investigator.

3. Procedure and duration:

The participants are chosen to take part in this study. Their honest answer is very important to our study. Data collectors will be collected data from selected client's by using pre-tested 73 structured questionnaire that taking 30-40 minutes through face to face interview and 40-60 minutes for 5 FGD guiding question, to provide me with pertinent data that is helpful for the study. So, I kindly request the participants to spare this time with me.

4**. Risk and benefit**

The risk of participating in this study were very minimal, but only taking 30-40 minutes for structured questionnaires and 40-60 minutes for FGD guiding question from the participant's time. There would not be any direct payment for participating in this study. But, the findings from this research may reveal important information for the local health planners. The result of this study will be addressed to the authorities in order to improve patients centered care to assure health care quality.

5. Confidentiality

The information that you provided was be kept confidential. There was no information that identified the participant's particular. The findings of the study were general for the study population and was not reflect anything particular about the individual clients. The questionnaires and FGD guiding question were coded to exclude showing names. No reference was made in oral or written reports that could link participants to the research.

6. Rights

Participation in this study is fully voluntary. The participants have the right to declare to participate or not in this study. If they decide to participate, they have the right to withdraw from the study at any time and this was not label them for any loss of benefits to which they otherwise are entitled. They do not have to answer any question that they do not want to answer. The Hospital has also the right to stop this study from being conducted if any misdeeds and unethical procedures are observed during the data collection process in the Hospital's premises.

7. Contact address

If there are any things unclear or you need furthers information's please contact

Name of PI**: Kedir Umer Boru, phone** No**. +125910506113 /+125909805360**

Email address, kedir123u@gmail.com

If you have any doubt about this research you can contact the responsible Institutional Health research Ethics Review Committee (IHRERC) Haramaya University, collage of health and medical science; office phone **0254662011 or P.O. Box 235, Harar,** Ethiopia.

8. Declaration of informed voluntary consent

I have read the participants information sheet. I have clearly understood the purpose of the research, The procedures, the risks and benefits, issues of confidentiality, the rights of participating, and the Contact address for any queries. I have been allowed to ask questions about things that may have been unclear. I was informed that participants have the right to withdraw from the study at any time or not to answer any question that they do not want. I am also informed that the Hospital has

the right to stop this study from being conducted if any misdeeds and unethical procedures are observed during the data collection process in the Hospital's premises.

Therefore, I declare my voluntary consent on behalf of _____ management to allow this study to be conducted in the Hospital with my initials (signature).

Name and Signature of Head of the Hospital: _____ _____ Date _____/___/____

Name and Signature of Principal Investigator: _____ _____ Date ____/____/_

8.2. Information sheet and informed voluntary consent form for Study Participants

My name is _____, I am working as a data collector for the study being conducted in this hospital by **Kedir Umer Boru** (BSc). Who is studying for his Master's degree at Haramaya University, College of Health and Medical Sciences? I kindly request you to lend me your attention to explain to you about the study and being selected as the study participant.

1. The study/project title:

Perceptions of patient-centered care and associated factors among adult patients admitted to west Hararge public hospitals from September 20, to October 20, 2024.

2. Purpose/aim of the study:

The findings of this study will be paramount importance for the hospitals to plan intervention programs on patient's perception of patient -centered care and it will provide information about the existing gap. Moreover, this study aims to write a thesis as a partial requirement for the fulfillment of a Master's program in Adult Health Nursing for the principal investigator.

3. Procedure and duration:

Data collector was collected data from selected client's by face to face interview questionnaire using pre-tested structured a questionnaire that contains around 73 questions, to provide me with pertinent data that is helpful for the study. The entire process only takes 30-40 minutes to complete.

4**. Risk and benefit**

The risk of participating in this study is very minimal, but only taking 30-40 minutes from the participant's time. There would not be any direct payment for participating in this study. However, the findings from this research may reveal important information for health institutions planners in order to improve patients centered care to assure health care quality.

5. Confidentiality

All identified information obtained from this study was kept strictly confidential. The information collected for this research project was kept secret. There was no information that identified you in particular. The findings of the study were general for public/all concerned body and was not reflect any thing particular of individual persons or housing. The questionnaires were coded to exclude

showing names. No reference was made in oral or written reports that could link participants to the research.

6. Rights

Participation in this study is fully voluntary. You have the right to declare to participate or not in this study. If you decide to participate, you have the right to withdraw from the study at any time and this will not label you for any loss of benefits to which you otherwise are entitled. You do not have to answer any question that you do not want to answer.

7. Contact address

If there are any questions or enquires any time about the study or the procedures, please contact Principal Investigator: **Kedir Umer Boru** at mobile phone**: +125910506113 /+125909805360 and Email address -kedir123u@gmail.com** as well as Institutional Health Research Ethics Review Committee (IHRERC) of Haramaya University College of Health and Medical Sciences at office **phone 0254662011 or P.O. Box 235, Harar**, Ethiopia.

8. Declaration of informed voluntary consent

I have read /he/she read to me the participant information sheet. I have clearly understood the purpose of the research, the procedures, the risks and benefits, issues of confidentiality, the rights of participating, and the contact address for any queries. I have been allowed to ask questions about things that may have been unclear. I was informed that I have the right to withdraw from the study at any time or not to answer any question that I do not want.

Therefore, I declare my voluntary consent to participate in this study with my initials (signature).

Name and signature of participant: _____ Date ___/_____/_____

Name and signature of Data Collector: _____ Date _____/_____/_____

Thank you for your cooperation

8.3. Questionnaires

Dear Respondents:

This questionnaire is prepared to assess Perceptions of patient-centered care and associated factors among adult patients admitted to west Hararge public hospitals from September 20, to October 20, 2024.

The assessment will be made as partial fulfillment for the requirements of Master's Degree in Adult Health Nursing Specialty for the principal investigator. The questionnaire will take only about 30-40 minutes to complete. You are kindly requested to provide a genuine response to the questions. The information you provide is confidential and used only for this study. If you have any confusion or question, please don't hesitate to ask the data collector. Your cooperation and participation until the completion of the questionnaire are very crucial for the successful completion of the assessment.

Thank you in advance for your cooperation!!!

Instruction: please circle the number in front of option the patients choose and fill in the blank space that best describe the patients at the right side of the table.

Questionnaire code: _____			
Data collection date: _____			
Data collector's name and signature: _____ _____			
Supervisor's Name and signature: _____ _____			
Hospital name: _____			
Section I: - Socio-demographic characteristics of respondent.			
S/NO.	**Variables**	**Response**	**Remark**
101	Your Sex?	1.Male 2.Female	
102	How old are you?	----------Years	
103	Your Residence?	1. Urban 2. Rural	
104	Your marital status?	1. Single 2. Married 3. Widowed 4. Divorced	

105	Your religion?	1. Orthodox 2. Muslim 3. Protestant 4. Other specify _____	
106	What is your educational level?	1. Cannot read and write 2. Can read and write 3. Primary School 4. Secondary School and above	
107	Your job status?	1.Farmer 2. Government employed 3.Non-Government employed 4 Merchants 5.House Wife 6. Others specify_____	
108	Your monthly Income levels?	_____ETbirr	

Section II: Institutional related factors

S/NO	**Variables**	**Response**	**Skip**
201	The numbers of hospitalization?	1. For the 1st time 2. Twice 3. Three times 4. Four and above	
202	Hospitalization duration?	_____days	
203	Ward	1. Medical 2. Surgical 3. Gyn	
204	Does hospital have reception room?	1. Yes 2. No	
205	Is the hospital structure (building, Environment) is attractive?	1. Yes	

		2. No	
206	Does your admission room have adequate space and clean?	1. Yes 2. No	
207	Is hospital toilet being clean?	1. yes 2. No	
208	How long did it take you to get to the facility?	_____minute/hours	
209	Is easy access to services in hospitals	1, Yes 2. No	
210	Types of service you get in this hospital is?	1.Payement 2. Free 3.Inssurance	
211	If you say payment for Q210 Is the service delivery cost is affordable to you?	1. Yes 2. No	If you say 2&3for q210 skip to q212
212	Is food and drinking prepared by hospital is based on your health preference (health care providers orders)?	1. Yes 2. No	
213	Do you think the hospital have enough medical equipment?	1. Yes 2. No	
214	Do you get all prescribed medication from this hospital?	1 Yes 2. No	
215	Do you get service in pharmacy and other diagnostic center at any time you want?	1. Yes 2. No	

Part III: - Health care providers related factors

S/NO.	**Variables**	**Response**	**Skip**
301	Does health care providers speak politely and respecting you during providing care to you?	1.Yes 2. No	
302	Do you get specialist at any consultation time?	1.Yes 2. No	

303	Do you get health care providers during your care on the time?	1.Yes 2. No	
304	Does information on your safety alert is provided by health profession?	1.Yes 2. No	
305	Do you think health care providers have skill on your care?	1. yes 2. No 3. I don't know	
306	Does health care providers' give full information about your treatment options?	1.Yes 2. No	
307	Does health care Providers' familiar with your disease?	1.Yes 2. No	
308	Does health care providers involve you in your management decision?	1.Yes 2. No	
309	Do you think health care providers give holistic care for you?	1.Yes 2. No	
310	How many times they give care to you per day?	1. Once 2. Two time 3. Three times 4. Four & above	

Par IV: Patients related factors

401	Do you have good health perception for yourself?	1.Yes 2. No	
402	Do you have any drug addiction?	1.Yes 2. No	
403	If say yes to q402 which one?	1. Alcohol 2. Chat 3. Smoking 4. Others Specify _____	If you say No to q402, Skip to 404.

404	Do you have any awareness about your diseases /diagnosis?	1.Yes 2. No	
405	Do you have intimacy with your health care providers?	1.Yes 2. No	

Section V: Questions to Assess Perception of Patient- Centered care among admitted adult patients to West Hararge zone Public Hospitals, Oromia Regional State, Ethiopia, 2024.

This will be assessed by five-point Likert using agreement (strongly disagree=1, disagree=2, neutral=3, agree=4 and strongly agree=5) then recorded or categorized as strongly disagree, disagree and neutral=1, agree and strongly agree=2 for analysis.

Note: Encircle from the given option.

S/No.	**Question on dimension of PCC**	**Response**				
	To what extent you are agree on the health care given to you by health professional.	**Strongly dis agree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
301	Attention was given to your diseases condition.	1	2	3	4	5
302	Your wishes and preferences were taken into account when choosing a treatment.	1	2	3	4	5
303	You were involved in decisions about your treatment.	1	2	3	4	5
304	The influence that the treatment can have on your life were taken into account.	1	2	3	4	5
305	You were helped to determine your own treatment goals.	1	2	3	4	5
306	You felt supported to achieve your treatment goals.	1	2	3	4	5
307	You received advice that you are really could use.	1	2	3	4	5
308	Attention was given to your physical comfort (such as the management of pain, shortness of breath).	1	2	3	4	5
309	Attention was paid to fatigue and insomnia.	1	2	3	4	5
310	The (waiting) rooms were clean.	1	2	3	4	5
311	The (waiting) rooms were comfortable.	1	2	3	4	5
312	In the treatment room(s) and at the counter there was sufficient privacy.	1	2	3	4	1
313	Everyone was well informed; you only had to tell your story once.	1	2	3	4	5
314	The care was well attuned between the practitioners involved.	1	2	3	4	5
315	You knew who was coordinating your care.	1	2	3	4	5

316	You could easily contact someone with questions.	1	2	3	4	5
317	When being referred to another care provider (specialist) you were well-informed about your treatment.	1	2	3	4	5
318	With a referral, all your information was passed on correctly.	1	2	3	4	5
319	Advice (such as medication) from different practitioners was well interrelated.	1	2	3	4	5
320	The treatment of the first care provider is in line with the treatment of other care providers.	1	2	3	4	5
321	Emotional support was also provided.	1	2	3	4	5
322	Attention was paid to possible feelings of fear, gloom and anxiety.	1	2	3	4	5
323	You were made aware of the possibilities for more intensive emotional support.	1	2	3	4	5
324	Attention was paid to the impact of your health on your private life (family, relatives, work, social life).	1	2	3	4	5
325	It was no problem to go from your home hospital and back again.	1	2	3	4	5
326	The general practice (getting service delivered in hospital) was easily accessible for you and others disable person.	1	2	3	4	5
327	You could easily schedule an appointment quickly.	1	2	3	4	5
328	On a visit I didn't have to wait long before it was my turn.	1	2	3	4	5
329	You could easily request a repeat recipe.	1	2	3	4	5
330	You were well informed.	1	2	3	4	5
331	The information you received were well explained to you.	1	2	3	4	5
332	You had easy access to your own data (lab results, medication overview, referrals).	1	2	3	4	5
333	You could ask all the questions you wanted.	1	2	3	4	5
334	With your consent, relatives were involved in your treatment.	1	2	3	4	5
335	Attention was given to care and support provided by your family members.	1	2	3	4	5
336	Attention was given to possible questions from your family members.	1	2	3	4	5

8.4. Afan Oromo Version of Information Sheet and Informed Voluntary Consent Form for the Study Participants

Duraan dursee nagaan Koo isin haa ga'u jechaa, maqaan Koo obboo_____jedhama.Yeroo ammaa kana Yunibarsiitii Haramaaya keessatti Fayyaa ga'essootanin digirii lammaffaaf eebbifamuuf qorannoo obboo kadiir Umariin gaggeefamu irratti odeeffannoo walittii qabuutti jirra. Qorannoo kana gaggeessuun dura haala fi maalummaa qorannoo kanaaf raga tahu isiniif ibsuufin yaala.

Mata duree qorannichaa: Baha Itiyoophiyaatti, bara 2016tti, mootummaa naannoo Oromiyaa, Goodia harargee lixaati hoospitaalota mootummaa kanneen uummataaf tajaajila Kennan keessatti hubannoo maaamiltoonni gargaarsa dhukkusataa giddu galeessa godhate irratti qabanii fi sababoota waldhaansa dhukkubsataa giddu galeesse godhate kanaaf hudhaa tahaan wajjiin kan walqabatan irratti Kan xiyyeeffatuudha.

Haalaa fi yeroo qorannichaa: Qorannoo kana irratti ragaan Kan walitti qabamu namoota umriin isaanii wagga kudha saddeeti olii kan ciisanii yaala fayyaa arkachaa jiran irratti kan xiyyeefatu tahaa.. Kanneen carraan ba'eef hundi odeeffannoo barbaachisaa ta'ee akka kennani fi akkasumas odeeffannoon ragaa af-gafii adda addaa kan fudhatamu ta'a. Qorannoon ogeessan ni godhama, akkasumas gaaffileen adda addaa ni gaafatamu. Namootan qorannoo kanaaf filatamtan Marti Kan qorannoo kana gaggeessinu yoo hayyama isin irraa argannee fi isin fedhii qabaataniidha, Kanaaf qorannoo gaggeessinuu fi gaafii isin gaafannuuf daqiiqaa 30-40 qofa isin duraa fudhanna.

Bu'aa fi miidhaa qorannoon Kun fiduu danda'u: Qorannoo kana keessatti hirmaachuu fi odeeffannoo kennuun miidhaa tokkollee isin irraan waan ga'u hin qabu. Garuu, yeroo keessan daqiiqa 30-40 isin jalaa akka fudhatuudha. Qorannoo kana irratti hirmaachuu keessaniif kaffalttiin isiiniif raawwatamuu ykn kennamu tokkolleen hin jiru. Akkasumas qorannoo kana irratti hirmaachuuf baasin isin baaftan tokkolleen hin jiru. Garuu qorannoon Kun gara fuula duraatti waldhaansi dhukkubsaataa giddu galeessa godhate akka dhukkusataaf kennamu gochuu keeysatti gahee guddaa akka taphatu isinitti himuun barbaada.

Iccitii odeeffannichaa: Odeeffannoon qorannoo kanaaf funaanamu hunduu iccitiin isaa Kan eegamuu dha. Namoonni odeeffannoo kana kennitan maqaan keessan hin barreeffamu, garuu mallattoo/lakkoofsi addaa Kan isinii kennamu ta'uusaa isiniif ibsuu barbaadaa. Itti dabaluun odeeffannoo kana Nama qorannoo kana adeemsisuun ala namni kammiyyuu akka hin-argine ni godhama.

Mirga qorannoo irratti hirmaachuu fi hirmaachuu dhiisuu: Qorannoo kana irratti hirmaachuu fi hirmaachuu dhiisuun mirga Nama dhuunfaa taha. Hubannoo gadi fageenyaan yoo barbaaddan teessoowwan armaan gadii dubbisuun argachuu dandeessu.

Abbaa qorannichaa: Maqaa: Kadiir Umar Boruu, Teessoon: Ciro, Bilbila: 0910506113/0909805360 ***Email: kedir123u@gmail.com*** Koree Jiddu Galeessa Qorannoo fi Qo'annaa: Haramaayaa Yunibarsiitii, koollejjii Saayinsii Fayyaa L.S.P: 235, Bilbila: 0254662011. Harar, Ethiopia.

Hayyamamoo ta'uu hirmaattootaa mirkanneessuu

Ani Kan armaan gaditti mallatteesse kaayyoo qorannoo kanaa hubadhee odeeffannoo gubbaa iratti kenname bu'ura godhachuun qorannoo kana hospitaala keenya keessatti ana waliin akka adeemsiftan isiiniif hayyameen jira.

Mallattoo warraa/hirmaata qoraanichaa _____Guyyaa____/____/_____

Maqaa fi mallattoo odeeffannoo walitti qabaa_____Guyyaa /___/_____

8.5. Afaan Oromo version questionaries

Kutaa 1ffaa: - Gaafilee haala hawaasummaa fi dimoograafii ilaalchisee.

Koodii gaafiiwwanii : _____			
Guyyaa odeefannoon itti sassaabamu : _____			
Maqaafi mallattoo odeefannoo sassaabdotaa : _____ _____			
Maqaa fi mallattoo hordofaa garee : _____ _____			
Maqaa hospitaalichaa :_____			
Lakk..	**Gaafii**	**Deebii**	**Darbii**
101	Saalli keessan	1.Dhiira 2.Dhalaa	
102	Umriin keessan	**Waggaa:_____**	
103	Iddoon jireenya keeysanii	1. Magaalaa 2. Baadiyyaa	
104	Haala fuudha fi heeruma keeysanii ilaalchisee ?	1. kan hin fuune/heerumne 2. kan fuudhe/heerumte 3. Gursummaa 4. kan wal hiikan/gargar bahan	
105	Amantaan kam hordofta	1.Ortodoksii 2.Muslima 3.Protestaantii 4.Kan biraa _____	
106	Sadarkaan barnoota keeysanii maal fakkaata ?	1.Kan bareesuufi dubbisuu hin dandeenye 2.Baressuu fi dubbisuu nin danda'aa garuu baruumsa idilee hin baraane 3.Sadarkaa 1ffaa (1-8) 4.Sadarkaa 2ffaa (9-12) fi isaa oli	
107	Hojiin keeysan ?	1.Qonnaaan bulaa	

		2. Hojjataa mootummaa 3.Hojjataa miti- mootummaa 4 Daldalaa 5. Kan biraa_____	
108	Galiin ji,atti arkattan tilmaaman qarshii meeqa ?	**Qarshii Ethiopia _____**	

Kutaa 2ffaa : Gaafilee muuxannoo dhaabata/hospitaala ilaalchisee.

Lakk.	**Gaafii**	**Deebii**	**Darbii**
201	Yeroo meeqaffaaf hospitaala kana dhuftee ?	1. Yeroo jalqabaatif 2.Yeroo lammaffaf 3.Yeroo sadafaaf 4. Yeroo afraffaafi sanii oliif	
202	Guyyaa meeqaf hospitaala kana ciiste?	Guyyaaa _____	
203	Kutaa kam ciiste ?	1.Kutaa dhukkuba keessoo 2.Kutaa baqaqsanii yaalu 3.Kutaa ciiphsaii yaaluu gadaamessaa	
204	Hospitaalli kutaa simannaa maamiltoota ni qabaa?	1. Eeyyen 2.Lakkii	
205	Haalli jaarmiya fi qulqullinni keessoo hospitaala nama ni hawwataa?	1.Eeyyeen 2.Lakkii	
206	Iddoon ciisicha keeysanii bal,aa fi qulqulluudha ?	1. Eeyyen 2.lakkii	
207	Manni fincaanii kan hospitaala qulqulluudha ?	1. Eeyyeen 2. Lakkii	
208	Hospitaala kana dhufuuf yeroo hammamii isinitti fudhata ?	Daqiiqa /sa'aatii_____	

209	Halli geejibaa fi meenshaleen hospitaala keeysati geejibaaf itti fayyadaman fknf kan akka ambulaanci, wiilcharii fi kkf gaaridha ?	1, Eeyyen 2. lakkii	
210	Gosootni tajaajila isin arkatan ?	1.kaffaltaani 2. Bilisa 3.Inshuraansii	
211	Yoo kaffaltiini jettan gaafi 210 f gatiin isaa madaalawaadha ?	1. Eeyyen 2.Lakkii	Gaafii 210nif Yoo2&3 ta'e darbii gar 212tti
212	Nyaataa fi dhugaatin hospitaala keeysatti qophaa'an fedhii keeysanii fi ajaja ogeeysa fayyaa keeysanirratti ni hundaayaa?	1. Eeyyen 2.lakkii	
213	Hospitaalli meenshalee waldhaansaa gahaa qaba jettee ni yaada ?	1. Eeyyen 2. Lakkii	
214	Qorichoota isiniif ajajaman hunda hospitaala keeysa ni arkattuu ?	1 Eeyyen 2. lakkii	
215	Tajaajila faarmaasiitii fi iddoolee qorannoo adda addaa yeroo barbaadanitti ni arkattuu?	1. Eeyyen 2. Lakkii	

Kutaa 3ffaa: - Rakkoolee ogeeyyi fayyaatin wal qabatan.

Lakk.	Gaafii	Deebii	Darbii
301	Ogeeysonni fayyaa yeroo tajaajila isiniif kennan kabajaan /haala qabeeysan isinitti ni dubbatuu?	1.Eeyyen 2. Lakkii	
302	Yeroo isin barbaachisetti ogeeysa speeshaalistii dhibee keeysanii ni arkattuu?	1.Eeyyen 2. Lakkii	
303	Ogeeysota isin tajaajilan yeroon ni arkattuu ?	1.Eeyyen 2. Lakkii	

304	Hubannoon ofeegannaa isin hospitaala keeysatti godhuu qabdanirratti isinii fi maati keeysaniif ogeeysa fayyaatin ni kennamaa?	1.Eeyyen 2. Lakkii	
305	Ogeeyyin fayyaa gargaarsa isiniif godhanirratti dandeettii ogummaa ni qabu jettee ni yaadda ?	1. Eeyyen 2. Lakkii 3.An hin beeku	
306	Filannoo waldhaansa keeysanirratti ogeeysi fayyaa hubannoo gahaa isiniif ni kennaa ?	1.Eeyyen 2. Lakkii	
307	Ogeeyyin fayyaa dhukkuba keeysanirratti hubannoo ni qabuu j?	1.Eeyyen 2. Lakkii	
308	Ogeeyyin fayyaa murtee waldhaansa keeysaniif godhamu irratti isin ni mariisisuu ?	1.Eeyyen 2. Lakkii	
309	Ogeeyyin fayyaa waldhaansa madaalawaa fi waliigalaa naaf kennu jettee ni yaadda?	1.Eeyyen 2. Lakkii	
310	Ogeeyyin fayyaa guyyatti yeroo meeqa isin laaluu ?	1.Tokko 2. Lama 3. Sadi 4. Afurii fi sanii ol	

Kutaa afur : Rakkoolee dhukkubsataan wal qabatan.

401	Fayyummaa kee/tee eeggachuurratti hubannoon ati qabdu gaariidha ?	1.Eeyyen 2. Lakkii	
402	Araada adda addaa ni qabdaa ?	1.Eeyyen 2. Lakkii	
403	Yoo niin qaba jette gaafi 402f isa kam qabda ?	1.Alkoolii 2.Jimaa 3.Sigaara 4.Kan biraa _____	Yoo lakkii ta'e gaafi 402ff darbii gaafi 404ti
404	Waa'ee dhukkuba keetiratti hubannoo ni qabdaa ?	1.Eeyyen 2. Lakkii	
405	Ogeeyyii fayyaa wajjiin walitti dhufeenya gaari ni qabdaa ?	1.Eeyyen 2. Lakkii	

Kutaa 5ffa: - Gaafilee hubannoo dhukkubsataan gargaarsa dhukkubsataa giddu galeessa godhate kan ogeeyyii fayyaatin hospitaala uumataa keeysatti kennamurratti qaban ittiinqoratan.

Sadarkaa deebi gargaarsa ogeeyyin fayyaa dhukkubsataaf kenniturrattii : 1= Guutumaan guututti hin deegaru 2= waa xiqqo niin deegara, 3= wallaba, 4 = Niin deegara, 5= Sirrittin deegara.

Hubadhu : filannoo dhukkubsataan filatetti marsii.

		Deebii				
Lakk.	Hammam takka deeggartaa gargaarsa ogeeyyii fayyaatin siif kenname.	**Guutumaa guututti hin deeggaruu**	**Waa xiqqo niin deeggaraa**	**walabaa**	**Niin deeggaraa**	**Sirrittin deeggaraa**
301	Haala dhukkuboota keetitiif xiyyeefannoon siif kennamee ture.	1	2	3	4	5
302	Yeroo wal'aansa filattu fedhii fi filannoon kee tilmaama keessa galfamee ture.	1	2	3	4	5
303	Murtoo waa'ee wal'aansa keetii irratti hirmaachaa turte.	1	2	3	4	5
304	Dhiibbaan wal'aansi dhiee keeti jireenya kee irratti fiduu danda'u tilmaama keessa galfamee ture.	1	2	3	4	5
305	Akka galma waldhaansa keeti dhugoomsituuf gargaarsi barbaachisu siif godhameeraa.	1	2	3	4	5
306	Kaayyoo waldhaansa keetii galmaan gahuuf gargaarsi itti quufinsa qabu siif godhameeraa. .	1	2	3	4	5
307	Gorsi dhugaan itti fayyadamtu siif godhameet jiraa.	1	2	3	4	5
308	Xiyyeefannoon haala mijataa qaama keetif uumu (kan akka dhukkubbii too"achuu, hargansuun sitti cicituuf) siif kennameera.	1	2	3	4	5
309	Xiyyeefannoon hirriiba dhabuu fi dadhabii keetif kennameera.	1	2	3	4	5
310	Kutaan ciisichaa (turtiikeessanii) qulqulluudhaa.	1	2	3	4	5
311	Kutaan ciisichaa(turtii keessanii) mijjataadha.	1	2	3	4	5

312	Kutaa waldhaansa keetii keeysattii fi kutaan alattiis qama keetii fi iccitiin dhukkuba keeti siif eegameera.	1	2	3	4	1
313	Namni hundi odeefannoo gahaa qabaa.waa'ee dhukkuba keeti yeroma takka qofa himaa turtee irra deddeebitee himaa hin ooltuu.	1	2	3	4	5
314	Gargaarsi ogeeyyii garaa garaatin siif goodhamu wal simataa turee.	1	2	3	4	5
315	Nama tajaajila siif kannamaa jiru kana qindeeysu ni beeyta turtee.	1	2	3	4	5
316	Haala salphaan nama barbaade gaafattee arkataa turtee.	1	2	3	4	5
317	Yeroo ogeeysa fayyaa tokkorraa kan biratti si dabarsan hubannoon waa'ee waldhaansa keeti sirritti siif kennamee.	1	2	3	4	5
318	Yeroo kutaa tokkorraa gara kutaa biratti yoo kan hospitaala tokkorraa kan biratti si ergan odeeffannoon sirrii karaa sirriitin siif darbaa turee.	1	2	3	4	5
319	Gorsi (kan akka qoricha) ogeeyyii fayyaa adda addaa irraa kenname walitti dhufeenya gaarii qaba ture.	1	2	3	4	5
320	Wal'aansi ogeessa kunuunsa jalqabaa wal'aansa kennitoota kunuunsa biroo wajjin kan walsimuu dha.	1	2	3	4	5
321	Deegarsi miira ati keeysa jirtuuf siif kennameera.	1	2	3	4	5
322	Miira sodaa, dukkanaa fi yaaddoo ta'uu danda'uuf xiyyeeffannaan siif kennameera.	1	2	3	4	5
323	Rakkoo miraa cimaa si qunnamuu dandamachuuf gargaarsi akka siif godhamu hubannoon siif godhameera.	1	2	3	4	5
324	Dhiibbaa fayyaan keessan jireenya dhuunfaa keessanii(maatii, fira, hojii, jireenya hawaasummaa) irratti qabu irratti xiyyeefannoon siif kennamee.	1	2	3	4	5
325	Mana jireenya keetirraa hospitaala dhaquu fi deebi'uf wanni si rakkisu hin jiru ture.	1	2	3	4	5

326	Tajaajila hospitaalli kennaa jiru haala salphaan arkattee turtee.	1	2	3	4	5
327	Beellamni kee haala salphaa fi siif mijjataa ta'een siif qabamee turee..	1	2	3	4	5
328	Yeroo laalamuuf hospitaala dhufte dabareen kee osoo yeroo dheera hin turre si gahaa turee.	1	2	3	4	5
329	Nagahee irra deebi'amee akka siif qophaa'u salphaatti gaafachuu dandeessa turte.	1	2	3	4	5
330	Hubannoon sirritti siif kennamee turee.	1	2	3	4	5
331	Hubannoon /odeefannoon siif kenname sirritti siif ibsamee turee.	1	2	3	4	5
332	Haala salphaa ta'een iddoo fi firii barbaade arkachuu dandeessee jirtaa (kan akka bu'a qorannoo laboratory, mana qorichaa, iddoo itti isin erganii).	1	2	3	4	5
333	Gaafi baraadde hunda gaafachuu ni dandeessaa.	1	2	3	4	5
334	Hayyama keetin, firoottan sitti dhihoo jiran tajaajila waldhaansa siif godhamu keessatti hirmaatanii turan.	1	2	3	4	5
335	Xiyyeefannoon deegarsa miseensonni maati keeti siif godhaa jiraniif kennamee jiraa.	1	2	3	4	5
336	Xiyyeefannoon gaafileee miseensota maaati keetirraa ka'uu dandahaniif kennamee jiraa.	1	2	3	4	5

8.6. Information Sheet and Informed Voluntary Consent Form for FGD Participants

My name is _____. I am working as a data collector for the study being conducted in this Hospital by **Kedir Umer Boru,** who is studying for his Master's degree at Haramaya University, the College of Health and Medical Sciences. I kindly request you to lend me your attention to explain to you about the study and being selected as the study participant.

1.The study/project title

Perceptions of patient-centered care and associated factors among adult patients admitted to west Hararghe public hospitals from September 20, to October 20, 2024.

2. Purpose/aim of the study

The findings of this study will be paramount importance for the hospitals to plan intervention programs on Perceptions of patient-centered care and it will provide information about the existing gap. Moreover, this study aims to write a thesis as a partial requirement for the fulfillment of a Master's program in Adult Health Nursing for the principal investigator.

3. Procedure and duration

Information will be gathered through focused group discussion guidelines. During discussion your voice will be record for analysis of the information. Your contribution in the study will be paramount importance in improving the quality of service provided by Perceptions of patient-centered care. The entries discussion will be taken approximately 40-60 minutes from your time.

4. Risks and benefits

The risk of being a participant in this study is minimal, but only taking a 40-60 minutes from your time. There would not be any direct payment for participating in this study. However, the findings from this research may reveal important information for the patient -centered care program and health institution planners.

5. Confidentiality

The information that you will provide will be kept confidential. There will be no information that will identify yours particular. The findings of the study will be general for the study population and will not reflect anything particular about the individual. The FGD guiding checklist will be coded to exclude showing names. No reference will be made in oral or written reports that could link participants to the research.

6. Rights

Participation in this study is fully voluntary. You have the right to declare to participate or not in this study. If you decide to participate, you have the right to withdraw from the study at any time and this will not label you for any loss of benefits to which you otherwise are entitled. You do not have to answer any question that you do not want to answer.

7. Contact address

If there are any questions or enquires any time about the study or the procedures, please contact Principal Investigator: kedir umer oru at mobile phone: **+251910506113/+251909805360** as well as Institutional Health Research Ethics Review Committee (IHRERC) of Haramaya University College of Health and Medical Sciences at office phone **0254662011 or P.O. Box 235**, Harar, Ethiopia.

8. Declaration of informed voluntary consent

I have read /he/she read to me the participant information sheet. I have clearly understood the purpose of the research, the procedures, the risks and benefits, issues of confidentiality, the rights of participating, and the contact address for any queries. I have been allowed to ask questions about things that may have been unclear. I was informed that I have the right to withdraw from the study at any time or not to answer any question that I do not want.

Therefore, I declare my voluntary consent to participate in this study with my initials (signature).

Name and signature of participant: _____ _____ Date _____/_____/____

Name and signature of Data Collector: _____ _____ Date _____/_____/_____

Thank you for your cooperation.

8.7. FGD guiding questions

1. How you perceived the health care provided to you in this hospital ?

2. Do you feel your health care providers respected your preference and values ?

3 what is your experience in this hospital about your health coordination and continuity of your health care ?

4. what is your experience about easy access to service delivery in this hospital ?

5. How you perceived the communication between you and health care providers?

6.How do you perceived about hospital environment?

7.How you perceived your involvement in your management decision-making processes?

8.How you perceived your relationship with health care providers?

9.How you perceived information provided to you on your treatment plan .

10.How you experienced the availability of medications in this hospital ?

11.What is your experience during your stays in this hospital ?

8.8. Oromic version information Sheet and Informed Voluntary Consent Form for FGD Participants

Duraan dursee nagaan Koo isin haa ga'u jechaa, maqaan Koo obbo_____ jedhama.Yeroo ammaa kana Yunibarsiitii Haramaaya keessatti Fayyaa ga'essootanin digirii lammaffaaf eebbifamuuf qorannoo obboo kadiir umariin gaggeefamu irratti odeeffannoo walittii qabuutti jirra. Qorannoo kana gaggeessuun dura haala fi maalummaa qorannoo kanaaf raga tahu isiniif ibsuufin yaala.

Mata duree qorannichaa: Baha Itiyoophiyaatti, bara 2016tti, mootummaa naannoo Oromiyaati Goodina harargee lixaatti hoospitaalota mootummaa kanneen ummataaf tajaajila Kennan keessatti hubannoo maaamiltoonni gargaarsa dhukkusataa giddu galeessa gadhatee irratti qabanii fi sababoota waldhaansa dhukkubsataa giddu galeesse godhate kanaaf hudhaa tahaan wajjiin kan walqabatan irratti Kan xiyyeeffatuudha..

Hojimaataa fi yeroo turtii.

Odeeffannoon kan walitti qabamu qajeelfama marii garee xiyyeeffannoo qabuun ta'a. Yeroo marii sagaleen kee odeeffannoo xiinxaluuf ni waraabama. Mariin kun yeroo keessan irraa tilmaamaan daqiiqaa 40-60 fudhachuu dandahaa. Gumaachi keessan qorannoo kana keessatti qulqullinni tajaajila dhukkubsataa giddugaleessa godhate akka fooyya'uff galtee tahaa.

Miidhaaf fi faayidaa qoranno

Miidhan qorannoo kana irratti hirmaatun isin qunnamuu dandahu xiqqaadha, innis yeroo keeysasan irraa daqiiqaa 40-60 qofa fudhachuudhaa. Qorannoo kanarratti hirmaachuuf kaffaltiin kallattiin isiniif kaffalamu hin jiruu. Haa ta'u malee, argannoon qorannoo kanaa sagantaa kunuunsa dhukkubsataa giddugaleessa godhatee fi karoorfattoota dhaabbilee fayyaatif odeeffannoo barbaachisaa ta'e mul'isuu danda'a.

Iccitii Qorannichaa

Odeeffannoon ati kennitu iccitiin isaa ni eegama. Odeeffannoon kan kee adda baasu hin jiraatu. Argannoon qorannichaa uummata qorannichaaf waliigalaa kan ta'u yoo ta'u, waa'ee nama dhuunfaa sanaa waan addaa kan hin calaqqisiifne ta'a. Tarreen sakatta'iinsa qajeelfama marii garee irratti xiyyee fate, maqaan dhuunfaa keeysanii akka hin dubbatamneef koodin isiniif kennamaa.Gabaasa afaaniin ykn barreeffamaan hirmaattoota qorannicha waliin walqabsiisuu danda'u keessatti eeruun hin kennamu.

Mirga qorannoo irratti hirmaachuu fi hirmaachuu dhiisuu: Qorannoo kana irratti hirmaachuu fi hirmaachuu dhiisuun mirga Nama dhuunfaa taha. Hubannoo gadi fageenyaan yoo barbaaddan teessoowwan armaan gadii dubbisuun argachuu dandeessu.

Abbaa qorannichaa: Maqaa: Kadiir Umar Boruu, Teessoon: Ciro, Bilbila: 0910506113/0909805360 ***Email: kedir123u@gmail.com*** Koree Jiddu Galeessa Qorannoo fi Qo'annaa: Haramaayaa Yunibarsiitii, koollejjii Saayinsii Fayyaa L.S.P: 235, Bilbila: 025466201, Harar,Ethiopia.

Hayyamamoo ta'uu hirmaattootaa mirkanneessuu

Ani Kan armaan gaditti mallatteesse kaayyoo qorannoo kanaa hubadhee odeeffannoo gubbaa iratti kenname bu'ura godhachuun qorannoo kana hospitaala keenya keessatti ana waliin akka adeemsiftan isiiniif hayyameen jira.

Mallattoo warraa/hirmaata qoraanichaa _____Guyyaa_____/_____/_____

Maqaa fi mallattoo odeeffannoo walitti qabaa_____Guyyaa____/_____/____

8.9. Afan Oromo version FGD guiding questions

Qajeelcha Gafilee garee xiyyeeffannoo marii.

1.Gargaasrsa waldhaansa keetif siif kennamaa ture akkamitti hubatta ?

2. Ogeeyyin fayyaa Fedhii tee siif guturratti maaltu sitti dhagahamaa ?

3. Hubannoon hordofii fi gargaarsa walitti fufiinsa qabu irratti isin qabdan maal fakkaata hospitaala kana keeysati?

4. Hubannoon tajaajila hospitaala kana keeysatti kennamu haala salphaa ta'een arkachurratti qabdan maal fakkaata ?

5. Haasawani siifi oggeeyyii fayyaa giddutti godhamaa ture maal fakkaata ?

6. Haala naannoo hospitaala irraa maal hubattaa ?

7. Waldhaan siif barbaachisu murteefachuu keeysatti hubbannoo maali qabda ?

8. Walitti dhufeenya siifi ogeeyyii fayyaa gidduu jiru akkamitti laalta ?

9. Hubannoo waa'e karoora waldhaansa keetirratti siif kennamaa turerraa maal fakkaata ?

10. Qorichoota siif ajajaman hospitaala keey arkachurratti hubannoo maali qabda ?

11. Turtii hospitaala kana keeysa turte keeysatti muuxannoo akkamii qabda ?

8.10. Curriculum Vitae (CV) Of the Principal Investigator

1. Personal Data

First Name Middle Name Sure Name

Kedir Umer Boru

Date of birth: september 1, 1994 (G.C)

Place of birth: Ancar, Western Hararge, Ethiopia

Gender: Male

Marital status: Married

Nationality: Ethiopia

Residence address

Region: 04, Zone: Western Hararge, Woreda: Ancar, Kebele: 012.

Contact address: Mobile: +251910506113, Email: kedir123u@gmail.com

2. Educational Background and Qualification

2.1. Higher Education

Institution: Jimma University

Subject of study: Nurse

Degree awarded: BSc degree

2.2. Preparatory School Education

School: Mechora preparatory school (2011-2012 G.C)

Education type: Natural science education only

Certificate awarded: Grade 11 cards and also grade 12 certificates

2.3. Secondary School Education

School: Ancar secondary (2008-209 G.C)

Education type: Natural and social science education

Certificate awarded: Grade 9 cards and also grade 10 certificates

2.4. Elementary Junior School Education

School: Dindin primary school (1-8grade) (1999-2007 G.C)

Education type: Natural and Social science education

Certificate awarded: Grade 1-7 cards and also grade 8 certificates

3. Language Skill

No	Languages	Indicators		
		Writing	Speaking	Reading Listening
1.	English	Excellent	Excellent	Excellent
2.	Amharic	Excellent	Excellent	Excellent
3.	Afan Oromo	Excellent	Excellent	Excellent

4. Work Experiences

I have 2 (two) years at Asabote primary hospital and 3(three) years in Chiro General Hospital, 3(three) years Oda Bultum University,west Hararghe zone, Oromia region, Ethiopia.

5. Activities/interests

Reading books, pamphlet, magazine, daily news, listening TVs

Taking part of voluntary public services

6. Special Skill

I have basic Community Based Education (CBE) and Team Training Program (TTP) skills and some related jobs.

7. Certificate

I have certified on Basic ART at Jimma University and Adama specialized hospital

I have certified on Compassionate and Respect full Care.

8. References

1. Dr. Fikadu Balcha (Asisstan professor, PHD)

Email: ero@ju.edu.et

Mobile: +251911004133

2. Dr. Ibrahim Jemal (MD,sinor gynacologist)

E-mail: ibrjml435@gmail.com

Mobile: +251910014138/0920455736

3. Mr. Murad Umradin (BScN, MSc in Adult Health Nursing)

Email: - Muradumardin658@gmail.com