COLLEGE OF SOCIAL SCIENCE, ARTS AND HUMANITIES

SCHOOL OF SOCIAL WORK

Clients' Satisfaction with Community-Based Health Insurance Scheme and Associated Factors: The Case of Black Lion Specialized Hospital.

By

Adafir Tadesse

A Thesis Submitted to Addis Ababa University, School of Social Work, for Partial Fulfillment of the Requirements for the Degree of Master's in Social Work (MSW).

October, 2025

Addis Ababa, Ethiopia

Addis Ababa University

College of Social Science, Arts and Humanities

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Advisor

Mesele Mengsteab (PhD)

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Declaration

This study, conducted on the title "**Clients' Satisfaction with Community-Based Health Insurance and Associated Factors: the case of Black Lion Specialized Hospital,**" was done under the supervision of Mesele Mengsteab (PhD). This thesis represents my original work, undertaken specifically to meet the academic requirements for the Master's degree in Social Work. It has been created solely by me and embodies my own research, analysis, and conclusions. I affirm that this work is unique and has not been previously submitted, either in whole or in part, to any other university or academic institution for the purpose of earning a degree or qualification. This declaration upholds the integrity and authenticity of my scholarly contribution to the field of social work.

Name of the investigator

Adafir Tadesse

Signature ---------- Date----------

Statement of the certificate

This statement formally confirms that the thesis titled "**Clients' Satisfaction with the Community-Based Health Insurance Scheme and the Associated Factors: the case of Black Lion Specialized Hospital"** was prepared and submitted by Adafir Tadesse as a key requirement toward earning the Master of Social Work degree. The research was conducted under the academic supervision of Dr. Mesele Mengsteab, ensuring professional guidance and adherence to scholarly standards throughout the study. Following a comprehensive review process, the board of examiners has evaluated the thesis thoroughly and determined that the student has met all necessary academic criteria and institutional requirements. Therefore, the board formally approves the thesis as meeting the required standards and authorizes the student to submit it officially to Addis Ababa University, the School of Social Work, supporting the candidate's advancement toward fulfilling the degree requirements.

Approved By the Boards of Examiners and Advisor

Advisor	Signature	Date
Mesele Mengsteab (PhD)	----------	----------
Internal examiner		
Mengistu Legesse (PhD)	----------	----------
External examiner		
Getachew Sinishaw (PhD)	----------	----------

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List of Acronyms

AOR---Adjusted Odds Ratio

AU--- -African Union

BLSH--- Black Lion Specialized Hospital

CBHI--- Community-Based Health Insurance

CBHIS--- Community-Based Health Insurance Schemes

CHF--- Community Health Fund

COR--- Crude Odds Ratio

EHIA--- Ethiopian Health Insurance Agency

FGD--- Focus Group Discussion

FMOH--- Federal Minister of Health

GDP--- Gross Domestic Product

HEP--- Health Extension Program

HSDP--- Health Sector Development Plans

IDI--- In-depth interview

IPD--- Inpatient Department

MoH--- Minister of Health

OOP--- Out-of-Pocket

SHI--- Social Health Insurance

SPSS--- Statistical Package for Social Science

UHC--- Universal Health Coverage

UNICEF--- United Nations International Children's Emergency Fund

USAID--- United States Agency for International Development

WHO--- World Health Organization

Abstract

Ethiopia has been implemented CBHI scheme since 2011 for informal sectors for the purpose of financial protection, enhance healthcare and equity health services. The objectives of this study was to assess clients' satisfaction with CBHI and associated factors in the case of BLSH. The study employed a mixed approach, cross-sectional descriptive and phenomenological design. The data were collected from 364 respondents (49.7% male and 50.3% female) using structured questionnaires for quantitative data and interviews with FGDs and IDIs for qualitative data from April 23 to May 23, 2025. Systematic and purposive data sampling techniques used to collect the quantitative and qualitative data respectively. The quantitative data were analyzed using SPSS 21 and the qualitative data were analyzed thematically. The result of this study revealed that the overall clients' satisfaction with CBHI scheme was 57.7 % and Satisfaction of clients was significantly associated with the clients' age between 40-50 (AOR=3.1, 95% CI: (1.35-6.8)(p<0.007), residency lived in rural areas (AOR=2.4, 95% CI(1.4-4.2)(P<0.001), monthly income from 2001-5000 birr (AOR=2.84, 95% CI:(1.45-5.58)(P<0.002) and knowledge on cosmetic surgery (AOR=0.02,95% CI:(0.003-0.0098)(P<0.000) were more satisfied than the counter parts. On clients experience, factors associated with clients' satisfaction were clients with some health problems (AOR=3.52, 95% CI: (1.92-6.46) (P<0.000), clients registered before their illness (AOR= 1.84, 95% CI: (1.06-3.12) (P<0.029), clients say CBHI enrollment and renewal period were comfortable (AOR=2.77, 95% CI: (1.56-4.92) (P<0.001) and clients voluntarily enrollment for CBHI (AOR=0.278, 95% CI: (0.13-0.58) (P<0.001).The study also revealed that clients were challenged by a shortage of medications and pharmaceutical supplies, inadequate services in the laboratory and imaging, insufficient hospital facilities, difficult setup of the hospital, and indirect costs. Clients were satisfied with health providers' services and unsatisfied with the hospital's healthcare service provision. The overall satisfaction of clients with CBHI was suboptimal concerning both health providers and hospital services. The study gave insight for different actors, such as the hospital itself, policy makers, social workers and researchers, to identify the gaps and improve the service provision related to prescribing drugs, laboratory services, imaging services and fulfilling the hospital infrastructures for clients' quality services and satisfactory healthcare services.

Key Words: Health insurance, Community-Based Health Insurance, level of Satisfaction

CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

Globally, about 150 million people were challenged by healthcare costs. Each year, most of them sink into deep impoverishment after paying for healthcare services. In developing countries, healthcare expenditure mostly depends on out-of-pocket (OOP) which accounts for 30% to 85% of the total health spending in the poorest countries and it accounts for 37% in Ethiopia (Jembere, 2018).

In low and middle-income countries, especially in Africa and Asia, healthcare expenditure is sourced from out-of-pocket (OOP). The highest healthcare cost is financed privately from OOP. OOP created the highest burden on the sick and the poorest portion of the communities and causing them financial catastrophe and preventing them from accessing healthcare services. Due to these reasons, WHO and other international bodies designed universal health coverage (UHC), which is primary health for all and governments strive to subsidize healthcare for the poorest communities. One of the best approaches to reaching UHC is community-based health insurance (CBHI) (John, 2017). In response to answer this initiative, high OOP outlay, low utilization and quality of healthcare service, Ethiopian government drafted two types of health insurance strategy: community-based health insurance (CBHI) and social health insurance(SHI) in 2011(Jembere, 2018).

To collect sufficient funds for the healthcare system, the healthcare financing system is a main part of the systems that protect individuals from financial hardship and assign resources for healthcare, and purchase goods and services in ways that increase quality, equity and efficiency health service. Ethiopia is challenged by its healthcare system. Clients are exposed to impoverishment due to catastrophic healthcare costs and limited to poor access to healthcare services. The Ethiopian healthcare system has made many efforts to reform, mobilizing appropriate resources and encouraging effective utilization to enable healthcare access for all societies without financial problems. Among this system, Health insurance is regarded as one of the most sustainable health funding systems in Ethiopia's healthcare financing plan, to provide residents with fair access to health services by

sharing risk through solidarity motives. The healthcare system approach planned two types of health insurance systems, which are social health insurance (SHI) for formal sector employees and community-based health insurance (CBHI) for informal sector workers (EIHA, 2020).

CBHI is a type of health insurance policy in the form of a micro-insurance program that helps low-income and vulnerable families regulate their health-related financial risks and avoid unexpected crises related to healthcare. CBHI depends on voluntary registration, a non-profit mission, predominant community leadership and management and the principle of mutual solidarity of the community. In most impoverished nations, the shortage of available funds restrains timely treatment. The majority of healthcare costs are paid for out of pocket (OOP) and they are the leading source of poverty. Health insurance can help disadvantaged people access to affordable treatment. In nations with a formal sector, insurance contributions are easily collected by salary deductions or taxes. In many developing nations, a significant number of the population works in the informal sector, restricting the ability to raise revenue through payroll deductions or taxes (Roy & Sarkar, 2018).

The CBHI benefit packages in Ethiopia comprehensively cover all services available in health centers and hospitals, excluding tooth implantation and eyeglasses or other cosmetic services, both curative and preventive healthcare services that are included in the country's essential health package. The package includes services such as treatment of common infectious and chronic diseases, basic diagnostics, laboratory services, outpatient and inpatient care, ensuring that essential health needs are met without imposing financial hardship on beneficiaries (EHIA, 2015).

Client satisfaction is a provision used to describe individuals' common preference towards the whole healthcare experience. It mediated between the expectation and experience of the health service from the patients' view. Low level of clients' satisfaction is due to the reasons of poor healthcare services and symbolic challenges of healthcare insurance scheme as it may be result in financial wastage and unsustainability. Clients' satisfaction with healthcare service under CBHI require that the service is good quality, delivery on time good interpersonal care with CBHI cards (Haile et al., 2023).

Healthcare facilities across all stages of care must deliver services that fulfill patients' expectations. Client satisfaction is associated with increased client compliance, continuity of care, improved clinical offerings, raised service utilization and effective risk management. Client satisfaction serves as a key marker of the quality of healthcare delivery and acts as an indicator for evaluating and improving healthcare services. Healthcare services should be efficient in terms of cost and methods, accessible to those in need, acceptable to the community, and provided at a reasonable or affordable cost. Clients also assess their satisfaction with the hospital based on staff proficiency enhancement, the cost of services relative to the value received, and the quality of healthcare facilities (KA & Adewale, 2024).

According to the study by Hailie et al. (2021) overall clients' satisfaction with CBHI was associated with clients' age, occupation, marital status, availability of medications, waiting time to visit service provider, plan to renew the CBHI card and affordability of the CBHIS card by bivariate logistic regression. The CBHI beneficiaries were also challenged by tremendous issues. These challenges include a lack of services such as absence and shortage of drugs in health sectors, a lack of Kenema pharmacies nearby and lack of medications in Kenema pharmacies, disrespect, a lack of awareness and poor attitude of health professionals and an inflexible premium payment period(B. Abebe, 2021).

Therefore, this study aims to assess clients' satisfaction with community-based health insurance and associated factors in the case of Black Lion Specialized Hospital regarding healthcare services.

1.2 Statement of the Problem

When Ethiopia launched the CBHI initiative to improve primary healthcare in 2011, Japan celebrated the 50th anniversary of achieving universal health coverage (UHC) that the country ensure all individuals can access quality health services, protecting them from public health risks, and shielding them from financial hardship due to illness, whether from out-of- pocket (OOP) expenses or loss of income when a community member gets sick. While the steps to UHC vary by country, it is hoped that nations can learn from each

other's experiences to explore different strategies and avoid potential pitfalls and risks (Wang & Ramana, 2014).

Ethiopia applied the CBHI strategy for two main reasons. The first one is the global initiative toward universal health coverage (UHC) and the second is the resource mobilization to prepare countries for the shift away from health-related donor support to use local resources. CBHI acknowledged considerable political support and early pilots provided valuable feedback on the scheme's expansion. CBHI has assisted in mobilizing community engagement and resources, improving access to and use of health services and providing financial security for the citizen (Mulat et al., 2022).

A study by Shimeles (2010) on CBHI schemes in the case of Rwanda showed that membership in the CBHI scheme could boost medical care utilization by around 15% after an illness sequence. Concerning catastrophic cost, the virtue model yielded a substantial effect in which insured households had a much lower risk of experiencing catastrophic expenditure than those without insurance. The average treatment effect of CBHIS membership on health service utilization and income protection for all households, including poor and non-poor households, was that households that were members of the CBHISs had higher utilization of healthcare facilities following an illness episode than uninsured households. CBHI has been shown to significantly increase health facility visits among its users compared to non-insured individuals.

According to Alemayehu et al. (2023), a study indicated that insured and non-insured communities with CBHI had a significant difference in healthcare utilization and financial protection between CBHI member and non-member households. CBHI package users showed a reduction in OOP of up to 43% compared to non-users. CBHI-enrolled households were less likely to be exposed to catastrophic health expenditures. As catastrophic expenditure is defined, OOP payments are higher than 10% of total household expenditure, compared to their non-member counterparts. This reduction of healthcare costs is important for enhancing financial protection against healthcare costs and mitigating financial risks associated with health spending.

According to Abebe (2022), a study conducted on the CBHI practice and challenges in the Amhara regional state, North Wollo zone, identified that CBHI users made payments to obtain adequate healthcare from health institutions but were disappointed when they

did not obtain the services and some people prefer to visit private clinics and pay for their healthcare through OOP. CBHI then took a long time to pay pack money to the beneficiaries. The members of CBHI beneficiaries were challenged in several ways, including inadequate laboratory equipment and a shortage of drugs and pharmaceutical supplies. Health facilities, particularly hospitals, frequently experience drug stock-outs that force patients to purchase items from private sellers at high costs.

The other challenges related to the CBHI scheme were misunderstanding and not awareness of beneficiaries regarding the CBHI scheme, limited participation in decision-making, maladministration, shortage of qualified personnel, and an increase in the number of patients who visit a hospital for common illnesses that created a workload on health providers, delayed payment of premiums, and in some contexts, community leaders influenced to pay the premium without voluntary consent, which is against the principle of CBHI scheme (Abebe, 2022).

In a similar study by Balcha et al. (2023,), in Addis Ababa, the CBHI-related problems noted were a medicine shortage, a negative attitude among health providers, the absence of drugs in a Kenema pharmacy, a lack of laboratory facilities, a lack of awareness about the CBHI system, and a rigid payment schedule. As a result, CBHI member households reported low levels of satisfaction (Zepre, 2023).

There are also various issues with CBHI, and many clients face problems related to the hospital structure and failure to provide clear instructions regarding their service placement. The Patients also frequently have difficulty navigating the hospital system and service locations, causing inconvenience in getting healthcare services. Shortage of drugs and often stock-outs in health institutions present significant challenges to CBHI utilization, which lead to delayed or inadequate healthcare. Providing basic information on the shortage of pharmaceutical supply at Kenema Pharmacy, the limitation of medications at the pharmacy is a big problem for CBHI users. The difficulty of ordering and introducing high-quality drugs to the CBHI list may limit access to important treatments because these products are not covered under the CBHI plan. Patients in various categories highlighted the scarcity of reagents and laboratory services as a barrier to getting diagnoses and appropriate treatment, threatening the quality of care and patient

outcomes. The inadequate number of healthcare personnel with a patient ratio and patients' flow is a significant obstacle to maximizing CBHI effectiveness (Keney et al., 2024).

BLSH was selected for this study because it is a large tertiary hospital that serves as a central hub for healthcare delivery in Ethiopia. Most healthcare services are provided at BLSH, whereas other hospitals in the area either offer limited services or none at all. This concentration of services means that BLSH handles a high volume of patients with diverse medical needs, requiring substantial resources, including specialized medical equipment, supplies, and skilled healthcare professionals. Due to the hospital's critical role in providing advanced care and its high demand for materials and personnel, it represents an ideal setting for studying healthcare service provision, resource allocation, and supply management in a tertiary care context.

In addition, most studies on clients' satisfaction and related factors regarding Community-Based Health Insurance (CBHI) have primarily focused on households outside health institutions and other health institutions, with no prior research conducted specifically on client satisfaction at BLSH until this study. Assessing client satisfaction directly within health sectors like BLSH is crucial to obtain accurate and reliable data, as it allows for firsthand observation and validation during data collection, ensuring the findings reflect the true experiences and perceptions of clients using CBHI services in the institutional setting. In addition, studying client satisfaction with the Community-Based Health Insurance (CBHI) scheme among admitted clients is crucial because these clients typically require more extensive healthcare resources compared to outpatients. Admitted patients often depend on a broader range of health providers, diagnostic investigations, hospital facilities, and longer stays within health institutions, which makes their experience and satisfaction levels particularly valuable for assessing the effectiveness and responsiveness of the CBHI program. By focusing on this, a researcher can gather important data that reflects the scheme's capacity to meet complex healthcare needs, identify gaps in services, and understand how well the insurance supports clients through treatment processes, ultimately providing a more comprehensive evaluation of CBHI's impact on health services.

BLSH is a tertiary and huge hospital that provides healthcare services in many disciplines of specialty and sub-specialty for hundreds of thousands of people in a year. Clients who

gain health services in the inpatient department (IPD) is selected for this study. Therefore, this study helps to analyze clients' satisfaction with CBHI and associated factors of CBHI in BLSH, specifically in the inpatient department (IPD) from April 23 to May 23/2025.

1.3. Objective

1.3.1. General Objective

The primary objective of this study is to assess clients' satisfaction with community-based health insurance (CBHI) and its associated factors in the case of Black Lion Specialized Hospital (BLSH) in Addis Ababa, Ethiopia.

1.3.2 Specific Objectives

- To evaluate the level of clients' satisfaction with the CBHI scheme at BLSH
- To describe the factors associated with clients' satisfaction level at BLSH
- To assess the knowledge of CBHI beneficiaries on the CBHI scheme at BLSH
- To assess the experience of CBHI beneficiaries on the CBHI scheme at BLSH
- To explore the perception of CBHI beneficiaries on the program about the challenges of CBHI at BLSH

1.4 Research Questions

- What is the level of clients' satisfaction with the CBHI scheme at BLSH?
- What factors are associated with clients' satisfaction with the CBHI scheme at BLSH?
- What is the knowledge of CBHI beneficiaries on the CBHI scheme at BLSH?
- What experience do CBHI beneficiaries have with the CBHI scheme at BLSH?
- What are the challenges of the CBHI scheme for the beneficiaries at BLSH?

1.5 Significance of the Study

The significance of studying clients' satisfaction with CBHI and related factors lies in its potential to address several healthcare issues. This study will help for stakeholders and hospital managers in several aspects in dealing with factors related to CBHI services and healthcare services. The findings also offer policymakers the opportunity to improve

strategies, standards, and interventions to resolve health service utilization issues in government health sectors. The findings assist the CBHI service and other similar organizations in providing a more accurate diagnosis and improving patient satisfaction with paid and acquired clinical services. Finally, the study will be used as a reference for other researchers who want to do a similar study.

1.6 Scope and Delimitations of the Study

The study focuses on assessing clients' satisfaction with Community-Based Health Insurance (CBHI) and identifying associated factors influencing this satisfaction among beneficiaries, specifically targeting those admitted as inpatients at Black Lion Specialized Hospital (BLSH) in Addis Ababa, Ethiopia. While healthcare services under CBHI are provided in multiple hospitals across the country, this research is geographically confined to BLSH within Addis Ababa, thus limiting the generalizability to other regions or facilities. The study population includes only CBHI scheme users who were hospitalized during the study period, excluding outpatient clients, healthcare professionals, and hospital resource suppliers to maintain focus on the inpatient experience. This delimitation ensures an in-depth analysis of the perspectives of admitted patients but excludes wider stakeholder views and outpatient service contexts, which could impact the overall understanding of CBHI satisfaction in Ethiopia.

1.7 Operational Definition of Terms

Clients: an individual or group who receives professional health-related and hospital-related healthcare services.

Insurance: Insurance is a contract that protects the insured against out-of-pocket expenses.

Health insurance: Health insurance provides protection against the risk of incurring medical bills for individuals and families.

Community-based health insurance: CBHI is a government-managed and operated insurance system for the informal sector that pools risks to cover all or part of the expenses of health care services.

Satisfaction: the attainment of one's desires, anticipations, or requirements obtained from the inpatient healthcare service. The study participants who scored above the mean were considered satisfied and those who scored less than the mean score were classified as dissatisfied. The clients' satisfaction was measured using a 5-point Likert scale from 1-highly dissatisfied to 5-highly satisfied. The level of client satisfaction using a 5-point Likert scale contains 18 questions.

Knowledge: refers to the awareness that respondents have about CBHI benefit packages and was measured using the nine items related to the CBHI benefit packages. It contains nine questions. Considering the time interval and the current awareness of clients, who answered eight or more questions were considered to have good knowledge, and those who answered fewer than eight were considered to have poor knowledge.

Experience of CBHI: is the practical trend or observation of CBHI beneficiaries on the CBHI scheme, starting from enrollment to the health facility where they receive healthcare and contains 12 questions.

1.8 Organization of the Thesis

This study is organized into five chapters. The first chapter is the introduction that covers the background, problem statement, objectives and research questions, operational definitions of terms, significance of the study, scope, and limitations of the study. The Literature review is the next chapter, which includes the CBHI concept, CBHI in Ethiopia, health insurance in sub-Saharan Africa, an overview of the Ethiopian health sector, benefits of the CBHI scheme, CBHI and financial protection, client satisfaction with CBHI and the CBHI beneficiaries' challenges. The third chapter covers research methodology, which includes the study approach and design, sample design, data sources, data collection technique, data collection tools, data analysis, data quality assurance, and ethical consideration. The fourth chapter includes results and discussion. The final chapter includes a conclusion and the implications of the study.

CHAPTER TWO: RELATED LITERATURE REVIEW

2.1 Community-Based Health Insurance (CBHI) Concept

CBHI is a type of health insurance plan that provides financial protection against the cost of illness and improves access to healthcare services for informal workers and communities. It is a yearly contract agreement between the member and the insurance agency in which the member pays annual payments in advance and registrations for a maximum of three months with specific instructions for completing the process and renewing before the expiration date in uninterrupted succession (EHIA, 2020).

CBHI is a strategy that can contribute to universal health coverage (UHC). Universal health coverage (UHC) is a way of ensuring that all citizens have access to appropriate healthcare without a financial burden. Achieving UHC necessitates long-term health finance methods and financial protection through national health packages. It is critical to enable widespread access to medications, vaccines, developing technologies, and the development of Human Resources for Health. Reforms to health services, management, and institutions are needed, as well as a greater emphasis on socioeconomic determinants of health and citizen engagement. UHC is an approach that provides health assurance and expands the scope of primary health care to all parts of the country (Jindal, 2014).

In similar concepts, CBHI is a risk-pooling technique that aims to disperse health expenses across families with varying health profiles to avoid catastrophic expenditures caused by unforeseen health events or chronic diseases and facilitate cross-subsidies from rich to poor populations. In theory, CBHI schemes have five characteristics which includes, "The dynamic risk pooling involves organizing schemes by and for individuals who share common characteristics (geographical, occupational, ethnic, religious, gender, etc.); Solidarity, where risk sharing is as inclusive as possible within a given community and membership premiums are independent of individual health risks; Participatory decision-making and management; Nonprofit status; and Voluntary affiliation"(EHIA, 2015).

2.2 Health Insurance in Sub-Saharan Africa

Policy reforms and attempts toward health for all in African countries can be traced back to 1978 when the Alma-Ata Declaration advocated health as a human right. To this day,

African governments prioritize universal health coverage. Each governments have a duty to the health of its citizens which can be met by implementing proper health and social policies. Primary healthcare is important to achieving this goal as part of social justice-oriented development. Participation in individually and collectively in the planning and delivery of their healthcare is the right and the responsibility of the people. Primary healthcare is essential healthcare that is based on practical, scientifically sound, and socially acceptable approaches. It is an essential component of the national healthcare system, where it serves as the primary purpose and focal point, as well as the community's general social and economic growth. Every country should develop national policies, strategies, and action plans to establish and sustain primary health care as part of a comprehensive national health system, in collaboration with other sectors. Economic and social development is important to achieving UHC and closing the healthcare gap between rich and developing countries. Promoting, protecting, and treating people's health is critical to maintaining economic and social development and contributing to better healthcare (WHO, 1978).

Africa's major health problems are infectious diseases, morbidity and mortality account for the majority of health problems. In addition to communicable and non-communicable diseases, injury and trauma have harmed African development, particularly on the socio-economic margin. While it is not the only requirement for achieving healthcare outcomes, sustainable and predictable health sector finance is vital to the establishment of viable health systems and is an important metric for improving equal access to healthcare and lowering poverty the communities. To maintain cost-effective healthcare in Africa, health investment in all healthcare system components would be required by considering the important equity issues for the most vulnerable and marginalized societies. Technological developments and generating and preserving human capital are necessary for the healthcare system (AU, 2016).

To maintain UHC, formal and well-functioning health insurance programs are often available in Sub-Saharan Africa for the small number of people employed in the formal sector. For the most part, healthcare is obtained through out-of-pocket expenses, which might lead to inefficient utilization of healthcare services. As a result, spending on health-related needs in some nations may be significantly higher, with clear disparities across the

income spectrum. As Shewamene et al. (2021) noted, CBHI had expanded in most sub-Saharan African countries during the last two decades, intending to improve equal access to health services for the informal sector population. However, population enrolment in CBHI and subsequent membership renewals remain stubbornly minimal. The challenges to CBHI adoption in Sub-Saharan Africa were complex. In the region, lack of awareness about the importance of health insurance, socioeconomic factors, health perceptions, lack of trust in scheme management, inadequate quality of health services, perceived health status, and limited health benefit entitlements were identified as barriers to CBHI enrollment and membership renewal.

In the developing countries, communities spend as much as those in relatively wealthy countries, but the health consequences are worse. One of the explanations could be the absence of a functioning health insurance program to protect communities from illness-related income or spending shocks. Formal health insurance plans for self-employed individuals and rural farmers are challenging to implement for a variety of reasons. Community-based health insurance schemes (CBHISs) are promising alternatives to the shared expenses of the healthcare system. This strategy should lead to better access to healthcare services, reduced illness-related income shocks, and, eventually, a sustainable and fully functional universal healthcare system (Shimeles, 2010).

The CBHI scheme in Rwanda are fascinating case investigations for a variety of reasons. The first and most important is that the country increased CBHI scheme coverage from roughly 35 percent in 2006 to nearly 85 percent in 2008, representing exponential growth in two years despite uncertainty about its potential impact on health service utilization and protection from unexpected health-related income or consumption shocks. This quick expansion and coverage is unmatched in the history of CBHI scheme. Second, officials in Rwanda have prioritized CBHI scheme, making them key aspects of the country's health program, with strong administrative and political backing for their expansion and operation. Third, the project is attracting the interest of other countries (Shimeles, 2010).

Starting its independence in 1963, Kenya has maintained a predominantly tax-funded health system while gradually introducing a series of health financing policy changes. User payments were implemented but later removed due to concerns about social justice. However, user charges for health services were formally reintroduced in 1989. In 1965,

Kenya the National Hospital Insurance Fund (NHIF) was established and it remained compulsory only for formal sector workers and has been linked to an inadequate insurance benefit package. In 2004, a new health financing reform was submitted to Parliament, proposing the establishment of the national social health insurance fund (NSHIF) to cover the entire Kenyan population. Kenya's healthcare financing system was mostly supported by general tax revenue. However, in the late 1980s, cost-sharing began to get significant governmental attention. In 1989, structural adjustment strategies and severe government budgetary limitations resulted in the implementation of user fees (cost-sharing) for outpatient and inpatient care at government health institutions. In June 2004, the Kenyan Minister of Health issued a policy statement stating that health treatment at the dispensary and health center level would be free for all Kenyans, except for a small registration charge in government health facilities (Okeyo et al., 2006).

In Ghana, the Catholic Diocese first experimented with and introduced CBHI in Sunyani District in the late 1980s. There were more than 140 CBHI schemes by 2002, but they barely covered 1-2 % of Ghanaians and provided minimal services. The national and local governments of Ghana provided minimal support in the late 1990s and early 2000s, which aided the growth of CBHI schemes. Significant population coverage gains happened only after the NHIS was implemented in 2003. Since its beginnings, political factors have had a significant impact on Ghana's National Health Insurance Scheme (NHIS). Technically oriented policymakers first developed an insurance expansion plan in 2001–2002, with outside funding, that would have carried on developing the initial community-based health insurance (CBHI) programs. Between 2012 and 2015, a pilot program in Ghana to implement capitation payment (where providers are paid a predetermined amount per enrolled patient rather than a fee for each service they give) to manage costs for primary care providers failed due to political and technical issues. The Ghanaian government contributed to the rapid expansion of health insurance by enacting the NHIS Bill in 2003, establishing the National Health Insurance Authority with the mandate to lead the NHIS, and defining contributions from formal-sector employees and non-exempt segments of the informal sector (Zelelew et al., 2018).

Generally, community-based health insurance (CBHI) schemes have been implemented in several sub-Saharan African countries to improve access to healthcare, particularly for

vulnerable communities. Ghana, Kenya, and Rwanda implemented different community health policies before Ethiopia initiated its CBHI program and the premium is collected from communities, the government and other donors.

2.3 Overview of the Ethiopian Health Sector

The Ethiopian government implemented numerous political and socioeconomic reform initiatives after the 1991 election. The government created the first national health policy among these and, beginning in 1997/98, four successive phases of comprehensive Health Sector Development Plans (HSDPs). The aim of HSDP I is to initiate primary healthcare access, improve health service delivery, and address key communicable diseases from 1997/98 to 2001/02. This program's focus was on building infrastructure, increasing human resources, and expanding essential health services, specifically in rural areas. The HSDP II (2002/03 - 2004/05) is to consolidate gains made in HSDP I by further expanding health facilities, increasing health workforce capacity, and strengthening health systems. The program aimed at accelerating improvements in maternal and child health, disease control, and health coverage to achieve better health outcomes. The HSDP III (2006/07 - 2009/10) is to accelerate health improvements with a focus on expanding services, enhancing health system efficiency, and improving quality of care. The main objectives of this program included increasing immunization coverage, reducing maternal and child mortality, and strengthening disease control programs. The last HSDP IV (2010/11 - 2014/15) aims to sustain and expand previous gains while aligning with national policies and international commitments. The program emphasizes health sector reform, infrastructure development, health system strengthening, better resource mobilization, and enhancing health outcomes through integrated strategies(MoH, 2010).

The federal government develops preventive, promotional, and curative components of healthcare; ensuring that healthcare is accessible to all segments of the population; democratizing and decentralizing the healthcare system; and promoting private and non-governmental organization involvement in the health sector are the cornerstones of health policy (MoH, 2010).

The Federal Minister of Health has the authority to endorse the country's national health policy. It spreads health services, settling and operating national referral hospitals and

national-level study and research centers, developing standards and operational protocols, regulating health services and professional education in public health, and preventing, controlling, and eradicating communicable diseases are the responsibilities of the Minister of Health. The minister develops policies, methods and standards for increasing services for disadvantaged communities then the regions adjust to their specific requirements. The Federal Minister of Health also helps regions enhance their healthcare systems by mobilizing extra resources to improve service delivery and building appropriate platforms for mutual accountability, information flow, and resource efficiency (Wang & Ramana, 2014).

The health sector is an important in human capital development and directly affects the health and productivity of the workforce. The Ethiopian five-year health policy aims to enhance the overall health of the population and improve access to basic healthcare services. The health sector in Ethiopia is arranged in a three-stage health service delivery system. The primary health care units include health posts, health centers and primary hospitals. These healthcare units provide essential health services, preventive care, maternal and child health services, immunization and basic curative healthcare. These units play an important role in reaching rural and underserved populations of the country. One health center is linked to five satellite health posts and serves 25,000 people and primary hospitals serve 100,000 people with inpatient and outpatient services. The secondary healthcare stage includes general hospitals that provide more specialized care and services than primary healthcare units are focused on treating more complex health conditions and disorders than primary healthcare units and serve one million people. The tertiary healthcare, which is the highest level of health service delivery, consisting of specialized hospitals and referral centers offering advanced medical care, specialized diagnostics, surgical services, and treatment for severe health conditions for 5 million people (UNICEF, 2024, and Zelelew, 2012).

In Ethiopia in all public health sector, the CBHI members have the right to get the available health services based on the prepayment of the scheme as the government schedule. As the right to gain the healthcare services, the members have an obligation to pay the premium and renew the CBHI card in the given period (EHIA 2015).

2.4 Community-Based Health Insurance in Ethiopia

The global initiative for universal health coverage (UHC) and local resource mobilization to prepare Ethiopians for the transition away from health-related donor support to implement the CBHI scheme. The political initiation and initial pilots gave valuable insights for the CBHI scheme's expansion. CBHI has supported in mobilizing community engagement and resources, improving access to health services, providing financial protection and empowering females (Mulat et al., 2022).

The health insurance strategy emphasized that the overall objective of insurance is to promote equitable access to sustainable quality healthcare, enhance financial protection, and improve social inclusion for most Ethiopian families through the health sector. The particular objectives of CBHI involve enhancing financial capability to healthcare services, improving the quality of healthcare services, increasing resource mobilization in the health sector, strengthening community involvement in managing health services, and building national capacity for policy development and expanding health insurance coverage in both rural and urban informal sectors (Solomon et al., 2015).

The Ethiopian government has established a three-tier public healthcare delivery system to provide essential health services and ensure referral linkages starting from the health extension program (HEP) which is an important healthcare strategy that contributes to universal health coverage (UHC) and offers free primary healthcare services at health posts. The country is in the early stages of initiating insurance schemes to provide financial protection for its citizens, including Social Health Insurance (SHI) for formal sector employees and Community-Based Health Insurance (CBHI) for rural residents and informal sector workers. Public facilities are expected to provide exempt services at no cost, and there is a fee-waiver system for the poorest (Wang & Ramana, 2014).

The CBHI scheme operates on the principle of risk pooling, where members contribute to a collective fund that covers healthcare costs. Its strategies are increasingly recognized as viable options for achieving universal healthcare in underdeveloped nations. Ethiopia has introduced CBHI in experimental regions across the country for the aim of increasing the utilization of healthcare services by eliminating financial barriers. The CBHI pilot in Ethiopia commenced in 2011 in 13 districts from four regions (Tigray, Amhara, Oromia,

and Southern Nations, Nationalities and Peoples) to provide risk protection mechanisms for those employed in rural and informal sectors. After three years, the Ethiopian government determined to expand the CBHI, initiating schemes in 161 districts. The evaluation of the outcome of the CBHI pilot schemes was designed to guide the scale-up process (EHIA, 2015).

Opportunities and obstacles from the pilot significantly influence expansion plans developed in collaboration with central and regional governments. CBHI started in 2018 in Addis Ababa and the Benishangul-Gumuz region was implemented in 2020 (EHIA, 2020). In 2011, CBHI was piloted in 13 districts and in less than a decade, CBHI coverage has to over 500 districts, or half of the country, providing financial stability to over 20 million Ethiopians. The CBHI initiative is generating considerable revenue through household contributions along with general and specific government subsidies (USAID, 2019). Nowadays, CBHI has been implemented across the country.

2.5 Benefits of the CBHI Scheme

Many studies have shown evidence that community-based health insurance has benefits in maintaining healthcare services utilization, equity, and improved health outcomes after becoming a member of it. As Alemayehu et al. (2023) study, the findings regarding community-based health insurance (CBHI) in Ethiopia, there were differences in healthcare utilization and financial protection between CBHI member households and non-member households in visiting the healthcare unit. CBHI membership resulted in a reduction of 28% to 43% in annual out-of-pocket (OOP) payments compared to non-member households. Households enrolled in CBHI were significantly less likely to incur catastrophic health expenditures. Healthcare expenses of OOP payments exceeding 10% of total household expenditure are a catastrophic healthcare expense.

CBHI has been shown to significantly increase health facility visits among its users compared to non-insured individuals. A similar study by Bayou et al., (2024) also indicated that CBHI users had more health facility visits than non-insured individuals.

2.6 Community-Based Health Insurance and Financial Protection

Ethiopia changed its health financing approach in 1998 after the FDRE came to power. The current strategy proposes to increase domestic public funding for the health sector through general and designated taxes. It also focuses on raising revenue from households and governments at various levels of the country (national and regional) through the expansion of prepayment/risk pooling techniques, Community-Based Health Insurance (CBHI) for the informal sector, and Social Health Insurance (SHI) for the formal sector (USAID, 2019).

Healthcare financing is the main component of the health system for raising appropriate funding for health, protecting people from financial burden, allocating resources, and purchasing goods and services to maintain quality, equity, and efficiency. The Ethiopian health system is challenged by a poor healthcare financing system, which exposes households to poverty. As a result, Ethiopian healthcare system has made significant efforts to restructure the health system to mobilize appropriate resources and encourage effective utilization, ensuring healthcare access for all segments of society without financial trouble. Health insurance is regarded as one of the most sustainable health funding systems in Ethiopia's healthcare financing plan, to provide residents with fair access to health services. This fair healthcare access is due to sharing risk through solidarity systems, which include social health insurance (SHI) for formal sector employees and CBHI for informal sector workers. Community-based health insurance (CBHI) is being implemented as one of the primary means of addressing the people of Ethiopia's informal sector, particularly its rural and low-income areas (EHIA, 2020).

The government of Ethiopian designed different strategies for health service in different period for the citizen to improve the health of the people and to solve their health service financial constrain. One of the main important method and this study assesses is community-based health insurance for the informal sectors and vulnerable segments of the communities.

2.7 Clients' Satisfaction with CBHI Scheme

According to Mekashaw et al. (2023), a systematic review study, Ethiopia had no evidence-based pooled data on patient satisfaction with CBHI beneficiaries and related factors, which patients' reports and ratings to evaluate the effectiveness and service. The overall Ethiopian pooled satisfaction with the CBHI beneficiaries was 66 percent and was influenced by other related factors. Factors include socio-demographic, health service, the scheme and knowledge-related factors. The highest CBHI beneficiary satisfaction levels were scored in the Amhara region, at 69 percent, followed by the South Nation, Nationalities and People region at 67 percent, Oromia at 63 percent and Addis Ababa at 53 percent.

Healthcare institutions across all stages of care must deliver services that fulfill patients' healthcare needs. The healthcare satisfaction of clients is associated with increased client compliance, continuity of care, improved clinical offerings, enhanced service utilization, and effective risk management. It serves as a key marker of the quality of healthcare delivery and acts as a critical indicator for evaluating and improving healthcare services. Healthcare services should be efficient in terms of cost and methods, should be readily accessible to those in need, should be acceptable to the community, and should be provided at a reasonable or affordable cost. Clients also assess their satisfaction with the hospital based on staff proficiency enhancement, the cost of services relative to the value received, and the quality of healthcare facilities (KA & Adewale, 2024).

Significant factors influence clients' satisfaction with healthcare services. A study conducted in Addis Ababa households on laboratory services, the results indicated that most of the patients were moderately satisfied. In this investigation, the satisfaction of the patients had no significant association with age, sex, educational level, marital status and religion. The availability the diagnostic tests during sample collection, the cleanness and comfort of the latrine, extra payment for laboratory tests out of the health center, inconsistency of laboratory test services due to electricity power interruption and water unavailability, shortage of fuel, lack of maintenance for the generator, shortage of waiting area, and lack of educating and entertaining materials, presence of service providers about

diagnostic tests during sample collection, cleanliness and comfort of the latrine were the cause of the low level of satisfaction in CBHI beneficiaries (Gashaw, 2020).

According to Uwingabire & Mureithi (2020), a study conducted in Rwanda at Kigeme Hospital on the perception and satisfaction with CBHI, respondents had a positive attitude towards CBHI and the satisfaction level with healthcare services that they received under CBHI was high. The study indicated that attitudes of CBHI were affected by socio-demographic factors, including respondents' sex, family size, marital status, changes in behavior, income level and knowledge of CBHI (Uwingabire & Mureithi, 2020).

A similar study conducted by Getaneh et al. (2023) at Leganbo district, north-east part of Ethiopia on the clients' satisfaction with CBHI beneficiaries and related factors that the beneficiaries' satisfaction with the CBHI scheme was moderate and most of the factors that affected the satisfaction were service-related variables. Such factors were laboratory and services of referral, non-delay care, time of office opening and time interval to use the packages, price amount, and circumstances of enrollment. A study by Babore et al. (2023) on client satisfaction and related factors on CBHI members in southern Ethiopia, factors associated with client satisfaction were age, residency, family size, frequency of visiting health facilities and knowledge.

2.8 Community-Based Health Insurance Beneficiaries' Challenges

CBHI, as seen earlier it has a tremendous purpose. However, CBHI implementation faces multiple challenges in healthcare facilities. According to Fatma and Ramamohan's (2023) study conducted in India, factors such as wait time for service, prior experience with care providers, users' distance from the facility, and socioeconomic and demographic factors such as annual income, educational qualification, and gender had a significant impact on patients' preferences when choosing healthcare facilities.

According to Abebe (2022), a study on community-based health insurance practice and challenges in the Northern Wollo zone found that healthcare service recipients paid for healthcare services from hired institutions, but were dissatisfied when they did not receive the services. Members of CBHI users complained about a variety of issues, including inadequate laboratory services and a lack of pharmaceutical supplies. Particularly,

hospitals face drug shortages that force CBHI members to pay excessive prices from private sellers.

The other issues related to the CBHI scheme were misunderstanding and unawareness of beneficiaries regarding the CBHI scheme, limited participation in decision-making, improper administration, shortage of qualified personnel, and an increase in the number of patients who visit a hospital for common illnesses that created a workload on health providers and the health facilities and demand more resources, delayed payment of premiums and in some contexts, community leaders influenced the community to pay the premium which is against the principle of CBHI scheme rather than voluntarily (Abebe, 2022).

In a similar study by Balcha et al. (2023) in Addis Ababa, the CBHI problems noted were a medicine shortage, a negative attitude among health professionals, the absence of medication in a Kenema pharmacy, a lack of laboratory facilities, a lack of understanding about the CBHI system and a tight payment schedule. As a result, CBHI member households reported low levels of satisfaction (Zepre, 2023).

Many clients confront issues related to hospital structure and failure to provide clear instructions regarding their service areas. The Patients also frequently have difficulty navigating the hospital system and service locations, causing inconvenience in getting healthcare services. Furthermore, medicine shortages and frequent stock-outs in hospitals present significant hurdles to CBHI utilization, resulting in delayed or inadequate healthcare. Providing basic information on the shortage of pharmaceuticals at Kenema Pharmacy, a scarcity of medications at the pharmacy is a serious issue for CBHI users. The difficulty of ordering and introducing high-quality drugs to the CBHI list may limit access to important treatments because these products are not covered under the CBHI plan. Patients in various categories highlighted the scarcity of reagents and laboratory services as a barrier to proper diagnoses and appropriate treatment, threatening the quality of care and patient outcomes. The inadequate number of healthcare personnel with patient flow is a significant obstacle to maximizing CBHI utilization (Keney et al., 2024).

The share of domestic finance between government and households in total health expenditure in Ethiopia is increasing from 49% in 2010/11 to 65% in 2016/2017. However, donor money for health remains significant, accounting for more than a third of

the total health expenditure. Given the intention of donor funding declines, Ethiopia's desire to become a lower-middle-income nation by 2025, and its commitment to achieve universal health coverage through primary health care, the government must immediately and considerably expand its domestic health finance. This comprises an increase in health spending as a percentage of GDP and an increase in government spending on health as a proportion of total government spending on health. Increased domestic financing, in conjunction with other domestic resource mobilization initiatives, helps to overcome the deficits resulting from a projected drop in donor funding, ensuring more resources to satisfy the increasing healthcare demands (USAID, 2019).

Even though the health sector budget increased, the actual budget decreased due to economic inflation. This remarkable rise in the capital budget provision to health occurs despite a decrease in the share of the national budget's capital budget due to limited fiscal capacity. Outside funding to the health capital budget has steadily decreased over time. This might be ascribed to global economic pressures, which have resulted in decreased official development aid. For these reasons, the government's budget is shifting away from external aid and loans and toward internal resources (UNICEF, 2024).

Generally, from the findings of the literature, the researcher can conclude that the CBHI strategy has a tremendous advantage for the healthcare system. However, it has many challenges in the accessibility and availability of healthcare resources and other health-related factors.

2.9 Conceptual Framework

The framework of the clients' satisfaction with CBHI in healthcare institutions is sourced from different literature. Clients' satisfaction is the expectation of patients and what they experienced during healthcare service in the health sector. The literature showed that clients' satisfaction with CBHI was associated with clients' socio-demographic, knowledge on the CBHI scheme and experience of clients on the CBHI scheme. Generally, the socio-demographics of clients, clients' knowledge on the CBHI scheme and experience of clients on the CBHI scheme are independent variables and clients' satisfaction with CBHI, including both health providers' service and hospital service provision are dependent variable.

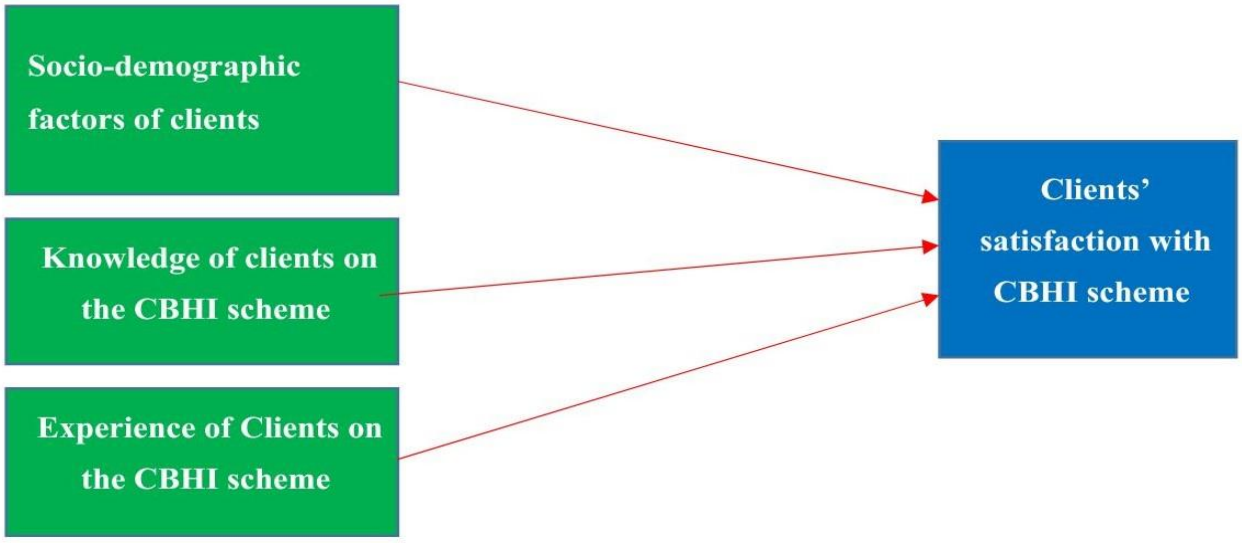

Figure 2.1: Conceptual framework for CBHI beneficiaries' satisfaction & associated factors, BLSH, Addis Ababa, Ethiopia, 2025

CHAPTER THREE: METHODOLOGY

3.1 Study Setting and Period

This study, "Clients' satisfaction with Community-based health insurance (CBHI) and associated factors," was conducted at Black Lion Specialized Hospital (BLSH) from April 23 to May 23, 2025. BLSH is one of the tertiary hospitals in Ethiopia. It is located in the capital city of Ethiopia, Addis Ababa. According to the hospital report in 2016, the hospital had over 3200 employees, more than 780 beds and 45 specialty and sub-specialty clinics. The hospital saw over 800,000 patients per year, more than 60,000 per month and more than 120 new cases referred to the hospital per day. BLSH was selected for this study because it is a tertiary hospital that enabled the researcher to get enough samples for the study.

The hospital provided healthcare services for both outpatient and inpatient clients starting from its establishment in 1964. The hospital started to provide healthcare services for community-based health insurance beneficiaries in January 2018.

3.2 Research Approach and Design

This study was conducted at the Black Lion Specialized Hospital (BLSH) using both quantitative and qualitative research approaches. The study also employed an institutional-based cross-sectional descriptive design for quantitate data and phenomenological design for qualitative data.

3.3 Criteria of Eligibility

3.3.1 Inclusive Criteria

All patients admitted to BLSH inpatient ward having CBHI coverage were included in the study. Specifically, the following participants were included in the study:

- CBHI beneficiaries whose ages were 18 years or above
- CBHI beneficiaries who enrolled before 6 months
- All CBHI beneficiaries who were volunteers and admitted inward and not critically ill.

3.3.2 Exclusive Criteria

The study excluded clients admitted to BLSH without CBHI package. The other clients who were excluded from this study were clients who gained healthcare services at BLSH with the CBHI scheme but were not admitted to the inpatient ward.

3.4 Sample Design

3.4.1 Population and Sample Size

The study population consisted of all clients who received healthcare services at BLSH, and the sample population was patients admitted to the inpatient ward using CBHI. The monthly CBHI beneficiary admitted patients in the wards were 1125. The sample size for the CBHI beneficiaries at BLSH was calculated using the single population proportion formula by considering a 95% confidence level and a 5% margin of error. For sample size calculation, the previous study conducted in southern Ethiopia on client satisfaction with the CBHI scheme (Babore et al., 2023) was used.

$$n = \frac{Z^2 p.q.}{e^2}$$

Where: - n= is the sample size to be selected

p=63.1 %, taking from the previous study

q=p-1

z- Significant level at 95% confidence interval

e= is the margin of error (acceptable sampling error) = 5% (0.05)

$$n = \frac{(1.96)^2 * 0.631 * 0.369}{(0.05)^2}$$

n= 358 (* sign of multiplication)

Adding 5%, the sample size's non-response rate is 18. So, the final sample size is 376. The monthly admitted patients in BLSH on average were 1125. To find the value of $K^{th,}$ divide the monthly admitted patients by the sample size. Finally, the data were taken from every 3 patients at their bed numbers.

In a qualitative study, the sample size was determined by the idea of data saturation, which occurs when further interviews or participants yield repetitive information without adding

new ideas. The qualitative study employed focus group discussions (FGDs) with five groups. There were also conducted in-depth interviews (IDIs) with 12 persons (seven males and five females). In addition to FGDs and IDIs, simultaneous interviews were conducted with the quantitative data collection. The simultaneous interviews helped the researcher to determine at what point the data were saturated. The researcher declared that the data were saturated after five focus group discussions and 12 in-depth interviews.

3.4.2 Data Sampling and Collection Techniques

The study used both probability and non-probability sampling techniques to collect the data. Probability and non-probability sampling techniques were used simultaneously for both quantitative and qualitative.

Quantitative section: A systematic data sampling technique used for quantitative data collection using structured questionnaires which included socio-demographic data of the clients, knowledge of the CBHI beneficiaries, clients' experience on CBHIS and clients' satisfaction with the CBHI users related to both healthcare professional and hospital healthcare services provision. The quantitative questionnaires were completed during a face-to-face interview at the clients' bedsides.

Qualitative section: for the qualitative data, a purposive sampling technique was used to collect data through FGDs and IDIs with clients, using semi-structured interview questionnaires to explore clients' perceptions and the challenges they faced during the healthcare services provided. To minimize potential bias, personal observations and experiences in the study area also helped the researcher to better understand the assessment of clients' satisfaction with the CBHI scheme.

3.5 Source of Data

3.5.1 Primary Source

The primary data for this assessment were first-hand sources collected from the clients who received healthcare services at Black Lion Specialized Hospital (BLSH) using the CBHI package. The primary data were collected through structured questionnaires, FGDs and IDIs.

3.5.2 Secondary Source

The researcher also used secondary data from various documents, including the community-based health insurance report on beneficiaries, the hospital report on CBHI beneficiaries and other related documents.

3.6 Data Collection Instrument

To assess the clients' satisfaction with the CBHI scheme at BLSH, the data collection instrument was first prepared in English, then translated local language, Amharic, to collect the data from respondents and translated back into English for analysis. The data were collected from April 23 to May 23, 2025. The data were daily recorded, checked and then coded.

3.7 Study Variable

A research variable is any attribute that can be measured or quantified. Variables are essential components of research because they allow for the measurement and analysis of data for a better understanding of correlations, causes, and consequences.

There are two types of variables:

Dependent variable: clients' satisfaction with the CBHI scheme

Independent variable: For this study, the independent variables include the socio-demographics of respondents, knowledge of the CBHI beneficiaries on the scheme, and the beneficiaries' experience on the scheme.

3.9 Data Analysis Method

Quantitative and qualitative data were analyzed separately. For the first objective or quantitative data, a descriptive data analysis was employed using SPSS version 21 and presented in terms of frequency, percentage, mean and standard deviation. To identify the association between dependent and independent variables, bivariate and multivariate logistic regressions were also used.

The qualitative data was analyzed qualitatively. It is used to understand non-numeric data, focusing on themes and meanings derived from qualitative data sources such as FGDs and

IDIs with open-ended responses, field notes and other textual or visual inputs. This qualitative data was analyzed thematically.

3.10 Quality Assurance

The reliability of the internal consistency is measured using Cronbach's alpha. To maintain its consistency, first the tools were prepared in English version, then the questionnaire was translated into Amharic versions, and then back to English for data analysis. The alpha value of this study was 0.801. The tools were adopted from previous studies with some modifications. The level of client satisfaction was assessed using a 5-point Likert scale ranging from highly dissatisfied to highly satisfied, with most measurement items adapted from KA and Adewale (2024). Additionally, instruments used to evaluate beneficiaries' knowledge of community-based health insurance (CBHI) were modified based on tools developed by Haile et al. (2023).

3.11 Ethical Consideration

Ethical considerations were important in conducting this study. For this reason, the study passed various ethical procedures to ensure ethical consideration of the study. Firstly, before starting data collection, the principal investigator took a supportive letter from Addis Ababa University School of Social Work and gave to letter to the BLSH clinical director's office and gain permission. In addition to collecting the data, the researcher obtained consent from study participants. The data collectors were also able to ensure the willingness of clients to participate in the study. After the above procedure, data collectors started data collection.

CHAPTER FOUR: RESULTS AND DISCUSSION

4.1 Quantitative Findings

4.1.1 Socio-Demographic of Participants

A total of 376 questionnaires were distributed to patients who used CBHI and were admitted to BLSH for healthcare services. Among the 376 questionnaires, 12 questionnaires were not completed due to different reasons after starting to fill out the questionnaires. Therefore, the response rate of the study was 96.8%.

181 (49.7%) of the participants were males and 183 (50.3%) were females. A large number of the 103 (28.3 %) of the participants were between the ages of 51 to 61 years; 19% of the participants were between the age of 40-50 years; 18.1% of the respondents were between the age of 29-39 years; 17.6 % of the participants were and greater than or equal to 61 years and the remaining 17% were between the age of 18-28 years.

Regarding participants' residency, the majority, 240 (65.9 %), were from urban and 222 (61 %) of the participants were married, and 33%, 5.5%, and 0.5% were single, separated, and widowed, respectively. Concerning the level of education, 258 (69.9 %) of the participants were educated at secondary education, diploma and above, 76 (20.6%) participants could read and write and 35(9.5%) of the participants were illiterate.

On the occupation of the participants, 93 (25.5 %) of the participants were merchant; 91(25%) were farmers, 66 (18.1%) were laborers; 53(14.6%) were house wives; and students, unemployed, Governmental employees, pensioners and drivers account 9.3%, 3%, 2.5%, 1.1% and 0.8% respectively. Based on the estimated monthly income of the family, 112(30.8%) of the participants had monthly income between 5001-8000 birr, 100(27.5%) had monthly income greater than 8000 birr, 99(27.2%) had monthly income between 2001-5000 birr and the remained, 53(14.6%) of the participants had less or equal to 2000 birr. Based on the numbers of family size 4-6 number of family size 201 (55.2 %) had a family size between 4-6 people, followed by 99 (27.2%), 1-3 family size and 64(17.6%) had a family size of 7 and above. (See table 4.1 below).

Table 4.1. Socio-Demographic Characteristics of the Study Participants at BLSH, Addis Ababa, Ethiopia: 2025

		Frequency	Percentage
Sex	Male	181	49.7
	Female	183	50.3
Age	18-28	62	17
	29-39	66	18.1
	40-50	69	19
	51-61	103	28.3
	61+	64	17.6
Marital status	Single	120	33
	Married	222	61
	Divorced	20	5.5
	Widow	2	0.5
Occupation	Farmer	91	25
	Merchant	93	25.5
	House wife	55	14.6
	Laborer	66	18.1
	Student	34	9.3
	Unemployed	11	3
	Government employee	9	2.5
	Pensioner	4	1.1
	Driver	3	0.9
Monthly estimated Income	≤2000 birr	53	14.6
	2001-5000 birr	99	27.2
	5001-8000 birr	108	29.7
	8000+	104	28.6
Education level	Illiteracy	79	21.7
	Read and write	106	29.1
	High school/preparatory	131	36

	Diploma/college and above	48	13.2
Residency	Rural	124	34.1
	Urban	240	65.9
Family size	1-3 size	99	27.2
	4-6 size	201	55.2
	≥7 size	64	17.6

4.1.2 Participants' Knowledge on the CBHI scheme

Regarding community-based health insurance covers only public health institution costs, community-based health insurance(CBHI) doesn't cover transportation; community-based health insurance covers inpatient and outpatient costs; community-based health insurance covers expenses within the country; community-based health insurance covers the cost of imaging services participants, 100 % answered "yes", and about CBHI covers dialysis service most, 332 (91.2 %) of the participants said "yes" and CBHI does not cover medical care for cosmetic surgery; most 341 (93.7 %) of the participants also agree. (See table 4. 2 below).

Table 4.2. Participants' Knowledge of the CBHI scheme at BLSH, Addis Ababa, Ethiopia: 2025

Variable	Category	Frequency	Percentage
CBHI covers only the public health institution costs	Yes	364	100
	No	0	0
CBHI covers expenses only within the country	Yes	364	100
	No	0	0
	Yes	364	100

CBHI doesn't cover the cost of transportation	No	0	0
CBHI covers inpatients and outpatients' cost	Yes	364	100
	No	0	0
CBHI covers the cost of surgical service	Yes	364	100
	No	0	0
CBHI covers cost of dialysis services	Yes	332	91.2
	No	32	8.8
CBHI covers the cost of laboratory services	Yes	364	100
	No	0	0
CBHI covers the cost of imaging services	Yes	364	100
	No	0	0
CBHI did not cover the costs for cosmetic surgery	Yes	341	93.7
	No	23	6.3

The overall knowledge of clients with the CBHI scheme at Black Lion Specialized Hospital, most of the participants, 309 (84.9 %) had good knowledge about the services covered by CBHI scheme but 55 (15.1 %) of the participants had inadequate knowledge about the CBHI basic services covered by it specifically on the CBHI covers cost of dialysis services and the CBHI did not cover the costs for cosmetic surgery. (See figure 4.1 below)

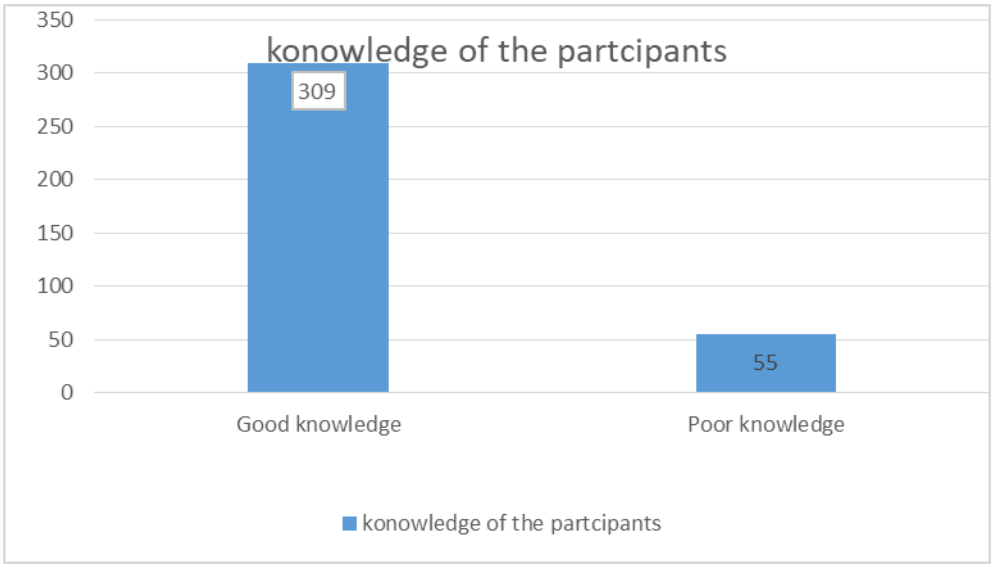

Figure 4.1. The Client's Knowledge on CBHI Services at BLSH, Addis Ababa, Ethiopia: 2025

4.1.3 Experience of CBHI Beneficiaries on the Scheme

Concerning CBHI reduced healthcare costs, all (100 %) participants said "yes". Participants perceived that CBHI enabled frequent visiting to healthcare institutions; most, 303 (83.2 %) of the participants and 328(90.1%) members improved their health after using the CBHI scheme.

Regarding about amount of money paid for CBHI registration and renewal, most 331 (90.9 %) of the participants paid less than 2000 birr and becoming a membership of CBHI was increased time to time. The additional payment for the enrollment was due to the age of children above 18 years and the involvement of other family members into the CBHI scheme rather than the basic family. Regarding the experience of beneficiaries using CBHI, the findings showed that the CBHI increased time to time. Only 146 (40.01 %) of the participants came to the hospital from short distance from their home and the other came from far and very far 218 (59.99%) from the hospital to receive healthcare. Most of the respondents 148(40.7%) admitted to the BLSH due to emergency illness followed by 110(30.2%) due to chronic disease and others, 106(29.1%) due to some health problems before.

Concerning on When did the members enrolled on CBHI, more than two-thirds of the participant enrolled before their illness and 112(30.8%) of respondents became members at the time of illness or after their illness, they became members of CBHI scheme. Even though, most participants were comfortable with the time of enrolment and renewal of CBHI package, a significant number of participants 106(29.1%) were not happy for the enrolment and renewal period of CBHI scheme and 46(12.6%) were forced by the local government to enroll and renew CBHI package. All beneficiaries will have the plan to renew the CBHI scheme card for future use. (See table 4.3 below).

Table 4.3. Experience of CBHI Beneficiaries on the Scheme at BLSH, Addis Ababa, Ethiopia: 2025

Variable	Category	Frequency	Percentage
CBHI reduced my healthcare costs	Yes	364	100
	No	0	0
CBHI enables frequent visits to healthcare institutions	Yes	303	83.2
	No	61	16.8
Health is improved after CBHI membership	Yes	328	90.1
	No	36	9.9
The premium is low and fair	Yes	362	99.5
	No	2	0.5
Amount of money paid for the CBHI register and renewal	<200 birr	331	90.9
	>200 birr	33	9.1
Years of experience in using CBHI	6months-2 years	121	33.2
	2-4 years	114	31.3

	4-6 years	76	20.9
	>6 years	53	14.6
The current health status	Emergency	148	40.7
	Some problem	106	29.1
	Chronic disease	110	30.2
When do you register in CBHI	Before my illness	252	69.2
	At the time of illness	112	30.8
The hospital distance from your home	Short: <100km	146	40.1
	Far:100-200km	84	23.1
	Very far:>200km	134	36.8
Is the CBHI enrolment and renewal time comfortable?	Comfortable time	258	70.9
	Non-comfortable time	106	29.1
Influence on the enrolment of CBHI	Voluntary	318	87.4
	Governmental influence	46	12.6
Plan to renew CBHI	Yes	364	100
	No	0	0

4.1.4 Satisfaction of Clients with CBHI on Health Providers

Regarding about healthcare service providers are respectful and compassionate, majority 223 (61.3 %) of the participants were satisfied followed by 116(31.9%) highly satisfied;

21(5.8%) and 4(1.1%) participants were dissatisfied and neutral respectively with a mean score of 4.19 and a standard deviation of 0.72. Respecting on the variable gaining immediate care from the health professional, most of respondents, 329 (90.4%) were satisfied and highly satisfied with a mean score 3.99 and standard deviation of 0.81. Based on the variable on maintenance of patients' privacy, most of participants 228(62.7%) were dissatisfied and highly dissatisfied; only 89(24.4%) of the patients were satisfied and highly satisfied; the remaining 47(12.9) were neutral on maintaining their privacy with a mean value 2.48 and standard deviation of 1.12.

Regarding the hospital having skilled professionals to provide healthcare delivery, most of the patients, 348(95.7%), were satisfied and highly satisfied with a 4.16 mean score and 0.60 standard deviation. The variable that the ability of service providers to explain diagnostic and treatment to the clients, the majority, 263 (72.3 %) of the participants were satisfied followed by 81(22.3 %) who were highly satisfied with a mean score of 4.11 and 0.66 standard deviation.

Concerning about availability of health provider staff during working hours, the majority of participants, 262 (72 %) were satisfied, 87(23.9%) were highly satisfied, only less than 5% of patients were dissatisfied and neutral to the services with a mean score value of 4.18 and standard deviation of 0.57.

Relating to the variable, good communication between health professionals to provide fast healthcare service to the patients after investigation, more than two-thirds, 253 (69.5 %) of the participants were satisfied and 65(17.9%) of the respondents were highly satisfied with a mean value of 3.99 and a standard deviation of 0.72.

Based on Health provider personnel's appearances (neatness, professional dressing) the finding showed that 361(99.2%) participants were satisfied and highly satisfied with a mean and standard deviation of 4.21 and 0.46, respectively.

Concerning clients' participation in decision-making about their treatment, the majority, 231(63.5%) of the participants were satisfied and 88(24.2%) were highly dissatisfied. Only 35(9.6%) participants were dissatisfied with the participation in decision-making about their treatment with a mean value of 4.02 and 0.81. (See Table 4.4 below)

Table 4.4. Satisfaction of Clients with CBHI on Health Providers at BLSH, Addis Ababa, Ethiopia: 2025

Variables	H.dissatisfied	Dissatisfied	Neutral	Satisfied	Highly Satisfied	mean	Std.
Healthcare providers are respectful and compassionate	0	21 (5.8%)	4 (1.1%)	223 (61.3%)	116 (31.9%)	4.19	0.72
Got immediate care from the health provider	8 (2.2%)	23 (6.3%)	4 (1.1%)	258 (70.9%)	71 (19.5%)	3.99	0.81
Maintenance of patients' privacy	65 (17.9%)	163 (44.8%)	44 (12.9%)	75 (20.6%)	14 (3.8%)	2.48	1.12
Skilled professional to provide healthcare delivery	0	12 (3.3%)	4 (1.1%)	263 (72.3%)	85 (23.4%)	4.16	0.6
Service providers' ability to explain diagnosis and treatment	2 (0.5%)	16 (4.4%)	2 (0.5%)	263 (72.3%)	81 (22.3)	4.11	0.66
Availability of health provider staff during working hours	3 (0.8%)	1 (0.3%)	11 (3%)	262 (72%)	87 (23.9%)	4.18	0.57
Good communication between health professionals to provide fast healthcare service after investigation	3 (0.8%)	18 (4.9%)	25 (6.9%)	253 (69.5%)	65 (17.9%)	3.99	0.72
Health provider professional dressing (neatness)	0	2 (0.5%)	1 (0.3%)	278 (76.4%)	83 (22.8%)	4.21	0.46
Your participation in decision-making about your treatment	0	35 (9.6%)	10 (2.7%)	231 (63.5%)	88 (24.2%)	4.02	0.81
Satisfaction of overall mean						**3.93**	

4.1.5 Satisfaction of Clients with CBHI on Hospital Health Service Provision

Concerning the bedroom is clean and full of facilities, more than half, 207 (56.9 %) patients were dissatisfied and highly dissatisfied, 134(34.8%) of participants were satisfied and highly satisfied and only 23(6.3%), were neutral with a mean score of 2.64 and a standard deviation of 1.24. 177 (48.6 %) of the participants were dissatisfied, 108(29.7%) were satisfied, 41(11.3%) were highly dissatisfied, 29 (8%) and 9(2.5%) were neutral and highly satisfied respectively with a mean value of 2.63 and standard deviation 1.1.

On variable that the hospital environment is clean and attractive, more than two-thirds of the participants, 252(69.4%) were dissatisfied and highly dissatisfied, 82(22.5%) were satisfied and highly satisfied, only 30(8.2%) were neutral with a 2.35 mean value and standard deviation of 1.1. On the variable that the hospital had an adequate seating or reception area, most of 252(69.2%), respondents were dissatisfied and highly dissatisfied, 82(22.5%) were satisfied and highly satisfied, and the remained percent were neutral with a mean value of 2.45 and standard deviation of 1.09.

Depending on the variable that the participants satisfaction with prescribed drug availability, most of the participants 297(81.6%) were dissatisfied and highly dissatisfied, 39 (10.7%) were neutral and the remaining 28(7.7%) were satisfied with the prescribed drug availability with a mean value of 1.89 and a standard deviation of 0.88.

On the satisfaction with laboratory service availability, 156(42.9%) patients were dissatisfied, 90(24.7%) were satisfied, 66(18.1%) were highly dissatisfied, 50(13.7%) were neutral and only 2(0.5%) were highly satisfied with a mean of 2.47 and standard deviation of 1.1.

Regarding satisfaction with medical imaging (x-ray, CT scan, MRI) service availability, more than half of the respondents, 200(54.9%) were dissatisfied and highly dissatisfied, 107(29.4%) were satisfied and highly satisfied and 57(15.7%) were neutral with a mean score of 2.68. The majority of respondents, 213(58.5%) were dissatisfied and highly dissatisfied, 105(28.8%) were satisfied and highly satisfied and 46(12.6%) were neutral with a mean score of 2.68 on the waiting time for getting an investigation result (laboratory and imaging).

164(45.1%) of the respondents were satisfied and highly satisfied, 222(33.5%) were dissatisfied and highly dissatisfied and 78(21.4%) were neutral with a mean value of 3.12 and standard deviation of 0.91 on the variable of satisfaction with the overall information provided in the hospital. Based on comfortable with the overall hospital setup or structure, most the respondents, 263(72.2%), were dissatisfied and highly dissatisfied, 53(14.6 %) neutral and 48(13.2%) were satisfied and highly satisfied with a mean value of 2.13 and a standard deviation of 0.98. (See Table 4.5 below)

Table 4.5. Satisfaction of Clients with CBHI on Hospital Health Service Provision at BLSH, Addis Ababa, Ethiopia: 2025.

Variables	Highly dissatisfied	Dissatisfied	Neutral	Satisfied	Highly Satisfied	mean	Std.
The bedroom is clean and full of facilities	72 (19.8%)	23 (6.3%)	135 (37.1%)	119 (32.7%)	15 (4.1%)	2.64	1.24
The hospital environment is clean and attractive	41 (11.3%)	177 (48.6%)	29 (8%)	108 (29.7%)	9 (2.5%)	2.63	1.1
There is an adequate reception area at the hospital	75 (20.6%)	177 (48.6%)	30 (8.2%)	74 (20.3%)	8 (2.2%)	2.45	1.09
Satisfaction with prescribed drug availability	135 (37.5%)	162 (44.5%)	39 (10.7%)	28 (7.7%)	0	1.89	0.88
Satisfaction with laboratory service availability	66 (18.1%)	156 (42.9%)	50 (13.7%)	90 (24.7%)	2 (0.5%)	2.47	1.07
Satisfaction with medical imaging availability	27 (7.4%)	173 (47.5%)	57 (15.7%)	103 (28.3%)	4 (1.1%)	2.68	1.00
Satisfaction with the waiting time for getting an investigation result	12 (3.3%)	201 (55.2%)	46 (12.6%)	103 (28.3%)	2 (0.5%)	2.68	0.94

Satisfaction with the overall information provided in the hospital	2 (0.5%)	120 (33%)	78 (21.4%)	160 (44%)	4 (1.1%)	3.12	0.91
Comfortable with the overall hospital setup or structure	102 (28%)	161 (44.2%)	53 (14.6%)	47 (12.9%)	1 (0.3%)	2.13	0.98
Satisfaction of overall mean						2.51	

The overall clients' satisfaction with CBHI and its associated factors at BLSH Was More than half (57.7 %), with 210 participants satisfied and 154 (42.3 %) unsatisfied.

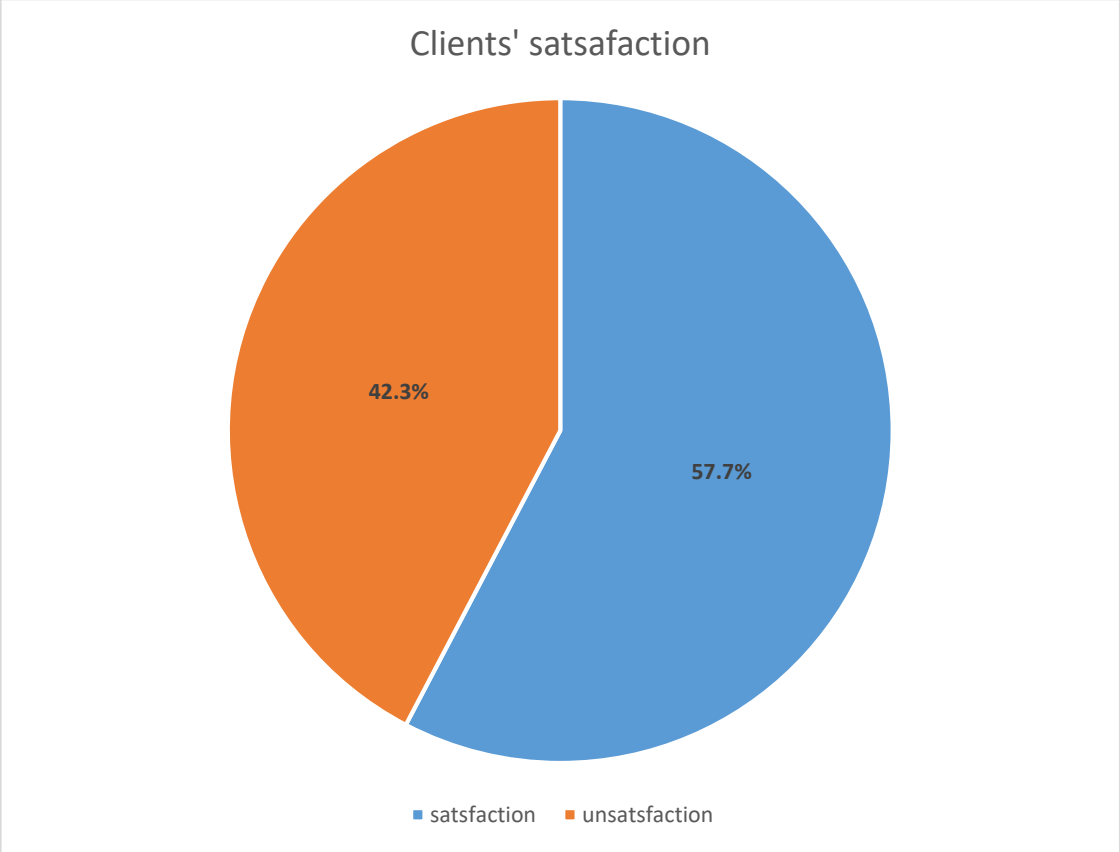

Figure 4.2. The Overall Clients' Satisfaction with CBHI at BLSH, Addis Ababa, Ethiopia: 2025

4.1.6 Factors Associated with Clients' Satisfaction with CBHI Beneficiaries

The logistic regression was done to identify the association between the dependent and independent variables. Binary logistic regression showed the association of each independent variable with clients' satisfaction with CBHI at a P-value less than 0.2, and then entered into multivariate regression to identify the independent variables prognosticating for the clients' satisfaction with CBHI and associated factors at a P-value less than 0.05. In bivariate logistic regression presented the following variables participant's age, monthly income, CBHI not cover medical care for cosmetic surgery, family size, residency and knowledge.

After multivariable logistic regression, the following factors were found to have an association with the assessment of clients' satisfaction with CBHI and associated factors. Those were participants' age from 40 to 50 years old, residency from rural, monthly income from 2001 to 5000 birr, family size from 4 to 6, CBHI does not cover medical care for cosmetic surgery and knowledge of the participants.

In the multivariate analysis result of the participant's age was significantly associated with client satisfaction on the CBHI. Participants aged from 40 to 50 years old were 3 times more likely to be satisfied than those participants older than 61 years old (AOR=3.1, 95 % CI: (1.35-6.8) (P<0.007).

Clients' residency was significantly associated with client satisfaction on CBHI. Residency clients who live in rural 2.4 times more likely to be satisfied than clients who live in urban areas (AOR=2.4, 95 % CI: (1.4-4.2) (P<0.001). Clients' monthly income was significantly associated with client satisfaction with CBHI. Monthly income from 2001 to 5000 birr was 3 times more likely to be satisfied than those clients' monthly income greater than 8000+ birr (AOR=2.84, 95 % CI: (1.45-5.58) (P<0.002). clients who agree with CBHI do not cover medical care for cosmetic surgery significantly associated with client satisfaction on CBHI. This was 98 % less likely to be satisfied than those clients not agree that community-based health insurance did not cover medical care for cosmetic surgery (AOR=0.02, 95 % CI: (0.003-0.098) (p<0.000). (See Table 4.6 below)

Table 4.6. Bivariate and Multivariable Logistic Regression Analysis on CBHI Beneficiaries at BLSH, Addis Ababa: 2025

Variables	Clients' satisfaction with CBHI & associated factors		COR 95% CI	AOR 95% CI	p-value
	Satisfied	Not satisfied			
Age					
18-28	32	30	2.2(1.07-4.62) *	1.8(0.7-4.6)	0.235
29-39	37	29	1.86(0.9-3.8) *	1.3(0.5-2.97)	0.601
40-50	37	32	2.05(1.002-4.2) *	3.1(1.35-6.8) **	0.007
51-61	59	44	1.78(0.9-4.43) *	2.1(0.99-4.43)	0.054
61+	45	19	1	1	
Residency					
Rural	55	69	2.29(1.5-3.56)	2.4(1.4-4.2) **	0.001
Urban	155	85	1	1	
Income					
≤2000 birr	32	21	1.332(0.67-2.67) *	1.8(0.65-4.94)	0.256
2001-5000 birr	41	58	2.87(1.6-5.1) *	2.84(1.45-5.58) **	0.002
5001-8000 birr	70	42	1.22(0.692-2.14)	0.98(0.52-1.87)	0.964

>8000 birr	67	33	1	1	
Family size					
1-3	68	31	0.63(0.325-1.2) *	2.10.86-5.09)	0.103
4-6	105	96	1.253(0.71-2.2)	2.8(1.3-6.02) **	0.009
7 +	37	27	1	1	
CBH not cover for cosmetic surgery					
Yes	9	201	0.061(0.014-0.264) *	0.02(0.003-0.098) **	0.000
No	21	133	1	1	

Key * statistically significant at p-value <0.2, in bivariate, 1= reference of the category

** Statistically significant at p-value <0.05, in multivariate

Multivariate logistic regression on clients' experience with CBHI scheme, factors associated to client satisfaction were current health status, patients who come to the hospital with some problems AOR=3.52, 95% CI, (1.92-6.46) (P<0.000). Clients with some health problems 3.5 times more likely to be satisfied than clients with chronic disease. Clients who registered before their illness AOR=1.84, 95% CI (1.06-3.17) (P<0.029). Clients who registered before their illness were 1.8 times more likely to be satisfied than its counterpart. Clients who agreed the time of CBHI enrolment renewal was comfortable of CBHI AOR= 2.78, 95% CI (1.56-4.92) (p<0.001). Clients who voluntarily enrolled with CBHI scheme AOR=0.28, 95% CI (0.13-0.58) (P<0.001). Clients who enrolled with a community-based health insurance scheme voluntarily were 0.28 less likely satisfied than clients who were enrolled by governmental influence. (See table 4.7 below).

Table 4.7. Multivariable Logistic Regression Analysis on CBHI Beneficiaries' experience at BLSH, Addis Ababa: 2025

Variables	Clients' satisfaction with CBHI & associated factors		AOR at CI: 95%	95% C.I. for AOR		p-value
	satisfied	Unsatisfied		Lower	Upper	
The current health status						
Emergency	85	63	1.69	.94	3.03	.079
Some problems	46	60	3.52	1.92	6.46	.000**
Chromic disease	79	31	1			
When you register CBHI						
Before my illness	137	115	1.84	1.06	3.17	.029**
After my illness	73	39	1			
Comfortability of CBHI enrollment and renewal period						
Comfortable time	138	120	2.77	1.56	4.92	.001**
Uncomfortable time	72	34	1			
influence for the enrolment of CBHI						
Voluntary	190	128	.28	.13	.58	.001**
Government influence	20	26	1			

Key 1= reference of the category, ** statistically significant at p-value <0.05, in multivariate

4.2 Qualitative Findings

The qualitative data for this study were collected using focus group discussions and in-depth interviews with the CBHI beneficiaries who were admitted to BLSH. There were five FGDs and 12 IDIs with clients who had gained healthcare services using CBHI at BLSH. Clients selected for FGDs and IDIs based of their knowledge on the CBHI scheme, experience with the CBHI scheme and communication skills, length of stay in the hospital, educational status and their volunteerism.

34 clients participated in the focus group discussion. Among 34 participants, 15 were females, 19 were males, 9 were patients, and 25 were patients' attendants, all in the 24-60 years age range. (See Table 4.8 below).

Table 4.8 Background of respondents for focus group discussion at BLSH, Addis Ababa, Ethiopia, 2025

FGDs code	Age range	Number of participants	Participants by sex	Attendants: patients
FGD1	28-56	6	2 were females	2 were patients
FGD2	24-45	7	4 were females	2 were patients
FGD3	31-60	8	3 were females	2 were patients
FGD4	25-48	6	3 were females	1 were patients
FGD5	24-52	7	3 were females	2 were patients

There were also conducted IDIs with 12 persons, seven males and five females. Among 12 participants, 8 were attendants and the age of the IDI participants ranged from 22 to 65 years. In addition to FGDs and IDIs, simultaneous interviews were conducted with the quantitative data collection. After the quantitative data were filled, clients invited to explore their ideas about the CBHI scheme, benefits, challenges, and shared their experiences. Then, the investigator accepted their important comments and recorded them in the notebook. These simultaneous interviews with quantitative data helped the researcher to determine at what point the data were saturated.

4.9. Background of respondents for in-depth interview at BLSH, Addis Ababa, Ethiopia, 2025

Code	Sex	Age	Education	Client type
IDI-1	Male	32	Degree	Patients
IDI-2	Female	22	Degree	Attendant
IDI-3	Female	40	Diploma	Attendant
IDI-4	Male	65	Read and write	Attendant
IDI-5	Male	60	Diploma	Patient
IDI-6	Male	35	Degree	Attendant
IDI-7	Female	28	Student	Patient
IDI-8	Male	32	Read and write	Attendant
IDI-9	Male	50	Degree	Attendant
IDI-10	Female	42	Illiteracy	Patient
IDI-11	Female	35	Diploma	Attendant
IDI-12	Male	56	Degree	Attendant

4.2.1 The Benefits of the CBHI Strategy for beneficiaries (theme 1)

CBHI has significant benefits for the beneficiaries. It enabled many patients to visit the health institute for healthcare services when they felt sick and reduced OOP expenses or sudden health expenses. The CBHI system also enabled the beneficiaries to go to the healthcare institute easily without fear of high healthcare expenses. One person from FGD1 stated the benefit of CBHI as: *"Nowadays, community-based health insurance is life, because it saved our lives and protects us from unnecessary expenses. In addition to financial benefits, it gives us mental rest and keeps us from further tension and stress related to healthcare expenses. No services are restricted to us to use in the hospital unless it is not available in the hospital. We use all things which are available in the hospital without restriction".*

In BLSH, there were no services that were provided for the payers and were not allowed for CBHI beneficiaries. The CBHI package covered services such as bed and health

professional services in addition to medications, laboratory services, and imaging services if the service was available in the hospital.

4.2.2 CBHI Beneficiaries' Challenges during Enrolment and Renewal (theme 2)

CBHI users faced tremendous problems related to enrolment and renewal. As the participants explained, those challenges were long renewal appointments, problems related to the renewal and the service gap, CBHI card renewal with tax payment and mixing the payment with other services at the district or kebele. One of the group members from FGD2 stated those challenges as *"we know what benefits we get from community-based health insurance. However, the CBHI card stayed long period at the woreda level for renewal. At the time, we couldn't get healthcare services with community-based health insurance. This is what happened to me this year".*

In addition, the person from FGD3 explained the other challenges related to CBHI enrollment and renewal as *"enrollment and renewal of CBHI were enforced by the government and the registration and renewal payment were with taxes, and payment was related to other services given by woreda or kebele. But, I am not disappointed by the government enforcement, because I am a beneficiary and get significant healthcare from the membership of the CBHI scheme".*

A significant number of participants were forced to become members of the CBHI scheme by the local government or leaders, but they were happy when they received the healthcare services. This may indicate that some communities need push factors to become members of the CBHI scheme.

According to the hospital CBHI unit report and documentation, the challenges related to the CBHI scheme that obstacle for proper care were listed as: "*incomplete information on the CBHI cards such as a lack of beneficiaries' photographs on the cards, unidentified and old photographs on the CBHI cards, expired CBHI cards, improper use of the CBHI cards, expunction and cajolement of CBHI cards were some challenges for the hospital to provide healthcare services at the hospital."*

4.2.3 CBHI Beneficiaries Challenges on the Hospital Facility (theme 3)

BLSH has been providing healthcare services for many patients, including neighboring countries such as Somalia and Eritrea. The hospital has high patient flow from the whole corners of the country. These high patient flows load the hospital with tremendous resource utilization. One of the services that the patients needed in the ward is water, toilets, bathrooms, and other resources. These facilities were not proportional to the patient flow of the hospital. One person from GDF3 explained these challenges as:

"There are not enough toilets in the ward. We use one toilet for this ward. Especially in the morning, we make a street for a long queue to use the toilet and there is not enough water to clean the toilet. We pour the water from another part of the hospital compound." A person from FGD2 explored the additional challenges at the hospital inpatient ward as:

"It is impossible to take a shower for patients due to a lack of water and bathrooms in the hospital. In this ward, there are many patients admitted to one room, and there are several attendants in addition. In this situation, it is also difficult to maintain patients' privacy".

In most wards, there were not enough screens to maintain patients' privacy. In addition, nearby beds and many patients admitted to one ward or a crowded ward restrict to keep patients' privacy properly.

4.2.4 CBHI Beneficiaries Challenges Related to Medications (theme 4)

CBHI scheme beneficiaries received all available medications from the hospital that were prescribed by health professionals. BLSH has been providing pharmacy services at both the hospital and community pharmacy levels. CBHI members also have the right to receive unavailable medications in the hospital from the hospital community and Kenema Pharmacy, according to the contractual agreement of their regions or city administrations with the hospital. However, the challenges were that the inconsistent supply and unavailable of medications in both the hospital and the Kenema pharmacy for BLSH clients. In both FGDs and IDIs, the availability and inconsistency of drug

supply were a serious challenge for the clients at the hospital who complained about the shortage of drugs, and other medical supplies like syringes, gloves and procedural instruments. One person from FGD4 explained the challenges of CBHI beneficiaries related to drug and supply availability as:

"We can't get all the ordered drugs at the hospital and the Kenema pharmacy. We are navigating the ordered medications starting from the hospital pharmacy to Kenema pharmacies. However, we also couldn't get enough drugs that were prescribed for us in Kenema pharmacy, and we purchased from a private pharmacy at a high cost."

Finding drugs and other medical supplies from Kenema pharmacy to the private pharmacy took a long time and resulted to the late treatment of patients in the hospital. It consumed not only money but also time. The contractual issues and overloaded needs of clients in the Kenema pharmacy also other challenges to get a fast response for the ordered medications, keeping on the availability of the orders.

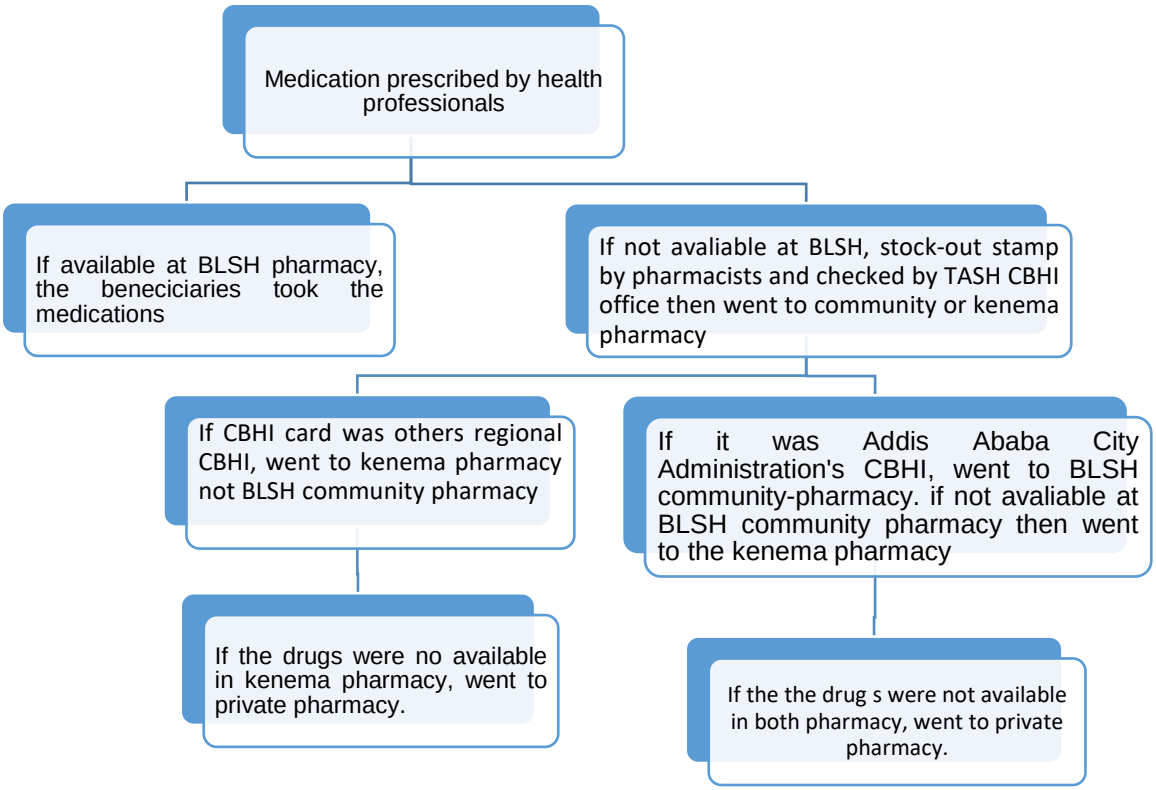

Figure 4.3: Navigation of Medication from BLSH to Private Pharmacies, BLSH, Addis Ababa, Ethiopia: 2025.

4.2.5 CBHI Beneficiaries Challenges Related to investigations (theme 5)

Laboratory investigation is one of the core elements for healthcare institutions to provide quality healthcare for patients. It enables healthcare providers to know the cause of the disease and provide evidence to prescribe the right drug to the right patients in the right way. BLSH has been providing laboratory services for the patients. All patients received the laboratory services that were available in the hospital. Besides these, some laboratory investigations were not available in the hospital. So, patients went to private clinics to get laboratory services at a high cost of the services.

Imaging investigations are also an important element for healthcare facilities like laboratory services. Several imaging instruments such as MRI, SC scan, X-rays, ultrasound, echocardiography machine and others are available in BLSH in keeping on the patients' load at the hospital. However, there were no magnetic resonance imaging (MRI) machines in the hospital or it was not functional. As BLSH served several clients, some imaging machines were not proportional to the patient flow of the hospital. These lead to patients to wait a long time or influence to going in private clinics with high expenses of the services. The challenges related to imaging investigation were the time to serve and the reading of the imaging results. The patients waited a week to a month for imaging results, specifically for CT-scan result reading, unless it was an emergency. One person who gained healthcare services for a long period of time from FGD5 stated this problem as:

"We can't get MRI services in the hospital and computed tomography (CT-scan) sometimes was not functional/interrupted the services. If the CT-scan is functional and we get the service, we wait for several days to get the result. Due to this, some patients who could afford the expense went to private health sectors to get the services at high prices. Unless we have no option rather to wait to get the service after a long time. The result after a long period also has other consequences that lead to repeating the investigation due to the time interval and the disease condition. In addition, lack of contrast or a medication named Iopamidol at the hospital for a better CT-scan imaging and high cost

of it from private pharmacy is a main challenge for us". One person from in-depth interview from the oncology ward complained that the shortage of radiation machines and long appointment was the main challenges for oncology clients who need radiotherapy.

Black Lion Specialized Hospital (BLSH) is the largest tertiary hospital in Ethiopia and provided healthcare for all Ethiopians and neighboring countries. It served healthcare services that were not available in other health institutions. The health services listed in the table below were noteworthy and the spoon of several services were provided by the BLSH.

The table below 4.10 shows the costs of healthcare services that the information obtained from patients who had paid for the separate private health institutions and the costs of health services at BLSH were obtained from the price document of the system. However, the purpose of this study is not to show the cost value of BLSH or to compare the hospital healthcare costs to other private health sectors, rather to show the following main points about CBHI strategy; (1) to magnify the benefit of CBHI and how much it protect the members from financial risk, (2) the availability of these services in the health institution are crucial for the healthcare and the institution must give attention to vast the services to protect the clients from additional health costs (3) to strength the idea of the clients who paid high costs when they gained health related services at private health sectors (4) the dramatic increase of healthcare cost which may expose clients for catastrophic health cost rather they insure by CBHI.

As shown in the table below, the costs of healthcare were increasing time to time. Health institutions may revise the healthcare costs to the services well and considering the current market of the pharmaceutical supplies and currency exchanges. The health institute plans to transition, the current market value, unavailability of some services in the hospital and devaluation of birr enter the low-income and vulnerable communities under question to gain quality health services. Many clients couldn't afford the private sector's health services. Those factors exposed the clients to different problems. Some of them left healthcare services and some fell into further poverty.

A person who was a member of the CBHI scheme, his/her health costs were covered by the CBHI that he/she had paid for before. This saved the member from sudden or emergency medical costs. For instance, a surgical patient who is planned for surgery may

need like X-ray, ultrasound, CT-scan or MRI, different kinds of laboratory investigations, different kinds of medicine, surgical instruments, other pharmaceutical supplies, bed, surgeons and other health professionals, follow-up clinic, etc.

However, if the person was a member of the Community-based Health insurance and services available in the institution, his/her health cost fee was covered by the prepayment premium according to the contractual agreement. Therefore, the community-based health insurance members received these services without sudden health costs for emergency and follow-up medical services.

BLSH is one of the largest health institutions that provides many healthcare services in Ethiopia. The hospital provided dialysis service for acute kidney injury (AKI) and CKD on AKI patients. It didn't provide dialysis service for chronic kidney disease (CKD). Patients who received this service were scheduled in the service and paid an updated for 3450 birr for each day, three days a week. If the patient is a member of a community-based health insurance package, the service fee is covered by the CBHI.

Before any other health sector in Ethiopia, BLSH started oncology or cancer treatment. The oncology health treatment includes surgery, chemotherapy and radiotherapy. As shown in the table below, the private service of radiotherapy costs at BLSH ranges from 47,000 birr to 110,000 birr according to the cases and the radiation cycle. This cost did not include chemotherapy medication and other services. A patient who was a member of CBHI, the service fee covered by the community-based health insurance package. The costs of the investigations varied depending on the site or the case of the investigated clients at BLSH and the private health sectors.

In general, a patient who was admitted to the hospital required many integrated healthcare services, including medication, investigation, beds, different hospital facilities, health professional consultations and other services. If the clients were members of CBHI, the costs of all their available healthcare services at the hospital covered by the CBHI package, based on the contractual agreement with the hospital or responsible bodies.

As the principal investigator explained before, we noticed that the BLSH provide a comprehensive health services in addition to list in the table below. The hospital provided investigations like bronchoscopy, colonoscopy, biopsy investigation, different kinds of laboratory investigation with a skilled professionals.

Table 4.10: Some healthcare services and their prices at BLSH and private health sectors, Addis Ababa, Ethiopia: 2025.

Type of service (investigation, medication and others)		Old prices at BLSH	New prices at BLSH	Price difference at BLH (new-old)	Prices range in the private health sector
CT-scan		535 birr	5000 birr	4465	6000-1000 birr
MRI		900 birr	Not-functional	No MRI service	8000-15000 birr
X-ray		100 birr	580 birr	480 birr	800-1200 birr
Ultrasound		80 birr	105 birr	25 birr	500-1200 birr
Mammography		80 birr	618 birr	538 birr	No information
Bronchoscopy		90 birr	765 birr	675 birr	No information
Colonoscopy		350 birr	4751 birr	4401 birr	No information
Endoscopy		350	2147	1797 birr	1000-1800 birr
Dialysis		7200 birr for the first session	8450 birr for the first session	1250 birr	17000-20000 birr for the first session
		2700 birr every session	3450 birr every session	750 birr per session	4500-5000 birr per session
Iopamidol (contrast)		800 birr	1200 birr	400 birr	3000-5800 birr
Bed	1st rank	318 birr/day	500 birr/day	180 birr/day	3500-6000 birr/day
	2nd rank	318 birr/day	500 birr/day	180 birr/day	3000-5000 birr/day

	3rd rank	170 birr/day	300 birr/day	130 birr/day	No information
Card processing		100 birr/month	300 birr/month	200 birr/month	500-1200 birr
Radiation price at BLSH by a private clinic		Minimum price	Maximum price		No information
		47,000 birr	110,000 birr		

4.2.6 CBHI Beneficiaries Challenges Related to Indirect Cost (theme 6)

Clients came to the Black Lion specialized hospital from a far distance to get different healthcare services. There were related costs in addition to the healthcare costs. Those indirect costs include food costs, transportation costs, and shelter costs until they got a bed in the hospital. Food and shelter costs in the surroundings of the hospital were a challenge for the clients. One person from FGD3 stated those problems as follows: "*It is difficult to get a bed when we come to the hospital. Some of us waited until we got a bed. It is impossible to sleep in the hospital compound at night. As a result, we paid for a bed in the hotel until we get the bed".*

The other attendant from the IDI from the ICU explained related to food costs as *"the health provider ordered us to prepare food for the patient. But I can't get the food in the hospital compound, and I ordered the food outside the hospital at a high cost".*

4.2.7 The Gaps of CBHI on Implementation at BLSH (theme 7)

CBHI scheme is for rural, low-income and vulnerable sections of the community. However, some formal employees used the CBHI scheme in the BLSH. Due to the health policy for formal employees not being fully implemented in the country, some formal employees are exposed to catastrophic health expenditure and choose to use

CBHI by different means. One of the patients from the IDI who used the CBHI scheme stated:

"I am a government employee. I suddenly became ill and tried to treat by out of pocket for the last six months. However, I can't afford it after a few movements. So, I decided to use the community-based health insurance and enrolled after many challenges. Nowadays, I am using community-based health insurance, and it helps me with some medical service costs that are available in the hospital."

In addition to the governmental employees, some patients received healthcare treatment due to a car accident, an electric shock, and a fall down accidents. According to the aims of the CBHI, these patients couldn't get healthcare treatment through the CBHI strategy. One of the victims of a road traffic accident stated his problems as:

"The road traffic accident happened to me and I spent a high expense on the treatment, but I couldn't get an expense for treatment from the insurance due to the procedural process. As a result, my family enrolled me for the CBHI scheme to reduce my healthcare expenses".

4.3 Discussion

This study was conducted to assess the clients' satisfaction with CBHI and related factors in the case of BLSH on admitted patients.

Concerning the participants' knowledge on the CBHI, most respondents had knew the basic services package of CBHI. This implied that there were no knowledge gaps in the services provided by using CBHI. The knowledge gaps were seen in the responses of CBHI covers dialysis services and CBHI does not cover medical care for cosmetic surgery, which account for 55 (15.1%) respondents. When this study was compared to the study conducted on the southern Ethiopia on client satisfaction and related factors towards the health services provided to CBHI members on the knowledge of CBHI scheme, the respondents of this study had greater knowledge on the scheme than the study conducted in southern Ethiopia that the scheme beneficiaries had inadequate knowledge of 36.24% (Babore et al., 2023). It also had a great difference that 45% of the CBHI beneficiaries had poor knowledge of the CBHI scheme (B. Abebe, 2021).

Regarding the experience of CBHI scheme beneficiaries, all of the CBHI package users reduced the cost their healthcare expense; 83.2% of the CBHI beneficiaries enabled frequent visiting health care institution; 90.1% the respondents were said “yes”, that they improved their health after being a member of CBHI scheme, 99.5% of the CBHI beneficiaries perceived that the premium is low and less than 2000 birr (90.9 %) yearly payment. This finding had a similar concept to the Ethiopian health insurance agency (EHIA, 2015), rather a slight difference.

According to EHIA, (2015) final report on evaluation of CBHI pilot schemes in Ethiopia, CBHI beneficiaries registered on the scheme because of different reasons, 37% reduce OOP healthcare expenses when they became ill; 35% of CBHI users to improve their health status, and 18% because of premium is less than their OOP costs and only 4 % because of government paid for the premiums. This report also revealed that there was no governmental or local official pressure on the communities to enroll or renew the CBHI and 84% of CBHI members perceived that the payment of the premiums was affordable. 97% of CBHI members plan to renew their membership when it expires. However, this study had a slight difference in the intention of the renewal plan of the CBHI scheme as all respondents of this study had the plan to renew the scheme package. In addition, this study revealed that 46 (12.6%) of the participants were influenced by the local leaders to enroll and renewed the scheme against the volunteer consent of the beneficiaries.

Respecting the time comfortability for enrolment and renewal, 258 (71.9%) of the respondents were comfortable with the time and 106 (29.1%) of the respondents said that the time was not comfortable for enrolment and renewal periods. This result compared with the study conducted in southern Ethiopia, showed greater comfort than (65%) (Babore et al., 2023). According to FGDs and IDIs, this was due to the mix of enrolment and renewal with other payments like taxes and related service payments and local leaders were influenced to pay the premium without voluntary consent, which is against the principle of the CBHI scheme. This result is similar to that of Abebe (2022).

Related to years of experience in using CBHI, 33.2% had the experience of 6 months to 2 years, 31.3% had the experience of 2-4 years, 20.9% of the respondents had the experience of 4-6 years and 14.6% had the experience of above 6 years on the use of CBHI scheme. This indicated that the enrolment and renewal of CBHI beneficiaries increased year to

year and the study checked the truth of the evaluation CBHI pilot scheme that increased the member of CBHI beneficiaries (EHIA, 2015). Most of the patients (59.9%) came from far and very far areas. This indicated that BLSH was not easily accessible to most clients to gain healthcare services nearby.

Regarding the level of clients' satisfaction with community-based health insurance, clients were highly satisfied with health professional services rating a mean value of 3.986 in "communication between health professionals to provide fast healthcare service to the patients after investigation" to 4.214 in "health professional appearances (neatness, professional dressing)". In percentage, the lowest and the highest percentages were 87.4% (satisfied and highly satisfied) on the variable communication between health professionals to provide fast healthcare service to the patients after investigation and 99.4% (satisfied and highly satisfied) on the variable of professional neatness. These results implied that clients were highly satisfied with the services provided by the health professionals (health providers). This finding was nearly similar to the study conducted in Niger (KA & Adewale, 2024). However, this study showed a low mean score that was 2.48 or 24.4% on the variable maintenance of patients' privacy which is less than the study done in Niger (84%) but greater in respect to respectfulness of clients (54%).

The mean value of the variables on hospital health services provision rating ranges from 1.89 to 3.12. The lowest mean value scored was 1.89 on the satisfaction of prescribed drug availability, 2.13 mean value on the clients' comfort with the overall hospital setup or structure, 2.35 on adequate seating/reception area at the hospital for clients, followed by 2.47 mean value on the Satisfaction with laboratory service availability. The highest mean score related to the hospital healthcare services was on the satisfaction with the information provided in the hospital (3.12 mean value). This implies that the clients' satisfaction with the hospital's health service provision is low. These findings on prescribed drug availability and the laboratory service were less than the study conducted in public hospitals in Eastern Ethiopia, where more than two-thirds of the services were available (Mohammed et al., 2024).

This study's findings were also lower when compared to the study conducted in Dilla University referral hospital on the variables of the cleanliness of the waiting area and the room. The mean value of the variable on the availability of an adequate reception area of

the BLSH was 2.35. When this result is compared to the study in Ghana, it is slightly less than Emmanuel (2012). On the comfort of the hospital's structural setup, this study was lower than the study conducted in South Ethiopia (3.93 mean value) (Babore et al., 2023).

The overall satisfaction of clients with community-based health insurance at BLSH was 57.7%. This result is nearly similar to that of the study conducted in the north-east of Ethiopia, 58.6% (Getaneh et al., 2023). However, this study is less than the national satisfaction level (Mekashaw et al., 2023). But overall satisfaction of clients of this study is greater than the study conducted in Dilla University, which was 52.2% (Melesse et al., 2022).

Clients complain about the current market value of the services, the unavailability of some services in the hospital and the devaluation of the birr or inflation for extra costs that were necessary for them. The explanation of the above challenges is strengthened by the study conducted by UNICEF (2024), the study indicated that the health sector budget raised from 79.4 billion birr in 2022/23 to 100.2 billion birr in 2023/24, which shows a 26% increase. However, the actual value of the budget has declined by 3% as a result of the economy's high rate of inflation. The government's allocation to the health sector raised from 8.1% in 2022/23 to 8.3% in 2023/24. However, the percentage remains lower than the plan at AU's Abuja Declaration for 2021, which was 15 percent of each country's GDP.

In multivariate analysis, the study revealed that age, income, family size, residency and knowledge were significantly associated with clients' satisfaction. In this study, sex and marital status were not significantly associated with clients' satisfaction. When this study was compared to a study conducted in Addis Ababa households on laboratory services, the result showed that the satisfaction of the patients had no significant association with age, sex, educational level, marital status and religion (Gashaw, 2020).

CHAPTER FIVE: CONCLUSION AND IMPLICATIONS

5.1 Conclusion

This study assessed the clients' satisfaction with community-based health insurance and associated factors based on their knowledge of the CBHI scheme, the experience they had with the CBHI scheme, and the satisfaction level related to health professional and hospital-provided services using a 5-point Likert scale as a measurement.

Nearly two-thirds of the respondents were urban residents aged 51-61 years old and most of them were married. More than two-thirds had an educational level of secondary or diploma and above. A significant number of formally employed (governmental employees, drivers by car accident, pensioners) clients were beneficiaries of CBHI. This was against the aims of the CBHI scheme.

Most of the participants knew about the basic services of healthcare provided using CBHI scheme. The gaps in knowledge had seen that the services related to the CBHI covered the cost of dialysis and cosmetic surgery.

Most of the CBHI beneficiaries benefited from the package that enabled the members to reduce healthcare expenses, to visit healthcare facilities when they were ill, and to improve their health status with an affordable premium. Due to those reasons, all members have a plan to renew the CBHI scheme package. However, in the experience of CBHI beneficiaries were challenged related to the time of enrolment and renewal, not enrolment of CBHI until people became ill, governmental enforcement to enrolment and renewal, and the distance to the hospital to receive the healthcare services.

Regarding to the level of clients' satisfaction with CBHI beneficiaries, clients were highly satisfied with health professional services, with a mean value ranging from 3.986 to 4.214 and the mean value ranged from 1.89 to 3.12 on the service provision of the hospital. These results indicated that patients were highly satisfied related to health providers' services and unsatisfied with hospital service provisions. The overall satisfaction of clients at BLSH was 58%.

The findings also revealed clients were challenged by a shortage and inconsistency of drugs availability in both the hospital and Kenema pharmacy, lack of laboratory and

imaging services, a shortage of medical supplies, inadequate facilities, a difficult structural setup of the hospital and extra costs.

CBHI is an important strategy that not only protects from healthcare financial burdens during illness, but also helps to mental rest and reduces anxiety and stress related to the tension of health-related issues.

In logistics regression, factors were associated with clients' satisfaction with the CBHI scheme. In bivariate logistic regression presented the following variables participants' age, monthly income, community-based health insurance not cover medical care for cosmetic surgery, family size, residency, and knowledge with a P-value less than 0.2. After bivariate logistic regression, in multiple logistic regression, the following factors were found to have a significant association with the assessment of clients' satisfaction with CBHI and associated factors. Those were participants' ages from 40 to 50 years old, residency from rural, monthly income from 2001 to 5000 birr, family size from 4 to 6, CBHI does not cover medical care for cosmetic surgery and knowledge of the participants. It also associated with clients come to the hospital with some health problems, clients enrolled for CBHI before their illness, patients say enrollment and renewal time for CBHI were comfortable and clients voluntarily enrolled for CBHI scheme.

5.2 Implication

5.2.1 Implications for the Hospital

BLSH provided healthcare services to all clients who came from all corners of Ethiopia and neighboring countries. The BLSH had high patient flow and provided comprehensive medical care, including internal medicine, surgery, orthopedics, obstetrics, and gynecology alongside anesthesiology, physiotherapy, radiology, laboratory and pharmaceutical services.

Despite the hospital giving healthcare services to thousands of patients in a year, there were many challenges related to hospital facilities, shortage and inconsistency of drug supply, inadequate laboratory and imaging services, difficulty of hospital structure for the clients, and shortage of reception/seating area. Due to those challenges, clients were unsatisfied in some healthcare services at BLSH.

The hospital also didn't have a clear structure for the clients for third-party insurance users or there was no clear demarcation between CBHI beneficiaries and third-party insurance users. There were no well-structured responsible bodies or solicitors for the third-party insurance beneficiaries at the hospital.

Enhancing the healthcare service provision reduces patients' weakness from navigating services and helps to get fast care from healthcare providers. It also reduced the workload of both the clients and the health professionals.

So, this study will give insight for the hospital management and other responsible parties to improve the hospital facilities and medical care supplies, including medication, and investigation services to increase the healthcare service quality and client satisfaction.

5.2.2 Implications for Social Work

Social work is an important profession to advocates for policies that are useful to the communities and protects the vulnerable segments of society. Clients in healthcare facilities are challenged by several issues related to their health status, economic and psycho-social issues. In these conditions, the social workers are important to the clients by providing psychological support and reassurance.

Nowadays, one of the most important policies in the public health sector is CBHI that designed for informal workers and the vulnerable communities. Even though millions of people are beneficiaries of the CBHI scheme, there are many challenges related to implementation issues, lack of services in the health and issues related to the communities themselves.

Social workers play a crucial role in the awareness and fulfilling the knowledge gaps of the benefits of the scheme. Social workers are also important in the implementation of the policy and identifying the gaps in the policy, and they used as a bridge between the policy makers (the government) and the CBHI beneficiaries. The social worker struggles for clients to improve the healthcare service provided by the provider.

5.2.3 Implications for Policy

The Ethiopian government endorsed community-based health insurance (CBHI) to the implication of the interest of the country and its people. The implications of community-based health insurance (CBHI) schemes include financial protection that reduces out-of-pocket payments (OOP), healthcare service equity that helps to pool the risks and strengthen solidarity, maintaining the health fund by domestic resources or reducing external funding, raising healthcare utilization, and maintaining community engagements (EHIA, 2015).

Nowadays, millions of Ethiopians use the CBHI package in all regions of the country. The package enabled to reduce the healthcare expenses, enhance easily visiting health facilities when they became ill. Ethiopia recorded a better outcomes due to the reforms done in the health sectors. CBHI scheme is one type of a yearly contractual payment of health insurance method that designed for the informal workers, the rural communities, low-income and vulnerable communities to protect them from sudden healthcare financial burdens and enable them to gain healthcare with equitable and affordable prepayment strategy. Despite of these, in some contexts CBHI is implemented without the aims of the package. The study found that, a significant number of formal employees, pensioners, drivers and others became beneficiaries due to different reasons like lack of solicitors for patients' accidental issues and impoverishment due to healthcare expenses.

The governmental policy makers and other concerned bodies must work towards the gaps of the policy and integrate the CBHI with SHI and third-party insurance in the healthcare institutions and a well-organized structure is needed from the Minister of Health towards the health facilities.

During in-depth interviews and simultaneous interviews with quantitative data collection with clients, some formal employees used the CBHI package without announcing themselves as formal employees. This was because of the late or incapable of full implementation of social health insurance (SHI) in the country for the formal workers of the communities. This indicated that the formal employees are also exposed to sudden healthcare expenses and there is a need for health insurance they protect them from the burden of healthcare-related costs.

On the other side, the government, especially local leaders enforced the communities to enroll and renew the CBHI package to become a member of the CBHI scheme. However, the communities not disappointed about the enforcement of the government after visiting healthcare facilities as they become ill. The clients believed that they will be more exposed to healthcare costs after the government enforced them. The communities need the push factors to enroll to become members of the CBHI scheme. Most probably, the push factors were the government and their health conditions.

Unless otherwise specified, the formal health insurance (social health insurance) will not be implemented, the system may be exposed to corruption, which leads to inequity and inequality in healthcare access between the communities.

Digitalizing the CBHI ID card and formulating a clear framework and boundaries are important to the CBHI package. Rather than enforcing the communities, it is better to be aware of the communities in different ways such as discussion, sharing the experience and promoting the program.

Many clients came from far distance to Black Lion Specialized Hospital to receive healthcare that are not given at other healthcare institutions. The policy must consider the healthcare services with its service expansion that helps the clients to gain the services nearby.

The costs of healthcare services and pharmaceutical supplies are dramatically increasing from time to time. In contrast to this, some people couldn't afford the costs of the CBHI package, even premium cost was low. The government should have the responsibility to compensate the waivers of the CBHI package for the poorest of the poor and at the same time revise the premium payment of the CBHI package according to the current market values of the services and inflation.

5.2.4 Implications for Practice

This study provides some insight for the government and the hospital management to see the gaps and strengths of the community-based health insurance (CBHI) implementation. Despite the hospital providing many services for the patients from all corners of the country, there were challenges related to drug availability, laboratory services, imaging services, and facilities like water, toilets, a bathroom, a café, and the structural setup of

the hospital. The hospital management works with other responsible bodies to improve the quality of healthcare services and continue the best practices.

To continue best practices and fill the gaps in the healthcare services, it needs the involvement of many concerned bodies, including hospital managements, governments, communities or clients, and health professionals to achieve better healthcare outcomes and to reduce healthcare-related issues.

5.2.5 Implications for Research

This study was conducted in a single institution at the BLSH inpatient wards to assess clients' satisfaction with community-based health insurance and associated factors. The sources of the study were only clients admitted to the Black Lion specialized hospital. The study didn't allow the participation of outpatients who used the CBHI scheme, patients who received medical care out of pocket. As a result, the level of clients' satisfaction may vary from one health facility to another health facility, even within the same health facility.

Further research is encouraged on the comparisons between CBHI scheme beneficiaries and non-CBHI scheme beneficiaries, and an all-inclusive study of CBHI scheme beneficiaries. The study assesses only the need side of the clients but not examine the supplier of healthcare like medication, procedural equipment, and other healthcare supplies. It is important to reason out the shortage of the healthcare supplies and assess the need and the demand supply of the pharmaceutical supplies.

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APPENDIX

Appendix 1: English Version Questionnaire

Consent

My name is Adafir Tadesse, and I am an MSW student at the AAU School of Social Work. I am here today to collect data on the title "client satisfaction with CBHI and associated factors in the case of BLSH". This study aims to analyze client satisfaction with CBHI and identify the causes of dissatisfaction among CBHI-insured patients at the BLSH inpatient ward. You are being asked to take part in this study and respond genuinely.

I understand that participation in this study is voluntary. I have been told that your answers to the question will not be given to anyone else and no reports of this study ever identify you in any way. I have also been informed that your participation or non-participation or any refusal to answer questions will not affect me. I understand that participation in this study does not involve risk. You have read this form or it has been read in the language you understand, all conditions stated above.

Therefore, are you willing to participate in this study?

- I agree to participate
- I don't agree to participate

Time started _____ time completed_____

Section 1: socio-demographic data

1. Sex: A. Male B. Female
2. Age: A. 18-28 years B. 29-39 years C. 40-50 years D. 51-61 years E. 61 above
3. Marital status: A. single B. married C. divorced D. widow
4. Occupation: A. farmer B. merchant C. housewife D. Laborer E. student F. unemployed G. governmental employee H. pensioner I. driver
5. Monthly income of the patient A. ≤ 2000 birr B. 2001-5000 birr C. 5001-8000 birr D. above 8000 birr
6. Educational background: A. illiteracy B. write and read/primary C. high school/preparatory D diploma/college and above

7. Residency: A. rural B. Urban
8. Family size A. 1-3 B. 4-6 C. 7 and more

Section 2: Knowledge of CBHI beneficiaries on the CBHI scheme

	Knowledge variable	Yes	No
1	CBHI covers only public institutions		
2	CBHI covers expenses within the country		
3	CBHI doesn't cover transportation		
4	CBHI covers the cost of inpatient and outpatient care		
5	CBHI covers the cost of the surgical service		
6	CBHI covers the dialysis service cost		
7	CBHI covers the laboratory investigation cost		
8	CBHI covers imaging (X-ray, CT-scan, MRI, ultrasound) services		
9	CBHI does not cover the cost of medical care for cosmetic surgery		

Section 4: Experience of CBHI beneficiaries on the scheme

	Variable	responses
1	CBHI reduced my healthcare costs	Yes B. No
2	CBHI enables visiting healthcare institutions	Yes B. No
3	Health is improved after CBHI	Yes B. No
4	The premium payment of CBHI is low	Yes B. No
5	Amount of money paid for CBHI enrolment or renewal	A. ≤ 2000 birr B. Greater than 2000 birr

6	Years of experience in using CBHI	6 months- 2 years B. 2- 4 years C.4-6 years D. above 6
7	The current health status	Emergency B. Some problems C. Chronic disease D. others
8	When you register CBHI	A. Before my illness B. At the time of illness
9	The distance of the hospital from your home	A. Short (around AA) B. Far (100-200km) C. Very far (>200 km)
10	The CBHI enrollment and renewal period and process	Comfortable time B. Uncomfortable time
11	Factor for enrolment of CBHI	A. Voluntarily B. government official pressure
12	Plan to renew CBHI	yes B. no

Section 5: Satisfaction of clients with CBHI on Health Provider (1-5 point Likert scale)

Please mark (/) in the area provided for each variable. The measurement is a 5-point Likert scale, ranging from 1 to 5 points. That are: highly dissatisfied (HD) =1, Dissatisfied (D) =2, Neutral (N) =3, satisfied (S) =4, highly satisfied (HS) =5

	Variable	1	2	3	4	5
1	Healthcare service providers are Respectful and compassionate					
2	Got immediate care from the health provider					
3	Maintenance of patients' privacy and confidentiality					
4	The hospital had skilled staff to provide healthcare delivery					
5	The ability of service providers to explain diagnostic and treatment					
6	Availability of health provider staff during working hours					
7	Good communication between health professionals to provide fast healthcare service to the patients after investigation					

8	Health provider personnel's professional appearances (neatness, professional dressing)					
9	your Participation in decision-making about the treatment					

Section 5: Satisfaction of clients with CBHI on hospital Health service Provision (1-5 point Likert scale)

Please mark (/) in the area provided for each variable. The measurement is a 5-point Likert scale, ranging from 1 to 5 points. That are: highly dissatisfied (HD) =1, Dissatisfied (D) =2, Neutral (N) =3, satisfied (S) =4, highly satisfied (HS) =5

	Variable	1	2	3	4	5
1	The bedroom is clean and full of facilities					
2	The hospital environment is clean and attractive					
3	There is an adequate seating/reception area at the hospital					
4	Satisfaction with prescribed drug availability					
5	Satisfaction with laboratory service availability					
6	Satisfaction with medical imaging(x-ray, CT, MRI) availability					
7	Satisfaction with the waiting time for getting an investigation result (laboratory and imaging)					
8	Satisfaction with the overall information provided in the hospital					
9	Comfortable with the overall hospital setup or structure					

SECTION 6: Interview for CBHI Beneficiaries (in-depth and focus group discussions)

Group code: ----------date of interview ----------interview place

1. Why do you enroll in CBHI and what kinds of benefits do you get from CBHI?
2. What are the challenges during enrollment and renewal?
3. What kind of service do you get at BLSH?
4. Do you believe the service and the cost of the hospital are fair?
5. Is there a medical service you don't get from CBHI at the hospital?
6. Can CBHI enable you to visit the hospital frequently when you feel sick?
7. What are the challenges you face when you use CBHI related to hospital structure CBHI processing, availability of medication, access to investigation, and others?

8. What are the challenges other than the direct cost of medical care in the hospital?

Appendix 2: Amharic Version Questionnaire

የመጠይቅ ስምምነት

ስሜ አዳፍር ታደሰ ይባላል። በአዲስ አበባ ዩኒቨርሲቲ የማህበራዊ ስራ ትምህርት ቤት የሁለተኛ ድግሪ ተማሪ ስሆን ዛሬ እዚህ የተገኘሁት "የማህበረሰብ አቀፍ የጤና መድህን ተጠቃሚዎችን እርካታ እና በጉዳይ ላይ ተያያዥ ምክንያቶች በጥቁር አንበሳ ስፔሻላይዝድ ሆስፒታል " ላይ መረጃን ለመሰብሰብ ነው። ይህ ጥናት የታካሚዎችን የማህበረሰብ አቀፍ የጤና መድህን አገልግሎት እርካታ እና ከአገልግሎት እርካታ ጋር ተያያዥነት ያላቸውን ችግሮችን በጥቁር አንበሳ ስፔሻላይዝድ ሆስፒታል በተኝቶ ታካሚ ክፍል ለመገምገም ያለመ ነው። በዚህ ጥናት እንዲሳተፉ እና እውነተኛ ምላሽ እንዲሰጡ በትህትና እጥይቃለሁ።

በዚህ ጥናት ውስጥ መሳተፍ ሙሉ በሙሉ በፈቃደኝነት ላይ የተመሰረተ ነው። ለጥያቄው የሰጡት መልስ ለሌላ ሰው ተላልፎ እንደማይሰጥ እና የዚህ ጥናት ውጤት በምንም መልኩ እርስዎን እንደማይጎዳ አረጋግጥልዎታለሁ። እንዲሁም የእርስዎ ተሳትፎ ወይም አለመሳተፍ ወይም ማንኛውም ጥያቄዎችን ለመመለስ ፈቃደኛ አለመሆን በአጥኝው ላይ ተጽዕኖ እንደማይኖረው ላረጋግጥልዎት እፈልጋለሁ። በጥናቱ ውስጥ መሳተፍ አደጋ የለለውና የጥናቱ ውጤትም ለውደፊት ለተጠቃሚውም ሆነ ለሆስፒታሉ የአገልግሎት አሰጣጥ መሻሻል የሚጠቅም ይሆናል። ስለዚህ፣ በዚህ ጥናት ለመሳተፍ ፈቃደኛ ኖት?

- ለመሳተፍ ተስማምቻለሁ
- ለመሳተ ፍ አልስማማም

ጥያቄውን ለመሙላት የጀመሩበት ሰዓት _____ የተጠናቀቀበት ሰዓት _____

ክፍል 1: ማህበራዊ-ስነ-ሕዝብ መረጃ

1. ጾታ፡ 1. ወንድ 2.ሴት

2. ዕድሜ፡- 1. 18-28 ዓመት 2. 29-39 ዓመት 3. 40-50 ዓመት 4. 51-60 ዓመት 5. 61 እና ከዚያ በላይ

3. የጋብቻ ሁኔታ፡- 1. ያላገባ 2. ያገባ 3. የተፋታ 4. በሞት የተለያዩ

4. ሥራ፡- 1.ገበሬ 2.ነጋዴ 3. የቤት እመቤት 4.የጉልበት ሠራተኛ 5. ተማሪ 6. ስራ የሌለው 7. የመንግስት ሰራተኛ፣ 8 ጡረተኛ

5. የቤተሰብ ወርሃዊ ገቢ 1. ከ2000ብር በታች 2. 2001-5000 ብር 3. 5001-8000 ብር 4. 8000 በላይ

6. የትምህርት ደረጃ፡- 1. ያልተማረ 2. መፃፍ እና ማንበብ/አንደኛ ደረጃ 3. ሁለተኛ ደረጃ/መሰናዶ 4. ዲፕሎማ እና ከዚያ በላይ

7. የመኖሪያ ቦታ፡- 1. ገጠር 2. ከተማ

8. የቤተሰብ ብዛት 1. 1-3 2. 4-6 3. 7 እና ከዚያ በላይ

ክፍል 2፡ በየማህበረሰብ አቀፍ የጤና መድህን እቅድ ላይ የተጠቃሚዎች እውቀት

	መጠይቅ	አዎ	አይደለም
1	የማህበረሰብ አቀፍ የጤና መድህን የሚሸፍነው የህዝብ/የመንግስት ተቋማትን ወጭ ብቻ ነው።		
2	የማህበረሰብ አቀፍ የጤና መድህን በሀገር ውስጥ ወጪዎችን ብቻ ይሸፍናል።		
3	የማህበረሰብ አቀፍ የጤና መድህን መጓጓዣ ወጪን አይሸፍንም።		
4	የማህበረሰብ አቀፍ የጤና መድህን የተኝቶ እና የተመላላሽ ህክምና ወጪዎችን ይሸፍናል።		
5	የማህበረሰብ አቀፍ የጤና መድህን የቀዶ ጥገና አገልግሎትን ወጪዎችን ይሸፍናል		
6	የማህበረሰብ አቀፍ የጤና መድህን የኩላሊት እጥበት ህክምና ወጪዎችን ይሸፍናል		
7	የማህበረሰብ አቀፍ የጤና መድህን የላብራቶሪ ምርመራ ወጪዎችን ይሸፍናል።		
8	የማህበረሰብ አቀፍ የጤና መድህን የ imaging አገልግሎት ወጭን ይሸፍናል		
9	የማህበረሰብ አቀፍ የጤና መድህን ለመዋቢያ ቀዶ ጥገና የሕክምና አገልግሎት ወጭ አይሸፍንም።		

ክፍል 3፡ የማህበረሰብ አቀፍ የጤና መድህን ተጠቃሚዎች ልምድ/ተሞክሮ

	መጠይቆች	መልስ
1	የማህበረሰብ አቀፍ የጤና መድህን ውጭ ቀነሰልኝ	1. አዎ 2. የለም
2	የማህበረሰብ አቀፍ የጤና መድህን ቶሎ ቶሎ ወደ ጤና ተቋም እንድሄድ አስቻለኝረ	1. አዎ 2. የለም
3	የማህበረሰብ አቀፍ የጤና መድህን መጠቀሜ ጤናየን አሻሻለልኝ	1. አዎ 2. የለም
4	የማህበረሰብ አቀፍ የጤና መድህን ክፍያ ዝቅተኛ እና ፍትሃዊ ነው።	አዎ 2 አይደለም
5	የጤና መድኑን ለመመዝገብ ወይም ለማደስ የከፈሉት	2000 ብር በታች 2. 2000 ብር እና በላይ
6	የማህበረሰብ አቀፍ የጤና መድህንን በመጠቀም ዓመት ልምድ	1. 6 ወር - 2 ዓመት 2. 2- 4 ዓመት 3. 4-6 ዓመት 4. 7 እና ከዚያ በላይ ዓመታት
7	ወደ ሆስፒታል ያስመጣዎት የጤና ሁኔታ	1. ድንገተኛ 2. አንዳንድ ችግሮች 3. ሥር የሰደደ በሽታ
8	የማህበረሰብ አቀፍ የጤና መድህን መቼ ተመዘገቡ?	1.ከህመሜ በፊት 2. በህመም ጊዜ
9	የሆስፒታሉ ርቀት ከቤትዎ	1 ቅርብ (አ አ አካባቢ) 2. ሩቅ (100-200 ኪሜ) 3. በጣም ሩቅ (>200 ኪሜ)
10	የማህበረሰብ አቀፍ የጤና መድህን ምዝገባ እና የማደሻ ጊዜ እና ሂደት	1. ምቹ ጊዜ 2. የማይመች ጊዜ

11	ለምንድነው የማህበረሰብ አቀፍ የጤና መድህን ኢንሹራንስ የገቡት?	1. በፍቃደኝነት 2. ከባለሥልጣናት ግፊት 6. ሌላ
12	የማህበረሰብ አቀፍ የጤና መድህን ካርዶችን ለማደስ አቅደዋል።	1. አዎ 2. አላድስም

ክፍል 4፡ በጤና ባለሙያዎች ላይ የማህበረሰብ አቀፍ የጤና መድህን የደንበኞች እርካታ (ከ1-5 ነጥብ ልኬት)

እባክዎ ለእያንዳንዱ ተለዋዋጭ በተሰጠው ቦታ ላይ (/) ምልክት ያድርጉበት። ልኬቱ ባለ 5-ነጥብ ልኬት ከ1-5 ባለ ነው። በጣም አያረካም =1፣ አያረካም =2፣ መግለጽ አልፈልግም =3፣ ያረካል =4፣ በጣም ያረካል =5

	መጠይቅ	1	2	3	4	5
1	ጤና ባለሙያዎቹ አገልግሎት ሲሰጡ በአክብሮትና በአዘኔታ ነዉ።					
2	በጤና ባለሙያዎቹ ፈጣን የጤና አግልግሎት አግኝቻለሁ።					
3	ስታከም ግላዊነቴና እና ሚስጥሬ ተጠብቆልኛል።					
4	ሆስፒታሉ የጤና አገልግሎት ለመስጠት ብቃት ያላቸው ባለሙያዎች ዐሉት።					
5	ስለ ምርመራ እና ህክምናዬ በባለሙያ በቂ ማብራሪያ ተሰጥቶኛል።					
6	የጤና ባለሙያዎቹ በስራ ሰዓት በመገኘት ህክምና ይሰጣሉ።					
7	ከምርመራ በኋላ ለታካሚዎች ፈጣን የህክምና አገልግሎት ለመስጠት በጤና ባለሙያዎች መካከል ጥሩ ግንኙነት አለ።					
8	የጤና ባለሙያዎች ሙያዊ ገጽታ ንጹሕና ሙያዊ አለባበስ የተከተለ ነው።					
9	ስለ ህክምናዬ ውሳኔ በሚሰጥበት ጊዜ በቂ ተሳትፎ ነበረኝ።					

ክፍል 5፡ በማህበረሰብ አቀፍ የጤና መድህን ተጠቃሚዎች በሆስፒታሉ የሚሰጡ የአገልግሎት መኖር ላይ ያላቸው እርካታ

እባክዎ ለእያንዳንዱ ተለዋዋጭ በተሰጠው ቦታ ላይ (/) ምልክት ያድርጉበት። ልኬቱ ባለ 5-ነጥብ ልኬት ከ1-5 ባለ ነው። በጣም አያረካም =1፣ አያረካም =2፣ መግለጽ አልፈልግም =3፣ ያረካል =4፣ በጣም ያረካል =5

	መጠይቅ	1	2	3	4	5
1	በመኝታ ክፍሉ ንፁህ እና የተሟላ መሆን					
2	የሆስፒታሉ አከባቢ ንጹህ እና ማራኪ መሆን					
3	ሆስፒታሉ ለታካሚዎች በቂ መቀመጫና መቀበያ ቦታ መኖሩ					
4	በታዘዘልዎት መድሃኒት መገኘት እረክተዋል።					

5	በላብራቶሪ አገልግሎት አቅርቦት እረክተዋል።					
6	በሕክምና ምስል (ኤክስሬይ፣ ሲቲ፣ ኤምአርአይ፡አልትራሳውንድ) ወዘተ መገኘት እርካታ					
7	ምርመራ ውጤት ለማግኘት የጠበቁበት ጊዜ እረክተዋል (ላብራቶሪ እና ምስል)					
8	በሆስፒታሉ ውስጥ በተሰጠው አጠቃላይ መረጃ እርካታ					
9	የሆስፒታል አሠራር ወይም መዋቅር ለታካሚዎች ምቹነቱ					

ክፍል 6፡ ለማህበረሰብ አቀፍ የጤና መድህን ተጠቃሚዎች የቀረበ ቃለ መጠይቅ (የትኩረት ቡድን ውይይቶች)

የቡድን ኮድ፡------የቃለ መጠይቁ ቀን ----------ቦታ/ዋርድ----------

1. የማህበረሰብ አቀፍ የጤና መድህን ለምን ተመዘገቡ? ከተመዘገቡ በኋላ ምን አይነት ጥቅሞች አገኙ?
2. የማህበረሰብ አቀፍ የጤና መድህን በምዝገባ እና በዕድሳት ወቅት ያጋጠመዎት ችግሮች ምንድን ናቸው?
3. በሆስፒታሉ ውስጥ በማህበረሰብ አቀፍ የጤና መድህን የማያገኙት የሕክምና አገልግሎት አለ? ካለ ምን?
4. የሆስፒታሉ አገልግሎት እና የማህበረሰብ አቀፍ የጤና መድህን ወጪ ፍትሃዊ ናቸው ብለው ያምናሉ?
5. የማህበረሰብ አቀፍ የጤና መድህን ሲታመሙ በቀላሉና በተደጋጋሚ ለመታከም አስችሎዎታል?
6. ማህበረሰብ አቀፍ የጤና መድህን በጥቁር አንበሳ ሆስፒታል ሲታከሙ ያጋጠመዎት ተግዳሮቶች ከሆስፒታል መዋቅር፤ የማህበረሰብ አቀፍ የጤና መድህን ሂደት፣ የመድኃኒት አቅርቦት፣ የምርመራ ተደራሽነት እና ሌሎች ተያያዥ ችግሮች ምን ምን ናቸው?
7. በሆስፒታሉ ውስጥ ካለው የሕክምና አገልግሎት ከቀጥተኛ ወጪ በተጨማሪ ተግዳሮቶች ምንድን ናቸው?