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Dignified care and associated factors among mothers who gave birth at public hospitals, in Sidama Regional State, southern Ethiopia, 2023

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Abstract

Background Dignified care is an important priority for childbearing mothers. Threats to this deteriorate the therapeutic relationship between healthcare providers and clients, which leads to a negative effect on the quality of care. However, little evidence is identified about dignified care and associated factors in the Ethiopian context. Therefore, this study aimed to assess dignified care and associated factors among mothers who gave birth at public hospitals in Sidama Regional States, southern Ethiopia, 2023.

Method An institution-based cross-sectional study was conducted among 418 mothers who gave birth at public hospitals in Sidama Regional States from July 30 to August 30, 2023. A systematic random sampling technique was employed to select study participants. An interviewer-administered structured questionnaire was used, and the data was collected by Kobotool and analyzed using SPSS Version 25. Bivariable and multivariable logistic regression analyses were conducted, and the crude and adjusted odds ratios, together with their corresponding 95% confidence, were computed. A P value < 0.05 was considered a level of statistical significance in this study.

Results In this study, the overall study participants' magnitude of dignified care was found to be 44.1%. Secondary education (AOR: 3.91, 95% CI: 1.56, 9.82), spontaneous vaginal delivery (AOR: 2.68, 95% CI: 1.31, 5.46), the presence of a companion during labor and delivery (AOR: 12.35, 95% CI : 7.08, 21.53), and less than two days hospital stay (AOR: 3.26, 95% CI: 1.37, 7.75), and midwife attendance of labour and delivery (AOR = 4.47 (1.40–14.25) were significantly associated with dignified care.

Conclusions The findings of this study showed that the dignified care of mothers who gave birth at public hospitals in Sidama Regional State was relatively low to the pooled prevalence of respectful maternity care in Ethiopia. In light of these results, it is recommended to prioritize midwife attendance during labor and delivery, promote the presence of companions, facilitate a shorter hospital stay, and enhance educational opportunities.

Keywords Dignified care, Mothers who gave birth, Sidama, Ethiopia

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Background

Dignified care is the way we treat others and a person's inner self. Dignified care is regarded as fundamental basis for health care delivery and is a pivotal component of strategies to improve the utilization of maternity services [1]. The imperative of providing dignified care for maternal well-being extends across all phases, from conception through the postpartum period, with heightened significance when a mother harbors concerns about potential risks to both her life and that of her child, particularly during the critical stages of labor and delivery [2, 3].

The World Health Organization (WHO) quality of care framework for maternal and newborn health highlights the paramount importance of simultaneously considering the delivery of evidence-based care and the experiential dimension of care. This experiential facet is chiefly characterized by effective communication, the respectful preservation of human dignity, and the provision of emotional support [4].

Respect for human dignity in care can bring a lot of advantages. These benefits include increased quality of health care services, decreased costs, more prompt recovery, and decreased length of stay in hospitals, lower risk of irreversible physical and spiritual damages, reduced depression, stress, anxiety, and improved quality of life [5].

Ethiopia is among the nations that have formulated their national strategies in compliance with the Universal Declaration of Human Rights and the WHO statement on the rights of clients. However, a number of obstacles stand in the way of implementing strategies and putting dignified care into practice. These obstacles include the physical environment, staff demeanor and attitude, crowded medical facilities, organizational culture, and clients' independence [6–8].

The lack of dignified care is one of the main reasons for not utilizing maternal health services. Humiliation and mistreatment in maternal services can hinder women from getting maternal healthcare services in the future [9, 10]. Despite the negative effects of a lack of dignified care and disrespectful care on the use of skilled health care, there is currently no international consensus on how to define and measure dignified care in a hospital setting scientifically [11, 12]. The actual foundation for clients should be treated with dignified care, which should be automatic in every health care service [5]. Existing research on dignity in care has predominantly centered on specific patient populations, including those receiving palliative care, hospitalized older adults, individuals with heart failure, and cancer patients [13–15]; [16]; [17].

Despite being fundamental to all individual clients in medical care services, there is currently a dearth of sufficient data regarding dignity in care, particularly concerning clients in maternal services settings who are often characterized as vulnerable groups. Research on dignified care is limited in Africa, even though the topic has demonstrated global interest [18]. In Ethiopia, there has never been a study identifying the factors that influence dignified care. Therefore, this study assessed dignified care and associated factors where the problem is not well addressed among mothers who gave birth at public hospitals in Sidama Region. The potential implication of this study can inform policies, enhance healthcare quality, and boost patient satisfaction, potentially increasing maternal healthcare utilization and improving outcomes.

Method

Study design, area and period

Institutional-based cross-sectional study was conducted at public hospitals in Sidama Regional State from July 30 to August 30, 2023. Sidama National Regional State is one of the regions in the southern part of Ethiopia. Hawassa, the capital city of the region, is 273 km away from Addis Ababa. The region has one comprehensive specialized hospital, Hawassa University comprehensive specialized hospital (HUCSH), five secondary level (general) hospitals (Adare, Yirgalem, Leku, Bona, and Bonsa Daye), 17 primary hospitals, and from these 14 are public primary hospitals, 137 health centers, and 553 health posts. The total population in Sidama Regional State is 4,369,214. Among the total population, 2,201,313 are female. (Non-published data of the Regional Health Bureau, 2021). The data was collected from all general hospitals and HUCSH. Maternal health services provided by this health facility include ANC, family planning (FP), delivery care, postnatal care (PNC), newborn care, pre-cervical cancerous lesion screening, comprehensive essential obstetric care (CEOC), and a gynecological unit.

Sample size determination

The sample size for this study was determined using a single population proportion formula with the assumption of a standard normal distribution corresponding to a 95% confidence interval, a 5% margin of error, 44.7% proportion of dignified care among postnatal women in the Amhara Region, and 10% possible non-response calculated as follow.

$$\mathrm{n} = \mathrm{Z}\alpha/\mathrm{I}^2\,\mathrm{p}\,(1-\mathrm{p})/\mathrm{d}$$

Where minimum sample size needed.

d = margin error (5%).

Z a /2 = 1.96 for a 95% confidence level.

P = 44.7% proportion dignified care among postnatal women in the Amhara Region, and 10% possible non-response the final sample size came.

$$\mathrm{n} = (1.96)2^{*}\,(0.447^{*}1-0.447)\,/(0.05)2 = 380$$

Based on these assumptions, the sample became 380.

10% reserves for non-response rate. The total sample size was 418.

Sampling technique and procedures

Sidama regional state was selected for this study, and all secondary and tertiary hospitals were included. Sidama regional state consists of 5 general hospitals (Adare, Bona, Leku, Yirgalem, and Bonsa Daye) and a tertiary hospital (HUCSH). Around 1815 mothers give birth every month in selected hospitals, and depending on the number of women who gave birth during the same period in the last year, a proportionate sample size of 418 was assigned to each of the hospitals. To choose study participants from each institution, a systematic random sampling technique was used. The first person was chosen at random, followed by selections at intervals of K. In this study, all hospitals have the same K value of 4.

Operational definition

Dignified care Dignified care was measured with 28 items on a 5-point Likert scale. Never (1 point), rarely (2 points), sometimes (3 points), usually (4 points), always (5 points). The sum of the total score ranged from 28 to 140. The mean was taken as a cutoff point. Mothers who scored greater than or equal to the mean are considered to receive dignified care. Conversely, mothers who scored below the mean are considered to be receiving non-dignified care [19].

Obstetric complication Mothers, who experience uterine rupture, obstructed labor, preterm delivery, antepartum hemorrhage, and premature rupture of membrane, preeclampsia/eclampsia, cord prolapse, prolonged labor, postpartum hemorrhage, and infection [8, 20, 21].

Physical environment Seven elements are considered for physical environment measurement, and 75% is taken as a cutoff point. Mothers who are greater than or equal to 75% are in a safe physical environment. Conversely, mothers who scored below 75% indicated an unsafe physical environment [22].

Data collection tool and procedures

The questionnaire was adapted from reviewing different literature and contextualized to the situation [1, 18, 19, 23].

The questionnaire contains four parts: part one: sociodemographic factors measure by eight items; part two: obstetrical-related factors measure night items; part three: facility-related factors measure fourteen; and part four: questions about dignified care measure by twenty-eight. Data was collected by Kobotool, and an interviewer-administered structured questionnaire was used to collect data from study participants. Data was collected by eight BSc midwives and supervised by one MSc clinical midwife and two MSc reproductive health specialists. The process of data collection was thoroughly observed by the supervisor.

Data quality control management

The questionnaire prepared in the English version was translated into the local languages. Two MSc clinical midwifery students and one MSc clinical midwifery lecturer, translated from English to Amharic. One MSc laboratory student and one Sidamu Afoo teacher translated from English to Sidamu Afoo, then translated back into English to assure consistency. Two days of training were given to both data collectors and supervisors on how to carry out their duty ahead of starting data collection, confidentiality of information, respondent's rights, and informed consent. A week before data collection, the principal investigator has done a pre-test on 5% [21] of the final sample size in Dilla University referral hospital to check the clarity and completeness of the questionnaires. Based on this, a necessary correction was made accordingly. The reliability of the data collection tool for the Likert scale question was checked by Cronbach's alpha, and content validity was checked by an expert. The scale has good internal consistency reliability, with Cronbach's alpha of 0.76. Based on the findings from the pretest, the questionnaire was modified. The whole process was facilitated and checked thoroughly by the principal investigator. During these sessions, thorough checking was done before receiving the filled-out questionnaires from each data collector, which helped to cross-check their performance and improve proper data collection.

Data processing and analysis

After data collection, the questionnaire was checked for completeness. After that, export the data to the statistical analysis program SPSS version 25. Descriptive statistics like frequencies, percentage, and cross-tabulation were performed. Bivariable logistic regression analysis was conducted to identify candidates for multivariable logistic regression analysis. All explanatory variables with a p-value of less than 0.25 in bivariable logistic regression analysis were included in the initial logistic model of multivariable logistic regression analysis to identify independent predictors and confounders. The overall goodness-of-fit and multicolinearity were checked by using the Hosmer-Lemeshow goodness-of-fittest (0. 347) and variance inflation factor (<10 for all items), respectively. The crude and adjusted odds ratios together with their corresponding 95% confidence intervals were computed. A p-value<0.05 was considered as a level of statistical significance in this study. Texts, tables, and charts were used to report results.

Table 1 Socio-demographic characteristics of the study participants among mothers who gave birth at public hospitals, in Sidama Regional State, south Ethiopia, 2023 (*N* = 418)

Variable Categories		Frequency	Percent
Age	15–19	25	6.0
	20–24	100	23.9
	25–29	193	46.2
	30–34	86	20.6
	35	14	3.3
Religion	Catholic	18	4.3
	Muslim	75	17.9
	Protestant	227	54.3
	Orthodox	90	21.6
	Other*	8	1.9
Educational status	Nonformula	216	51.8
	Primary	110	26.3
	Secondary	41	9.7
	College and above	51	12.2
Occupation	Housewife	322	77.2
	Govt. employ	33	7.4
	Private	49	12.0
	Student	14	3.3
Marital status	Married	394	94.3
	Single	11	2.6
	Divorced	10	2.4
	Widowed	3	0.7
Husband occupation	Civil servant	65	16.5
	Merchant	132	33.5
	Farmer	149	37.8
	Daily labourer	40	10
	Students	8	2
husband educational status	Non formal	135	34.2
	Primary school	167	42.3
	Secondary school	31	7.68
	College and above	61	15.5

Note other* Jova, Harit (only Jesus), Adventist

Results

Socio-demographic characteristics of the respondents

Four hundred eighteen mothers have been participated in this study, with a response rate of 100%. The mean age of the women was 26 years, with a standard deviation of ±4.3 years. Most participants, 193 (46.2%), were in the age range of 25–29 years. Most of the respondents, 227 (54.3%), were followers of the protestant religion, while 216 (51.8%) were in the non-formal education category. The majority of respondents, 394 (94.3%), were married, and 322 (77.2%) were housewives. More than half of the respondents, 258 (61.7%), were living in rural areas. Regarding the participants' husbands occupations, 149 (37.8%) were farmers, and 167 (42.3%) of them attended primary education (See Table 1).

Table 2 Obstetrics characteristics of the study participants among mothers who gave birth at public hospitals, in Sidama Regional State, southern Ethiopia, 2023 (*N* = 418)

Variable	Categories	Frequency	Percent
Parity	Multigravida	237	56.7
	Primiparous	84	20.1
	Grand multiparous	97	23.2
ANC follow-up	No	26	6.2
	Yes	392	93.8
Current route of delivery	C- section	109	26.1
	Instrumental	69	16.5
	SVD	240	57.4
Obstetric complication	Preterm labor affected	12	2.9
	APH	10	2.4
	PROM	10	2.4
	Cord prolapsed	3	0.7
	PPH	8	1.9
	Prolonged labor	13	3.1
Birth outcome	Alive	406	97.1
	Dead	12	2.9
If death	Early neonatal death	7	1.7
	Stillbirth	5	1.2

Obstetrics characteristics of the study participants

More than half of the respondents, 237 (56.7%), were multigravida; 392 (93.8%) respondents had ANC follow-up. Majority of respondents 358 (85.6%) reported were planned their recent pregnancies. More than half 240(57.4%) of mothers gave birth vaginally. Nearly one in five respondents 81(19.4%) reported that they had experienced an obstetrical complication during their recent labor and delivery. Among those 25(6.0%) of participants encountered preeclampsia. About 7 (1.7%) respondents had a history of early neonatal death, and 5 (1.2%) had a stillbirth in their recent pregnancies. (See Table 2)

Facility-related characteristics of the study participants

Approximately 279 mothers or 65.8% of the total, say the medical facility where they received care was a physically safe place. A total of 138 mothers, or one-third of the respondents, spend more than three days in hospitals, and 110 mothers (26.3%) were referred to the facility from other institutions. Out of the total, 218 (52.1%) mothers were attended by male health professionals, while two-thirds (66%) of the mothers were attending labor and delivery by midwifery. Among the 195 mothers surveyed, over half (54.8%) said they were permitted to have family members present during labor and delivery. (See Table 3)

The magnitude of dignified care

In this study, the magnitude of dignified care at public hospitals in Sidama Regional State was 44.1% (95% CI: 39.9, 48.9).

Table 3 Facility-related characteristics of the study participants among mothers who gave birth at public hospitals, in Sidama Regional State, southern Ethiopia 2023 (*N* = 418)

Variable	Categories	Frequency	Percent
Situation of accompaniment	With family	374	89.4
	Arrive lonely	44	10.6
Physical environment items			
During this hospital stay labor and delivery in a private room or shared room	Private room	62	14.6
	Shared room	356	85.2
Mothers had access to private bedpans	Yes	276	66
	No	142	34
Beds have screening	Screen	256	61
	No screen	162	39
During this hospital stay, is history taking done privately or in the presence of others	Private manner	168	40.2
	With other	250	59.8
Personal questions is it done privately or in the presence of others	Private manner	179	42.8
	With other	239	57.2
During this hospital stay, how do you describe the bathroom	Clean	271	64.8
	No/ yes but not clean	147	35.2
During this hospital stay, how do you describe the toilet	Clean	229	54.8
	No/ yes but not clean	189	45.2
How long did you stay in the hospital	Less 2 day	280	67
	3 and 4 days	88	21
	5 and above	50	12
Who health professional was attending labor	General practitioner	30	7.2
	IESO	31	7.4
	Midwifery	276	66
	Resident	40	9.5
	Ob/Gyn senior	41	9.6

Dignified care items of the study participants

Qualities of respondents are associated with respectful care. Questions Nos. 7, 9, 14, 19, 21, and 25 were the most consistently reported items by participants regarding the dignified care they received. Specifically, 46.9% of respondents stated that healthcare providers inquire about mothers' problems and attempt to resolve them (question No. 9); 38.0% stated that healthcare providers answer questions from mothers accurately or unequivocally (question No. 14); and 45.5% felt that healthcare providers respect ethnicities, dialects, accents, and religious beliefs (question No. 20). In addition, 47.8% of participants stated (in response to question No. 7) that medical professionals promptly fulfill mother requests.

The two most significant items (question nos. 2 and 4) were the ones to which respondents indicated that healthcare providers had not frequently preserved these items. When it comes to asking permission before performing procedures on mothers' bodies, 34.7% of mothers said they rarely do so (question No. 2), and 32.3% said they rarely make sure the body is cleaned up after each procedure (question No. 4). The one primary item for which participants indicated that medical professionals had never preserved it is item No. 1; 56.2% of participants responded that medical professionals never greeted patients before performing any procedures.(Question #1) (See annex 1).

Factor associated with dignified care

Secondary education, current route of delivery with SVD, the presence of a companion during labor or delivery, hospital stays less than two days, and health professionals attending labor and delivery were significantly associated with dignified care (See Table 4).

Discussion

In this study, magnitude of dignified care was found to be 44.1% (95% CI: 39.9–48.9). This finding is in line with the study done in Gondar (44.7%) [24], south Wollo (41.7%) [25], and pooled prevalence of respectful maternity care in Ethiopia (48,44%) [26] but it is lower than the study in Hawassa city Ethiopia (86.2%) [27]. The observed difference may be tools used to measure dignified care, and study settings. The current study used likert scale items while Hawassa study employed yes/no questions for the same purpose. Using Likert scales, participants can give a variety of answers, allowing for a more complex assessment of their perceptions. Whereas, questions that are dichotomous in nature could lead to answers that oversimplify the experiences of the participants. Furthermore, the current study was done in secondary and tertiary level of governmental hospitals while Hawassa study was done in private and public health institutions including health centers. This might encourage private health institutions to place more emphasis on dignified care to attract more clients and ensure sustainable utilization of their services [28].

Similarly, the finding of this study is lower than study done in the Gedeo zone of south Ethiopia (59.5%) [29]. This variation may be difference in study settings; women were interviewed at their homes after discharge since they developed recall bias. Due to the fact that recall bias can affects the overall result. Furthermore this the finding of this study is lower than studies done in Arba Minch (63.3%) [30], and Jimma (50%) [31], western Oromia (65%) [32], two studies in Addis Ababa (85.2%), (87%) [33, 34] and Kenya (82%) [35]. The current study was conducted within general and comprehensive hospitals, characterized by high case flows and substantial workloads. In contrast, the aforementioned studies encompassed health centers, where case flows are lower, and workloads are comparatively reduced. Evidence showed that healthcare professionals working in environments characterized by higher case flows and substantial

Table 4 Bivariate and multivariate logistic regression analysis to identify factors associated with dignified care among mothers who give birth at public hospitals in Sidama Regional State, southern Ethiopia, 2023 (*N* = 418)

Variable	Categories	Dignified care		COR(95% CI	AOR(95%CI	*P* value
Age		Yes	No (%)			
	15–19	12(2.8)	13(3.0)	**1**	**1**	
	20–24	34(8.1)	66(17.8)	0.56(0.23,1.36)	0.31(0.09, 1.01)	1.05
	25–29	99(23.7)	94(22.5)	1.10(0.50,2.63)	0.78(0.25,2.42)	0.67
	30–34	35(8.4)	51(12.2)	0.70(0.30,0.82)	0.94(0.28,3.16)	0.91
	≥ 35	4(1.0)	10(2.4)	0.43(0.11,1.76)	0.68(0.11,4.22)	0.68
Residence	Rural	103(24.6)	155(37.1)	**1**	**1**	
	Urban	81(19.4)	79(18.9)	1.5(1.04,2.29)	0.92(0.52,1.63)	0.77
Occupation	Housewife	130(31.1)	192(45.9)	2.50(0.68,9.07)	2.35(0.44,12.58)	0.32
	Gov. employ	23(5.5)	10(2.4)	8.40(2.00,20.93)	6.75(2.89,20.00)	0.06
	Private	28(6.7)	21(5.0)	4.90(1.21,19.75)	5.79(0.89,20.58)	0.065
	Student	3(0.7)	11(2.6)	**1**	**1**	
Educational status	Non-formal	81(19.4)	135(32.3)	**1**	**1**	
	Primary	43(10.3)	67(16.0)	1.07(0.67,1.71)	1.20(0.63–2.28)	1.57
	Secondary	27(6.5)	14(3.3)	**3.21(1.59,6.49)**	**3.91(1.56,9.82)**	**0 0.00****
	≥College	33(7.8)	18(4.3)	3.06(1.62, 5.78)	2.45(0.95,6.29)	0.06
Accompaniment	With family	161(38.5)	213(51.0)	0.69(0.37,1.29)	1.74(0.81,3.78)	0.16
	Arrive lonely	23(5.5)	21(5.0)	**1**	**1**	
Route of delivery	C-section	29(7.0)	81(19.4)	**1**	**1**	
	Instrument	26(6.0)	43(10.3)	1.70(0.87,3.18)	1.49(0.61,3.63)	0.38
	SVD	129(30.8)	111(26.5)	**3.20(2.00,5.26)**	**2.68(1.31,5.46)**	**0.01***
Presence companion	Yes	139(33.3)	56(13.4)	**9.80(6.26,15.41)**	**12.35(7.10,21.5)**	**0.00****
	No	45(10.7)	178(42.6)	**1**	**1**	
Hospital stay	Less 2 days	145(34.7)	135(32.3)	**2.70(1.43,5.35)**	**3.26(1.37,7.75)**	**0.01***
	3 and 4 days	25(6.0)	63(15.0)	1.00(0.47,2.21)	1.98(0.71,5.56)	0.19
	≥ 5	14(3.3)	36(8.6)	**1**	**1**	
Professionals attend labor and delivery	Doctor	7(1.7)	23(5.5)	**1**	**1**	
	ISEO	6(1.4)	25(6.0)	0.78(0.23,2.70)	1.14(0.24,5.39)	0.87
	Midwifery	127(30.4)	149(35.6)	**2.80(1.16,6.74)**	**4.47(1.40,14.25)**	**0.01***
	Resident	26(6.2)	14(3.3)	**6.10(2.10,17.73)**	**10.99(2.60,21.2)**	**0.00****
	Seniors	18(4.3)	23(5.5)	**2.57(0.90,7.33)**	**5.49(1.38,21.88)**	**0.02***
Sex of professional	Female	81(19.4)	119(28.5)	0.76(0.52,1.12)	0.71(0.42,1.21)	0.211
	Male	103(24.6)	115(27.5)	**1**	**1**	

workloads may face challenges in providing dignified care [36]. Likewise, the finding of this study is lower than studies done in different global settings such as Ghana (71.5%) [37], Colombia (57.2%) [38], low-income country (70.4%) [39], and Malawi (57.2%) [40].

This is because of different study areas, periods, sampling techniques used, and tools for measuring dignified care. In the low-income country study, convenience sampling was employed. This method may inadvertently introduce individuals who are more likely to exhibit the studied condition and this may affect the overall results. Similar studies conducted in Colombia were only selected delivered by vaginal but the current study included delivered thorough C-section. Likewise, in Malawi, the observation sampling technique is used. This clinical observation ended after immediate newborn care, so it is not possible to know how the client was treated after the labor and delivery [40].

On the contrary, the findings of this study are higher than those of a study done in Iran (20.3%) [41]. The discrepancy might be due to different cultural perspectives, differing understandings, and approaches to receiving dignified care. Iran does not prioritize the needs of the mother during childbirth; instead, medical interventions like repeated vaginal exams, oxytocin use regularly, and episiotomies performed without the mother's input are prioritized. Healthcare providers' disregard for women's rights results in a loss of dignified care and negatively impacts women's delivery experiences when medical interventions are carried out without consent from the mother [42, 43].

In conclusion, the findings of this study indicate that the level of dignified care provided to mothers who give birth in public hospitals within the Sidama region is comparatively lower. This discrepancy can be attributed to several factors prevalent in developing countries, such

as resource constraints, inadequate healthcare infrastructure, and professional burnout, gaps in medical education, cultural and systemic barriers, and administrative challenges. These factors collectively contribute to the compromised quality of care and can impact the provision of dignified care both directly and indirectly. Addressing these issues is crucial for improving maternal care standards and ensuring that all mothers receive the dignity and quality of care they deserve.

The findings of this study underscore the critical need for collaboration among various stakeholders, including the federal Minister of Health of Ethiopia, the Office of Maternal and Child Affairs, the administration of the Regional Health Bureau, and the Zonal Health Department. It is essential to develop comprehensive policies that address the existing deficits in infrastructure and training within the healthcare system. Key areas to focus on include resource allocation, healthcare training, international support and aid, community engagement, systemic reforms, as well as monitoring and evaluation. Furthermore, this study suggests that the government and health professionals should prioritize the presence of midwives during childbirth. Advocacy for the inclusion of companions during labor is vital, alongside efforts to optimize hospital processes to enable shorter patient stays without compromising the quality of care provided. Additionally, promoting educational opportunities for women must be a focus to empower them within the healthcare framework. These strategies are crucial for enhancing maternal and child health outcomes in Ethiopia.

The other objective of this study was to assess factors associated with dignified care among mothers who give birth in Sidama regional states. The result showed that secondary educations were significantly associated with dignified care. This may be attributed to the enhanced communication and advocacy skills often associated with higher education levels. Individuals with secondary education may be more adept at expressing their expectations, potentially influencing healthcare providers' attitudes and behaviors to ensure a more dignified care experience [44]. This finding is supported by a study done in Wollega [32], and Arba-Minch [30], where women who have no formal education were more likely being treated with non-dignified care. Similarly, This finding is supported by a study done in Iran [45]. The finding of this study also supported by a study conducted in Ghana reveals that there is also some suggestive evidence that women with formal education are higher in experiencing consented and dignified care [37].

The finding of this study shows that mothers who deliver by spontaneous vaginal delivery are more likely to have preserved dignified care as compared to mother who delivers by C-section. This may be because SVD mothers typically receive midwife-led continuity model care and recover more quickly than those who have C-sections; additionally, this event strengthens the bonds between mothers and staff.

The finding of this study is supported by a study done in Wollega reveals that who gave birth through caesarian section are more likely to experience loss of dignified care than those who gave birth through vaginal delivery (AOR=4.52(95%CI; 1.64, 12.42) [32] This may be because, in contrast to mothers who had C sections, breastfeeding and immediate skin-to-skin contact are frequently easier to achieve following a spontaneous vaginal birth. This encourages a stronger bond between the mother and newborn, which may result in a feeling of dignity in car among the mothers [46].

The findings of this study show that mothers whose companion was present during labor and delivery were more likely to have preserved dignified care as compared to mothers whose companion was absent during labor and delivery.(AOR=12.35,95%CI(7.08,21.53). This finding showed assist with Wollega Oromia women who were without a companion throughout the delivery were more likely to lose their dignified care than women who had a companion to encounter (AOR=2.41, 95%(1.66, 3.50) [32].

This finding is supported by a study conducted in Brazil where having a companion improved maternity and newborn outcomes [47]. This might be because having a companion present can provide emotional support to childbearing mothers and helps reduce anxiety, stress, and fear during labor, delivery, and postpartum period creating a more positive and comfortable environment. A study done in Colombia reveals those women who present with their families during labor and delivery perceived higher levels of dignified care than those who have no family present [38]. This might be the presence of the companion who can act as an advocate, ensuring that their wishes and preferences are respected and communicated effectively to the healthcare team. This can help maintain the dignified care of mothers during the labor, delivery, and postpartum process. The presence of a companion can create a sense of familiarity and trust for the childbearing mothers. In many cultures, the presence of a family special mother during labor and delivery is considered important and valued for dignified care [48, 49]. This evidence is also supported by other research done on low-and middle-income countries. It is believed that the presence of a family can bring blessings, strength, and positive energy to the birthing process and cultural belief can contribute to a more preserved dignified care experience [50].

Participants who stay less than two days were more likely to have preserved dignified care as compared to mothers who stay five and above days

(AOR=3.26,95%CI(1.3, 7.75). This might be due to a short hospital stay allowing mothers to regain control over their daily activities and care for their newborns in their preferred manner. The findings of this study support a study done in Iran and Indonesia that showed clients who stayed a short time in the hospital have perceived dignified care (Nåden, 2013; Asmaningrum, 2020). This might be due to shorter hospital stays can potentially reduce the financial burden on the mother; her family and discharge in a short period feel a sense of dignified care.

Mothers who are attended by midwifery professionals were more likely to maintain dignified care as compared to mothers who attended by general practitioners (GP) (AOR=4.474,95%CI (1.40,14.25). According to research conducted in Ghana, midwives are substantially less likely women to lose their sense of dignified care during childbirth [37]. Mothers who attended by residence (specialty follower) profession was more likely to maintain dignified care as compared to mothers who attended by general practice (10.99, 95% CI (2.62,46.19) and also mothers who attended by senior were more likely to have preserved dignified care as compared to mothers who attended by GP (AOR=5.49,95%CI1.38,21.88). This might be due to Midwifery, specialty followers, and seniors being educated and trained specifically to provide care for women during, childbirth, and the postpartum period, and have experience in obstetrics and gynecology through their training and frequently collaborating closely with obstetricians throughout a year. This makes full encouragement, and individualized care resulting in more respectable treatment and a satisfying experience.

Conclusion

This study indicated that the dignified care among mothers who gave birth at public hospitals in the Sidama Regional State was relative low to the pooled prevalence of respectful maternity care in Ethiopia. When a mother gives birth through spontaneous vaginal delivery, has less than a two-day hospital stay, has secondary education, has a companion with her during labor and delivery, and whose labor and delivery were attended by a midwife, resident and senior are predictably more likely to preserve dignified care. The federal minister of health and health professionals working in the study areas focus on key strategies in the health care system: prioritizing midwife attendance during labor and delivery, advocating for the presence of companions to provide emotional support, streamlining processes to ensure a short hospital stay without compromising necessary care, and promoting educational opportunities for women.

Abbreviations

WHO World Health Organization
ANC Antenatal Care

Supplementary Information

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Supplementary Material 1

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Author contributions

WG designed the study, participated in data collection, analysis, and interpretation of the findings, and contributed to the preparation of this version of the manuscript. RF, TA, and MD assisted in the design and the proposal development, monitored data collection, assisted during analysis, and revised subsequent drafts of the paper. All authors read and approved the final manuscript.

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Data availability

Full data for this research is available through the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate

This research has been done in accordance with the Declaration of Helsinki. Ethical clearance was obtained from the Institution Review Board (IRB) of the College of Medicine and Health Sciences (Ref No. IRB/357/15 on June 29, 2023). The Institutional Review Board (IRB) of Hawassa University College of Medicine and Health Sciences is responsible for reviewing research involving human subjects. We submitted a research proposal to the IRB that included details on participant recruitment and consent procedures. The research was subsequently approved by the IRB. Formal A letter of cooperation was written to the regional health bureau from the department of midwifery, and then the regional health bureau wrote letter cooperation to the respective referral hospitals, and permission was obtained accordingly. Participants were informed about the purpose and benefits of the study, and following the explanation, written informed consent was obtained from each participant. Assent was taken from the women whose age was below 18 years after informed consent was taken from their parents. For those who cannot write and read, the consent form was read in front of a witness (their friends, relatives, and independent body of the research team), and the witness signed and provided written informed consent. All participants have assured confidentiality of information and privacy of their personal information. To preserve confidentiality, the data was not exposed to any third party except the investigators. Confidentiality of the information was assured and collected anonymously. Personal privacy was respected by interviewing alone with screening. Also, they were informed about their right to not participate in the study or withdraw at any time.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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