ASSESSMENT OF DIGNIFIED CARE AND ASSOCIATED FACTORS AMONG ADULT PATIENTS ADMITTED TO JIMMA MEDICAL CENTER, OROMIA REGIONAL STATE, SOUTH WEST ETHIOPIA, 2023

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A RESEARCH THESIS SUBMITTED TO THE SCHOOL OF NURSING, FACULTY OF HEALTH SCIENCES, INSTITUTE OF HEALTH, JIMMA UNIVERSITY, FOR PARTIAL FULFILLMENT OF THE REQUIREMENTS OF A MASTER OF SCIENCE DEGREE IN ADULT HEALTH NURSING

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JIMMA,ETHIOPIA

JIMMA UNIVERSITY
INSTITUTE OF HEALTH
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Abstract

***Background**: Dignified care is treating patients as being of worth in a respectful way, considering them as valued individuals. It enhances overall patient well-being, satisfaction, psychological comfort, and confidence. Even though necessary, little is known about dignified care in Ethiopia, particularly in Jimma. Analyzing dignified care, therefore, helps health care providers and the program managers to design better strategies.*

***Objective**: To assess dignified care and associated factors among adult patients admitted to Jimma Medical Center, Oromia, Southwest Ethiopia, 2023.*

***Methods:** A facility-based cross-sectional study design using the quantitative method supported by qualitative descriptive data collection was employed among 422 and 13 patients, respectively. Simple random sampling for quantitative and purposive sampling techniques for qualitative was utilized to collect the data. Data were collected by using pretested interviewer-administered questionnaires and an in-depth interview. Binary and multivariable logistic regression was conducted to identify factors associated with dignified care; a P-value < 0.05 at 95% CI was used to declare a statistically significant association. For qualitative data, thematic analysis was conducted using ATLAS-ti 7.1 software.*

***Results**: Of the 422 samples, 405 participated, resulting in a response rate of 96%. The finding revealed that 50.90% (95% CI: 45.97–55.75%) of patients had adequate dignified care. Good care provider-patient relationships [AOR=2.92; 95% CI (1.79-4.75); p<0.001], being an employee [AOR=0.23; 95% CI (0.07-0.75); p=0.014], being female [AOR = 0.18; 95% CI (0.11-0.30); p < 0.001], living in rural areas [AOR = 0.45; 95% CI (0.21-0.96]; p = 0.049] and being 18–24 years old [AOR=3.48; 95% CI (1.48–8.15); p = 0.004] were associated with dignified care. The qualitative study explored six key themes: communication, autonomy, respect, privacy, clinical, and patient factors.*

***Conclusion and recommendation**: Nearly half of the study participants received adequate dignified care. Care provider-patient relationship, gender, occupation, residence, and age were factors associated with dignified care, and six themes emerged from a qualitative study. Therefore, health professionals and hospital administrative staff should work with their maximum effort to maximize dignified care.*

***Keywords:** adult patient, dignity, dignified care, Jimma Medical Center*

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List of abbreviations and acronyms

ANA…….AMERICAN NURSES ASSOCIATION

AOR……ADJUSTED ODD RATIO

CICU.....CHRONIC INTENSIVE CARE UNIT

COR.....CRUDE ODD RATIO

CRC.....COMPASSIONATE RESPECTFUL CARE

ETB……..ETHIOPIAN BIRR

ICN….....INTERNATIONAL COUNCIL OF NURSES

JMC……..JIMMA MEDICAL CENTER

JU…….JIMMA UNIVERSITY

JUIRB……..JIMMA UNIVERSITY INSTITUTIONAL REVIEW BOARD

MOH.....MINISTRY OF HEALTH

SPSS.....STATISTICAL PACKAGE FOR SOCIAL SCIENCE

UN.....UNITED NATION

WHO.....WORLD HEALTH ORGANIZATION

CHAPTER ONE: INTRODUCTION

1.1 Background

Dignified care is care that supports, promotes, and does not undermine the patient's self-worth, regardless of any differences in sociodemographic characteristics between the patient and care providers (1). Dignified care is a component of compassionate and respectful care and consists of four attributes: respect, autonomy, privacy, and communication (2–4). It is considered a fundamental human need and is recognized as a central concept in health science (5). In its 1994 declaration, the WHO considered dignity an essential factor in improving patient health and the right to give informed consent, access to health services, information confidentiality, and privacy (6). According to the United Nations Declaration, every person is entitled to freedom and equality concerning dignity and care (7).

According to the International Council of Nurses Code of Ethics 2012, dignity should not be limited by an individual's age, color, creed, culture, gender, sex, nationality, race, social status, or health status (8). The Nursing and Midwifery Council Code of Professional Conduct states that care providers must prioritize the care of people by treating them as individuals and respecting their dignity(9). Maintaining a patient's dignity is an ethical goal of nursing care and a fundamental human right (10). One of healthcare professionals' most important professional and moral responsibilities is to provide dignified care to improve communication between patients and caregivers, boost patient satisfaction, and thus improve the quality of care (11). Furthermore, delivering dignified care increases satisfaction and confidence in care, shortens hospital stays, and enhances the Patient's mental health (12).

Some factors affect dignified care, such as sociodemographic-related factors (Patient's age, gender, education, employment status, income, and religious affiliation) (13) and patient medical history-related factors (duration of the disease, number of hospitalizations, number of chronic diseases) (14). In addition to these, other factors affect dignity care, like physical environment-related factors (type of ward, number of patients in one room, facilities, and physical space) (15) and the care provider-patient relationship (16).

To maintain patient dignity, care providers should consider the above factors, make effective communication, including spending time with them, attending to their repetitive requests, and evaluating patients' human values, beliefs, and all aspects of their existence (17). In addition, patient dignity is preserved when patients are treated with respect and compassion, given privacy, and have close family members involved in physical care (18).

1.2. Statement of problem

The issue of undignified care is a concerning problem in the world, particularly in low- and middle-income countries(19). Undignified care can hurt the patients' overall well-being, psychological comfort, trust in the healthcare system, and satisfaction, which can lead to depression, loss of will to live, and feelings of worthlessness (20). Although dignified care is essential to human rights and is required for high-quality health care (21), reports have consistently raised low dignified care in hospitals (20).

When patients require hospitalization, they are at a higher risk of losing their dignity (22). High levels of dependence during hospitalization threaten patient dignity, especially regarding personal care, which conflicts with standards and personal values, putting patient dignity at risk (23). Due to this, it is the ethical responsibility of healthcare professionals to communicate effectively, keep privacy, respect patients, ensure autonomy, demonstrate empathy, foster trust, and provide dignity therapy (24).

Dignified care is one of the most essential values patients sensitively perceive in health care (25). Still, patients are frequently dissatisfied with how care providers deliver dignified care in hospitals (26). Reports have highlighted undignified care, suggesting it is a widespread concern. Still, its specific global prevalence is challenging to measure due to various factors, including differences in healthcare systems, cultural norms, and perceptions of dignity (25). A report from North China indicates that about three-fourths of patients experienced a loss of satisfaction (27). Another study conducted in northwestern Iran revealed that the dignity of Iranian cancer patients is not fully respected in clinical settings (28). Further reports from Ghana indicate that approximately half of the patients get low- to moderate-dignified care(29).

Suppose dignified care is not carried out effectively. In that case, healthcare organizations may suffer negatively, ranging from low patient satisfaction to non-repeat service utilization and a potentially diminished financial bottom line due to patients seeking healthcare elsewhere (28). Patients who have experienced undignified care may also be less likely to seek timely healthcare services in the future, potentially worsening their health outcomes(30). Addressing the consequences of undignified care, such as treating complications arising from delayed care-seeking or managing patients' psychological distress, can add to the burden on healthcare resources (31).

Globally, efforts are being made to address undignified care through healthcare policies, professional guidelines, and quality improvement initiatives, which aim to promote dignified care (32). Even though there has been an increasing emphasis on dignity in healthcare, less attention has been placed on low-resource settings (33). To bridge this gap, the Ethiopian government has been implementing the CRC

program and attempting to improve person-centered care for the last five years; however, many healthcare practitioners still need to provide dignified care to clients (34).

Even though it is necessary, little is known about dignified care in Ethiopia, particularly in Jimma. Therefore, analyzing dignified care helps healthcare providers and program managers design better strategies. Therefore, this study assesses dignified care and associated factors among adult patients admitted to Jimma Medical Center in Oromia Regional State, southwestern Ethiopia.

1.3 Significance of the study

This study's findings will help patients, care providers, hospital authorities, researchers, and other organizations.

The insights obtained from the findings will be helpful for patients if policymakers identify specific areas that need improvement and implement policies that can enhance and promote dignified care. In addition, the results derived from the findings will help healthcare providers working in JMC identify potential barriers and enabling factors for providing dignified care and identify areas for improvement.

The result of this study is invaluable for the JMC's authorities because, by examining the magnitude of dignified care, they can gain insight into the current state of care delivery and identify areas for improvement, allowing them to enhance care delivery and implement changes that promote dignified care. Moreover, this study will serve as a resource for government organizations in developing appropriate dignified care guidelines, which facilitate transforming healthcare organizations to become more patient-centered.

Furthermore, this study contributes to the existing body of literature by providing specific insights into the status of dignified care provided to adult patients. Finally, it can serve as a resource for future research, guiding researchers toward areas of improvement, intervention development, and contextual understanding of dignified care.

CHAPTER TWO: LITERATURE REVIEW

The literature of the study was searched from Pub Med, Scopus, Embase, Cochrane trials, the Web of Science, Science Direct, and CINAHL databases. These databases were searched using search terms such as "dignified care," "dignity in care," or "status of patient dignity in a hospital." This study's literature review includes an overview of dignified care, the status of dignified care, and factors that affect dignified care, such as sociodemographic-related factors, care providers-patient relationships, patient medical history, and physical environment-related characteristics.

2.1 Overview of Dignified Care

A systematic review of articles on dignified care concludes that patients' dignity is upheld when healthcare professionals communicate effectively, keep privacy, respect patients, ensure autonomy, demonstrate empathy, foster trust, and provide dignity therapy (23,24). According to a descriptive cross-sectional study conducted on 150 patients in Turkey in 2017, the patients stated that the most critical factor for dignified nursing care was the protection of their rights (30).

2.2 status of dignified care

According to a mixed longitudinal cohort study conducted on 271,915 patients in Sweden between 2016 and 2018 to assess patients' expectations of the status of their dignity, 36% of patients reported that the status of dignified care they received was adequate; however, both groups experienced a decrease in dignity satisfaction between 2016 and 2018 (35). A cross-sectional study was conducted in Modena, Italy, in 2012 on 100 patients in 10 general hospitals to investigate inpatients' perceptions of dignity; the magnitude of adequate dignified care was 65.5% (4).

According to a 2019 cross-sectional study of 202 cancer patients in North China, 71% experienced mild loss of dignity, and 5% experienced severe loss of dignity (27). Furthermore, in a cross-sectional study conducted in 2011 in Zanjan, Iran, most patients reported that staff always ensure adequate privacy (55.5%) and respect their request for a caregiver in their room (53.9%). Nevertheless, the majority of patients responded that staff never took care to use curtains around their bed before performing a procedure (56.3%), that their room door was never kept closed while undergoing medical procedures (38.3%), and that medical staff never introduced themselves to them at their first meeting in the hospital

(36.6%) (5). Another cross-sectional study conducted on patients in 2016 and 2021 in Iran revealed that the Status of dignified care was inadequate (3,32).

Another descriptive-analytical study on 401 inpatients in Isfahan, Iran, in 2017 found that 91.8% of the participants rated privacy protection as good/moderate, 84.4% said their independence was maintained; they were involved in decision-making, and they were satisfied with the level of respect they received(31). According to a descriptive-correlational study conducted in 2015 among 250 cancer patients in East Azerbaijan Province, Iran, Iranian cancer patients' dignity is not fully respected in clinical settings (28). Another cross-sectional study conducted in 2023 among 270 patients in Ghana to assess the status of dignified care revealed that approximately half of the respondents (54.1%) reported low to moderate dignified care (29).

2.3 Factors associated with dignified care

2.3.1 Sociodemographic factors

In a meta-analysis of nine qualitative and thirteen quantitative studies conducted at the Chinese University of Hong Kong in 2021, patients' characteristics, such as education, employment status, and religious affiliation, were associated with their sense of dignity (13). A cross-sectional study on 253 Chinese older adults in 2021 revealed that time spent in cities was associated with a higher scale (37).

A 2021 cross-sectional study on 206 patients at Qom Medical Sciences in Iran found that patient dignity was related to the patient's educational level (38). According to a descriptive-correlational study conducted in 2015 on 250 cancer patients in East Azerbaijan Province, Iran, and in 2016 at Mazandaran University of Medical Sciences, Iran, on 300 patients, overall patient dignity was statistically associated with participants' education and occupation (14, 28). In addition, the study showed that factors such as place of residence influence patients' dignity (14). Further, a cross-sectional survey conducted in Kashan, Iran, 2021 states that marital and educational status were associated with dignified care (39).

Several studies conducted in many countries revealed that the Patient's age is the most critical factor in dignified care (13,27,27,28,30,40,41). Furthermore, numerous studies showed that gender was associated with dignified care (13,14,35,38,40). According to a study in France 2021 on 125 geriatric inpatients, patients with higher education rated their dignity more positively one month after hospitalization in a long-term care ward, as self-sufficiency improved and depression decreased (42).

2.3.2. Patient medical history-related factors

According to a cross-sectional study conducted in Iran in 2015 on 200 patients admitted to Kerman University of Medical Sciences and a qualitative study conducted in 2014 in Kerman, Iran, there was a significant statistical correlation between the frequency of hospitalizations and dignified care (12,14,43). A descriptive cross-sectional study conducted on 150 patients in Turkey in 2017 found that the duration of the admission and the number of hospitalizations are factors in dignified care (30). Another cross-sectional study on 253 Chinese older adults in 2021 found that a higher Dignity score was associated with fewer chronic diseases (37).

2.3.3. Hospital Environmental related factors

According to a narrative review conducted in Taiwan in 2013, dignified care is influenced by the private space provided by nurses as well as the general physical environment of the hospital (44). A descriptive-analytical study of 401 inpatients in Isfahan, Iran, 2017 found that patients' dignity had significant relationships with the type of ward and the number of patients in one room (15). Furthermore, a cross-sectional study conducted in Ilam, Iran, in 2014 on 280 inpatients to determine their perspectives on their state of human dignity revealed that hospitals had an almost favorable status for human dignity (45). Another study conducted in the U.K. in 2015 showed that the environment of care related to physical features of the environment that could facilitate dignified care, such as privacy in care (46). According to a qualitative study conducted on 24 patients in Iran between April 2016 and February 2017, patients admitted to a peaceful hospital environment respected their dignity more (47).

2.3.4. Care provider-patient relationship

According to a narrative review conducted in Taiwan in 2013, dignity in care is influenced by a patient's ability to control their relationship with the nurses and the private space provided by the nurses (44). A cross-sectional study conducted in 2019 on 250 cancer patients admitted to Tabriz Shahid Ghazi, Iran, identified that the score of the nurse-patient relationship is significantly correlated with the Status of dignified care (21). According to a descriptive-analytical study conducted on 401 inpatients in Isfahan hospitals in Iran in 2017, 91% of patients rated their relationships with nurses as good (15).

Another cross-sectional study conducted in 2015 on 200 patients admitted to the Kerman University of Medical Sciences in Iran revealed that establishing a sense of security and an effective relationship between Patient and nurse, including a respectful relationship, affects

human dignity (16). One study conducted with patients in coronary care units in Iran in 2016 reported that the nurse-patient relationship quality could facilitate and reduce patient dignity (12). According to a study conducted in the United Kingdom in 2020 on ten patients to investigate their views on dignity, patients promoted their dignity through attitudes (rationalization, use of humor, acceptance), developing relationships with staff, and retaining ability and control (48).

To sum it up, different studies have tried to show dignified care. There are noted discrepancies in the findings of these studies in different countries. Some studies showed an adequate status of dignified care, whereas others showed an inadequate status. Additionally, this literature review discusses various factors associated with dignified care. Studies have identified factors such as gender, age, marital status, educational status, occupation, residence, nurse-patient relationships, inter-professional collaboration, previous admission, length of hospitalization, presence of co-morbidity, number of beds in each room, type of ward, toileting, status of the room, the smell being controlled, use of a bed screen, and the flow of individuals in the room that are associated with dignified care.

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2.4 Conceptual framework

The following conceptual framework is developed after reviewing different literature on factors affecting dignified care in other parts of the world (9,14,16,19,24,27,31,32,45,48).

NB: A solid line shows the effect of independent variables on dependent variables.

The broken line shows the effect of independent variables on each other, but it is not the study's concern.

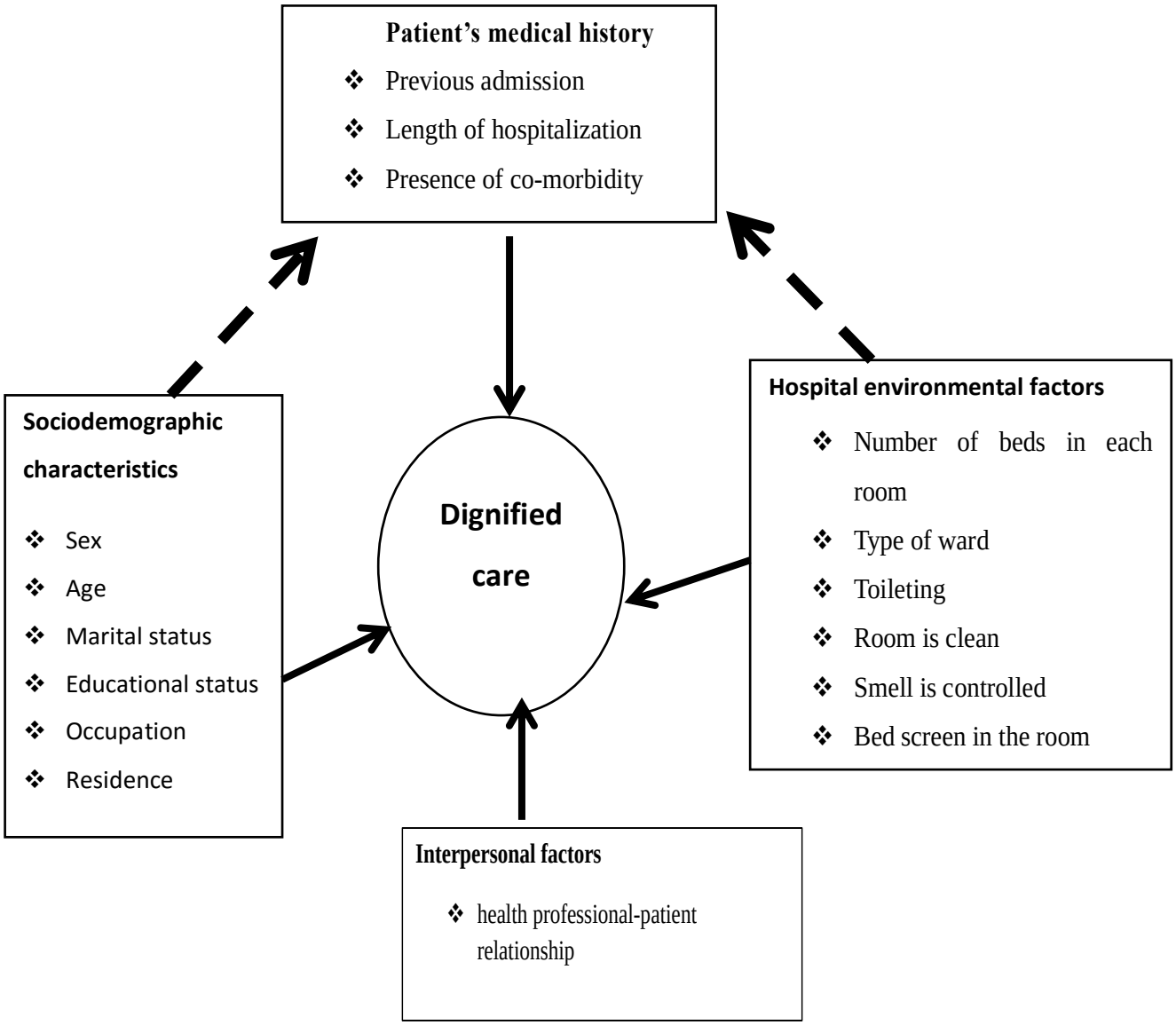


Figure 1: A conceptual framework to show factors associated with dignified care among adult patients admitted at JMC, Oromia region, southwest Ethiopia, from June 1-30, 2023

CHAPTER THREE: OBJECTIVES

3.1 General objective

To assess dignified care and associated factors among adult patients admitted at Jimma Medical Center, Oromia Regional State, Southwest Ethiopia, 2023

3.2 Specific objectives

1. To determine the status of dignified care among adult patients admitted at Jimma Medical Center, Oromia Regional State, Southwest Ethiopia, 2023

2. To identify factors associated with dignified care among adult patients admitted at Jimma Medical Center, Oromia Regional State, Southwest Ethiopia, 2023

3. To explore Patient's viewpoints toward dignified care among adult patients admitted at Jimma Medical Center, Oromia Regional State, Southwest Ethiopia, 2023

CHAPTER FOUR: METHOD

4.1 Study area and study period

Jimma Hospital was established in 1930 E.C. by Italian invaders to serve their soldiers, and it is now known as Jimma Medical Center. It is approximately 352 kilometers southwest of Ethiopia's capital, Addis Ababa. It is situated east of Jimma town, about 3 km from the downtown Jimma municipality. JMC is the only referral hospital in southwest Ethiopia. It serves approximately 15 million people in a catchment area of roughly 250 kilometers in southwest Ethiopia. It receives about 221,344 patients per year. JMC has a bed capacity of 800 with a bed occupancy rate of 91%. JMC has 972 health professionals on staff, among which 573 are nurses. Among nurses, 14 were MSc degree holders, 446 were BSc degree holders, and 113 were clinical nurses. It has a total of 45 inpatient and outpatient departments. There are major departments for adult inpatient care at JMC: internal medicine, surgery, gynecology, maternity, ophthalmology, and the psychiatry ward. Therefore, the study was conducted at Jimma Medical Center from June 01–30, 2023 (49,50).

4.2 Study design

A facility-based cross-sectional study using quantitative findings supported by qualitative descriptive data was employed (51–53). By employing a convergent strategy, the study aimed to integrate quantitative and qualitative data to understand dignified care and associated factors comprehensively. Because of subjective experiences of dignified care, the findings from both data types were likely compared and merged to provide a more holistic understanding of dignified care.

4.3 Populations

4.3.1 Source population

All adult patients who were admitted to Jimma Medical Center

4.3.2 Study population

All sampled adult patients who were admitted to Jimma Medical Center

4.4 Eligibility criteria

4.4.1 Inclusion criteria

All patients whose ages were over 18, who stayed at the hospital for more than 24 hours during the data collection period, and who were willing to participate were included in the study.

For qualitative study

The selection criteria followed the principles of maximum variation and the willingness to engage in the study.

4.4.2 Exclusion criteria

Patients who could not respond at the time of the study were excluded.

4.5 Sample size determination

The sample size was determined using the single population proportion formula with the following assumptions: Z = the standard normal deviation at the 95% confidence interval; = 1.96; d = margin of error that can be tolerated, 5% (0.05) and proportion was assumed to be 0.5 (50%) in the absence of previous similar studies.

n= $\frac{\frac{z\alpha}{2}p(1-p)}{d^2}$ ni= $\frac{(1.96)^2\ 0.5(1-0.5)}{0.05^2} = 384$

Then, after considering a 10% non-response rate, the final sample size was 422.

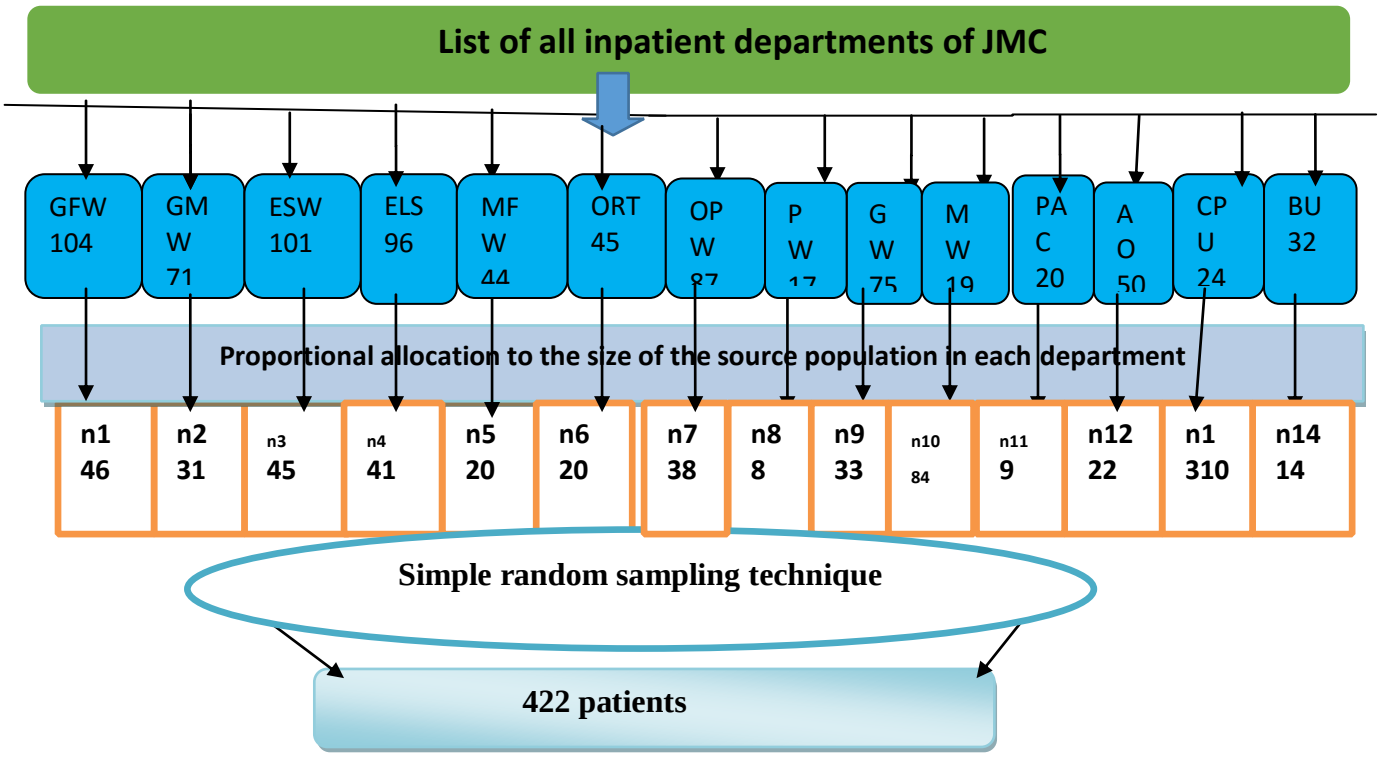
For the qualitative study, thirteen patients were selected based on the saturation of the required information.

4.6 Sampling technique

Proportional allocations of the samples were implemented for all adult inpatient departments of JMC based on the previous two quarters (September 1-Februry 30) statistics report. Averages of 956 patients were admitted to the inpatient department of JMC per month. In each department, patients were selected using a simple random sampling technique, the computer-generated lottery method. Then, eligible individuals from all departments were enrolled in the study. A list of beds in each department during the study period was obtained and served as the sampling frame.

Proportional allocation of Patients from all departments

$$n = \frac{number\ patients\ in\ \text{department} \times total\ sample\ size}{total\ number\ of\ patients\ from\ all\ \text{departments}}$$



Key: GFW-General female ward, GMW-General male ward, ES-Emergency surgery, ELS-Elective surgery, OW-Orthopedic, OPT-Ophthalmology, PW-Psychiatry ward, MFW-Maxillofacial ward, GW-Gynecology ward, MW-Maternity ward, PAC-Post abortion care unit, AO-Adult oncology, CPU- Cardiac & pulmonary unit, BN-Burn unit.

Figure 2: Schematic presentation of sampling procedures for assessing dignified care and associated factors among adult patients admitted to JMC, Oromia region, Southwest Ethiopia, from June 1-30, 2023.

Sampling technique for qualitative study

The maximum variation-based purposive sampling technique was employed, and purposefully selected individuals who possess unique experiences and information related to the care given and can provide valuable insights on dignified care. These include those who stay in the hospital for more than 11 days and are admitted at least twice. Selecting participants for in-depth interviews follows maximum variation principles: age, gender, educational status, occupation, type of department, type of disease, duration of admission, and frequency of admission of the Patient were taken into account. The purpose was to get detailed information from those participants who met the criteria. Patients not participating in the quantitative study were selected for an in-depth interview.

4.7. Study variables

4.7.1 Dependent variables

Dignified care

4.7.2. Independent variables

Socio-demographic characteristics: Sex, age, marital status, educational status, occupation, and residence

Hospital physical environment: Type of ward, number of beds in each room, availability of individual bed screens, controlling flow of individuals during care, cleanliness of the toilet, cleanliness of the room, and smell of the room

Patient medical history: Previous admission history, Duration of admission, Presence of co-morbidity.

Interpersonal factors: Care provider-patient relationship

4.8 Operational definitions and definition of terms

Dignified care: The care that supports, promotes, and does not undermine the patient's self-worth regardless of any differences in sociodemographic characteristics between the Patient and HCPs (1).

Adequate dignified care: The provision of healthcare services that uphold and respect patients' human dignity and rights. It considers treating patients with respect, compassion, and cultural sensitivity and involves aspects such as privacy, autonomy, communication, and involvement in decision-making (54).

Inadequate dignified care: The situations where patients are not treated with the respect and dignity they deserve (54).

Adequate dignified care: By taking the mean scores as a cut-off point, the outcomes of dignified care greater than or equal to the mean score were considered adequate dignified care (3).

Inadequate dignified care: Taking the mean scores as a cut-off point, the outcomes of dignified care below the mean score were considered inadequate dignified care (3).

Health professional-patient relationship: is a supportive relationship built on mutual respect and trust, the fostering of faith and hope, awareness of self and others, and using knowledge and expertise to help patients meet their physical, emotional, and spiritual needs (55).

Good Health professional-patient relationship: Using the median scores as a cut-off point, the outcome of care provider-patient relationship questions greater than or equal to the median score is considered good Health professional-patient relationship (55).

Poor Health professional-patient relationship: By taking the median scores as a cut-off point, the outcome of care provider-patient relationship questions less than the median score is considered poor health professional-patient relationship (55).

4.9. Data collection instrument and procedure

Quantitative data

Data were collected using structured, interviewer-administered questionnaires. A validated instrument was used for determining the status of dignified care, which was adapted from the inpatient dignity scale and developed by Torabizadeh C. (3). The tool was prepared in English. The tool is customized and contextualized to suit the specific population or setting being studied. Before being administered to patients, the questionnaire is submitted to seven experts for consultation and modified according to their comments. Based on the pretest results, the necessary revisions were made to increase the messages' simplicity, clarity, and understandability. The questionnaire was translated into local languages such as Amharic and Afan Oromo and re-translated to English to maintain consistency in translation.

The questionnaire consists of five parts with a total of 52 items. The first part includes seven questions on the sociodemographic details of the patients. The second part consists of questions on patient medical history that can influence dignified care and consists four items (14,56). The third part consists of seven questions related to environmental factors (2); the fourth part consists of eight questions on the care provider-patient relationship (57). The fifth part consists of 26 questions related to dignified care. Each dignified care question was measured on a 5-point Likert-type scale from 5 (always) to 1 (never). The minimum and maximum scores of the items were 26 and 130, respectively. Data were collected using the Afan Oromo and Amharic versions of the questionnaire. Data was collected by four BSc nurses who have previous data collection experience, and one MSc R.H. supervised them.

Qualitative data

Qualitative data was collected to provide a deeper understanding of the quantitative findings. The data was collected simultaneously with a quantitative one by a separate data collector. The study participants were selected from all adult inpatient departments at JMC. In-depth interviews were undertaken during the discharge so that patients could discuss their experiences of dignified care and their dignity during hospitalization. The principal investigator conducted in-depth interviews in Afan Oromo and Amharic. A semi-structured question guide was used to lead the discussion. A tape recorder and notebook were used to capture their opinions fully after they were told about the objective of the study and their consent was taken. Interviews were conducted in a private room free from noise and prepared for this purpose. The duration of each interview was 35 minutes on average.

4.10 Data Quality Assurance

For quantitative data

Before data collection, one day of orientation was given to data collectors on the technique of data collection, the purpose of data collection, the content of the questionnaires, how to interact with the responders and handle any issues that can come up while gathering data. A pretest was conducted at Shenen Gibe General Hospital by taking 5% (20 patients) of the total sample size one week before the actual data collection, and appropriate corrections were made, such as the logical order of some questions; some words difficult to understand were revised; and some items were removed. The overall standardized Cronbach's alpha for internal consistency, or the reliability score of measurement, was 0.93. The principal investigator made an ongoing checkup of the questionnaires for completeness and accuracy each day during the data collection.

For qualitative data

The rigor criteria outlined by Lincoln and Guba (1985), namely credibility, transferability, dependability, and conformability, were used to enhance the trustworthiness of the findings.

Credibility: This is achieved by members checking and verifying interpretations or findings with participants to ensure accuracy. It means reframing a participant's response to ensure that the participant's point of view was understood correctly.

Transferability: Understandings were compared to previous similar studies. There were thorough explanations given of the participants, context, and data analysis procedures. This enables readers to assess the applicability of the results to their particular situation.

Conformability: Achieved by keeping records for an audit trail of entire documents and checking transcripts for errors regularly. An audit trail involves documenting the decision-making process, raw data, data analysis, and interpretations, allowing for transparency and accountability. This ensures that the researcher's biases and preconceptions do not influence the data analysis.

Dependability: To establish dependability, researchers document their research processes thoroughly, including data collection procedures, coding schemes, and analytic decisions. Blind readings of interview text were performed by one epidemiology student who has no connection to the study to ensure transparency and potential replication.

4.11 Data processing and analysis

Quantitative

The data was entered into Epidata version 4.6 after being double-checked for accuracy after collection, which was then exported to SPSS version 25.0 for analysis. Descriptive statistics like frequencies, percentages, medians, means, and standard deviations were done. The status of dignified care was categorized using the median value. A binary logistic regression analysis was done to sort candidate variables with a value less than or equal to 0.25 for multiple logistic regression.

A multiple logistic regression analysis was conducted to identify factors associated with dignified health care. Finally, the association was declared with a p-value less than 0.05 and an adjusted odds ratio (AOR) at a 95% confidence interval. Hosmer and Lemeshow's test was insignificant (p-value= 0.991), and the Omnibus test was significant (p-value =0.000), indicating that the model was fitted.

Qualitative

The qualitative data were analyzed using ATLAS—ti 7.1 version software. Data analysis was started at the same time as the data collection period, and each interview was transcribed verbatim and analyzed before the next one took place, with each interview providing the direction for the next one. The accuracy and completeness of transcribed data were checked by comparing them to audio-taped interviews and interview notes. Transcribed data were translated from Amharic and Afan Oromo to English. The translated Word document was converted to a PDF document. The PDF format of the document was uploaded to the ATLAS—ti 7.1 version software. First, concepts were identified and labeled by a word or phrase line by line using descriptive coding. Then, similar codes were grouped into the same categories to form a family. Further, similar families developed a super family (themes).

4.12 Ethical considerations

The Jimma University Institute of Health's institutional review board approved ethical clearance before data collection. A cooperation letter was received from the nursing school and submitted to the JMC clinical directorate. A permission letter was obtained from the hospital before data collection. Written consent was obtained from each participant, stating that participation is voluntary and they have the right to withdraw at any time from the study. The written consent consists of the study purpose and procedures, potential risks and benefits, voluntary participation, and right of withdrawal, and the information provided by each respondent was kept strictly confidential. Respondents were also informed that their answers to the questions were grouped with other respondents' answers and reported as part of a research study.

4.13 Dissemination plan

The findings of the study will be disseminated through the scientific presentation and submission of hard and soft copies to relevant authorities (School of Nursing, Institute of Health, Jimma University, and JMC). Furthermore, efforts will be made to publish in local or international reputable journals.

CHAPTER FIVE: RESULTS

5.1. Socio demographic characteristics of the participants

Out of 422 samples targeted to participate in this study, 405 patients participated, resulting in a response rate of 96%. The study participants were characterized as: 245 (60.50%) were females, 275 (67.90%) were Muslims, 277 (68.40%) were married, 236 (58.30%) had informal education, 284 (70.10%) were farmers and 283 (69.90%) of them lived in rural areas. The mean age of the participants was 37.48 ± 13.60 SD years, and 109 (26.90%) of them were in the age group of over 45 years (table 1).

There were thirteen informants, seven female, and six male, for the qualitative study. The ages of the participants ranged from 23 to 55, their duration of admission ranged from 11 to 32 days, their frequency of admission ranged from 2-3 times, and they were selected from 12 departments.

Table 1: Socio-demographic characteristics of patients admitted to Jimma Medical center, Oromia region, Southwest Ethiopia, from June 1-30, 2023 (n=405).

Characteristics	Category	Frequency	Percent (%)
Sex	Female	245	60.5
	Male	160	39.5
Age	18-24	78	19.3
	25-29	62	15.3
	30-34	61	15.1
	35-39	48	11.9
	40-45	47	11.6
	>45	109	26.9
Religion	Muslim	275	67.9
	Orthodox	83	20.5
	Protestant	31	7.7
	Others@	16	4
Marital status	Single	91	22.5
	Married	277	68.4

	Divorced	20	4.9
	Widowed	17	4.2
Educational level	Informal education	236	58.3
	Primary education	99	24.4
	Secondary education	53	13.1
	College/University	17	4.2
Occupation	Farmer	284	70.1
	Student	50	12.3
	Employee (any type)	24	5.9
	Merchant	47	11.6
Residence	Urban	114	28.1
	Rural	291	71.9

5.2. Patient Medical History

The majority of respondents, 330 (81.50%), have no previous admission history, and 375 (92.60%) have no co morbid illness. One hundred eighty-seven (44.4%) of them stayed from two to seven days; the mean admission duration of the respondents was 11.62 ± 10.67 SD days (58).

Table 2: Patient Medical History of patients admitted to Jimma Medical center, Oromia region, Southwest Ethiopia, from June 1-30, 2023 (n=405).

Characteristic	Category	Frequency	Percent (%)
Previous admission history	Yes	75	18.5
	No	330	81.5
Duration of admission	2-7 days	187	44.4
	8-15 days	148	35.2
	≥16 days	86	20.4
Presence of co morbidity	Yes	30	7.4
	No	375	92.6

5.3. Hospital environmental (characteristics) factors

One hundred fifteen (28.40%) of the respondents were from the surgical ward; 323 (79.80%) of them were from rooms that had more than two beds; 298 (73.60%) of them reported that care providers did not draw bed screens during the procedure; and 246 (60.70%) of respondents reported that the flow of individuals in the room was controlled while providing care.

Table 3: Hospital environmental factors of patients admitted to Jimma Medical Center, Oromia region, Southwest Ethiopia, from June 1-30, 2023 (n=405).

Characteristics	Category	Frequency	Percent
Name of ward	Medical	84	20.7
	Surgical	115	28.4
	Orthopedic	20	4.9
	Maternity	77	19
	OBGN	45	11.1
	Adult oncology	22	5.4
	Ophthalmology	35	8.6
	Psychiatry	7	1.7
Number of beds per room	Single bed	24	5.9
	Two Bed	58	14.3
	>Two bed	323	79.8
Draw bed screen during Procedure	Yes	107	36.4
	No	298	73.6
Flow of individuals controlled during care	Yes	246	60.7
	No	159	39.3
Is the toilet clean	Yes	333	82.2
	No	72	17.8
Is the room clean	Yes	370	91.4
	No	35	8.6

Is the smell in the room controlled	Yes	310	76.5
	No	95	23.5

5.4. Health professional-patient relationship

The study showed that the median score of the health professional-patient relationship among respondents was 30; with maximum and minimum scores of 32 and 19, respectively, and an Interquartile range value of 13. Based on the median score of the health professional-patient relationship questions, 217 (53.6%) of patients had a good relationship. Three hundred forty-one (84.20%) respondents reported that they usually develop trusting relationships with their care providers. Two hundred seventy-nine (68.90) of the respondents reported that health professionals usually understand their needs during care. For more detail Table7

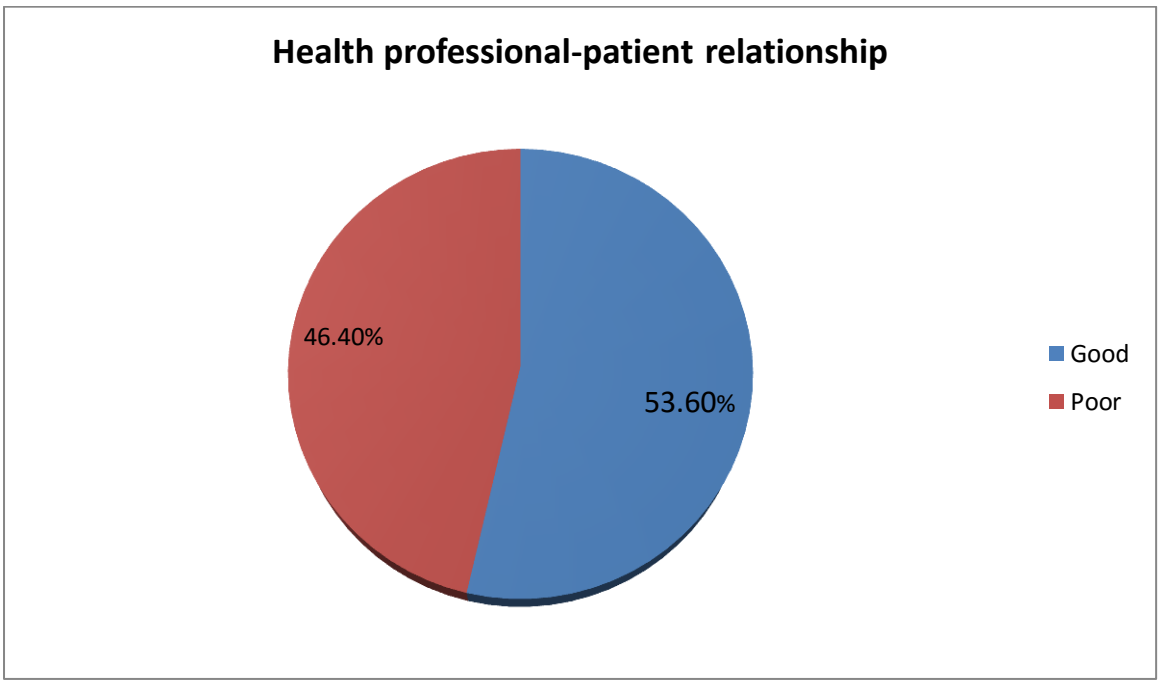


Figure 3: Health professional patient relationship among patients admitted to Jimma medical center, Oromia region, Southwest Ethiopia, from June 1-30,2023 (n=405).

5.5. Status of dignified care

This study showed that 329 (81.20%) health professionals always get patients' informed consent before performing procedures. However, 148 (36.50%) of health professionals usually cover irrelevant areas of the Patient's body during the procedure. One hundred forty-eight (36.50%) health professionals rarely address patients by name. Concerning self-introduction, 163 (40.20%) respondents stated that health professionals rarely introduce themselves upon first meeting patients. One hundred sixty-seven

(41.20%) respondents said they were never introduced to their care providers or the environment at admission. One hundred eighty-three (45.20%) of health professionals always listen to patients patiently.

Concerning decision-making, about 155 (38.30%) of respondents always have the right to make decisions about their care. This is supported by qualitative findings: "...*Health professionals inform me about my condition, treatment plans, and medication, and I make my own decisions*..." (A 55 -years old male).

Concerning patient privacy (60.70%), H.P. always ensures patient privacy (e.g., closing doors, drawing curtains) before any procedure. This is supported by qualitative findings: "...*The health professionals close the door and draw a bed screen before any procedure; this is very interesting. It is the rule to lock the door when any procedure is done because if you close it, no one else can see the human body. Otherwise, it is unpleasant or annoying..."* (A 37- years- old female, A 40- years-old female, A 55 -years old male).

Concerning confidentiality, One hundred seventy-six (43.7%) respondents reported that H.P. does not usually share patients' information unless medically indicated or without patient consent. This is supported by qualitative findings: *"... I am not afraid that information gathered during care will be shared with others who are not concerned about it because they keep it confidential*..." (A 55 -years old female, A 55 -years old male).

One hundred fifty-two (37.5%) of H.P. usually inform patients about their condition, treatment plans, and medication to help them make informed decisions. This is supported by qualitative findings: "... *I was given information about my diagnosis, medication, my stay in the hospital, and a full explanation of any procedures carried out on me..."* (A 55 -years old female, A 48 -years- old male, A 44 -years old female).

Concerning respect, about 162 (40%) H.P. always speak to patients respectfully. 164 (40.5%) of H.P. always consider patients' opinions or answer patient questions. This is supported by qualitative findings:"... *Health professionals talk with me politely, consider my needs, and treat me as valued. It's pleasant to hear someone speak in a soothing language. If health personnel are rude to patients, their care will not cure anyone*..." (A 37- years- old female, A 34- years- old female, A 55 -years old male).

One hundred eighty-eight (46.4%) respondents reported that H.P. usually respects patients' ethnicities, dialects, accents, and religious beliefs. One hundred seventy-one (42.2%) respondents reported that H.P. always respects them regardless of their financial and social status. This is supported by qualitative

findings: "... *Patients need to be respected; they also need to treat me as a human being and respect my cultural values and beliefs. Care providers respected my ethnicity and religious beliefs and gave me appropriate care regardless of my financial and social status. I performed my religious affiliation as much as I could. Nothing is lost*..."(A 55 -years old female, A 44 -years old female).

Two hundred twenty-seven (56.0%) of respondents stated that H.P. always explains the purpose of every care procedure to patients before it is performed. This is supported by qualitative findings: "...*I was provided with information concerning my diagnosis, my hospital stay, and a purpose of any procedure performed on me*..."(A 55 -years old male).

Table 4: Status of dignified care among adult patients admitted to Jimma medical center, Oromia region, Southwest Ethiopia, from June 1-30, 2023 (n=405).

Subscales	**Mean**	**SD**
Privacy	17.45	2.08
Autonomy	20.19	3.81
Respect	39.70	5.94
Communication	24.78	4.16
Overall	**102.12**	**13.87**

The mean score of the dignified care was 102.12±13.87 SD, with maximum and minimum scores of 126 and 60, respectively, and the Interquartile range value was 66. Accordingly, about 206 (50.9%) (95%CI; 45.97, 55.75) of the study participants had adequate dignified care (Figure 4). This is supported by qualitative findings "... *There are experienced and ethical health professionals here. They help exactly as much as they can, and the status of dignified care provided by this hospital is adequate..."* (A 28 -years old male, A 23 -years old female). For more detail Table8

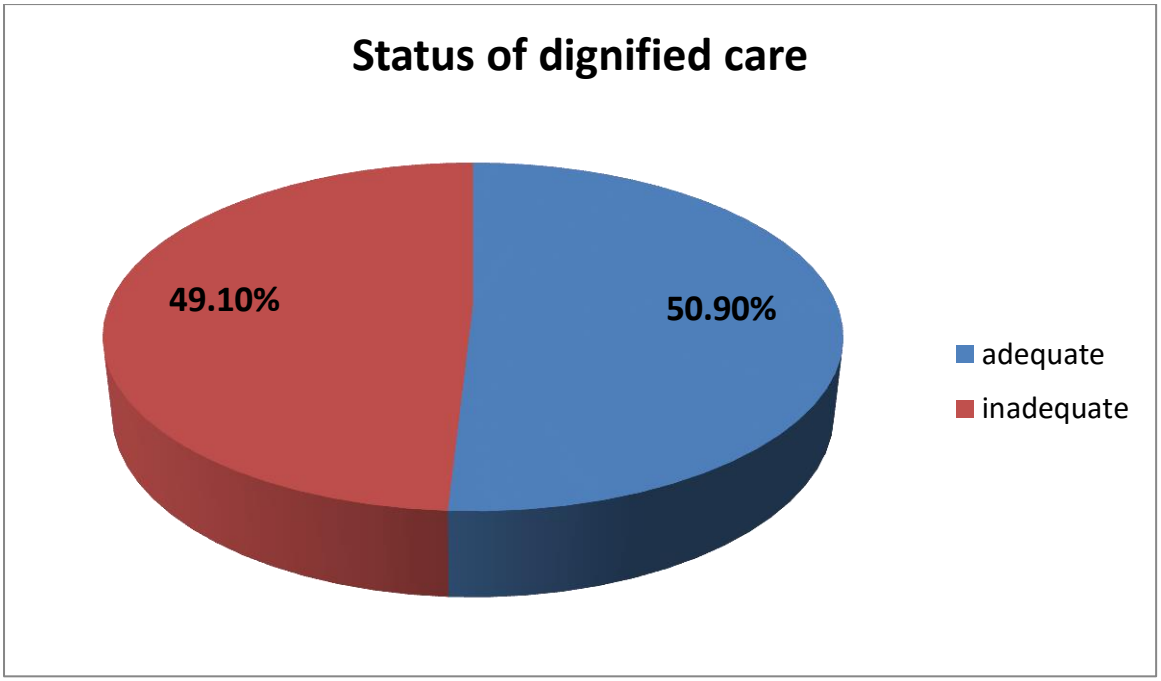


Figure 4: The overall Status of dignified care among adult patients admitted to Jimma medical center, Oromia region, Southwest Ethiopia, from June 1-30, 2023(n=405).

5.6. Factors associated with dignified care

The bivariate analysis revealed that at a p-value less than or equal to 0.25 at the significance level, nine variables, namely age, sex of the respondent, patient's level of education, occupation of the respondent, residence of the respondent, previous admission history, number of beds per room, and health professional-patient relationship, were identified as candidate variables for multivariable logistic analysis. All candidate variables were entered together into a multivariable logistic regression using the backward likelihood ratio method to determine variables that were statistically associated with dignified care by controlling for potential confounders.

In a multivariable logistic regression, five variables were found to be statistically associated with dignified care, with a p-value of < 0.05 and at 95% CI. Accordingly, age of the respondent, sex of the respondent, occupation of the respondent, residence of the respondent, and health professional-patient relationship were statistically associated with dignified care.

The study also showed that female participants [AOR = 0.18; 95% CI (0.11-0.30); p < 0.001] had an 82% decrease in the likelihood of having dignified care when compared to male participants by keeping other variables constant. This is supported by qualitative findings "...*Women often need dignified care*

more than men. Because women and men are different by nature biologically, and for us, privacy is often very important. For example, receiving care for special areas of the body is more embarrassing for women than for men..."(A 34 -years old female).

The study also showed that those who live in rural areas [AOR = 0.45; 95% CI (0.21-0.99); p = 0.049] had a 55% decrease in the likelihood of having dignified care when compared to male participants by keeping other variables constant. This is supported by qualitative findings "*...It's even worse when there are a lot of people watching and examining you. That kind of thing embarrasses me because I come from a rural area. Another thing is that it is impossible for me to reach an agreement with care providers because in rural areas we use only Afan Oromo. As a result, I am unable to speak with them and express my worry...*" (A 37 -years old female).

The study also showed that employed respondents [AOR = 0.23; 95% CI (0.07-0.75); p = 0.014] had a 77% decrease in the likelihood of having dignified care when compared to male participants by keeping other variables constant. This is supported by qualitative findings "*...Some health professionals do nothing but bother me with questions; nevertheless, asking too many questions of a sick person produces illness in and of itself. Patients at this hospital need minimal treatment and should not be practiced on. I know there are private hospitals that provide dignified care, but you know how much a government employee gets in salary. In addition, employees are unable to get health insurance coverage..."* (A 28 -years old male).

The study revealed that those who had good relationships with health care professionals [AOR = 2.92; 95% CI (1.79-4.75); p < 0.001] were 2.92 times more likely to receive dignified care when compared to those who had poor relationships with health care professionals by keeping other variables constant. This is supported by qualitative findings "*...The care providers made me feel reassured and warm. We have a good relationship with care providers. A person who has a good relationship with care providers can agree on everything, which means that the trust between them will be stronger. This means that he can receive dignified care..."* (A 46 -years old female, A 28 -years old male, A 48 -years old male).

The study revealed that those participants between 18 and 24 years old [AOR = 3.48; 95% CI: 1.48–8.15; P = 0.004] were 3.48 times more likely to receive dignified care when compared to those who were greater than 45 years old, by keeping other variables constant.

This is supported by qualitative findings "...*It is older people who are more concerned about their dignity; when you are old; you are too bothered by dignity because elders are powerless and unable to meet their needs. Nothing is wrong with me right now, and I am extremely pleased with the treatment I am receiving*..." (A 37-years old female, A 28 -years old male).

Table 5: Multivariable logistic regression showing factor affecting dignified care among adult patient admitted to Jimma medical center, Oromia region, Southwest Ethiopia, from June 1-30, 2023 (n=405).

Variables	Category	Status of dignified care		COR(95%CI)	AOR(95%CI)	P Value
		Adequate N (%)	Inadequate N (%)			
Sex	Female	87(35.5)	158(64.5)	.19(.12-.30) *	.18(.11-.30) **	<.001
	Male	119(74.4)	41(25.6)	1	1	
Occupation	Farmer	131(46.1)	153(53.9)	.69(0.37-1.29)*	1.43(.56-3.67)	.452
	Student	41(82.0)	9(18)	3.68(1.46- 9.26)*	1.87(.60-5.86)	.285
	Employee	8(33.3)	16(66.7)	.40(.15-1.13)*	.23(.07-.75)**	.014
	Merchant	26(55.3)	21(44.7)	1	1	
Residence	Rural	133(45.7)	158(54.3)	.47(.30-.74) *	.45(.21-.99)**	.049
	Urban	73(64.0)	44(36.0)	1	1	
Age	18-24	64(82.05)	14(17.95)	7.02(3.51-14.05)*	3.48(1.48-8.15)**	.004
	25-29	37(59.70)	25(40.30)	2.27(1.20-4.29)*	1.92(.91-4.08)	.089
	30-34	24(39.35)	37(60.65)	.99(.52-1.89)	.58(.27-1.26)	.169
	35-39	20(41.67)	28(58.33)	1.01(.55-2.19)	1.09(.49-2.42)	.833
	40-45	18(38.30)	29(61.70)	.95(.47-1.92)	1.08(.48-2.42)	.848
	>45	43(39.45)	66(60.55)	1	1	
HP-patient relationship	Good	139(64.1)	78(35.9)	3.22(2.141- 4.84)*	2.92(1.79-4.75)**	<.001
	Poor	67(35.64)	121(64.36)	1	1	

NB: *= (P<.0.25) in bivariate, 1 = Reference group,** = statistically significant in multivariable

5.7. Qualitative finding

In an in-depth interview, 38 codes and 13 categories were identified. Six main themes emerged from those subthemes. The main themes identified were communication, autonomy, respect, privacy, clinical factors, and patient factors. For more detail supportive document

Table 6: Perspectives toward dignified care of an adult patient admitted to Jimma Medical Center, Oromia region, Southwest Ethiopia, from June 1–30, 2023 (n = 13)

Codes	Categories	Themes
Inform treatment	Information	Communication
Inform health conditions		
Talk in jargon	language	
Language difference		
Active Listening	Interpersonal interaction	
Mutual understanding		
Interactions		
Trust building		
Decide my care	decision-making	Autonomy
Involvement in care plan		
Physical activity	promoting independence	
Physical care		
Control over oneself		
Treat as human being	treated with respect	Respect
Consider cultural values		
Show empathy	compassion from care providers	
Individual personal needs		
Communicate politely		
Close door	environmental privacy	Privacy
Draw bed screen		
Flow of individuals		
Discussion personal issue	informational privacy	

Documented information		
Qualified health professionals	care provider factors	Clinical factors
Number of HP examine		
Behaviour of HP		
Sex of care provider		
Status of room	organizational factors	
Lack of supply		
Facility		
Private room		
Age of the patient	socio-demographic factors	Patient factors
Gender		
Residence		
Language		
Lack of money	socioeconomic factors	
Health insurance		
Occupation		

CHAPTER SIX: DISCUSSION

This study revealed that the overall magnitude of patients who had adequate dignified care was 50.90% (95% CI: 45.97-55.75). This indicates that almost half of the patients were not getting dignified care, which might have a negative impact on the patient's overall well-being, psychological comfort, trust in the healthcare system, and satisfaction and lead to depression, loss of will to live, and feelings of worthlessness. On the other hand, being female, having an employee occupation, living in rural areas, being between 18 and 24 years old, and having a good healthcare professional-patient relationship were statistically associated with dignified care.

The findings of this study were lower than the findings of previous studies done in Modena, Italy (65.5%) (4) and Isfahan, Iran, in 2017 (88.10%) (35). The discrepancy in this finding might be due to patient sociocultural differences. Ethiopia has a diverse cultural landscape with various ethnic groups and traditions, each with its own set of values and beliefs. On the other hand, there is religious homogeneity in Iran, where most of the population shares the same religion, and Italy has unique cultural contexts shaped by its history, religion, and societal norms. Different sociocultural contexts, such as cultural and religious factors, can influence healthcare practices and perceptions of dignified care (25). In addition to this, in Iran, the study was conducted in multiple settings, including public and private hospitals. Including different healthcare settings may introduce variations in the findings due to differences in resources, quality of care, and patient experiences across these settings.

However, this result is higher than a study conducted in Sweden (36%) (35), East Azerbaijan Province, Iran in 2015, in which patients' dignity was not fully respected in clinical settings(28), and in North China (29%) (27). The discrepancy might be due to the difference in inclusion criteria, which were limited to specific diseases (250 and 202 cancer patients, 198 dementia patients). Additionally, the cut-off point they used differed from the one used in this study. This study used the median as the cut-off point, but other studies used the mean.

More than half of the study participants reported good patient-health professional relationships. The study revealed that those who had good relationships with healthcare professionals were more likely to receive dignified care when compared to those who had poor relationships with healthcare professionals. This finding is in line with studies done in the United Kingdom and Taiwan, which state that having a good health professional-patient relationship enhances dignified care (16,44). The possible explanation might be that developing functional care provider-patient relationships is critical in facilitating dignified

care. Violations of patient dignity during care are more common when the relationship between patient and care provider becomes asymmetric. Because having good relationships with patients creates high opportunities for care providers to listen to them carefully, understand their needs, identify their problems, do as they wish, and deliver dignified care accordingly (59).

Further, the patient's age was associated with dignified care. The study revealed that participants between 18 and 24 years old were more likely to receive dignified care compared to those over 45 years old. This finding is similar to a study conducted in Ghana, Czech Republic, and Iran (25,29,41). This finding is, however, inconsistent with the results of a systematic study conducted in Australia, in which younger age was associated with lower dignified care levels (24,27). This may be because older adults are exposed to high levels of dependence, which threatens patient dignity, especially with regard to personal care. That is the standard and value that most people embrace throughout their adult lives, putting patient dignified care at risk (23). In addition, as people get older, they are more likely to suffer from a loss of dignity due to a loss of autonomy and the ability to make decisions about their lives. Aging causes a gradual loss of physical ability and a greater dependence on others for daily activities (60).

This study revealed that female participants were less likely to receive dignified care when compared to male participants. This is consistent with a study conducted in China, Iran, Sweden, Ghana, and the U.K. (13,14,29,35,38,61). The possible explanation might be that dignity is a cultural concept. Considering their religious and cultural beliefs, female participants felt shame, anxiety, and discomfort when they had to be partially nude and were examined by a male nurse or doctor. They perceived such a situation as immoral, undermining their dignity (48). In addition to this, Women are often more expressive, mainly when they express their need for help, than men, and then women are more vulnerable to psychological distress and depression than men, which undermines their dignity (62).

The study also showed that being an employee is associated with a decreased likelihood of a respondent receiving dignified care. This finding is similar to a study conducted in Iran and China (13,14,28). However, This finding is inconsistent with the results of a 2022 study conducted in Ghana, in which unemployment was associated with a lower dignified care level (18). Government-employed patients could possess higher levels of health literacy and be more proactive in advocating for their care,

potentially leading to different perceptions of care experiences. This means they already know their rights and obligations, so they can maintain negative attitudes toward the care they receive.

In this study, the Patient's residence was also statistically associated with dignified care. The study showed that those who lived in rural areas were less likely to receive dignified care when compared to those living in urban areas. This finding was almost in line with the study conducted at Mazandaran University of Medical Sciences, Iran (14). This finding is, however, inconsistent with the results of a 2017 study conducted at Tabriz University of Medical Sciences, Iran, in which living in a rural area was associated with higher dignified care levels (19). The possible explanation might be that traditional values influenced people in rural areas and emphasized the concept of family more than those in cities(63). They also had a traditional belief that they would be cared for at home by their children and that living in a long-term care facility meant living in deplorable conditions or having an unfaithful family(64). Thus, we expected that this negative notion among rural residents would significantly impact their experience of dignity.

This study has provided useful information regarding dignified care among adult patient. A mixed study was used to enhance the credibility and reliability of the findings through triangulation, as almost all of the finding support each other. Additionally the mixed strategy provides a comprehensive understanding of the factors influencing dignified care. Despite this, the scientific communities should consider the following limitations while generalizing the findings of this study. First, there is also a limitation of literature on this topic in Ethiopia so that comparison of study results was done with other countries where the health institutions' setup, health policy and other factors are quite different. Second, the cause-and-effect relationship was not established since a cross-sectional design was used because of time constraints. Thirdly, study participants were recruited from a single hospital, which may affect the findings' generalizability. Additionally, sociodemographic characteristics, such as gender representation, are not considered.

Furthermore, limited perspectives from healthcare providers and family members and emotional and psychological support variables are not addressed. Finally, dichotomizing the data may result in misclassifying participants and misrepresenting their experience, as individuals near the mean might be placed in different categories despite having similar responses.

This study has implication for clinical practice, by identifying factors associated with dignified care, care providers can be aware of these factors and tailor their care accordingly. Also, it enables care providers to enhance their communication skills, providing clear and

respectful communication while actively involving patients in their care decisions. Additionally, it emphasizes the importance of recognizing and honoring patients' autonomy in decision-making and respecting their values, beliefs, and preferences. Enable care providers to ensure adequate privacy during patient interactions, examinations, and discussions, maintaining their dignity and improving the patient experience. It could also encourage care providers to build therapeutic relationships with patients to enable them to identify their need for respect and dignified care.

Moreover, the findings may be used to develop practical guidelines and formulate more specific strategies in dignified care. It could also inform policy formulation in the health sector to support dignified care. The development of a model for maintaining dignified care derived from a conceptual framework should be integrated into practice protocols and disseminated to care professionals in clinical care settings.

CHAPTER SEVEN: CONCLUSION AND RECOMMENDATION

7.1 Conclusion

The findings reveal that a significant proportion of study participants—nearly half—did not receive adequate dignified care, which might have a negative impact on the patient's overall well-being, psychological comfort, trust in the healthcare system, and satisfaction and lead to depression, loss of will to live, and feelings of worthlessness. Being female, living in rural areas, having a good health care professional-patient relationship, being between 18 and 24 years old, and having an employee occupation were statistically associated with dignified care. The qualitative study explored six key themes: communication, autonomy, respect, privacy, clinical, and patient factors. These findings collectively emphasize the need for targeted interventions to improve dignified care at Jimma Medical Center.

7.2 Recommendation

Based on the findings of this study, the following recommendations were forwarded to different concerned bodies**.**

Hospital Management bodies

❖ Efforts should be made to enhance the status of dignified care for the patients admitted to JMC because nearly half of the participants didn't get adequate dignified care.

Nursing leaders (supervisor, head nurses, nursing service director)

❖ Nursing leaders should create conducive environments to improve dignified care.

Health care professionals

❖ Healthcare professionals should develop strong relationships with patients to enhance dignified care.

❖ Healthcare providers should be aware of and treat patients as unique and individualized rather than making generalizations based on sociodemographic characteristics.

Researcher

❖ Further studies are also suggested to investigate care provider perspectives.

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Annex II: Questionnaire

Information sheet

Read the statements

My name is_____and I am from the School of Nursing of Jimma University. I am conducting a research study titled "Assessing dignified care and associated factors among adult patients admitted at JMC, Oromia regional state, South West Ethiopia, 2023"

The study sponsored by Dilla university

Purpose of the research: This study is aimed to assess status of dignified care and associated factors among adult patients admitted at JMC, Oromia regional state, South West Ethiopia, 2023

Procedure: To collect my data, I invite you to take part. It will take you 10 to 15 minutes to participate.

Risk and /or discomfort: By participating in this research you may feel some discomfort especially on sacrificing your time otherwise, no risk in participating in this research, so your response provides important input to show the gap and means to improve dignified care.

Benefits: If you will be participating in this research, the output of the study will have both direct and indirect benefits for you

Incentives/payments for participating: There won't be any compensation or incentives for you to participate in this study.

Confidentiality: All data gathered for this research project will be kept private and confidential. The information about you that this study gathers will be maintained in a file with a code number instead of your name.

Right refusal or withdrawal: You have the full right to refuse from participating in this research.

Person to contact: If you want more information, you can contact; Dhinsaamiidhagsaa.430@gmail.com or +251917356739

With the due understanding of the mentioned information, are you willing to participate in the study? A. yes b. no

If yes Signature of the participant----------date----------

Consent form

I am informed fully in the language I understand about the aim of above mentioned research and other important points mentioned in the information sheet. I understood the purpose of the study entitled **"**Assessing dignified care and associated factors among adult patients admitted at JMC, Oromia regional state, South West Ethiopia, 2023". I have been informed this study involves collecting information regarding my health literacy. I have also read the information sheet. In addition I have been told all the information collected throughout the research process will be confidential. I understood my current and future services or other related issues will not be affected, if I refused to participate withdraw from the study.

I _____, after being fully informed about the detail of this study, hereby gave my consent to participate in this study and approve my agreement with signature.

Name……Signature……..Date:...../……/……

Investigator……Signature……..Date:...../……/……

Questionnaires

I. Demographic characteristics of the patients.

1. Age (in years) _____

2. Gender 1. Male 2. Female

3. Religion 1. Muslim 2.Orthodox 3.Protestant 4. Others_____

4. Marital status 1. Single 2.Married 3.Divorced 4. Widowed

5. Level of education 1. Informal education 2. Primary education 3. Secondary education 4. College/ university

6. Occupation 1. Farmer 2.Student 3.Employee 4. Merchant 5. Others

7. Residence 1. Urban 2. Rural

II. Patient's medical history

1. Previous admission history 1. Yes 2. No

2. Duration of admission 1. 2-7 days 2. 8-15 days 3. ≥16 days

3. Presence of co morbidity illness 1. Yes 2. No

4. If yes to question #4 above, specify_____ (If no, skip to next question)

III. Hospital environmental factors

1. Name of ward_____

2. Number of beds per room 1. Single bed 2. Two beds 3. More than two beds

3. Is there individual bed screen near the bed? 1. Yes 2. No

4. Is the flow of individuals in the room controlled while providing care? 1. Yes 2. No

5. Is the toilet clean 1. Yes 2. No

6. Is the room cleans 1. Yes 2. No

7. Is the smell in the room controlled 1. Yes 2. No

IV. Health professional-patient relationship

Health professional -patient relationship		Always	Usually	S/times	Never
101	How often do Health professionals develop trusting relationship with the patient?	4	3	2	1
102	How often Health professionals focus on the patient and give them one's undivided attention?	4	3	2	1
103	How often do Health professionals understand the patient need during care?	4	3	2	1
104	How often do Health professionals communicate with you freely and ask for translator If there is language barrier?	4	3	2	1
105	How often do Health professionals give an opportunity for you to enhance your self-care abilities?	4	3	2	1
106	How often do Health professionals advice and treat or prevent side effects and/or complications for the patient?	4	3	2	1

107	How often do Health professionals speak freely about their feelings and emotions with the patient?	4	3	2	1
108	How often do Health professionals help the patient to set realistic goals for their health situation?	4	3	2	1

V. Dignified care questions

	Items	Never(1)	Rarely(2)	S/times(3)	Usually(4)	Always(5)
201	HPs get patients' informed consent before performing clinical and nursing procedures	1	2	3	4	5
202	HPs ensure patient's privacy (e.g. closing doors, drawing curtains) before any clinical or nursing acts	1	2	3	4	5
203	HPs didn't share patient's information with others unless medically indicated or without patient consent	1	2	3	4	5
204	HPs cover irrelevant areas of patient's body during medical acts (e.g. bandaging, examination)	1	2	3	4	5
205	HPs inform to patient about their condition, treatment plans, and medication to make informed decisions	1	2	3	4	5
206	Patients have the right to make decisions about the care they are judged to require	1	2	3	4	5
207	HPs allow patients to perform	1	2	3	4	5

	their daily activities (e.g. getting dressed, walking) alone if they can					
208	HPs take patients' opinions into consideration or answer pt question	1	2	3	4	5
209	HPs effectively support the patient to care for themselves independently	1	2	3	4	5
210	HPs speak to patients respectfully	1	2	3	4	5
211	HPs provide cares according to patients' individual needs	1	2	3	4	5
212	HPs address patients with their names	1	2	3	4	5
213	If a patient needs help, HPs take action immediately	1	2	3	4	5
214	Patients have access to hygienic hospital facilities and equipment	1	2	3	4	5
215	Patients' ethnicities, dialects, accents, and religious beliefs be respected	1	2	3	4	5
216	Patients be respected regardless of their financial, social, and cultural status	1	2	3	4	5
217	Patient provided with proper clothing	1	2	3	4	5
218	HPs coordinated to prevent any delays in the provision of care	1	2	3	4	5
219	There is adequate facilities for the patients' companions to rest and make themselves	1	2	3	4	5

	comfortable					
220	HPs introduce themselves upon first meeting patients	1	2	3	4	5
221	Patient introduced to their care providers and the environment	1	2	3	4	5
222	HPs communicate with patient according to patients' individual personality types	1	2	3	4	5
223	HPs friendly and kind to patients	1	2	3	4	5
224	HPs listen to patients patiently	1	2	3	4	5
225	HPs explain the purpose of every care procedure to patients before it is performed	1	2	3	4	5
226	HPs establish an effective communication with patients' companions	1	2	3	4	5

Key: HPs= Health professionals

Dabalata II: Gaaffii

Waraqaa odeeffannoo

Ibsa kenname dubbisaa/ siniif nan dubbisa

Maqaan kiyya ----------jedhama, Mana Barumsaa Narsii Yuunivarsiitii Jimmaa irraati. Ani qorannoo mata dureen isaa "sadarkaa kunuunsa fayyaa kabajamaa ta'eefi wantoota kanaan walqabatan kan dhukkubsattootagiddugala yaalaa jimmaa seenanii, naannoo Oromiyaa, Kibba Lixa Ethiopia, 2023

Kaayyoo qorannichaa: Qorannoon Kun sadarkaa kunuunsa fayyaa kabajamaa ta'e fi wantoota kanaan walqabatan dhukkubsattoota giddugala yaalaa jimmaa seenan, naannoo Oromiyaa, Kibba Lixa Ethiopia, Bara 2023 madaaluuf kan kaayyeffatedha

Adeemsa: Daataa ko walitti qabuuf akka hirmaattan isin afeera. Hirmaachuuf daqiiqaa 10 hanga 15 sitti fudhata.

Miidhaa fi /ykn mijataa ta'uu dhabuu: Qorannoo kana irratti hirmaachuudhaan keessumaa yeroo kee aarsaa gochuu irratti miira tasgabbii dhabuu tokko tokko sitti dhaga'amuu danda'a, qorannoo kana irratti hirmaachuu keessatti balaa hin qabu, kanaaf deebii kee qaawwa jiru agarsiisuuf galtee barbaachisaa ta'ee fi mala kabaja dhukkubsataa fooyyessuuf kenna.

Faayidaa: Qorannoo kana irratti hirmaachaa kan deemtan yoo ta'e, bu'aan qorannichaa kallattiinis ta'e al-kallattiin faayidaa siif qabaata.

Onnachiiftuu/kaffaltii hirmaachuuf: Qorannoo kana irratti hirmaachuuf onnachiiftuu ykn kaffaltiin kamiyyuu siif hin kennamu.

Iccitii: Odeeffannoon pirojektii qorannoo kana irraa walitti qabame iccitii ta'ee kan eegamu yoo ta'u, odeeffannoon waa'ee kee qorannoo kanaan walitti qabame faayila keessatti, maqaa kee malee, garuu lakkoofsa koodii itti ramadame keessatti ni kuufama.

Mirga diduu ykn ofirraa baasuu: Qorannoo kana irratti hirmaachuu diduu mirga guutuu qabda.

Nama qunnamuu qabdan: Odeeffannoo dabalataa yoo barbaaddan kanaan qunnamuu dandeessu; Dhinsaamiidhagsaa.430@gmail.com ykn +251917356739.

Odeeffannoo caqafame sirriitti hubachuudhaan qorannicha irratti hirmaachuuf fedhii qabdaa?

a.Eeyyee b. Lakki

Yoo eeyyee ta'e Mallattoo hirmaataa_____guyyaa_____

Unka hayyamaa

Hirmaannaa koo qorannicha ilaalchisee odeeffannoon armaan olii ifa naaf ta'eera. Gaaffiiwwan akkan gaafadhu carraan naaf kennameera, isaanis, deebii naaf quufa argataniiru. Qorannoon kun fedhii kootiin hirmaachaa jira. Galmeen koo dhuunfaatti akka eegamu fi yeroo barbaadetti qo'annoo sana keessaa bahuu akkan danda'u nan hubadha. Hirmaannaan koo akka na hin tuqne nan hubadha

Yoo hirmaachuuf walii galtan mallattoo keessan armaan gadii kaa'aa

Mallattoo _____ guyyaa _____ .

Gaaffiilee

I. Amaloota hawaas-dimoogiraafii dhukkubsattootaa.

1. Umurii_____

2. Saala 1. Dhiira 2. Dubartii

3. Amantii 1. Muslima 2. Ortodoksii 3. Pirootestaantii 4. Kan biroo_____

4. Haala gaa'elaa 1. Qeenxee 2. Heerumte/fuudhe 3. Hiikaa 4. Kan irraa du'e/duute

5. Sadarkaa barnootaa 1. Dubbisuu fi barreessuu dadhabuu 2. Dubbisuu fi barreessuu kan danda'u 3. Barnoota sadarkaa tokkoffaa4. Manneen barnootaa sadarkaa lammaffaa 5. dippiloomaa 6. yuunivarsiitii

6. Hojii 1. Qonnaan bulaa 2. Barataa 3. Hojjetaa 4. Daldalaa 5. Kanneen biroo

7. Mana jireenyaa 1. Magaalaa 2. Baadiyyaa

II. Seenaa yaalaa dhukkubsataa

1. seenaa hospitaala ciisuu duraanii1. Eeyyeen 2.Lakki

2. Dheerinni turtiiyeroo kanatti 1. Guyyaa 2-7 2. Guyyaa 8-15 3. Guyyaa 16 fi isaa oli

3. Dhukkubsataan dhukkuba kan biraa qabaa? 1. Eeyyeen 2.Lakki

4. Gaaffii #4 armaan olii irratti eeyyee yoo ta'e,ibsi_____(Yoo hin jiru ta'e gara gaaffii itti aanutti darbi)

III. Sababoota naannoo hospitaala

1. Gosa kutaa_____

2. Gosa Baay'ina siree kutaa tokkoo 1. Siree tokko 2. Siree lama 3. Siree lamaa ol

3. Siree biratti iskiriinii siree dhuunfaa jiraa? 1. Eeyyee 2. Lakki

4. Yeroo kunuunsa kennanitti sochii namoota dhuunfaa kutaa keessaa ni to'atamaa? 1. Eeyyee 2. Lakki

5. Manni fincaanii qulqulluudhaa 1. Eeyyee 2. Lakki

6. Kutaan dhukkubsataa qulqulluudhaa 1. Eeyyee 2. Lakki

7. Urgaa kutaa keessa jiru to'atamaa jiraa 1. Eeyyee 2. Lakki

IV. Hariiroo ogeessota fayyaa-dhukkubsataa

Qajeelfama: Gaaffiiwwan sirriitti dubbisiitii filannoo kee marsi

Lakk.	Hariiroo ogeessota fayyaa -dhukkubsataa	Yeroo hunda	Yeroo baayee	Yeroo tokko tokko	Gonkumaa
101	Ogeessonni fayyaa dhukkubsataa waliin hariiroo wal amantaa yeroo meeqa uumuu?	4	3	2	1
102	Ogeessonni fayyaa yeroo meeqa dhukkubsataa irratti xiyyeeffatanii xiyyeeffannoo nama tokkoo kan hin qoodamne	4	3	2	1

	isaaniif kennu?				
103	Ogeessonni fayyaa yeroo kunuunsaa barbaachisummaa dhukkubsataa yeroo meeqa hubatu?	4	3	2	1
104	Yeroo meeqa ogeessonni fayyaa bilisaan si waliin haasa'anii hiikkaa gaafatu Yoo danqaan afaanii jiraate?	4	3	2	1
105	Ogeessonni fayyaa dandeettii of kunuunsuu kee akka guddistu yeroo meeqa carraa siif kennu?	4	3	2	1
106	Ogeessonni fayyaa yeroo meeqa dhukkubsataa irratti miidhaa cinaa fi/ykn rakkoolee mudatan gorsu fi yaalu ykn ittisu?	4	3	2	1
107	Ogeessonni fayyaa yeroo meeqa waa'ee miiraa fi miira isaanii dhukkubsataa wajjin bilisaan dubbatu?	4	3	2	1
108	Ogeessonni fayyaa dhukkubsataa haala fayyaa isaaf galma qabatamaa akka kaa'u yeroo meeqa gargaaru?	4	3	2	1

VI. kunuunsa fayyaa kabajamaa qabu

Lakk.	Gaaffilee	Gonkumaa(1)	Darbee darbee(2)	Yeroo tokko tokko(3)	Yeroo baayee(4)	Yeroo hunda(5)
201	Ogeeyyiin fayyaa gochaa kilinikaa fi narsii raawwachuu isaanii dura hayyama dhukkubsattootaa odeeffannoo irratti hundaa'e argataniiru					
202	Ogeeyyiin fayyaa gocha kilinikaa ykn narsii kamiyyuu dura icciitii dhukkubsataa (fkn. balbala cufuu, golgaa kaasuun) mirkaneessaniiru.					
203	Namoonni kunuunsa kennan odeeffannoo dhukkubsataa namoota biroof hin qoodne					

204	Ogeeyyiin fayyaa yeroo gocha yaalaa (fkn. baandaajii, qorannoo) naannoo qaama dhukkubsataa barbaachisaa hin taane uwwisaniiru?					
205	Ogeeyyiin fayyaa karoora wal'aansa isaaniif ba'e murtii odeeffannoo irratti hundaa'e akka godhaniif dhukkubsataa beeksisaniiru					
206	Dhukkubsattoonni waa'ee kunuunsa isaaniif taasifamu irratti mirga murtii kennuu qabu					
207	Ogeeyyiin fayyaa dhukkubsattoonni yoo danda'an hojii guyyaa guyyaa isaanii (fkn. uffata uffachuu, deemuu) kophaa isaanii akka raawwatan hayyamaniiruu					
208	Ogeeyyiin fayyaa yaada dhukkubsattootaa tilmaama keessa galchaniiru					
209	Ogeeyyiin fayyaa dhukkubsataanof danda'ee akka of kunuunsuuf deeggarsa bu'a qabeessa ta'e ni kennuu?					
210	Ogeeyyiin fayyaa dhukkubsattootatti kabajaan dubbataniiru					
211	Ogeeyyiin fayyaa akka fedhii dhuunfaadhukkubsattootaatti kunuunsa kennaniiruu? .					

212	Ogeeyyiin fayyaa dhukkubsattoota maqaa isaaniitiin waamu turan					
213	Dhukkubsataan gargaarsa yoo barbaade, Ogeeyyiin fayyaa hatattamaan tarkaanfii fudhataniiru					
214	Dhukkubsataanbakkaa fi meeshaalee qulqullinaa hospitaalaaargataniiruu					
215	Sabni,loqoda, fi amantiin dhukkubsataa ni kabajamaa?					
216	Dhukkubsattoonni maallaqa, hawaasummaa, . fi sadarkaa aadaaosoo hin ilaalin ni kabajamuu					
217	Yeroo seenu dhukkubsataan uffata sirrii ta’e kennameefii jiraa?					
218	Kenniinsa kunuunsaa irratti harkifannaa kamiyyuu akka hin uumamneef ogeeyyiin fayyaa qindoominaan ni hojjetu?					
219	Bakki gahaan maatiin dhukkubsattootaa itti boqotanii fi mijataa akka ta’anif ni jiraa?					
220	Ogeeyyiin fayyaa yeroo jalqabaaf dhukkubsattoota waliin wal argan of beeksisaniiru					
221	Yeroo dhukkubsattoonni dura seenan kunuunsaa isaanii fi naannoo isaanii wajjin wal					

	barsiisaniiruu?					
222	Ogeeyyiin fayyaa dhukkubsattoota waliin akkaataa’ .eenyummaa dhuunfaa dhukkubsattootaatti waliin dubbatuu?					
223	Ogeeyyiin fayyaa dhukkubsattootaaf michuu fi gara laafessadhaa?					
224	Ogeeyyiin fayyaadhukkubsattoota obsaan dhaggeeffataniiruu?					
225	Ogeeyyiin fayyaa kaayyoo adeemsa kunuunsaa hunda osoo hin raawwatamin dura dhukkubsattootaaf ibsaniiru					
226	Ogeessonni fayyaa qunnamtii bu’a qabeessa ta’e maatii dhukkubsattootaa waliin uumaniiruu?					

አባሪ ፡መጠይቅ

የመረጃ ወረቀት

መግለጫዎቹን ያንብቡ

ስሜ_____እኔ ከጅማ ዩኒቨርሲቲ የነርስ ትምህርት ቤት በጂኤምሲ፣በኦሮሚያ ክልላዊ መንግስት፣ በደቡብምዕራብኢትዮጵያ፣2023ለተቀበሉ በታካሚዎች መካከል የተከበረ የጤና እንክብካቤ ደረጃ እና ተያያዥ ምክንያቶች ርዕስ የምርምር ጥናት እያካሄድኩ ነው።

የጥናቱዓላማ፡-ይህ ጥናት በጂኤምሲ፣በኦሮሚ ያክልላዊ መንግሥት፣በደቡብምዕራብኢትዮጵያ፣ 2023 በታካሚዎች መካከል የተከበረ የጤና እንክብካቤ ደረጃ እና ተያያዥ ምክንያቶች ለመገምገም ያለመ ነው።

ሂደት፡የእኔን መረጃ ለመሰብሰብ፣እንድትሳተፉ እጋብዛችኋለሁ።ለመሳተፍ ከ10 እስከ 15 ደቂቃ ይወስዳል።

ስጋትእና/ወይምአለመመቸት፡በዚህ ጥናት ውስጥ በመሳተፍ በተለይ ጊዜዎን በመስዋዕትነት ላይ አንዳንድ ምቾት ሊሰማዎት ይችላል፣ በዚህ ጥናት ውስጥ ለመሳተፍ ምንም አይነት ስጋት የለም፣ስለዚህ ምላሽዎ ክፍተቱን ለማሳየት ጠቃሚ ግብአት ይሰጣል እና የታካሚ ክብርን ለማሻሻል የሚረዱ መንገዶች።

ጥቅማ ጥቅሞች፡ በዚህ ጥናት ውስጥ የሚሳተፉ ከሆነ የጥናቱ ውጤት ቀጥተኛ እና ቀጥተኛ ያልሆነ ጥቅም ይኖረዋል ለመሳተፍ ማበረታቻ/ክፍያ፡ በዚህ ጥናት ላይ ለመሳተፍ ምንም አይነት ማበረታቻ ወይም ክፍያ አይሰጥዎትም።

ምስጢራዊነት፡- ከዚህ የምርምር ፕሮጀክት የሚሰበሰበው መረጃ በሚስጥር ይጠበቃል እና በዚህ ጥናት የሚሰበሰበው መረጃ በፋይል ውስጥ ያለ ስምዎ ይቀመጣል ነገር ግን የተመደበለት ኮድ ቁጥር።

መብት አለመቀበል ወይም መሰረዝ፡ በዚህ ጥናት ውስጥ ላለመሳተፍ ሙሉ መብት አለዎት።

የሚያነጋግረው ሰው፡ ተጨማሪ መረጃ ከፈለጉ ማነጋገር ይችላሉ; Dhinsaamiidhagsaa.430@gmail.com ወይም +251917356739

የተጠቀሰውን መረጃ በሚገባ ከተረዳህ በጥናቱ ለመሳተፍ ፈቃደኛ ነህ? አ.አዎ ለ. አይ

አዎ ከሆነ የአሳታፊው ፊርማ_____ቀን_____

የፍቃድ ቅፅ

በጥናቱ ውስጥ ያለኝን ተሳትፎ በተመለከተ ከላይ ያለው መረጃ ግልጽ ሆኖልኛል. ጥያቄዎችን እንድጠይቅ እድል ተሰጥቶኛል ይህም እርካታ አግኝቻለሁ። በዚህ ጥናት በፈቃደኝነት እየተሳተፍኩ ነው። መዝገቡቼ በምስጢር እንደሚቀመጡ እና ጥናቱን በማንኛውም ጊዜ መተው እንደምችል ተረድቻለሁ። የእኔ ተሳትፎ እንደማይጎዳኝ ተረድቻለሁ

ለመሳተፍ ከተስማሙ ፊርማዎን ከዚህ በታች ያስቀምጡ

ፊርማ _____ ቀን _____

መጠይቆች

I. የታካሚዎችሶሲዮዲሞግራፊባህሪያት.

1. ዕድሜ _____

2. ፆታ 1. ወንድ 2.ሴት

3. ሃይማኖት 1. ሙስሊም 2.ኦርቶዶክስ 3.ፕሮቴስታንት 4.ሌሎች_____

4. የጋብቻሁኔታ 1. ያላገባ 2.ያገባ 3.የተፋታ 4.ባልየሞተባት

5. የትምህርትደረጃ 1. ማንበብናመጻፍአለመቻል 2.ማንበብናመጻፍየሚችል 3.የመጀመሪያደረጃትምህርት ሁለተኛደረጃትምህርትቤቶች 5.ዲፕሎማ 6.ዩኒቨርሲቲ

6. ሥራ 1. ገበሬ 2.ተማሪ 3.ተቀጣሪ 4.ነጋዴ 5. ሌሎች

7. የመኖሪያቦታ 1. ከተማ 2.ገጠር

II. ከታካሚጋርየተያያዙምክንያቶች

1. የቀድሞ የመግቢያ ታሪክ 1. አዎ 2.አይደለም

2. .በዚህ ጊዜ የሚቆይበት ጊዜ 1. .2-7 ቀናት 2. .8-15 ቀናት 3. ≥.16

3. አብሮበሽታ 1. አዎ 2.የለም

4. ከላይ ላለው #4 ጥያቄ አዎ ከሆነ፣ ይግለጹ_____(አይ ከሆነ ወደሚቀጥለው ጥያቄ ይዝለሉ)

III. የሆስፒታልአካባቢያዊሁኔታዎች (በምልከታላይየተመሰረቱየፍተሻዝርዝሮች)

1. ሆስፒታል ክፍል:_____

2. በክፍል ውስጥ ያሉአልጋዎች ቁጥር 1. ነጠላ አልጋ 2.ሁለትአልጋ 3.ከሁለትአልጋ በላይ

3. ከአልጋው አጠገብ የግለሰብ አልጋ ስክሪን አለ? 1. አዎ 2. አይደለም

4. እንክብካቤ በሚሰጥበት ጊዜ በክፍሉ ውስጥ ያሉ የግለሰቦች ፍሰት ቁጥጥር ይደረግበታል? 1. አዎ 2. አይደለም

5. መጸዳጃ ቤቱ ንጹህ ነው 1. አዎ 2. አይደለም

6. የታካሚው ክፍል ንጹህ ነው 1. አዎ 2. አይደለም

7. በክፍሉ ውስጥ ያለው ሽታ ቁጥጥር ይደረግበታል 1. አዎ 2. አይደለም

IV. የጤናባለሙያዎች- የታካሚግንኙነት

መመሪያ፡ጥያቄዎቹን በጥንቃቄ ያንብቡእና ምርጫዎን ከበቡ

የጤና ባለሙያዎች - የታካሚ ግንኙነት		ሁል ጊዜ	አብዛኛውን ጊዜ	አንዳንድጊዜ	በጭራሽ
101	የጤና ባለሙያዎች ከታካሚው ጋር ምን ያህል ጊዜ የመተማመን ግንኙነት ያዳብራሉ?	4	3	2	1
102	ምንያህል ጊዜ የጤና ባለ ሙያዎች ለታካሚው ያልተከፋፈለ ትኩረት ይሰጣሉ?	4	3	2	1
103	የጤና ባለሙያዎች በሽተኛው በእንክብካቤ ወቅት የታካሚ ፍላጎት ምን ያህል ጊዜ ይገነዘባሉ?	4	3	2	1
104	የጤና ባለሙያዎች ምን ያህል ጊዜ ከእርስዎ ጋር በነፃነት ይገናኛሉ እና የቋንቋ ችግር ካለ ተርጓሚ ይጠይቁዎታል?	4	3	2	1
105	የጤና ባለሙያዎች ምን ያህል ጊዜ እራስን የመንከባከብ ችሎታዎትን እንዲያሳድጉ እድል ይሰጡዎታል?	4	3	2	1
106	የጤና ባለሙያዎች ምን ያህል ጊዜ ምክር ይሰጣሉ እና ለታካሚ የጎንዮሽ ጉዳቶችን እና/ወይም ውስብስቦችን ይከላከላሉ?	4	3	2	1
107	የጤና ባለሙያዎች ከታካሚው ጋር ስለ ስሜታቸው እና ስሜታቸው ምን ያህል ጊዜ በነፃነት ይናገራሉ?	4	3	2	1
108	የጤና ባለሙያዎች በሽተኛው በጤና ሁኔታቸው ላይ ተጨባጭ ግቦችን እንዲያወጣ ምን ያህል ጊዜ ይረዷቸዋል?	4	3	2	1

V. የተከበረ የጤና እንክብካቤ ደረጃ

የተከበረ የጤና እንክብካቤ ደረጃ		በጭራሽ (1)	አልፎ አልፎ(2)	አንዳንድ ጊዜ(3)	አብዛኛውን ጊዜ(4)	ሁል ጊዜ (5)
201	የጤና ባለሙያዎች ክሊኒካዊ እና የነርሲንግ ሂደቶችን ከማድረጋቸው በፊት የታካሚዎችን በመረጃ የተደገፈ ስምምነት አግኝተዋል?					
202	የጤና ባለሙያዎች ከማንኛውም ክሊኒካዊ ወይም የነርሲንግ ድርጊቶች በፊት የታካሚውን ግላዊነት (ለምሳሌ በሮች መዝጋት፣ መጋረጃዎችን መሳል) አረጋግጠዋል።					
203	የእንክብካቤ አቅራቢዎች የታካሚውን መረጃ ለሌሎች አላጋሩም።					

204	በህክምና ተግባራት ወቅት የጤና ባለሙያዎች አግባብነት የሌላቸውን የታካሚውን የሰውነት ክፍሎች ይሸፍኑ ነበር (ለምሳሌ ማሰሪያ፣ ምርመራ)					
205	የጤና ባለሙያዎች ስለ ህክምና ዕቅዳቸው ለታካሚ አሳውቀዋል በመረጃ የተደገፉ ውሳኔዎች					
206	ሕመምተኞች ስለሚያስፈልጋቸው ክሊኒካዊ እና የነርሲንግ ተግባራት ውሳኔ የመስጠት መብት አላቸው?					
207	የጤና ባለሙያዎች ሕመምተኞች ከቻሉ ብቻቸውን የዕለት ተዕለት ተግባራቸውን (ለምሳሌ ልብስ መልበስ፣መራመድ) እንዲያደርጉ ፈቅደዋል?					
208	የጤና ባለሙያዎች የታካሚዎችን አስተያየት ግምት ውስጥ ያስገባሉ					
209	የጤና ባለሙያዎች በሽተኛው ራሱን ችሎ እራሳቸውን እንዲንከባከቡ በብቃት ይደግፉ ነበር?					
210	የጤና ባለሙያዎች ታማሚዎችን በአክብሮት አነጋግረዋል					
211	የጤና ባለሙያዎች በበሽተኞች የግለሰብ ፍላጎቶች መሰረት እንክብካቤ ያደርጉ ነበር?					
212	የጤና ባለሙያዎች ለታካሚዎች ስማቸው ይጠሯቸዋልነበር					
213	አንድ ታካሚ እርዳታ የሚያስፈልገው ከሆነ, የጤና ባለሙያዎች ወዲያውኑ እርምጃ ወስደዋል					
214	ለታካሚዎች እንዲያርፉ እና እንቅልፍ ጸጥ ያለ አካባቢ ተዘጋጅቷል?					
215	የታካሚዎች ብሔረሰቦች፣ ቀበሌኛዎች፣ ንግግሮች እና ሃይማኖታዊ እምነቶች ይከበራሉ?					
216	ታካሚዎች ምንም አይነት የገንዘብ, ማህበራዊ, እና የባህል ደረጃ ምንም ይሁን ምን ይከበራሉ?					
217	በመግቢያው ጊዜ ታካሚ ተገቢውን ልብስ ይሰጥዎታል?					
218	የጤና ባለሙያዎችን በቅንጅት በመያዝ በእንክብካቤ አቅርቦት ላይ ምንም አይነት መዘግየት እንዳይኖር ያድርጉ					
219	ለታካሚዎች አጋሮች ለማረፍ እና እራሳቸውን እንዲመቻቹ በቂ መገልገያዎች አሉ?					
220	የጤና ባለሙያዎች ለመጀመሪያ ጊዜ ታካሚዎችን ሲገናኙ እራሳቸውን አስተዋውቀዋል?					
221	በመግቢያው ጊዜ ታካሚ ከእንክብካቤ ሰጪዎቻቸው እና ከአካባቢው ጋር ይተዋወቃል					
222	የጤና ባለሙያዎች ለታካሚዎች ወዳጃዊ እና ደግ ናቸው					
223	የጤና ባለሙያዎች ታካሚዎችን በትዕግስት ያዳምጡ ነበር					
224	የጤና ባለሙያዎች ለታካሚዎች ጥያቄ የማያሻማ መል ስ ሰጡ?					
225	የጤና ባለሙያዎች ለታካሚዎች ሁኔታቸው፣ የእንክብካቤ እቅዳቸው፣					

	ስለመድኃኒትዎ ወዘተ በበቂ ሁኔታ አሳውቀዋል።					
226	የጤና ባለሙያዎች ከሕመምተኞች ጓደኞች ጋር ውጤታማ ግንኙነት መሥርተዋል?					

Annex III: In-depth Interview Guide

English version of In-depth Interview Guide

PART I:- Background information							
Ward/Unit: Date: Start time : Finish time:							
PART II:- Participant information							
Participant's reg. No	Age	Sex	Education	Occupation	Disease	Duration of admission	Ethical consent
							Verbal

In-depth interview for patients

1. Can you explain dignified care? (Probe: your understanding of its definition, important?)
2. Can you explain your perception of dignified care in this hospital?
3. What are the barriers for dignified care in this hospital? (Probe: patient-related factors, care-provider-related factors, institutional-related factors, interpersonal-related factors, etc.)

Afan Oromo version of the in-depth interview guide

KUTAA I:- Odeeffannoo duubee
Kutaa hospitaalaa Guyyaa Yeroo itti jalqabame Yeroo itti xumurame
PART II:- Odeefannoo hirmaattotaa

Lakk	Umurii	Saala	Barnoota	Hojii	Dhukkuba	Turtii	Hayyama hirmaachuu

Af-gaaffii odeeffattoota

1. Kunuunsa kabajamaa ibsuu dandeessaa? (hubannoon ati hiika isaa irratti qabdu, barbaachisummaa isaa?)
2. Hospitaala kana keessatti kunuunsa kabajamaa ilaalchisee ilaalcha qabdu ibsuu dandeessaa? (kabaja, iccitii, ofiin of bulchuu, qunnamtii)
3. Hospitaala kana keessatti kunuunsa kabajamaa ta'eef wantootni dandeessisan maali? (dhimmoota dhukkubsataa wajjin walqabatan, dhimmoota dhiyeessaa kunuunsaa wajjin walqabatan, wantoota dhaabbilee wajjin walqabatan, wantoota namoota gidduutti walqabatan fi kkf)

Amharic version of the in-depth interview guide

ተሳታፊ	ዕድሜ	ጾታ	ትምህርት	ሙያ	በሽታ	የሚቆይበት ጊዜ	የሥነ ምግባር ስምምነት
							የቃል

ቃለመጠይቅ

1. የተከበረ እንክብካቤን ማብራራት ትችላለህ? (መርማሪ፡ ስለ ትርጉሙ ያለዎት ግንዛቤ፣ አስፈላጊ?)
2. በዚህ ሆስፒታል ውስጥ ስለ ክቡር እንክብካቤ ያለዎትን አመለካከት ማስረዳት ይችላሉ?
3. በዚህ ሆስፒታል ውስጥ ለተከበረ እንክብካቤ የሚረዱ ምክንያቶች ምንድን ናቸው? (መመርመሪያ፡- ከታካሚ ጋር የተገናኙ ሁኔታዎች፣ የእንክብካቤ አቅራቢ-ነክ ጉዳዮች፣ ተቋማዊ ነክ ጉዳዮች፣ ከሰው ጋር የተያያዙ ጉዳዮች፣ ወዘተ.)

Annex IV: Supportive document

Table 7: Health professional-patient relationship factors of patients admitted to Jimma Medical center, Oromia region, Southwest Ethiopia, from June 1-30, 2023 (n=405).

Items	Frequency			
	Always	Usually	S/times	Never
How often do Health professionals develop a trusting relationship with the Patient?	11(2.7)	341(84.2)	53(13.1)	
How often do Health professionals focus on the Patient and give them their undivided attention?	6(1.5)	256(63.2)	142(35.1)	1(0.2)
How often do Health professionals understand the Patient's needs during care?	13(3.2)	279(68.9)	113(27.9)	0
How often do Health professionals communicate with you freely and ask for a translator if there is a language barrier?	13(3.2)	259(64.0)	133(32.8)	0
How often do Health professionals allow you to enhance your self-care abilities?	18(4.4)	247(61)	140(34.6)	0
How often do Health professionals advise and treat or prevent side effects and complications for the Patient?	22(5.4)	240(59.3)	143(35.3)	0
How often do Health professionals speak freely about their	14(3.5)	269(66.4)	122(30.1)	0

feelings and emotions with the Patient?				
How often do Health professionals help Patient set realistic goals for their health situation?	11(2.7)	120(29.6)	200(49.4)	74(18.3)
Health professional-patient relationship	**good**	**217 (53.60%)**		
	poor	**188 (46.40%)**		

Table 8: Status of dignified care among adult patients admitted to Jimma medical center, Oromia region, Southwest Ethiopia, from June 1-30, 2023 (n=405).

Items	Frequency (%)				
	Always	Usually	S/times	Rarely	Never
Privacy					
H.P.s get patients' informed consent before performing clinical and nursing procedures	329(81.2)	61(15.1)	15(3.7)	0	0
H.P.s ensure Patient's privacy (e.g., closing doors, drawing curtains) before any clinical or nursing acts.	246(60.7)	119(29.4)	35(8.6)	5(1.2)	0
H.P.s do not share Patient information with others unless medically indicated or without patient consent	148(36.5)	176(43.5)	72(17.8)	9(2.2)	0
H.P.s cover irrelevant areas of the Patient's body during medical acts (e.g., bandaging, examination)	142(35.1)	148(36.5)	101(24.9)	14(3.5)	0

Autonomy					
H.P.s inform Patient about their condition, treatment plans, and medication to make informed decisions	136(33.6)	152(37.5)	94(23.2)	22(5.4)	1(0.2)
Patients have the right to make decisions about the care they are judged to require	141(34.8)	155(38.3)	86(21.2)	22(5.4)	1(0.2)
H.P.s allow patients to perform their daily activities (e.g., getting dressed, walking) alone if they can	150(37.0)	137(33.8)	93(23)	22(5.4)	3(0.7)
H.P.s take patients' opinions into consideration or answer pt question	164(40.5)	131(32.3)	82(20.2)	28(6.9)	0
H.P.s effectively support the Patient to care for themselves independently	165(40.7)	146(35.8)	71(17.5)	23(5.7)	1(0.2)
Respect					
H.P.s speak to patients respectfully	162(40.0)	137(33.8)	86(21.2)	20(4.9)	0
H.P.s provide care according to the patient's individual needs	169(41.7)	129(31.9)	83(20.5)	23(5.7)	1(0.2)
H.P.s address patients with their names	37(9.1)	46(11.4)	133(32.8)	148(36.5)	41(10.1)
If a patient needs help, H.P.s take action immediately	164(40.5)	148(36.5)	75(18.5)	16(4)	2(0.5)
Patients have access to hygienic hospital facilities and equipment	305(75.3)	63(15.6)	31(7.7)	5(1.2)	1(0.2)
Patients' ethnicities, dialects, accents, and religious beliefs be respected	159(39.3)	188(46.4)	44(10.9)	14(3.5)	0
Patients should be respected regardless of their financial and social status	171(42.2)	159(39.3)	64(15.8)	11(2.7)	0
The patient provided with proper clothing	187(46.2)	147(36.3)	55(13.6)	15(3.7)	1(0.2)
H.P.s coordinated to prevent any delays in the provision of care	185(45.7)	141(34.8)	65(16)	13(3.2)	1(0.2)

There are adequate facilities for the pts' companions to rest and make themselves comfortable	42(10.4)	96(23.7)	154(38)	96(23.7)	17(4.2)
Communication					
H.P.s introduced themselves upon first meeting patients	4(1.0)	25(6.2)	51(12.6)	163(40.2)	162(40.0)
At the time of admittance, the patient is introduced to their care providers and the environment	8(2.0)	21(5.2)	49(12.1)	160(39.5)	167(41.2)
H.P.s communicate with Patients according to patients' personality types	143(35.3)	146(36.0)	83(20.5)	25(6.2)	8(2.0)
H.P.s is friendly and kind to patients	176(43.5)	157(38.8)	57(14.1)	15(3.7)	0
health professionals listen to patients patiently	183(45.2)	156(38.5)	57(14.1)	9(2.2)	0
H.P.s explain the purpose of every care procedure to patients before it is performed	227(56.0)	122(30.1)	45(11.1)	11(2.7)	0
H.P.s establish effective communication with pt's companions	184(45.4)	133(32.8)	69(17)	17(4.2)	2(0.5)
Overall (Mean ± SD)	**102.12 ±13.87**				

Key: HPs= Health professionals

Table 9: Perspectives toward dignified care of an adult patient admitted to Jimma Medical Center, Oromia region, Southwest Ethiopia, from June 1–30, 2023 (n = 13)

Questions	Verbatim	Codes	Categories	Themes
Can you explain your perception of dignified	*"...Stuff Interactions made me feel in control by explaining and giving information related to my illness, and gaining consent..."(*A 37 -years old female*)*	Inform treatment	Information	Communication
	"...I was given information about my diagnosis,	Inform health		

	*medication, my stay in the hospital, and a full explanation of any procedures carried out on me..." (*A 55 -years old female, A 48 -years old male, A 44 -years old female*)*	conditions		
	*"...HP during ward rounds talks in jargon that I do not understand. They are dealing with my body because something is wrong with it..."(*A 46 -years old male*)*	Talk in jargon	language	
	*"...But the challenge I have is that I know only Afan Oromo, and this has caused me troubles...."(*A 46-years old female*)*	Language deference		
	"*...Most of the health workers are very helpful, and when I ask questions, they listen carefully and answer...*"(A 34 -years old male)	Active Listening	Interpersonal interaction	
	*"...We have a mutual understanding with care providers, and they respect my perspectives, values, and preferences and acknowledge all of them..."(*A 46 -years old male*)*	Mutual understanding		
	*"...Interactions that I believed were helpful because they enhanced my dignity. I believe that a good voice is superior to anything else. In practice, their interaction was regularly observed..."(*A 46-years old female*)*	Interactions		
	*"...I have established a sense of trust with care providers because they make me feel comfortable, respected, and confident in the care I receive..."(*A 23-years old female*)*	Trust building		
	*"...Offering choices between different treatment options, gaining consent..."(*A 34-years old female*)*	Decide my care	decision-making	Autonomy

	*"...They will simply write the prescription and hand it to you without checking to see if you can pay the price, whether they are writing a prescription for medicine or a laboratory test..."(*A 28-years old male*)*	Involvement in care plan		
	*"...They stop me from going here and there, but I can go; this has been very painful for me..."(*A 46 -years old male*)*	Physical activity	promoting independence	
	*"...It is better if family members are with me when performing procedures because they know my needs even without telling them...(*A 23-years old female*)*	Physical care		
	*"...I have no control over myself. Everybody takes my card and sees and practices on me..."(*A 23-years old female*)*	Control over oneself		
	"...Patients need to be respected; they also need to treat me as a human being during care provision..."(A 48-years old male*)*	Treat as human being	treated with respect	Respect
	*"... Patients need to be respected; They respected my cultural values and beliefs. Care providers respected my ethnicity and religious beliefs and gave me appropriate care. I performed my religious affiliation as much as I could. Nothing is lost..."(*A 55 -years old female, A 44 -years old female*).*	Consider cultural values		
	*"...When I tell them about how terrible the pain is at times, they do all they can to make me feel better. Their care is empathetic, which upholds my dignity because it gives me the impression that they are attentive to my needs..."(*A 44 -years old female*)*	Show empathy	compassion from care providers	
	"...H.P. considers my personal needs and treats me as	Individual		

	*valued. It's pleasant to hear someone speak in a soothing language. If health personnel are rude to patients, their care will not cure anyone..." (*A 37-years old female, A 34-years old female, A 55-years old male*).*	personal needs		
	"...Health professionals communicate with me politely, and we have a good relationship with them..."(A 34-years old female*)*	Communicate politely		
	"...The health professionals close the door before any procedure, which is very interesting because it is not pleasant if someone sees someone's body..."(A 55-years old male*)*	Close door	environmental privacy	Privacy
	*"...The health professionals draw a bed screen before any procedure; this is very interesting. It is the rule to lock the door when any procedure is done because if you close it, no one else can see the human body. Otherwise, it is unpleasant or annoying..." (*A 37-years old female, A 40-years old female*)*	Draw bed screen		
	"...The HPs S/times didn't control flow of individuals before procedure, which is very frustrating, because it is not pleasant if someone sees someone's body..."(A 48-years old male*)*	Flow of individuals		
	*"...But it is important to emphasize the need for health care workers to lower their voices while discussing issues with them behind drawn curtains, as curtains are not soundproof..."(*A 55-years old female*)*	Discussion personal issue	informational privacy	
	*"...I am not afraid that information gathered during care will be shared with others who are not concerned about it because they keep it confidential..." (*A 55-years old female, A 55-years old male*).*	Documented information		

What are the barriers to dignified care in JMC?	*"...There are qualified health professionals, and the quality of services provided by this hospital is good..."(* A 40-years old female*)*	Qualified health professionals	care provider factors	Clinical factors
	"...Doctors rounds are intimidating for some patients, but I do not care about them. Sometimes Ten or Twelve doctors stand around the patient. Procedures are done in front of all these people, sometimes without explaining why they are there..."(A 40-years old female*)*	Number of HP examine		
	*"...I am healed, and I will not spoil their gratitude, but if there is anything that annoys me, they get angry with me..."(*A 40-years old female*)*	Behaviour of HP		
	"...I do feel comfortable when a female nurse comes to insert a catheter or perform other procedures because they are female like me, and I like them a little more than males...(A 37-years old female*)*	Sex of care provider		
	*"...I'm in a tidy, secure, and comfy room, and what is clean is pleasant. As a result, I enjoyed it..."(*A 48-years old male*)*	Status of room	organizational factors	
	"...I was dissatisfied with the hospital's lack of medical facilities, which was exhausting, and I was subjected to a slew of charges for which I lacked the money...(A 48-years old male*)*	Lack of supply		
	"...The toilet and washing facilities of this hospital are clean and pleasant to the eye, and I'm happy to be treated here because the hospital I was in before was not so good..." (A 55-years old female, 55-years old male*).*	Facility		
	"...I am in a private room that is clean, safe, and	Private room		

	comfortable. Because of this, I have liked it a lot. I have been to other hospitals, but this one is different..."(48-years old male*)*			
	"...It is older people who are more concerned about their dignity; when you are old, you are too bothered by dignity. because elders are powerless and unable to meet their needs. Nothing is wrong with me right now, and I am extremely pleased with the treatment I am receiving..."(A 37-years old female, *A* 28-years old male*)*	Age	socio-demographic factors	Patient factors
	*"...Women often need dignified care more than men. Because women and men are biologically different, privacy is often essential for women. e.g., receiving care for special areas of the body is more embarrassing for women than for men..."(*34-years old female*)*	Gender		
	*"...It's even worse when there are a lot of people watching and examining you. That kind of thing embarrasses me because I come from a rural area..." (*A 37-years old female*)*	Residence		
	*"...My challenge is that I don't know any language other than Afan Oromo, which has caused me trouble. Many health professionals do not speak Afan Oromo, and because of this, I couldn't explain my problem to them..." (*A 46-years old female*)*	Language		
	*"...You have to have resources to get respectful treatment, and a person with money has everything. Here, individuals with health insurance are getting adequate treatment; they use everything for free. Here I am now, knowing the benefits, and I am feeling very frustrated..." (*A 48-years old male, A	Lack of money	socioeconomic factors	

	40-years old female*)*			
	*"...Here, individuals with health insurance are get adequate treatment; they use everything for free. Here I am now, knowing the benefits, and I am feeling very frustrated..." (*A 37-years old female, A 40-years old female*)*	Health insurance		
	"...Some health professionals do nothing but bother me with questions; nevertheless, asking too many questions of a sick person produces illness in and of itself. Patients at this hospital need minimal treatment and should not be practiced on. I know there are private hospitals that provide dignified care, but you know how much a government employee gets in salary. In addition, employees are unable to get health insurance coverage..."(A28-years old male)	Occupation		