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Patients' Health Rights Awareness and Utilization of Health Services at Mbarara Municipal Council Health Centre IV, Uganda

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ABSTRACT

Background: Patients' rights can strengthen trust and participation in care, but awareness may not overcome financial and organizational barriers. This study examined awareness and experience of health rights and their association with healthcare-service utilization at Mbarara Municipal Council Health Centre IV. Methods: A cross-sectional mixed-methods design included structured questionnaires from 90 patients and interviews with 10 key informants. Descriptive statistics, chi-square or Fisher's exact tests, Spearman correlations, exploratory binary logistic regression and thematic analysis were used. Results: Although 72.2% had heard of patients' rights, 44.4% had high detailed awareness and 28.9% knew where to report violations. Education was associated with high awareness (p=0.010). Thirty respondents (33.3%) had high utilization (four or more visits in the previous year). At bivariate analysis, high utilization was associated with high awareness (p=0.011), reporting knowledge (p=0.033) and positive rights experience (p=0.036). Adjusted estimates remained positive but inconclusive; high awareness had an adjusted odds ratio of 2.74 (95% CI: 0.97-7.74; p=0.058). Major barriers were long waiting time (72.2%), inadequate information (43.3%), weak complaint mechanisms (30.0%) and high costs (28.9%). Conclusion: Rights awareness and favourable experiences may support utilization, but cannot substitute for accessible, affordable and responsive services. Facilities should combine plain-language rights education with waiting-time reduction, respectful-care training, privacy protection and confidential complaint systems.

1. Introduction

Health rights include access to care, understandable information, informed consent, privacy, confidentiality, dignity, participation, non-discrimination and access to complaint or redress mechanisms. Uganda's Patients' Rights and Responsibilities Charter translates these entitlements into expectations for clinical practice and health-service organization (Ministry of Health Uganda, 2019). However, the existence of a charter does not ensure that patients know specific rights or can exercise them during care.

Evidence from Uganda and other African settings shows incomplete awareness and uneven implementation of patient rights. At Uganda's national referral hospital, awareness, responsiveness and practice were limited (Kagoya et al., 2013). Studies in Ethiopia and South Africa similarly found that many patients could not identify rights or report consistent observance (Dessalegn et al., 2022; Thema & Sumbane, 2021). These gaps occur alongside constraints such as staffing shortages, long queues, medicine costs and weak complaint systems. Awareness may influence utilization by shaping expectations, confidence, participation and willingness to return, yet Andersen's Behavioral Model emphasizes that service use also depends on enabling resources and healthcare need (Andersen, 1995). Facility-level evidence was lacking on how detailed rights awareness, reporting knowledge and rights experience related to use of services at Mbarara Municipal Council Health Centre IV. This study assessed awareness, examined associations with accessibility, affordability and utilization, identified implementation challenges, and documented preferred improvement strategies.

2. Literature Review

2.1 Rights awareness and implementation

Functional awareness is more demanding than having heard of patient rights: it requires recognition of specific entitlements, understanding their application and knowing how to seek redress. International rights frameworks define access through availability, accessibility, acceptability and quality, while contemporary patient-safety guidance emphasizes information, supported decision-making, privacy and fair resolution (Committee on Economic, Social and Cultural Rights, 2000; World Health Organization [WHO], 2024). Communication and health literacy therefore determine whether formal rights become usable in practice.

2.2 Rights experience and service utilization

Respectful communication, privacy and participation can strengthen trust and perceived quality, but utilization is also shaped by affordability, distance, service readiness and need. Ugandan evidence has documented geographic and financial inequalities in healthcare access (Dowhaniuk, 2021; Kwesiga et al., 2015). Patient-centred access emerges at the interface between service characteristics and people's abilities to perceive, seek, reach, pay for and engage with care (Levesque et al., 2013). A rights-based analysis should therefore avoid attributing service use to awareness alone.

3. Methodology

3.1 Study design, setting and participants

A facility-based cross-sectional mixed-methods study was conducted at Mbarara Municipal Council Health Centre IV in Mbarara City, southwestern Uganda. The quantitative component included 90 adult patients, while 10 key informants provided administrative and clinical perspectives. The health centre delivers outpatient, laboratory, HIV/AIDS, maternity, immunization, family-planning and related services. Structured questionnaires measured awareness, rights experience, visit frequency and barriers; semi-structured interviews explored implementation and improvement strategies.

3.2 Measures and analysis

Detailed awareness was the sum of six rights: access, confidentiality/privacy, informed consent, non-discrimination, respectful care and information about diagnosis or treatment. High awareness was defined as four or more rights. High utilization was defined as four or more facility visits in the preceding 12 months. A rights-experience score combined explanation, participation, privacy and dignity; discrimination or fear of seeking care formed a negative-event indicator. These were study-specific analytical classifications. Categorical data were summarized using frequencies and percentages. Chi-square or Fisher's exact tests assessed associations, Cramer's V described effect size, and Spearman's rho assessed selected ordinal relationships. Exploratory binary logistic regression produced adjusted odds ratios (aORs), 95% confidence intervals and p-values. Qualitative records were summarized thematically and compared with quantitative findings. Statistical significance was assessed at $p<0.05$, but estimates were interpreted with attention to sparse outcomes, wide confidence intervals and the cross-sectional design.

3.3 Ethical considerations

Ethical approval was obtained from the Bishop Stuart University Research Ethics Committee (Approval No. BSU-REC-2025-1326). Participation was voluntary, written informed consent was obtained, and confidentiality was protected. Administrative permission was obtained from Mbarara Municipal Council Health Centre IV.

4. Findings and Discussion

4.1 Participant profile and awareness

The mean age was 49.0 years (SD 13.7; range 21-75), 61.1% were female and 62.3% had at least secondary education. Although 65 respondents (72.2%) had heard about patient rights, only 40 (44.4%) met the high-awareness threshold and 26 (28.9%) knew where to report a violation. Health workers were the most frequently reported information source. Education level was associated with high awareness (chi-square=11.32, df=3, p=0.010; Cramer's V=0.355), whereas age, sex, marital status, occupation and residence were not.

Table 1: Awareness of patients' health rights (n=90)

Indicator	n	%
Ever heard about patient rights	65	72.2
Access to healthcare	46	51.1
Confidentiality and privacy	43	47.8
Informed consent	42	46.7
Respectful care	42	46.7
Non-discrimination	41	45.6
Information on condition/treatment	37	41.1
Knew where to report a violation	26	28.9
High awareness (at least 4 of 6 rights)	40	44.4

Source: Research Data, 2025

The difference between general exposure and detailed, actionable knowledge is consistent with evidence that publication of a charter does not guarantee functional awareness (Dessalegn et al., 2022; Kagoya et al., 2013). The education association suggests that existing messages may be easier to use for patients with stronger literacy resources. Plain-language, multilingual and pictorial communication is therefore an equity intervention, not merely a dissemination preference.

4.2 Utilization and rights experience

Thirty respondents (33.3%) reported four or more visits in the previous year. Outpatient care was used by 86.7%, laboratory services by 48.9% and HIV/AIDS care by 24.4%. Most participants rated quality as good or excellent (76.7%), and 68.9% had a positive rights experience. Privacy and dignity were always observed for 66.7% and 64.4%, respectively, but only 38.9% were always involved in treatment decisions, identifying shared decision-making as an important quality gap.

Table 2: Service utilization and experience of patients' rights (n=90)

Domain	Indicator/category	n (%)
Visit frequency	Once	27 (30.0)
	2-3 times	33 (36.7)
	4-5 times	24 (26.7)
	More than 5 times	6 (6.7)
Derived utilization	At least 4 visits	30 (33.3)
Rights experience	Diagnosis/treatment always explained	53 (58.9)
	Always involved in decisions	35 (38.9)
	Privacy always protected	60 (66.7)
	Always treated with dignity	58 (64.4)
	Positive rights experience	62 (68.9)
	Negative rights event	10 (11.1)

Source: Research Data, 2025

4.3 Associations with high utilization

At bivariate analysis, high awareness, reporting knowledge and positive rights experience were associated with high utilization. In the adjusted model, effect estimates remained positive but confidence intervals included unity. High awareness narrowly missed the conventional significance threshold (aOR=2.74; 95% CI: 0.97-7.74; p=0.058). Awareness score was positively correlated with visit frequency (rho=0.320; p=0.002), but temporal direction cannot be established: awareness may support attendance, repeated attendance may increase exposure to information, or healthcare need may influence both.

Table 3: Selected associations with high healthcare utilization (n=90)

Predictor	Bivariate p	Cramer's V	aOR (95% CI)	Adjusted p
High awareness	0.011	0.269	2.74 (0.97-7.74)	0.058
Knew reporting channel	0.033	0.225	2.24 (0.74-6.74)	0.151
Positive rights experience	0.036	0.221	2.56 (0.75-8.66)	0.132
Negative rights event	0.486*	0.100	0.30 (0.05-1.92)	0.202
Cost barrier	0.869	0.017	1.12 (0.39-3.26)	0.830
Waiting-time barrier	0.244	0.123	1.02 (0.31-3.38)	0.968

Source: Research Data, 2025

* Fisher's exact test. Adjusted estimates are exploratory and should not be interpreted causally.

The findings support a plausible relationship between usable rights knowledge, favourable care experiences and service contact, while also showing that awareness alone explains little of utilization. This interpretation aligns with Andersen's model and with patient-centred access theory, in which awareness and trust interact with affordability, service readiness and need (Andersen, 1995; Levesque et al., 2013). The adjusted uncertainty and modest sample require emphasis on effect sizes and confidence intervals rather than a binary significant/non-significant conclusion.

4.4 Implementation barriers and preferred strategies

Every respondent reported at least one barrier. Long waiting time was dominant (72.2%), followed by inadequate information (43.3%), weak complaint mechanisms (30.0%) and high costs (28.9%). Key informants contextualized these patterns through staff and supply shortages, heavy workload, limited privacy space and weak management follow-up. The near-universality of waiting-time concerns may explain why this barrier showed little between-group association with utilization while remaining operationally important.

Table 4: Implementation barriers and patient-prioritized strategies (n=90)

Type	Barrier or strategy	n (%)
Barrier	Long waiting time	65 (72.2)
Barrier	Lack of information	39 (43.3)

Type	Barrier or strategy	n (%)
Barrier	Weak complaint mechanisms	27 (30.0)
Barrier	High costs	26 (28.9)
Barrier	Fear of mistreatment	16 (17.8)
Strategy	Reduce waiting time and improve staffing	20 (22.2)
Strategy	Train staff in respectful rights-based care	15 (16.7)
Strategy	Display the Patients' Charter clearly	15 (16.7)
Strategy	Strengthen confidential complaint mechanisms	12 (13.3)
Strategy	Provide regular rights education	10 (11.1)

Source: Research Data, 2025

A grievance mechanism is ineffective if patients cannot locate it, doubt confidentiality or receive no feedback. Similarly, rights education without shorter queues, adequate staffing and privacy safeguards risks placing responsibility on patients for structural problems. The practical implication is a combined intervention: visible and understandable rights information, competent respectful communication, routine monitoring, confidential redress and service-flow improvement.

5. Conclusion and Recommendations

5.1 Conclusion

General exposure to patients' rights was substantial, but detailed and actionable awareness remained limited. High awareness, reporting knowledge and positive rights experience were associated with greater utilization at bivariate level; adjusted estimates were positive but inconclusive. The study therefore supports a potentially reinforcing relationship between knowledge, respectful experience and service contact, while confirming that awareness cannot independently overcome cost, waiting time, staffing and accountability constraints.

5.2 Recommendations

Mbarara Municipal Council Health Centre IV should display a simplified Patients' Rights Charter in English and Runyankore-Rukiga, integrate brief rights education into registration and waiting areas, and require clear explanations and teach-back during consultations. Management should map patient flow, strengthen triage and appointment systems, advocate for staffing, protect privacy with feasible infrastructure measures, and establish a confidential complaint pathway with documented feedback and resolution times. Training institutions and facility supervisors should treat communication, consent, shared decision-making, confidentiality, dignity and complaint handling as assessable clinical competencies. Future research should use larger multi-facility samples and longitudinal designs, validate the awareness and experience thresholds, measure healthcare need and service availability, and retain complete questionnaires, interview transcripts and approval records in an auditable study archive.

5.3 Limitations

The cross-sectional design prevents causal inference. The single-facility sample of 90 limited statistical power and generalizability, and sparse outcomes produced wide confidence intervals. Utilization and experience were self-reported and may be affected by recall or social-desirability bias. Analytical thresholds were study-specific, multiple exploratory tests increased the possibility of chance findings, and repetitive qualitative records limited claims about thematic diversity or saturation. The original completed questionnaires, consent forms, recruitment records and interview transcripts were not independently audited during the reported analysis.

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