

Factors contributing to patients' delay in seeking healthcare services at St Padre Pio health centre III, Mityana district. A descriptive cross-sectional study.

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Abstract

Background: In Uganda, healthcare access is affected by a combination of patient-related, socioeconomic, and health facility-related factors. This study therefore aimed to determine the factors contributing to patients' delay in seeking healthcare services at St Padre Pio Health Centre III, Mityana District.

Methods: The study employed a descriptive cross-sectional study design where a simple random sampling technique was used to obtain a sample of 45 respondents. Data were collected using structured questionnaires and analysed using Microsoft Excel, with results presented in tables, figures, and pie charts.

Results: Majority of respondents, 16 (36%), were aged 20–29 years, 28 (62%) were female, and 24 (53%) resided in rural areas. 20 (44%) reported that they usually waited and observed symptoms before seeking care, 18 (40%) believed illnesses would go away on their own, and 18 (40%) were not confident in knowing when to seek medical attention. 20 (44%) of respondents had no source of income, 18 (40%) said healthcare was hard to afford, and 28 (62%) paid out-of-pocket for services. 20 (44%) reported that limited healthcare resources always affected their decision to seek care, 22 (49%) were affected by poor cleanliness, and 20 (44%) indicated that long waiting times always caused them to delay seeking care.

Conclusion: Patients' delay in seeking healthcare services was influenced by poor recognition of illness severity, cultural beliefs, financial constraints, and inadequacies in health facility resources such as long waiting times, frequent referrals, and poor cleanliness.

Recommendation: Targeted interventions including health education, financial support mechanisms, and improvements in health facility infrastructure are recommended to reduce delays in healthcare seeking.

Keywords: Patients' delay, seeking healthcare services, St. Padre Pio health centre III

Background of the Study

Timely access to healthcare services is crucial in preventing disease progression, reducing complications, and improving treatment outcomes (Sharma et al., 2025). However, in many low-income countries, patients often delay seeking medical attention, which negatively affects their health and contributes to higher morbidity and mortality rates. These delays can result from multiple factors including individual behaviour, socioeconomic conditions, and health system inefficiencies.

Globally, studies have shown that patients delay seeking care for various reasons. In a study conducted in India by Sharma et al., (2025) it was revealed that over 40% of patients delayed seeking healthcare due to perceived minor symptoms, lack of knowledge about the severity of illness, and self-

medication. Similarly, in the United States, even with advanced healthcare infrastructure, patient delay is still seen, especially among minority populations due to mistrust, financial barriers, and lack of health literacy (Faugno et al., 2025).

In Africa, patient delays are significantly higher. A study in Nigeria by Azubuike & Alawode, (2024) found that 62% of patients reported delayed healthcare seeking behaviour, mainly due to poverty, traditional beliefs, and the long distances to healthcare facilities.

Furthermore, health facility related challenges such as long waiting times, inadequate staffing, and poor customer care have been cited as significant barriers to timely healthcare access (Alalade et al., 2024).

In East Africa, the issue persists. In Kenya, a study by Mbuthia et al., (2018) highlighted that 55% of

patients attending primary health facilities delayed seeking care, with contributing factors including the cost of services, poor health seeking behaviour, and fear of stigmatization. Similarly, in Tanzania, Sharma et al., (2025) found that limited knowledge about illness and poor infrastructure were major contributors to delays in accessing healthcare.

In Uganda, the problem of delayed health seeking behaviour remains widespread, particularly in rural areas. A study conducted by Muttamba et al., (2019) reported that in rural Uganda, over 60% of patients delay seeking medical care until their condition becomes critical. Contributing factors include financial constraints, lack of transport, cultural beliefs, and dissatisfaction with services at health facilities.

At St Padre Pio Health Centre III in Mityana District, health workers have reported that many patients present at advanced stages of illness, often requiring more intensive and prolonged treatment. The cause to this delay is not clearly known. Despite ongoing health education programs and community outreach initiatives, delays remain prevalent. Therefore, the aim of this study was to determine the factors that contribute to delays in seeking healthcare services at St. Padre Pio health centre III.

Methodology

Study design.

This study employed a descriptive cross-sectional study design. This design was appropriate as it allowed data to be collected at a single point in time to assess the health-seeking behaviours and the factors contributing to delays among patients at St Padre Pio Health Centre III. The descriptive nature of the study enabled exploration of relationships between patient, facility, and socioeconomic factors without manipulating any variables.

Study setting

The study was conducted at St Padre Pio Health Centre III, a private not-for-profit faithbased health facility located in Mityana District, Uganda. Mityana District is bordered by Kiboga District to the north, Nakaseke District to the northeast, Wakiso District to the east, Mubende District to the west, Mpigi District to the southeast, and Butambala and Gomba Districts to the south. The district headquarters at Mityana are approximately 77 kilometres (48 mi) west of Kampala, Uganda's capital and largest city. The coordinates of the district are 00 27N, 32 03E.

It offered a wide range of essential health services including general outpatient care, antenatal and postnatal services, immunization programs, family planning, health education, HIV counseling and testing, laboratory diagnostic services, and management of common communicable and non-

communicable diseases. The maternal and child health (MCH) unit was a key component, providing services such as delivery care, growth monitoring, and prevention of mother-to-child transmission (PMTCT) of HIV.

Study population

The target population for this study consisted of patients aged 18 years and above who attended St Padre Pio Health Centre III for healthcare services and had experienced delays in seeking care.

Sample size determination

In this study, the sample size was determined using a formula originally developed by Roscoe in 1975, which proposed the rule of thumb for determining sample size. Where a sample size larger than 30 and less than 500 was appropriate for most research, therefore, according to this background, the study involved 45 respondents basing on UHPAB guidelines 2024.

Sampling procedure

A simple random sampling method was used to sample all the patients meeting the inclusion criteria to participate in the study because it eliminated bias and gave equal chance for all the participants to be included in the study. Pieces of paper with two written choices "yes" and "no" were placed in a container. Each respondent was requested to pick one of the papers at random. The individual who picked the "yes" response was included in the sample and those who picked pieces of papers with "no" were excluded. The sampled respondents were taken through the study procedure and then presented with a consent form, and upon consent, they were given questionnaires for their opinions.

Inclusion criteria

This included patients aged 18 years and above, those seeking or receiving healthcare services at St Padre Pio Health Centre III and those who consented to the study.

Exclusion criteria

This excluded critically ill patients unable to respond to the questionnaire and those who did not consent to participate in the study.

Independent variables

Patient related factors
Health facility related factors
Socioeconomic factors

Dependent variable

Delay in seeking healthcare services

Data collection tools

Data were collected using a structured questionnaire. The questionnaire contained closed ended questions written in English and translated into Luganda for those who did not understand English.

Data collection procedure

An introductory letter was obtained from the principal Lubaga Hospital Training School to seek permission from St Padre Pio Health Centre III administration. Once ethical clearance was obtained, eligible patients attending healthcare services were identified and approached. The purpose of the study was explained, and informed consent obtained. Trained research assistants administered the questionnaires in a private setting to ensure confidentiality.

Data management and analysis

After data collection, each questionnaire was checked for completeness and consistency before leaving the study site. All completed questionnaires were stored securely in locked cabinets. Digital data were kept on encrypted devices to ensure confidentiality and were accessible only to the researcher and research assistants. Data were analysed using MS Excel to generate descriptive statistics and then presented in tables, graphs, and pie charts.

Quality assurance**Validity**

The questionnaire was reviewed and validated by the research supervisor and the health facility in-charge

to assess its relevance, clarity, and applicability to the study objectives. Feedback from this review was used to make necessary adjustments to ensure the tool met standard research requirements and captured accurate information.

Reliability

The development of the research proposal and tools was conducted under close supervision of the research supervisor to ensure consistency and accuracy. Prior to data collection, four trained research assistants were oriented on the objectives of the study and proper administration of the questionnaire. They were also equipped to clarify questions to participants when needed, ensuring uniformity in data collection and minimizing interviewer related errors.

Ethical considerations

Ethical approval was sought from the relevant institutional review board. The study observed the following ethical principles. Participants were informed about the study's purpose, procedures, risks, and benefits, and signed a consent form. Participant information was kept confidential and used strictly for research purposes. Participants were informed of their right to withdraw at any time without any consequences to their care

Results**Socio-demographic characteristics of respondents****Table 1: Showing Socio-demographic Characteristics of Respondents (n=45).**

Variable	Category	Frequency	Percentage (%)
Age	Below 20 years	5	11
	20–29 years	16	36
	30–39 years	14	31
	40 years above	10	22
Gender	Male	17	38
	Female	28	62
Education	No school attended	14	31
	Primary level only	13	29
	Secondary level only	12	27
	Tertiary level	6	13
Residence	Urban area	9	20
	Semi-urban area	12	27
	Rural area	24	53

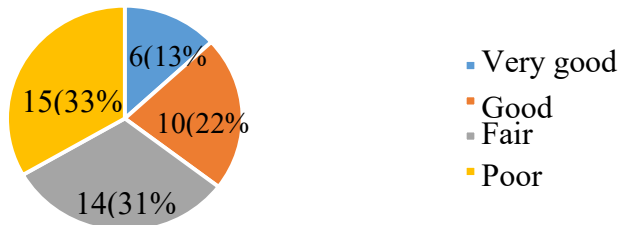
From the table, the majority 16 (36%) of respondents were aged 20–29 years, followed by 14 (31%) aged 30–39 years. Those aged 40 years and above were 10 (22%), while the minority, 5 (11%), were below 20 years. In terms of gender, most respondents were female, 28 (62%), while the least, 17 (38%) males. Regarding education, a large number, 14 (31%), had no formal education, followed by 13 (29%) with primary education. Respondents with secondary and tertiary education were 12 (27%) and a small

number, 6 (13%) respectively, showing that low education levels were prominent, which may contribute to delays in seeking healthcare. In terms of residence, the majority 24 (53%) lived in rural areas, followed by 12 (27%) in semi-urban areas and minority, 9 (20%) in urban areas, indicating that most respondents faced geographical challenges in accessing health services. Overall, the data suggests that young adults, females, those with low education, and rural dwellers formed the largest group of

participants who may be at risk of delayed healthcare seeking.

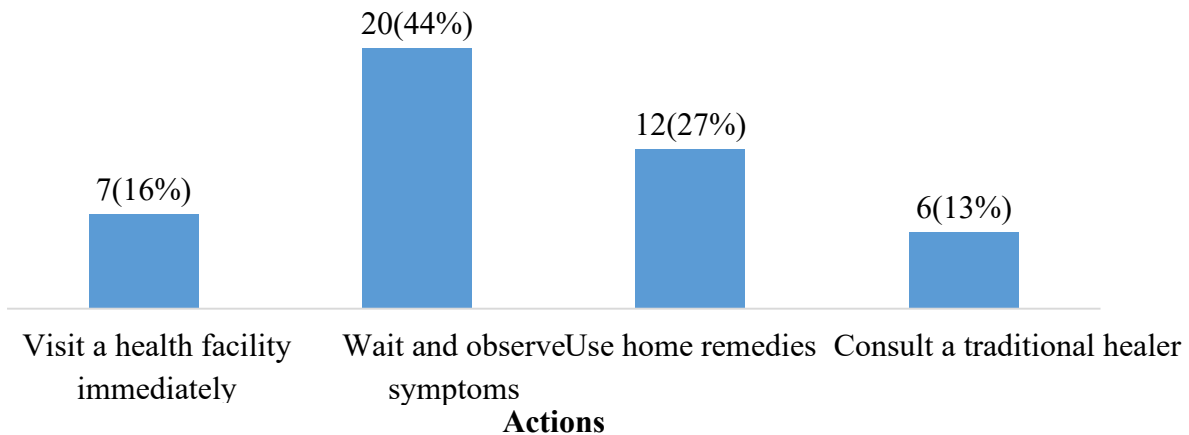
Patient-Related Factors contributing to patients' delay in seeking healthcare services.
Figure 1: Shows patient-related factors regarding recognition of illness seriousness

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From figure, the majority 15 (33%) of respondents reported that their ability to recognize when a health condition is serious was poor, followed by 14 (31%) who described it as fair. Those who rated their ability as good were 10 (22%), while a minority 6 (13%) considered it very good.

Figure 2: Showing first actions taken when unwell



Regarding the first action when feeling unwell, most respondents 20 (44%) said they usually wait and observe symptoms, followed by 12 (27%) who used home remedies. Only 7 (16%) visited a health facility immediately, while the least, 6 (13%), consulted a traditional healer. This indicates that many patients delay seeking care due to poor recognition of illness severity and reliance on self-care.

Table 2: Showing patient-related factors regarding reasons for delaying health care, confidence. (n=45)

Variable	Category	Frequency	Percentage (%)
Main reason for delaying healthcare	Illness will go away on its own	18	40
	Fear of medical tests	10	22
	Rely on home/traditional treatments	12	27
	Don't know where to go for care	5	11
Confidence in understanding when to seek care	Very confident	8	18
	Somehow confident	14	31
	Not confident	18	40
	Not sure	5	11

From the table, the majority 18 (40%) of respondents reported that their main reason for delaying

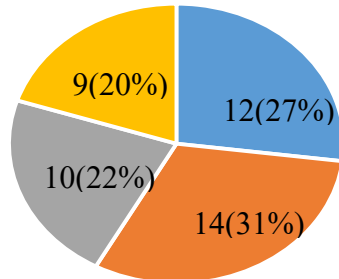
healthcare was the belief that the illness would go away on its own, followed by 12 (27%) who relied

on home or traditional treatments. Fear of medical tests accounted for 10 (22%), while the minority, 5 (11%) did not know where to go for care. In terms of confidence in understanding when to seek medical

attention, the largest number, 18 (40%) were not confident, followed by 14 (31%) who were somehow confident. Very confident respondents were 8 (18%), and the smallest number, 5 (11%) were not sure.

Figure 3: Showing Cultural/traditional beliefs influence

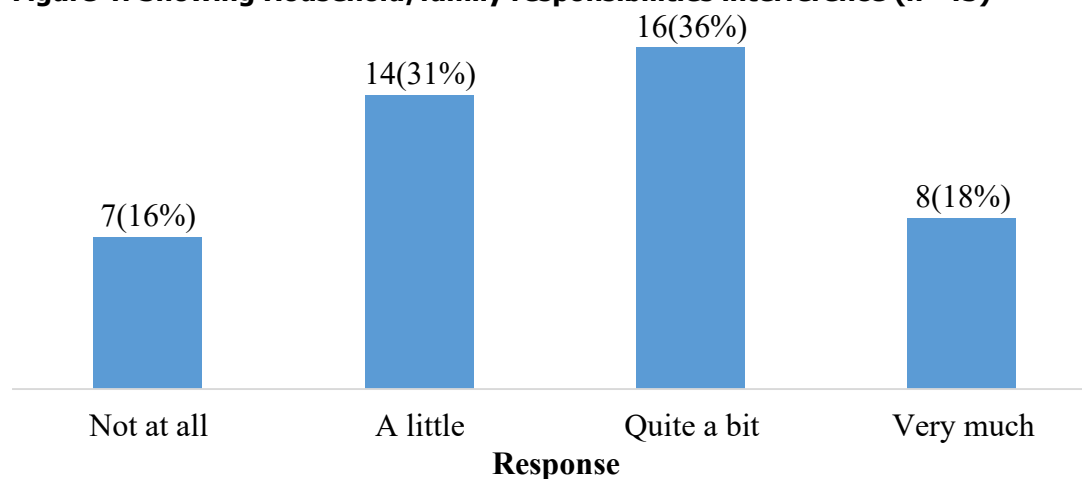
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■ Always ■ Often ■ Sometimes ■ Never

Regarding the influence of cultural or traditional beliefs, most respondents 14 (31%) reported that it often influenced their decision, followed by 12 (27%) who said it always did. About 10 (22%) sometimes considered such beliefs, while the least, 9 (20%) never did.

Figure 4: Showing Household/family responsibilities interference (n=45)



Regarding household or family responsibilities interfering with healthcare seeking, most respondents 16 (36%) reported that these responsibilities interfered “quite a bit,” followed by 14 (31%) reporting “a little” interference. Those who experienced “very much” interference were 8 (18%), while the least, 7 (16%) reported no interference. This shows that poor confidence, family obligations, and cultural beliefs significantly contribute to delays in seeking healthcare.

Socioeconomic Factors contributing to patients’ delay in seeking healthcare services

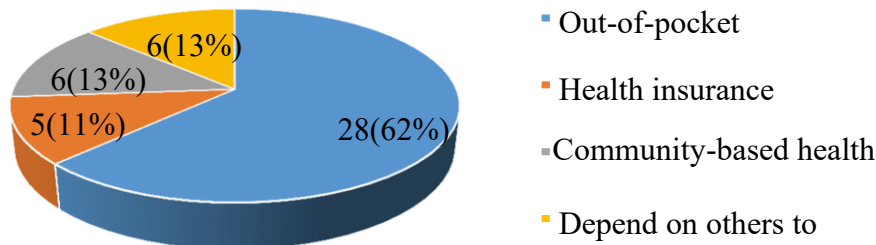
Table 3: Showing respondents’ main sources of income, affordability of healthcare (n=45)

Variable	Category	Frequency	Percentage (%)
Main source of income	Formal employment	8	18
	Informal work	10	22
	Farming	7	16
	No source of income	20	44
Affordability of healthcare	Easily affordable	5	11
	Somehow affordable	12	27
	Hard to afford	18	40
	Not affordable at all	10	22

The highest number, 20 (44%) of respondents reported having no source of income, followed by 10 (22%) who engaged in informal work, 8 (18%) in formal employment, and the lowest number, 7 (16%) in farming. Regarding healthcare affordability, most respondents 18 (40%) said healthcare was hard to afford, followed by 12 (27%) who found it somehow affordable. The least, 5 (11%) found it easily affordable, while 10 (22%) reported it was not affordable at all.

Figure 5: Showing payment methods for healthcare services

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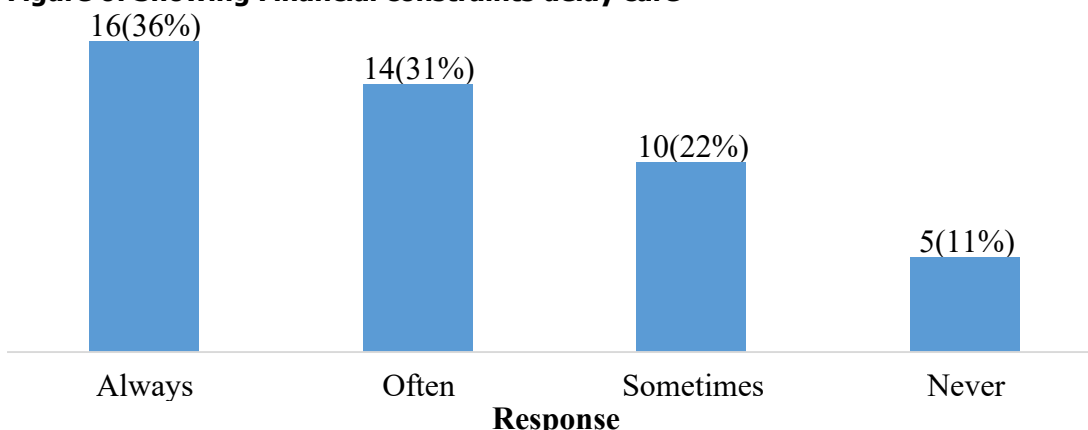
Concerning payment methods, the largest number, 28 (62%) paid out-of-pocket, while 6 (13%) depended on others, another 6 (13%) used community-based health schemes, and the smallest number, 5 (11%) had health insurance. This shows that financial limitations are a major barrier contributing to delays in seeking care.

Table 4: Showing respondents' experiences with financial constraints and transport costs affecting healthcare access

Variable	Category	Frequency	Percentage (%)
Transportation costs affect healthcare access	Very much	18	40
	Sometimes	15	33
	Not affected	12	27
Healthcare costs stop seeking care	Very often stop	15	33
	Sometimes stop me	14	31
	Rarely stop me	10	22
	Never stop me	6	13

From the table, regarding transportation costs, most respondents 18 (40%) said these costs affected them very much, followed by 15 (33%) who said sometimes, and the least, 12 (27%) who were not affected. Finally, concerning healthcare costs stopping them from seeking care, the majority 15 (33%) reported that costs very often prevented them from seeking care, 14 (31%) said sometimes, 10 (22%) rarely, and minority, 6 (13%) never. This indicates that both financial and transport-related barriers play a significant role in delaying healthcare access.

Figure 6: Showing Financial constraints delay care



Majority 16 (36%) of respondents reported that financial constraints always delayed them from seeking medical care, followed by 14 (31%) who said it often delayed them. 10 (22%) reported sometimes being delayed, while the minority, 5 (11%) were never affected.

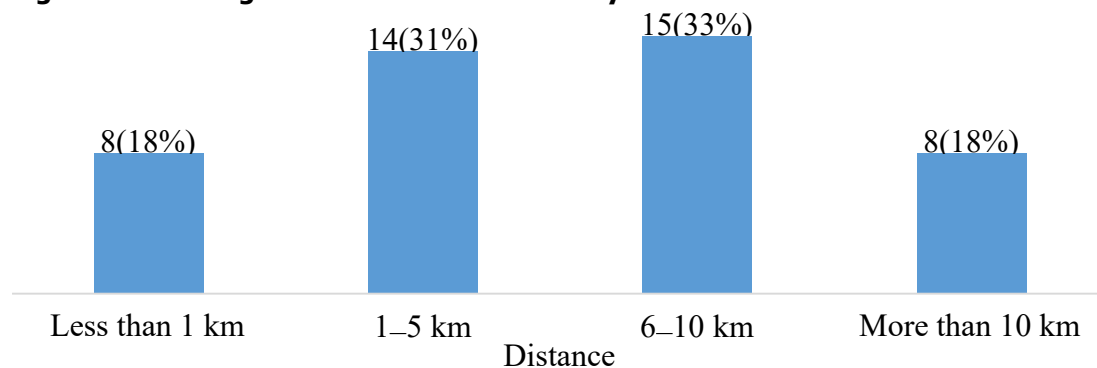
Health Facility Related Factors Contributing to Patients' Delay in Seeking Healthcare Services.

Table 5: Showing the influence of limited healthcare resources, waiting times, distance to the facility, and cleanliness on patients' healthcare-seeking behaviour (n=45)

Variable	Category	Frequency	Percentage (%)
Limited healthcare resources affect care	Always	20	44
	Often	12	27
	Sometimes	8	18
	Never	5	11
Waiting time before receiving services	Less than 30 minutes	6	13
	30 minutes – 1 hour	12	27
	1–2 hours	15	33
	More than 2 hours	12	27

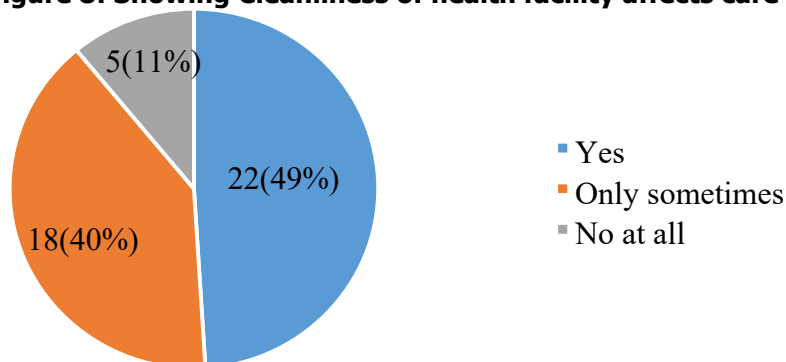
From table 5, the majority 20 (44%) of respondents reported that limited healthcare resources always affected their decision to seek care promptly, followed by 12 (27%) who said often. 8 (18%) said sometimes, while the minority, 5 (11%) reported never. Regarding waiting time, the largest number of respondents 15 (33%) waited 1–2 hours, followed by 12 (27%) who waited 30 minutes–1 hour, another 12 (27%) waited more than 2 hours, and the smallest number, 6 (13%) waited less than 30 minutes.

Figure 7: Showing Distance to nearest facility



For distance to the nearest facility, most 15 (33%) of the respondents lived 6–10 km away, 14 (31%) lived 1–5 km away, 8 (18%) less than 1 km, and the least, 8 (18%) more than 10 km.

Figure 8: Showing Cleanliness of health facility affects care



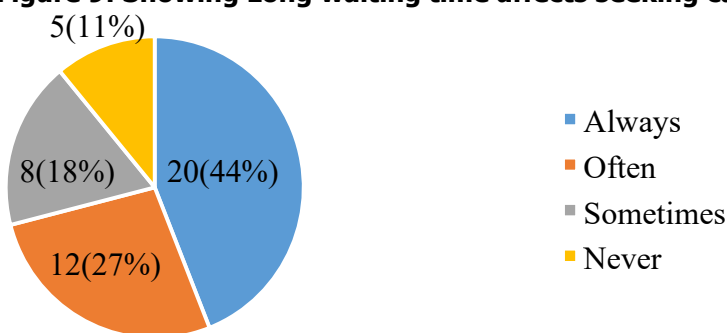
Concerning cleanliness, almost half, 22 (49%) of the respondents said it affected them, 18 (40%) only sometimes, and the least 5 (11%) said it did not affect them. These findings indicate that resource limitations, long distances, and poor cleanliness are significant barriers to timely healthcare access.

Table 6: Showing patients' experiences with referrals, clarity of information.

Variable	Category	Frequency	Percentage (%)
Referred due to missing equipment/tests	Yes, frequently	18	40
	Yes, occasionally	14	31
	Rarely	9	20
	Never	4	9
Information about available services	Very clear	8	18
	Clear	15	33
	Somehow clear	17	38
	Not clear at all	5	11

From table 6, the majority 18 (40%) of respondents reported that they were frequently referred to another facility due to missing equipment or tests, followed by 14 (31%) who experienced occasional referrals. 9 (20%) said rarely, while minority, 4 (9%) said never. Regarding clarity of information about available services, the largest number, 17 (38%) said the information was somehow clear, 15 (33%) said clear, 8 (18%) very clear, and the smallest number, 5 (11%) not clear at all.

Figure 9: Showing Long waiting time affects seeking care



Concerning long waiting times, the majority 20 (44%) reported that it always made them avoid or delay seeking care, followed by 12 (27%) who said often, 8 (18%) sometimes, and the minority, 5 (11%) never. This shows that unclear information, frequent referrals, and long waiting times contribute significantly to patient delays.

Discussion

Socio-demographic Characteristics of Respondents

The majority of respondents, 16 (36%), were aged 20–29 years. Young adults are generally more active in the workforce and community, which increases their exposure to situations requiring healthcare services, explaining their higher representation. This aligns with McMahon et al. (2022) in Kenya, who reported greater health-seeking behaviour among young adults due to autonomy and access to health information.

Conversely, the minority, 5 (11%), were below 20 years. This group is often dependent on parents or guardians for health decisions, limiting their ability to seek care independently. Their lower representation may also reflect social and cultural restrictions placed on younger individuals.

Regarding gender, the majority, 28 (62%), were female. Women are more involved in caregiving and family health, making them more likely to interact with health services and participate in community studies. This is supported by Morgan et al. (2017) in Uganda, which reported higher female participation in community health research due to their domestic and caregiving roles. The minority, 17 (38%), were male. Men's lower participation may be due to social norms that view healthcare seeking as less central to men's roles or because men prioritize work over clinic visits, which reinforces the findings of Morgan et al. (2017) on gender disparities in health engagement.

In terms of education, the majority, 14 (31%), had no formal education, which limits their understanding of health risks, recognition of symptoms, and knowledge of appropriate healthcare practices, delaying timely care-seeking. This is in line with Maghous et al. (2016) in Morocco, who found that individuals with lower education delayed care due to insufficient knowledge. On the other hand, 6 (13%), had tertiary education and likely possessed greater health literacy, enabling them to interpret health symptoms accurately, seek prompt care, and make informed decisions. This demonstrates how higher education can mitigate delays in healthcare access, supporting Maghous et al. (2016). Regarding place

of residence, most respondents, 24 (53%), lived in rural areas, where long distances, poor transport, and limited access to health information hinder timely care. Nogueira et al. (2022) similarly reported that rural residents delayed healthcare seeking due to these barriers. In contrast, the minority, 9 (20%), lived in urban areas with closer facilities, better transport infrastructure, and easier access to health education, allowing them to seek care more promptly. This highlights the advantage of urban residency in overcoming geographic and informational barriers to maternal health services as reported by Nogueira et al. (2022).

Patient related factors contributing to patients' delay in seeking healthcare services.

The majority of respondents, 15 (33%), reported that their ability to recognize when a health condition is serious was poor, while only a minority, 6 (13%), considered their ability very good. This is because many individuals lack adequate health knowledge and depend on self-judgment, which often leads to misinterpretation of symptoms. This finding is consistent with a study by Babatunde et al., (2015) in Nigeria, which revealed that patients frequently delayed seeking care because they underestimated the seriousness of their illness. The similarity in these studies may be due to limited health literacy in both populations, which affects early recognition of danger signs.

Regarding the first action when feeling unwell, most respondents, 20 (44%), said they usually wait and observe symptoms, while very few, 7 (16%), visited a health facility immediately. This could be because many patients rely on self-assessment or hope for spontaneous recovery before seeking medical care. This finding agrees with a study by Kallon et al., (2022) in South Africa, which reported that patients often delayed visiting health facilities due to misjudging their symptoms. The similarity may result from a common tendency among patients to prioritize self-care and observation before seeking professional consultation.

The majority of respondents, 18 (40%), delayed seeking healthcare because they believed the illness would go away on its own, while only 5 (11%) reported not knowing where to go. This is because individuals often depend on natural recovery or home remedies before considering medical intervention. This finding is in agreement with a study by Sk et al., (2019) conducted in India, which found that many patients preferred using home or traditional remedies before seeking formal healthcare. The similarity may be attributed to cultural beliefs and behavioural patterns that

encourage reliance on non-medical interventions initially.

In terms of cultural or traditional beliefs, most respondents, 14 (31%), said these beliefs often influenced their health-seeking decisions, while only 9 (20%) said they never did. This could be because traditional practices remain deeply rooted in many communities, shaping individuals' choices regarding when and where to seek care. This agrees with findings by Sk et al., (2019) in India, which revealed that cultural beliefs contributed significantly to delays in seeking professional healthcare. The similarity is due to the strong influence of cultural norms on health behaviour across different societies. Regarding confidence in knowing when to seek medical attention, the majority, 18 (40%), were not confident, while only 8 (18%) were very confident. This is because limited health knowledge reduces individuals' ability to assess the severity of their conditions accurately. This finding aligns with a study by McMahon et al., (2022) in Kenya, which emphasized that lack of confidence and fear of diagnosis contributed to delayed healthcare seeking. The similarity may be explained by low self-efficacy in health decision-making among patients in both settings.

Finally, concerning family or household responsibilities, most respondents, 16 (36%), reported that these responsibilities interfered "quite a bit" with their ability to seek healthcare, while a small number, 7 (16%), reported no interference. This could be because caregivers, especially women, often prioritize domestic duties and childcare over their personal health needs. This finding agrees with a study by Morgan et al., (2017) in Uganda, which found that caregiving roles contributed to delays in seeking healthcare among women. The similarity may arise from social expectations that assign family responsibilities primarily to women, limiting their ability to seek timely care.

Socioeconomic Factors Contributing to Patients' Delay in Seeking Healthcare Services

The majority of respondents, 20 (44%), reported having no source of income, while only a small number, 7 (16%), relied on farming. This is because many individuals are unemployed or dependent on unstable informal work, which limits their ability to finance healthcare services. This finding is consistent with a study by Mpimbaza et al., (2017) in Uganda, which revealed that financial instability led many rural patients to postpone medical care due to inability to meet out-of-pocket costs. The similarity in both studies may be explained by widespread economic vulnerability that affects timely health-seeking behaviour.

Regarding healthcare affordability, most respondents, 18 (40%), found healthcare hard to afford, while only a minority, 5 (11%), found it easily affordable. This is because medical costs such as consultation fees, laboratory tests, and medicines are often beyond the reach of low-income individuals. This finding agrees with a study by Boyanagari et al., (2023) in India, which reported that high healthcare costs caused delays among low-income earners. The similarity arises from the financial burden that discourages timely healthcare use across low-resource settings.

Concerning payment methods, the majority, 28 (62%), paid for healthcare out-of-pocket, while only 5 (11%) had health insurance. This could be because insurance coverage is limited or inaccessible, forcing most patients to depend on personal funds. This finding aligns with Mpimbaza et al., (2017), who also found that lack of insurance contributed to delayed healthcare seeking. The similarity is due to heavy reliance on out-of-pocket payments, which increases financial strain and delays in seeking care. The results further showed that transportation costs significantly affected access to healthcare, with the majority, 18 (40%), saying these costs affected them very much, while only 12 (27%) were not affected. This could be because many respondents lived in rural or semi-urban areas where transport is costly or unreliable. A similar trend was reported by Makene et al., (2022) in Tanzania, where high transport costs delayed patients' access to health facilities. The similarity may be attributed to geographical and infrastructural barriers common in low-income communities.

Finally, the majority, 15 (33%), reported that healthcare costs very often prevented them from seeking care, while only 6 (13%) said costs never stopped them. Additionally, 16 (36%) stated that financial constraints always delayed them from seeking medical attention. This is because the cumulative burden of treatment fees, drugs, and transport makes healthcare unaffordable. This finding is in agreement with Haque et al., (2018) in Bangladesh, which identified healthcare costs as a major cause of delays among low-income households. The similarity is because financial inaccessibility remains a dominant barrier to timely healthcare across resource-limited populations.

Health Facility Related Factors Contributing to Patients' Delay in Seeking Healthcare Services.

The majority of respondents, 20 (44%), reported that limited healthcare resources always affected their decision to seek care, while only 5 (11%) said it never affected them. This could be because shortages of equipment, medications, and personnel create

doubt about receiving adequate treatment. This finding is in agreement with a study by Umoke et al. (2021) in Nigeria, which reported that inadequate health infrastructure contributed to delay healthcare seeking. The similarity arises from persistent resource constraints in primary health facilities that discourage prompt care-seeking.

Regarding waiting time, most respondents, 15 (33%), waited 1–2 hours before receiving services, while the smallest group, 6 (13%), waited less than 30 minutes. This is because overcrowding and limited staffing slow service delivery. This finding agrees with Biya et al. (2022) in Ethiopia, which found that prolonged waiting times in congested facilities discouraged patients from seeking timely care. The similarity is due to systemic inefficiencies that prolong queues and delay patient flow.

For distance to the nearest health facility, the majority, 15 (33%), lived 6–10 km away, whereas only 8 (18%) lived less than 1 km. This could be because rural settlements are widely scattered, requiring patients to travel long distances. This finding is consistent with Mhalu et al., (2019) in Tanzania, which highlighted that long travel distances contributed to delays in accessing healthcare. The similarity results from geographical barriers that hinder timely access to health services across rural communities.

Concerning cleanliness and the facility environment, nearly half of respondents, 22 (49%), reported that poor cleanliness affected them, while a minority, 5 (11%), reported no effect.

This is because unhygienic conditions reduce patients' confidence and increase fear of contracting infections. This finding aligns with Mistry et al., (2016) in India, where poor sanitation and facility conditions contributed to delay care-seeking. The similarity arises from patient perceptions that unclean environments reflect low-quality care.

Regarding referrals to other facilities due to lack of equipment or tests, the majority, 18 (40%), experienced frequent referrals, while only 4 (9%) never did. This could be because primary-level facilities often lack diagnostic tools, forcing patients to seek services elsewhere. This finding agrees with Kasujja et al. (2021) in Uganda, which found that inadequate diagnostic capacity caused significant delays in receiving appropriate care. The similarity stems from limited-service availability in lower-level facilities that disrupt timely treatment.

On clarity of information about services, the largest number, 17 (38%), said the information was somehow clear, while only 5 (11%) found it not clear at all. This may be because communication within facilities is inconsistent or inadequately structured. This finding is in agreement with Noman et al.,

(2024) in Bangladesh, where unclear information caused patients to postpone care. The similarity is due to communication gaps that reduce patients' confidence in navigating available services.

Finally, concerning the impact of long waiting times, the majority, 20 (44%), reported that it always made them delay or avoid seeking care, while the minority, 5 (11%), were never affected. This could be because long queues discourage patients who may already have limited time or resources. This finding supports Biya et al., (2022), who found that long waiting times significantly increased healthcare delays. The similarity is explained by common service inefficiencies that overwhelm patients and contribute to defer healthcare seeking.

Conclusions

The major influencing factors were age, gender, education level, and place of residence, poor recognition of illness severity and reliance on self-care, financial constraints and affordability issues, limited healthcare resources, long waiting times, and unclear information.

Recommendations

To the Ministry of Health

Through strengthening health education campaigns, expanding financial support programs such as subsidies and community-based health insurance, and improving health facility infrastructure, including reducing waiting times and ensuring availability of medical equipment.

To the Health workers

Should provide targeted counseling and guidance to patients, especially young adults, females, and rural residents, on recognizing serious health conditions and seeking care promptly.

To the Respondents

Particularly those with low education, no income, or living in rural areas, should actively seek healthcare promptly, utilize available health education resources, and participate in community health programs to reduce the risk of delayed care.

Acknowledgement

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List of abbreviations

CDC: Centers for Disease Control and Prevention

MOH: Ministry of Health

NGO: Non-Governmental Organization

UHPAB: Uganda Health Professionals Assessment Board.

WHO: World Health Organization.

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Data availability: Data supporting the findings may be obtained upon request from the corresponding author.

Informed consent: Written informed consent was obtained from all participants prior to their inclusion in the study. Participants were informed about the purpose of the study, procedures involved, potential risks and benefits, and their right to withdraw at any time without penalty.

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