EFFECT OF AN EDUCATIONAL INTERVENTION ON PATIENTS' RIGHTS AWARENESS AMONG PREGNANT WOMEN ATTENDING ANTENATAL CARE CLINICS IN KIRINYAGA COUNTY, KENYA

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Effect of an Educational Intervention on Patients' Rights Awareness among pregnant women attending Antenatal Care Clinics in Kirinyaga County, Kenya

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DECLARATION

This thesis is my original work and has not been presented for a degree in any other University

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DEDICATION

I dedicate this thesis to my parents, Mr. & Mrs. Jeremiah Kitur, for their consistency in education and immense support throughout life and the opportunity to learn through all the levels. To my husband, Kibet Tonui and our dear children Xedriques, Vanessann and Dwight, I am doing this for you – to proof that nothing is impossible. My special dedication goes to my beloved grandparents, Job Sigilai and Martha Sigilai, now 105 and 96 years old. This achievement is a testament to the fruits of the seeds you planted through your love, sacrifice, and hard work over the years. Thank you for your unwavering support and for the strong foundation you gave me. I am finally done with this chapter. To my good friends, Joan Soi and R. Sudoi who have always cheered me on the journey. May our God pour you blessings according to his riches in His glory.

To the great people of Kirinyaga County, I believe the information herein will be beneficial to them all including patients.

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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
FGD	Focus Group Discussion
HSS	Health System Strengthening.
HSA	Health Systems Accountability
HSR	Health System Responsiveness
NHIF	National Health Insurance Fund
JKUAT	Jomo Kenyatta University of Agriculture and Technology
KEMRI	Kenya Medical Research Institute
KNBS	Kenya National Bureau of Standards
KII	Key Informant Interviews
LMIC	Low- and middle-income countries
MOH	Ministry of Health
NACOSTI	National Council of Science Technology and Innovation
NCD	Non-communicable diseases

PHC	Primary Health Care
PRC	Patient Rights Charter
SERU	Scientific Ethics Review Unit
SPSS	Statistical Package for Social Sciences
UHC	Universal Health Coverage
WHO	World Health Organization

DEFINITION OF OPERATIONAL TERMS

Term	Definition
Patient's rights charter	The document details the patients' rights, responsibilities, and dispute handling mechanism for health systems service delivery (MOH, 2013)
Patient's service charter	A statement of commitment by the Ministry of Health-on-health care expectations and responsibilities, which outline what service users, can and should expect every time they use health services and what service providers can do to deliver safer and more effective health services in Kenya. (MOH, 2013).
Implementation	It's the process of using strategies to facilitate the health awareness of patients concerning their rights and responsibilities.
Patient Knowledge of their rights	The awareness by the patient and their health seeking behavior indicates implementation of the components of the patient's rights charter.
Awareness of patients' rights charter	Patient education on their rights, and the practice of their responsibilities and mechanism of conflict resolution.

Health care provider/Worker	Any person or institution involved in the management of a patient or client.
Clients	Users of health services require preventive, promotive and curative services from Health Systems.
Practice of Responsibilities	Patients' health seeking behaviour and knowledge of personal care required.
Practice of feedback mechanism	Patient's ability to raise complaints when aggrieved with health care provided and seeking feedback on action taken.

ABSTRACT

Patients' rights are a fundamental human right and is a global health concern in health services delivery. The majority of maternal health intervention programmes across sub-Saharan Africa have focused on improving coverage of skilled birth attendance and emergency obstetric and newborn care however there has been a lack of focus on interventions and programmes that seek to provide comprehensive and individualized care for women and their babies before and after childbirth. Pregnant women frequently experience abuse, which may significantly contribute to maternal morbidity and mortality. In 2020, 95% of maternal deaths in the world occurred in low and lower-middle-income countries, Kenya's maternal mortality rate stands at 355 per 100,000 births which is significantly higher than the WHO's SDG target goal 3.1 of less than 70 per 100,000 by 2030. Awareness of the patients' rights increases maternal health literacy. The study's main objective was to determine the effect of an educational intervention on patients' rights awareness among pregnant women attending antenatal clinics. Educational intervention involved the use of health talks and bookmarks where a mixed method with a quasi-experimental quantitative arm study design that utilized convergent parallel was employed with two health centers purposively sampled. The study targeted 168 respondents where convenience sampling was used to sample pregnant women attending ANC clinics and purposive sampling for health care providers. An interviewer administered semi structured questionnaire, a key informant interview and focus group discussion guide were used to collect qualitative and quantitative data at pre-intervention and post-intervention phases. Quantitative data were analyzed using SPSS version 26.0, with chi-square used to assess associations and variables that were included into the multivariable model to show the effect of the intervention. Qualitative findings were transcribed and analyzed thematically using NVIVO version 12. Ethical approvals were sought from SERU. Majority of the participants 66(68%) were between the ages of 18-30years, married 74(77%), and had attained secondary education 54(56%). The level of awareness of patient rights was 19(19.8%) Of those who had knowledge of patient rights, 60(68.4%) of them reported that healthcare providers were their source of information. The quantitative analysis demonstrated pregnant women in the intervention group reported higher proportions of good awareness 40(41.7%) compared to the control group 15(20.8%, $\chi^2 = 8.11$, df = 2, $p = 0.017$). Similarly, tertiary education and three or more ANC visits were strongly associated with good awareness ($\chi^2 = 18.566$, $p = 0.017$ and $\chi^2 = 19.035$, $p = 0.015$, respectively). There was a significant improvement in awareness of patient rights from 19(19.8%) to 61(67.8%) at post-intervention. The multiple linear regression model demonstrates that the intervention significantly enhances perceived quality of care and patient rights awareness, with a 6.314-unit increase for the intervention group and an additional 6.806-unit increase over time (DiD effect). Significant variables include education level ($\beta = 1.643$, $p = 0.001$), ANC visits ($\beta = 1.770$, $p = 0.002$), and service quality ($\beta = 0.845$, $p < 0.001$. From the qualitative findings, pregnant women

acknowledged the role of HCP in sensitizing ANC clients, the need to translate the PRC into local languages and frequent monitoring of implementation for efficiency. In conclusion, healthcare provider-led health education proved effective in improving the knowledge of patient rights and awareness. With these findings, the study underscores the importance of integrated continuous sensitizations using translated educational materials which are sustainable. The Ministry of Health should scale up interventions, implement regular training and develop educational materials to sustain these initiatives.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Patients' Rights are a fundamental human right, a quality assurance measure that protects healthcare recipients against abuse, discrimination and promotes ethical practices. The United Nations established the universal declaration of Human rights in 1948 and has been implemented all over the world (Al-Rebdi *et al.*, 2021.). Patient rights are an essential part of healthcare practice, since patients are one of the most vulnerable members of society, thus improving the knowledge on rights of patients is considered a priority in medical services.

In most countries across the globe, health-care institutions have established regulations and have put measures on implementation to achieve patients' awareness and satisfaction (Krzych, 2013). Awareness of rights promotes rational and ethical practices and improves health outcomes (Kagoya, *et al*, 2013). Patients have the right to care, treatment, and service that safeguard their personal dignity and respect their cultural, psychosocial, and spiritual values. These values often affect the patient's treatment needs and preferences.

By understanding and respecting patients and their values, providers can help meet the patients' needs for treatment and services and protect the patients. Also defending patient's rights is essential to maintaining dignity and respect, and if observed, a good relationship can be established between healthcare providers and patients, and the quality of patient care will be improved. In the past, it was imagined that only health care providers were aware of the health and well-being of patients and were permitted to make decisions on patients' destiny. However, in today's world, it is paramount to observe and respect basic rights of patients as human beings.

To ensure observance of these rights, healthcare systems in different countries have developed guidelines such as Patient's Bill of Rights. Accordingly, health care facilities are obliged to provide the patient with the information on this bill, so that they can know their rights and take action when necessary (Abuya *et al*., 2015). Patient's Bill of Rights states that every patient, regardless of age, gender, race and other differences, has the right to knowledge, respect, confidentiality, privacy, proper care and treatment as well as protection and objection. In this way, health care providers including nurses have the duty to observe these rights. For patients' rights to be observed, patients and health care providers should be aware of these rights. Physicians' and nurses' lack of awareness lead to their inability to recognize patients' legal and ethical issues and reduce the quality of services provided (Mastaneh *et al*., 2013).

Although the Kenya Patients' Charter empowers patients to demand quality care, the major challenge has been on equitable access. Pregnant women have continuously encountered abuse, detention, egregious violations of their basic rights at health facilities where they frequently visit for antenatal and post-natal care services (Abuya *et al*., 2015). Poor standards of healthcare in health facilities result in patients not seeking care even when in need. This has in turn led to unmet need and there resulted in high maternal and neonatal mortality rates.

Globally, pregnant women are mostly vulnerable and are often face abuse whilst they seek antenatal care services. This kind of sub-standard quality of care during pregnancy and delivery has been acknowledged to negatively influence subsequent health care seeking and could be an important cause for maternal morbidity and mortality (Halawany, H *et al*., 2016). In 2020, about 287,000 women died worldwide from pregnancy-related causes, with nearly 95% of these deaths occurring in low and lower-middle-income countries, Kenya's maternal mortality rate stands at 355 per 100,000 births which is significantly higher than the WHO's SDG target goal 3.1 of less than 70 per 100,000 by 2030 (WHO, 2020).

Studies have reported abusive language of health care workers, rudeness, intimidation, lack of empathy, lack of privacy, uninformed decision making, physical assault and denial of service (Kumbani *et al*., 2012). Such disrespectful treatment is a clear indication that several patients' rights principles are violated, in particular, the right of every woman to be treated with respect for their dignity. Lack of awareness about health rights during pregnancy and child delivery, influences women's uptake of health care before and after delivery (Mirlohi *et al*., 2015).

Most countries acknowledge Patients' Rights Charter as universally acknowledged that all patients deserve to be treated with dignity, respect, and integrity (WHO, 2017). The World Health Organization further advises that "the existence of Patients' Charters without efforts to raise awareness among patients does not improve the quality of health care". It also predicts that the patient rights will in turn make patients more conscious of their responsibilities when seeking and receiving care (WHO, 2017). Observing patients' rights is one of the effective measures of patient's satisfaction in healthcare services. Health care providers, and most importantly those dealing with patients directly i.e. nurses, physicians, midwives have the greatest responsibility to preserve and advocate for patients' rights, only if they are knowledgeable about these rights. A study by Aljeezan *et al*., (2022) reports that it's not only important for the patients to be made aware of their rights but also the healthcare providers. The fundamental reason for the importance attached to patients' rights is that respecting patients' rights is an essential part of providing good health care and it calls for an accommodative provider-patient relationship. Ideally, this would guarantee the patient the right to autonomy, free expression, self-determination, information, personalized attention, and non-discrimination.

Kenya is not an exception to this; a study by Abuya *et al*., (2015) showed that healthcare providers have become barriers in the path of patients' rights being realized, allowing them susceptible to abuse and violence at healthcare facilities. When patients' rights are infringed upon, their points of view affect their satisfaction, compromising the doctor-

patient relationship and degrading the expected level of care. The healthcare providers awareness and sensitivity to patients' rights improves the quality of treatment and increases patient confidence and satisfaction (Saleh *et al*., 2023).

Some studies conducted in several parts of the world indicate that most patients are not aware of their rights. Nurses' knowledge on these rights and practice of patient's rights in various health facilities is at moderate level, varying from 30% to 60% (Iltanen *et al.,* 2012; Mohammad Nejad *et al.,* 2012;). It has been shown that educational interventions for health care providers can result to changes of attitude and practice in them, leading to provision of better services to patients. Furthermore, providing education-based interventions for patients and health care providers leads to improved and enhanced observance of Patient's Bill of Rights, and improved quality of services and patient satisfaction (Atela, M *et al*., 2015). Since health care providers will not be able to provide good quality of care without awareness and training about concept and content of patient's rights, and in attention to very limited number of studies on patient's education about Patient's Rights, the present study was conducted with the aim to determine the effect of educational intervention on level of awareness of patient rights among pregnant women.

Whilst there are myriads of other interventions addressing this matter, very few are projected towards increasing awareness of the patients, especially pregnant women, and the healthcare providers. Some studies have shown that the implementation of educational interventions for healthcare workers and hospital staff significantly increases compliance with patients' rights and patients' satisfaction (Rostami-Moez *et al*., 2021).

1.2 Statement of the Problem

Patient rights violations among pregnant women encompassing mistreatment, abuse, neglect and denial of dignified care during antenatal care visits and childbirth constitutes a global and Kenyan public health concern. Globally, the World Health organization recognizes disrespectful maternity care as a violation of women human rights,

undermining a universal health coverage and sustainable development goal 3 of good health and well-being and 5 of gender equality, with millions of women experiencing barriers to safe maternal health services that contribute to preventable morbidity and mortality. In Kenya, where maternal mortality remains high at approximately 355 per 100,000 live births which is one of the highest rates in East Africa, far exceeding the global Sustainable Development Goal target of under 70 by 2030, up to 32% of adolescent mothers and 20% of women overall have reported verbal abuse, physical abuse, stigma, discrimination or neglect during maternal care, often exacerbated by low awareness of patient rights which are enshrined under the 2010 constitution (Article 43) and national health policies. Most nurses in public health facilities treat patients badly, abuse them, and dehumanize them; this is especially true in settings where patients receive basic and prenatal care (Ebrahim et. al., 2024). Such experiences deter women from seeking timely antenatal care services, leading to lower attendance rates (e.g., only 58% of women complete the recommended four ANC visits), delayed interventions for complications like hemorrhages during pregnancy or infection, and preventable deaths—accounting for nearly 5,000 maternal fatalities annually (Bohren *et al*., 2019).

Inadequate access to health information exacerbates a lot of risks related to pregnancy and child birth; for instance, poor nutrition knowledge during pregnancy results in unbalanced diets deficient in key nutrients, causing birth defects such as neural tube defects (e.g., spina bifida or anencephaly from folic acid deficiency), congenital heart defects, orofacial clefts, and cretinism from iodine deficiency. These deformities lead to underweight or overweight infants, prolonged suffering, developmental disabilities, higher morbidity (e.g., respiratory issues, cognitive impairments), and elevated neonatal mortality. For pregnant women, such outcomes trigger increased stress, postpartum depression, and long-term mental health challenges, amplifying family and societal burdens. This awareness gap among ANC women perpetuates suboptimal health outcomes, reduced health-seeking behavior and systemic inequities.

This problem undercuts the Kenya's public health framework, including Universal Health Coverage (UHC) initiatives under bottom-up economic transformation agenda (BETA) and national policies like the Kenya Health Policy 2014–2030, which emphasize equitable access to care. Economically, it burdens the healthcare system with increased costs from untreated complications and lost productivity, while socially, it reinforces gender inequalities and erodes trust in public health institutions. The educational intervention directly targets this problem by enhancing knowledge of patients' rights thus empowering women to advocate for respectful, informed health practices and equitable care.

Whilst many studies have been conducted about patient rights, there is limited studies done on the awareness level among the pregnant women, the practice and attitudes for healthcare providers particularly in Kirinyaga County.

1.3 Justification of the Study

There is need to address the pervasive violations of pregnant women's rights, which contribute to preventable maternal and neonatal health consequences globally and locally. Low awareness of patient rights results in delayed interventions which are life-threatening, nutritional deficiencies, economic and social distresses which could be averted by improving their knowledge. This experimental study fills a critical gap by testing an educational intervention to enhance awareness thereby empowering women to advocate for dignified care and informed health practices potentially resulting in reduced mistreatment, multi-component programs, aligning with Kenya's Constitution, Health Policy 2014–2030, and SDGs, and providing evidence for scalable, cost-effective strategies to lower morbidity, mortality, and inequities in maternal health. The current study addresses this challenge by introducing educational intervention to increase the knowledge of patient rights.

The significance of this study relies on the fact that patient care is the ultimate goal of medical institutions. This study offers an opportunity to assess patients' awareness and satisfaction regarding their rights and could drive the attention of the community towards this issue. Moreover, there are limited studies regarding this subject locally and regionally.

Promoting patients' rights is a multidimensional issue and in order to achieve it, comprehensive efforts should be put in place. The constitution of Kenya 2010, through the Bill of Rights places the responsibility on the health sector to ensure realization of right to health by all citizens. The goal for the health sector as indicated in the Kenya Health Policy 2014-2030 —is to provide equitable, affordable and quality health care to all citizens (MOH, 2014b). The findings of this study will contribute towards implementation of policy in primary health care facilities.

Healthcare providers are responsible for advocating for and maintaining patients' rights (Alzeftawy *et al.*, 2018). Increased patients' rights awareness improves the healthcare provider-client relationship, improves the adherence of treatment and guidelines, decreases the chances of maternal and child mortalities, improves the recovery rates of patients, decreased length of stay in hospitals, lower risk of irreversible physical and spiritual damages, and more importantly, increased dignity of patients through informing them about their rights to participate in decision making (Aljeezan *et al*., 2022.).

The findings of this study may contribute to the interventions put together by the Ministry of Health (MoH) to establish and extensively publicize guidelines for patients to report cases of violation of patient rights and avenues to improve delivery of service to its patients. The MoH can also commit more resources to ensure availability of basic resources for implementing patients' rights issues and improve service delivery. Though there are policies to monitor the implementation of the patient rights, the findings of this study is important in formulation of policies to not only measure the right to complain but to monitor and evaluate the adherence of these rights (Parsapoor *et al*., 2012).

In addition to this, the findings will be most useful to MoH in devising strategies for ensuring patients' rights are understood, practiced and protected in all healthcare institutions. Patients can be educated about their rights as patients by health-care providers using workable channels i.e. seminars, health talk forums, media or use of booklets. The attitude of health-care professionals needs to be in line with the Patients' Rights in all situations (Sheikhtaheri *et al*., 2016). This study also offers opportunities for identifying strategies whereby policy, legislative and programmatic developments can strengthen systems for practice of patients' rights in resource constrained public health settings like Kirinyaga County, towards improving health outcomes.

1.4 Study Objectives

1.4.1 Broad Objective

To determine the effect of an educational intervention on patients' rights knowledge among pregnant women attending antenatal clinics in Kirinyaga County, Kenya.

1.4.2 Specific Objective

1. To determine the levels of awareness of patient's rights at baseline among pregnant women attending antenatal clinics at primary health facilities in Kirinyaga County
2. To explore the knowledge, practices, and attitude of health care providers towards patient rights awareness at primary health facilities in Kirinyaga County
3. To determine the effect of an educational intervention on patients' rights knowledge among pregnant women attending antenatal clinics in Kirinyaga County

1.4.3 Research Questions

The following research questions guided the above objectives: -

1. What are the levels of awareness of patient’s rights at baseline among pregnant women attending antenatal clinics at primary health facilities in Kirinyaga County?
2. What is the knowledge, practices and attitude of health care providers towards patient rights awareness at primary health facilities in Kirinyaga County?
3. What is the effect of an educational intervention on patients' rights among pregnant women attending antenatal clinics in Kirinyaga County?

1.5 Conceptual Framework

This study is guided by a conceptual framework that examines the relationship between independent and dependent variables with health education as a key intervening variable. There are several modes that have been developed that serve as a foundation for defending patients' rights. This is accomplished by recognizing and resolving the difficulties patients have when pursuing healthcare services.

The independent variables comprise various domains including the sociodemographic factors such as age, level of education, and existing attitudes and practices that influence the pregnant woman ability to comprehend and internalize information related to patient rights. The other factors including patient rights awareness include prior knowledge and exposure to training, perceived barriers (e.g., literacy, cultural norms), and healthcare provider attitudes, shape baseline knowledge and receptivity to new information. Some health system factors, such as availability of patient rights charters in the facilities, adequacy of resources, policy and implementation and prevailing practices within healthcare facilities, determine the extent to which patient rights are promoted and reinforced within the hospital environment.

The intervening variable in this study is the utilization of health education through structured educational talks and informational materials (e.g., bookmarks). This intervention serves as a mediating mechanism through which independent variables

influence the outcome. Specifically, the educational sessions delivered by the healthcare providers are designed to enhance understanding, address misconceptions, and provide actionable knowledge on patient rights, thereby reducing the effect of existing barriers and disparities in baseline awareness.

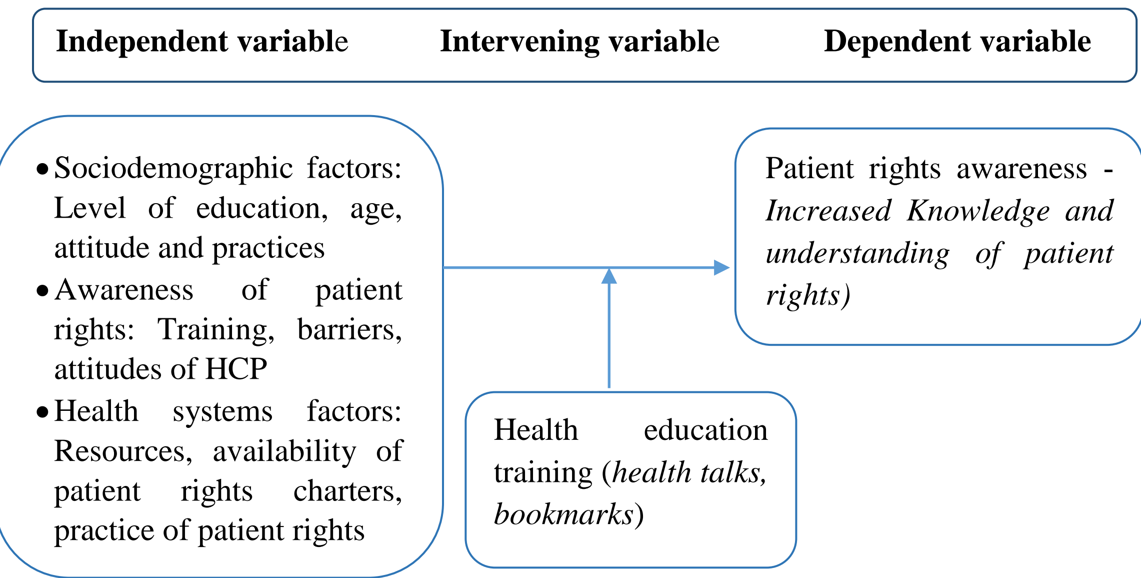


Figure 1.1: Conceptual Framework

Source: (Adopted from Lodestein et al., 2013)

The dependent variable is patient rights awareness, operationalized as the level of knowledge and understanding of patient rights among pregnant women attending antenatal care services. This includes awareness of key rights such as informed consent, privacy and confidentiality, respectful care, and the ability to seek redress.

The relationships depicted in this framework are supported by established behavioral and learning theories. The Health Belief Model posits that cues to action, such as health education, can influence individuals' perceptions and motivate behavior change.

In the broader context, the conceptual framework anticipates that educational intervention will positively influence patient rights awareness among pregnant women, while accounting for variations in individual characteristics and health system contexts.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents the literature that informed the study with the focus on the objectives. The philosophy of the study research has been discussed as well as the theoretical framework and conceptual framework are presented. The literature on the specific components of patient rights charter and the level of awareness is presented. The research gaps have been highlighted.

2.2 Background

Based on the Alma Ata declaration of 1978, Primary health care (PHC) is defined as essential heath care based on practical, scientifically sound, and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

Access to primary healthcare is widely acknowledged as key to reducing the global burden of morbidity and mortality. Primary health care facilities are the first contact that patients have with health systems and serve 68% of the population that lives in the rural settings in Kenya (KNBS, 2019). Despite the coverage of primary health services, there is evidenced low health seeking behaviors including the most critical services like antenatal, postnatal care and immunization for under-fives. Studies have shown that health facility design have an impact on both health care provider and patients' satisfaction with health systems (Kagoya *et al*., 2013). Preventive, promotive and curative health services are provided in community-based tier 2 health facilities, the first contact that the patients have with the health care provider.

The Constitution of Kenya enshrines the right to health under the Bill of Rights. Specifically, Article 43(1) a) provides that every person has the right to the highest attainable standard of health, including the right to health care services and reproductive health care and the sub-article provides that a person shall not be denied emergency medical treatment. Despite these provisions, patients and specifically for this study pregnant woman still face abuse and disrespect while seeking medical care at the facilities and this is largely attributed to many factors including the awareness of their rights as recipient of healthcare.

The Kenya National Patients' Rights Charter (2013) outlines the rights and responsibilities of patients in Kenya's healthcare system. These rights are based on the Constitution of Kenya (2010) and international health standards.

Table 2.1: List of Patient Rights and Responsibilities

	Patient rights	**Patient responsibilities**
1	Right to Safety and Quality Care	To promote hygiene while at the facility
2	Right to receive emergency treatment	To give HCPs relevant and accurate information to facilitate diagnosis and treatment
3	Right to safe and hygienic environment	To keep scheduled appointments as advised by HCPs
4	Right to Confidentiality	To express any concerns through the right channels confidentially.
5	Right to Informed Consent	To follow instructions, adhere to and not abuse or misuse prescribed medication or treatment
6	Right to privacy during examination	Respect the rights of others and not endanger their life and health
7	Right to be treated with dignity and Respect without discrimination based on race, gender, religion, disability, or financial status.	Treating healthcare providers and other patients with dignity and respect
8	Right to access Healthcare	To be aware of the available healthcare services to make informed choices while

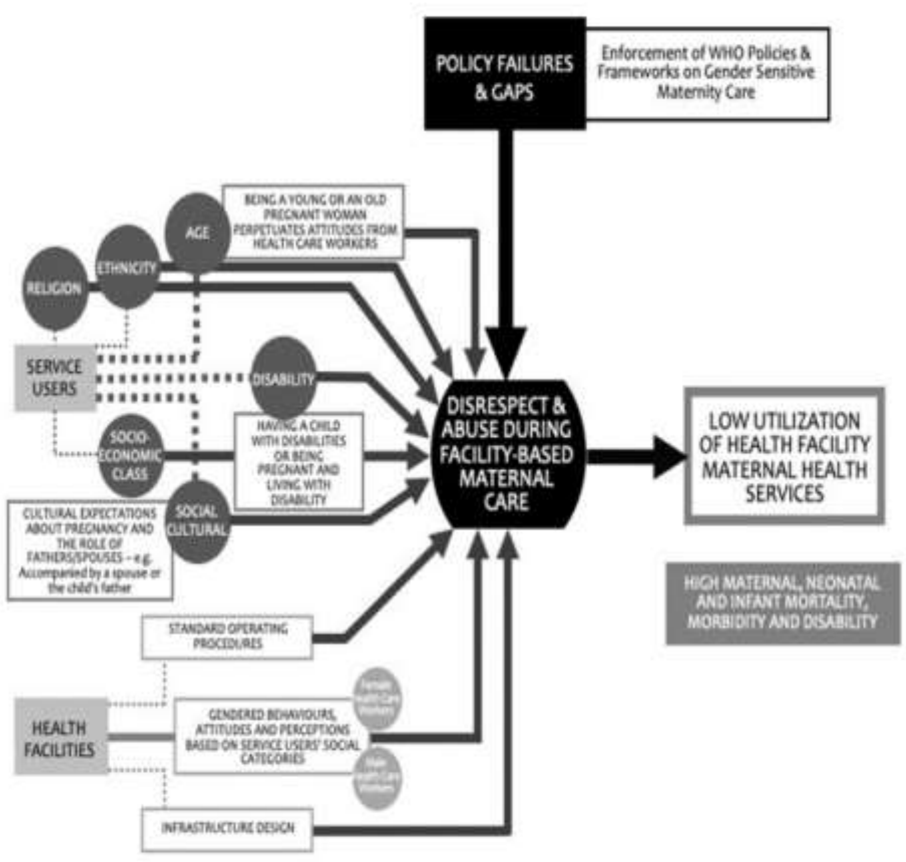
	Patient rights	Patient responsibilities
		utilizing them
9	Right to refuse treatment	To abide by hospital rules and safety regulations
10	Right to Referral and Second Opinion. Patients can seek a second opinion and request referrals to other healthcare facilities.	To seek treatment at the earliest opportunity
11	Right to be informed. Patients to be informed about their health status, diagnosis, treatment options, and risks	To enquire about costs of treatment and other services and make appropriate arrangements for payments
12	Right to choose a health provider	Providing the name of a person who can act on my behalf when incompetent to make informed health decisions
13	Right to access medical records	To take care of the health records in my possession and provide them when needed
14	Right to participate in care decision making. Right to be involved in decisions regarding care and treatment.	To take care of health by adopting healthy lifestyle
15	Right to Redress and Complaints	

2.3 Patient Rights Violations

Disrespectful and abusive behaviors on woman during the process of childbirth at health facilities is a public health concern, which violates woman dignity, integrity, and respectful care in maternity units. Disrespectful maternity care is not only the absence of respectful care that can threaten the dignity, privacy, and confidentiality of mothers but, also, causes psychological or physical harm to the mother through discrimination and maltreatment, obstruct or prevent choice in treatment, and fail to provide support to the mother and baby during labor and childbirth. The adoption and contextualization of standards of respectful care and quality measures are important to reinforce facility-based care among mothers, leading to better delivery experiences and outcomes for mother and baby (WHO, 2020).

Every woman has the right to get quality of health care, which is respectful, dignified, free of violence, free of discrimination, the right to know the procedure and any activities related to health care. Nevertheless disrespect, abuse and abandonment of women during the process of childbirth at health facilities constitute seriously violation of women rights, which has been acknowledged across the world. Human rights violations or a disregard for them may have detrimental effects on one's health. Discrimination occurs both within the healthcare workforce and between providers and patients (WHO, 2021). Human rights violations, such as forced or forceful treatments and procedures, neglect during treatment, may affect persons with disabilities, indigenous peoples, HIV-positive women, pregnant women and adolescents (Rubenstein & Amon, 2019). Additionally, disregarding these patients' rights in clinical practice undermines patient-provider trust and endanger patients'

According to studies done by Lusambili, A *et al*., (2019) women experience disrespectful maternity care by some healthcare workers, particularly by female staff during their routine facility visits. The presence of disrespectful maternal care throughout the maternity process appears to be even greater among women who are poor, young, distant, or have children with disabilities. Consistent with research in other LMICs (Oyugi B *et al.,* 2023) examining disrespectful maternity care, there is no reason to believe that the results would not be generalizable to other Kenyan communities.



Fiqure 2.1: A Summary of Factors that Influence Disrespectful Maternity Care Adopted from (Lusambili et al., 2020)

The widespread practice of disrespectful care has the potential to undermine the efficacy and reputation of the entire Kenyan public maternity health care system and can lead to low utilisation of maternal care thus reduces maternal and child mortality. These findings raise issues around various aspects of delivering acceptable and respectful care including social cultural norms, the gendered nature of maternity care, the stigma around poverty, age, pregnancy, and disabilities, and the structural barriers and inadequacy of resources for maternal care. Moreover, the consistency of these reports with findings from other low- and middle-income countries (Abuya T *et al.,* 2015), especially the treatment of adolescent women, shows that these are not isolated experiences suggesting

there are social cultural undercurrents that guide treatment towards these more marginalized groups. These findings demonstrate an urgent need to address these social and cultural issues to ensure that care provided under the Kenyan Free Maternal Policy is safe and satisfactory care to reduce infant and maternal mortality.

To prevent patient rights from being violated, interventions should be implemented. In-service training regarding patient rights laws and continuing but sustainable education programs should receive more consideration (Sookhak *et al*., 2019).

2.4 Awareness of Patients' Rights Charter

The United Nations established the Universal Declaration of Human Rights in 1948, and which has been implemented all over the world. Health policies, initiatives, and programs should be designed to enhance equitable access to the right to health for all individuals, particularly the most vulnerable —while explicitly adopting a rights-based approach. (WHO, 2021). Patient rights form an integral part of healthcare practice. In fact, patients are one of the most vulnerable members of society and as a result, improving the rights of patients is considered a priority in healthcare.

The Kenya's Ministry of Health launched the first Kenya National Patients' Rights Charter in 2013 (MOH, 2013). Patients' Rights Charters (PRC) is a model for health system accountability that targets the relationship between the users of facilities and health professionals (Atela, M *et al.,* 2015). The charter provides information on standards of care that patients can expect to receive and demand as basic human rights. The aims of the patients' rights charter are — to improve client-oriented service of health providers, promote awareness among the population, of rights to health and appropriate health seeking behavior and promote awareness (Aazami & Mozafari, 2015). Primary health care facilities are the first contact of the patients with health systems and provide a platform for interventions that contribute to the achievement of the goals of health systems.

The institutionalization of patients' rights is a recent phenomenon in Kenya. And with time and dissemination of information, Kenyans are now becoming aware of their rights. The new Constitution contains an elaborate bill of rights which, among other things, guarantees the fundamental human right to health and other related rights such as the right to life. Its enactment marked the end of years of struggle and provided a useful opportunity to better articulate a legal and constitutional framework suited to advancing the right to health (Ojwang *et al*., 2010).

Article 43(1) of the Kenyan Constitution guarantees every individual the highest attainable standard of health and provides that no individual may at any moment be denied emergency medical care which is important to the realization of the right to life. It is important to note that in framing the right to health, the Kenyan Constitution adopted the right to the highest attainable standard of health recognized in regional and international human rights instruments. Although the compilation and promulgation of the Charter of Patients' Rights is a valuable step to fulfilling the rights of patients, studies indicate that the observance of patients' rights in health centers varies (Yarney *et al.,* 2016).

The Ministry of Health in Kenya presents all health services in its facilities to patients without any discrimination of any manner be it age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy gender identity or expression, national origin, medical condition, and marital status (Constitution of Kenya). Also, it acknowledges the rights of patients and their families or care givers during their treatment in health facilities and anticipates that the patients will receive services to their satisfaction as expected. All healthcare providers are focused on patients' rights and understand that these are the service of health delegates.

The implementation of patients' rights charter by countries has occurred at different times since the declaration by the United Nations in 1948. The patients' rights charter has three components: the patients' rights, the patient's responsibilities, and mechanisms

of dispute handling (MOH, 2013). There are statements within the patients' rights charter that are implied in the concept of responsiveness therefore suggesting a relationship between patients' rights charter and responsiveness. A graduate from a health institution should be able to implement these rights and practice since it's inculcated in their training curriculum (Shayo, P *et al*., 2020). Despite the professional preparation of health care providers, complaints by patients of being ill-treated as they sought services have been found in many countries. This informed the focus by Ministries of Health to implement the patients' rights charter as a policy with methods of implementation that vary between countries.

For many years, patients have not been made aware of their rights; that they can advocate for and demand better health care; that they can demand access to medications. Recipients of healthcare services have rights which must be acknowledged and protected. Such rights include observance of acceptable patient's physical mental, spiritual, and social needs guided by commonly accepted rules and regulations.

Patients' awareness of their rights can bring about a lot of advantages such as increased quality of health care services, decreased costs, more prompt recovery, decreased length of stay in hospitals, lower risk of irreversible physical and spiritual damage, and more importantly, increased dignity of patients through informing them about their rights to participate in decision making. A study involving Tanzanian women records that they experienced unfavorable conditions when delivering in health facilities (Ulkualp, N *et al*. 2016). Healthcare providers, women and their families must be made aware of women's rights to respectful care. This study recommended for further research include investigations of the prevalence and dimensions of disrespectful care and abuse, on mechanisms for women and their families to effectively report and redress such abusive events and on interventions that could mitigate abuse among pregnant women. Respectful care is indeed a critical component to improve maternity (McMahon, S.A *et al*. 2014). On the other hand, a lack of respect for patients' rights may result in risks and health security concerns of the patient. To overcome perceptions and information gaps

among patients, all healthcare actors should provide adequate information regarding the patients' rights charter.

Patients are expected to know their rights and practice their responsibilities when accessing health services in primary health care facilities (MOH 2014a). Some inpatients and outpatients do not have proper knowledge of their rights and responsibilities, and that could lead to misunderstanding between them and the health care provider. There are many studies that have been done regarding patients' rights and responsibilities.

A study done in Turkey about patients' awareness of their rights in a developing country indicates that patients seeking services are not yet aware of their rights, as 9 out of 10 patients were not aware of the relevant hospital legislation and 4 out of 10 patients were not aware of the complaints process (Kuzu *et al*., 2006), which is consistent with the findings of other similar studies. A similar study done in Uganda reported that most patients (81.5%) and healthcare workers (69.4%) had never heard of the Uganda Patients' Charter. Over half of the patients (55.5%) indicated that they did not fully know their rights as patients, despite 72% having a secondary education (Kagoya *et al*., 2013b). This study is consistent with a study done in Sudan which stated that only 4.6% of patients were aware of the Sudanese Patients' Bill of Rights. Most patients (93%) were not aware of any of their rights (Younis *et al*., 2017). Another study at the University College Hospital Ibadan in Nigeria, found that most of the respondents (94.2%) had a good knowledge of rights, and few (37.2%) of them denied being actively involved in making decisions on issues concerning their care. However, about half (50.8%) claimed that they were not fully informed about the diagnosis and treatment plans regarding their health conditions. About 75.0% of the respondents reported that they would seek to redress if their rights are infringed upon (Abolarin & Oyetunde, 2013). Even though this researcher concludes that patients have good knowledge of their rights, the patients are not fully exercising these rights. Patients should be encouraged to participate in the decision-making process on their health issues because it is a channel towards achieving positive patient outcomes. Adequate information about

care, including the risks of procedures, cost implications of care and possible outcomes of care among others, should be provided. Provision of more information by health care providers may enhance patients' decision making and exercise of rights (Parsapoor *et al.*, 2012).

Another study showed that only 46% of the respondents were aware of their rights (Aljeezan *et al*., 2022.) and this is consistent with another study done in a developing country, Iran, where it showed that 59.4% of the patients showed moderate awareness of their rights (Mossadegh Rad & Esna Ashari, 2012). Some of the patient rights parameters seem to have been well understood by patients and the most and least awareness respectively are named as trust and assurance to confidentiality of treatment team and providing sufficient information about treatment options and their complications. These findings confirm that there may be problems in correct perception and practical implementation of all elements of the patient rights charter.

The knowledge of the existence of patient’s charter plays a critical role in the awareness of the patient charters in health facilities (Yakong, *et al*., 2010). Whereas these charters are available, a lot of effort needs to be put in place to disseminate and educate clients on the contents of the charter. A study done in a teaching hospital in Sudan showed that, only 48.4% of the participants knew the existence of it (Abdalla *et al*., 2019).

Health systems that implement patients’ rights should ensure that awareness on the specific contents of the charter is raised. Awareness by patients on the content and application of patients’ right charter has been extensively researched in various country contexts of outpatient specialist (Abou *et al*., 2013; Krzych & Ratajczyk, 2013). In a study in Sari, Iran, there was a relationship between the age of patients, education level and awareness of patients’ rights charter (Holmes *et al*., 2014). In another study by Parniyan, patient awareness was associated with the type of services sought either as in patient or outpatient (Parniyan *et al*, 2016). In another study, respect was significantly related to patient education in the implementation of patients’ right charter (Padgett *et*

al., 2014). Studies have demonstrated a relationship between patients knowledge, and access to information (Kagoya *et al*., 2013).

2.5 Knowledge, Practices and Attitudes of Patient Rights

It's expected that when the knowledge of patients is good then the observance of the domains of patient rights is high, however in most settings, the observance is quite low. The degree of adherence would make policymakers understand the impact of patients' rights and thus provide them with evidence to provide quality health-care service delivery and patient care through patients' rights. The healthcare facilities can adhere to the patients' rights by observing them.

In a study in Uganda, patients' rights-related information was displayed on departmental notice boards or clinic notice boards and patients had access to information at an information center outside of the hospital (Kagoya *et al*., 2013). Key informants and HCPs at the hospital reported participating in community and media sensitization campaigns and continuing medical education to create awareness of patients' rights. Only 46% of healthcare providers reported engaging in activities to create awareness of patients' rights during patient consultations or community campaigns. Aspects commonly communicated to patients included nature of disease and treatment, health services offered, consent, procedures to be undertaken, arriving at a decision and implications (Yaghobian *et al*.,2014).

According to a study done in Egypt by Sabsevari *et al*., (2016) observance of human rights was recorded as high as by 84.4% of the respondents. The highest proportion of observance of patients' rights was on respecting patients' privacy and observing the principle of confidentiality, which was observed by all subjects (100%). The lowest value of patients' rights observance was related to presenting appropriate and adequate information for patients, which was observed among 48.1% of subjects. It also recorded that there was no significant relation between personal details (age, gender, education and career) and observance of patients' rights ($p>0.05$). This study recommended that

since, the observance of patients' rights by healthcare providers is optimal in most areas, the area of providing appropriate and adequate information needs to be promoted by sensitizing them (Visscher *et al*., 2018). More stringent regulatory policies can be compiled by the government and implemented to the items of Patients' Rights Charter along with training courses, to strengthen healthcare provider awareness in this regard.

Exploration of healthcare providers' awareness on patient rights is important in shaping approaches to support their moral behavior at the patients'/families' best interest. Although various aspects of patient rights have been extensively addressed in the literature, it is difficult to form a comprehensive and integrative picture on patient rights, especially from the perspectives of the healthcare providers (Parniyan *et al*., 2016)**.** Studies investigating particular aspects of the patient's rights topic do not provide evidence on which rights receive low priority compared to others; possible inconsistencies between education and clinical practice; or advocating for patient rights. Based on the above, the study will aim at reviewing the current evidence on HCP' knowledge and attitudes regarding the entire spectrum of patient rights. The study was explored based on a) the sources of HCPs' knowledge, b) HCP's level of knowledge and associated factors, and c) HCPs practices and attitudes towards patient rights (Yakov *et al*., 2010).

Patients often look at the attitude of health workers as either good or bad depending on how they are received or handled. Staff attitude is continuously coming under the spotlight as policy makers start to see the relevance in service delivery and utilization. Studies have shown that in cases where patients find staff with a bad attitude, they tend to skip appointments. Healthcare providers have been found to link their attitude with job satisfaction in previous studies. According to Abusamra *et al.,* (2023), open communication among health workers improves quality of service provision in terms of shared delivery methods. Staff attitude and staff satisfaction are instinctively linked to patient safety satisfaction with the service, which ultimately leads to reduced missed appointments.

Health care providers need access to information on patients' rights as and when they need to. Most studies have shown that HCPs get information through brochures, media, booklets and school curriculum but there is a need for refresher once they are working. Due to the arising of new institutional and legal adjustments about practicing of the patient rights, knowledge taught during formal education becomes insufficient. Therefore, it is obvious that addressing this issue in institutional service education, keeping the institutional service education up to date and improving it are needed (Atela *et al*.,2015).

A study done in Egypt identified undergraduate nursing courses, educational programs and sharing experience with colleagues, and to a lesser extent the media or hospital brochures (Ibrahim *et al.*, 2017). In another study among nurses from Turkey reported ethics content to be part of the hospital educational program during nursing orientation training (Mohamed, 2019). One Iranian study found that nurses with a master's degree and sufficient work experience seemed to be more aware regarding patient rights (Sheikhtaheri *et al*., 2016), while on the contrary in a study done in Finland, about 61% of the nurses had received formal training related to most ethical issues (Iltanen *et al.*, 2012). In other studies, hospital seminars, lectures and personal study seemed to be the sources of knowledge for HCPs, this was reported in studies done in Sudan, Turkey and Barbados (Abdalla *et al*., 2019).

Patient satisfaction can be evaluated by assessing health care systems and organization of maternal child healthcare services. In view of that, meeting the patient's needs consists in one of the main purposes of the health care system. Patients consider healthcare providers attitudes and behaviors as one the ways to assess the quality of health care services (Zebiene *et al*., 2014). The expectations of patients in respect to personal rights, good communication and attention, clean and safe environment and a qualitative service consist of basically the attitude and behavior that are relevant to the purpose of patients' rights.

An Iranian study (Parsapoor *et al*., 2012), assessed the nurses' attitudes towards the patient rights to privacy, non-discriminatory treatment and freedom to choose treatment; the participants put less emphasis on the patient's right to access personal medical records, while emphasized both the need for access to an active complaint system, and for disclosure of medical errors. In a survey in Nigeria, 91.8% of the participants agreed that nurses should have an advocacy role in practicing patients' rights (Mohammed *et al*., 2018). In a Turkish study, approximately 98% of respondents agreed that healthcare services recipients should be cared for in a safe and friendly environment, with respect and no discrimination (Akca *et al*., 2015), while in another Turkish study nurses emphasized positive attitudes towards the patient rights to privacy, confidentiality and informed consent (Gurung & Ghimire, 2020). On the contrary, a Korean study on nurses' attitudes towards the patient rights to autonomy, privacy, informed consent and confidentiality revealed that the respondents had poor awareness on these topics (Kim *et al.*, 2018).

According to studies done in Sudan (Abdalla *et al*., 2019), only 65.8% of nurses had acceptable level of knowledge (scored more than 75% of the total knowledge score) of patients' rights. In other studies, it was found that level of knowledge regarding patient rights was found to be low, despite the fact that human rights and protection of the public both receive high priority in the nursing codes of ethics (Mpouzika *et al*., 2021). Given the role of nurses as patient advocates and educators, low level of knowledge on patient rights among them may also be associated with low patient rights awareness among patients themselves (Abedi *et al*., 2017). In a quasi-experimental study done in two hospitals in Egypt, the results showed remarkable improvement in nurses' knowledge and perceptions about patients' rights after implementation of the training sessions was remarkable (Ibrahim *et al.,* 2017). Moreover, an improvement in patients' perceptions regarding their rights was reported. The researcher suggested repetition of the training sessions is suggested to achieve continuous improvement. Provision of

posters and booklets about a bill of patient rights within the hospitals (Srivastava *et al*., 2015).

Patients tend to avoid facilities where their expectations are not met. Patients also tend to show up for their 47 medical appointments when they are certain about the professionalism of the health care providers (Abuya T *et al*., 2015). In addition, there is a high likelihood of minimal missed appointments where workers are professional and friendly to the patients. Competent staff have the skills, abilities, and knowledge required to deliver the services to the patients in a friendly manner without any form of discrimination. Health providers who are competent are in a position to identify the health needs of the patient, and deliver the same services effectively, thereby encouraging patients to consistently attend their medical appointments, including antenatal clinics. Patients often look at the attitude of health workers as either good or bad depending on how they are received or handled. Staff attitude is continuously coming under the spotlight as policy makers start to see the relevance in service delivery and utilization (Starfield *et al*., 2012). Studies have shown that in cases where patients find staff with bad attitude, they tend to skip appointments. Hospital staff have been found to link their attitude with job satisfaction in previous studies.

According to Abusamra *et al*., (2023), open communication among health workers improves quality of service provision in terms of shared delivery methods. Staff attitude and staff satisfaction are instinctively linked to patient safety satisfaction with the service, which ultimately leads to reduced missed appointments. For example, nurses who are satisfied with their jobs tend to be happy serving patients. Therefore, it is a great deal for health workers to be satisfied with their jobs as this has a direct impact on their attitude to delivery service. Health leaders are encouraged to create a work environment and culture that are satisfying to the health workers in order to ease and improve their attitude in the delivery of health services. Staff attitude is crucial in ensuring the utilization of health services on the part of patients, which in turn translates to sustainability and quality of health care provision. Previous literature shows declining

job satisfaction among health workers in many countries including Kenya that face related 48 issues collapsing health care services because health workers are losing their motivation. The quality of care provided depends on the staff's job satisfaction. When few health workers are serving a large population, the quality of care is likely to be low and satisfaction levels are expected to decline (Zhou *et al*., 2017). The signs of job dissatisfaction result in bad staff attitude, high absenteeism, labor unrest, low productivity, high labor turnover, and industrial action. This may lead to low patient turnovers in fear of poor-quality services, hence high missed appointment rates.

2.6 Quality of Services at the Health Facilities

The Alma Ata declaration in 1978 has long aligned with health policymakers to focus on improving access to health care, particularly in marginalized environments. However, disparities in health outcomes remain wide and it has become increasingly clear that poor quality of care is an impediment in translating access to better health care. The Lancet Global Health commission argued that a high-quality health system should exhibit an "absence of disparities in the quality of health services between individuals and groups with different levels of underlying social disadvantage" (Kruk, *et al.,* 2018). However, evidence on the inequalities in quality of care remains scarce. Although a few studies have shown that poorer groups are more likely to receive lower quality care questions remain regarding the underlying drivers of these inequalities. Delivery of quality healthcare to those who deserve is a human right. Health care is an indispensable element for economic growth and development of individuals and nations. Higher healthcare quality results in satisfaction for the patients and the community in general, healthcare providers and leads to improved productivity. If quality of healthcare services improves, costs decrease, productivity increases and a better service would be available for clients, which in turn enhances better health outcomes (Mantwill *et al.,* 2015).

Healthcare service quality is associated with patient satisfaction, ensuring the safety and security of patients, reducing mortality and morbidity, and improving the quality of life.

Patient satisfaction with health service is linked to increased utilization following Contentedness with healthcare received from health providers. There is an increasing public perception of poor quality of care among patients visiting public health facilities which translates into service dissatisfaction. Meanwhile, patient dissatisfaction will more likely result in poor utilization of healthcare service disregard for medical advice and treatments non-adherence. Such disregard can lead to pregnant women totally missing their appointments for antenatal care (Ali *et al*., 2025). Patient satisfaction plays an important role in maintaining relationships between patients and health care providers, compliance with medical regimens, and continued use of healthcare services. Also, patient satisfaction is felt to be of paramount importance with respect to quality assurance and the expected outcome of health care. However, the relevance of patient satisfaction studies with respect to quality management and improvement in the health care sector is often questioned because of conceptual and operational problems.

In most developing countries, evidence has revealed patients' satisfaction has been remarkably low. Health facilities have to be patient-centered and focus on service marketing to ensure the sustainability of their services. For instance, in Ghana, the Ministry of Health oversees the formulation of policies and strategies, and healthcare for the populace are generally implemented by the implementing partners of MoH (Owusu *et al*., 2024). The MoH coordinates the implementation of primary health care policy with other ministerial agencies. The major cities and regions in Ghana have typically attracted the best health facilities and significant proportion of health staff, and these professionals provide health services to patients, including out-patient services. Some of these out-patient services include general health services such as triage, health promotion and preventive services and general medical surgical, pediatric and maternal services, offering this line of treatments of primary care in a safe and pleasant environment.

Studies in Ghana have revealed a fierce competition between public and private health providers, as healthcare quality has become a critical component of national healthcare

policies. Patients seem to prefer private health care facilities despite the fact that public health providers have a more complex structure and employ the bulk of health experts in the country (Owusu *et al.*, 2024).

Patients at public facilities, in some instances, are misdiagnosed and poorly treated, often forcing them to resort to treatment at private facilities. Perceived effectiveness, confidence, service quality, interpersonal relationship, and shorter waiting time influence patients' preference of private health facilities over public facilities and this has not only been observed in Ghana, but in mist LMIC's. Additionally, physical environment and outcome quality influence choice of facilities patients visit. Despite the perceived benefits and quality associated with utilizing private health facilities to public, majority of the populations seem to rely often on public health facilities for healthcare services, and this could be due to the higher cost of accessing service at private healthcare facilities, and poor economic status among many patients. This percentage of Ghanaians utilizing public health facilities experience sub-optimal quality care, translating into poor patient satisfaction (Mantwill *et al*., 2015).

It is becoming increasingly clear from previous studies that perceived poor quality of care results in patients' dissatisfaction, as well as acts as determent to utilization of healthcare utilization. Quality of care is a major factor that could explain the disparities and the unsatisfactory health outcomes. Patients who are dissatisfied with health services are less likely to utilize health facility, disregard medical advice, and not adhere to treatment regimen (Mantwill *et al*., 2015).

For many low and middle-income countries poor quality health care is now responsible for a greater number of deaths than insufficient access to care. This has in turn raised concerns around the distribution of quality of care in LMICs: do the poor have access to lower quality health care compared to the rich.

A quasi-experimental study showed that training effectively improved inter-professional relationships between healthcare providers and patients, provided safe learning experiences, and reduced the gap between emergency readiness of rural and urban healthcare providers. Such sensitizations training positively impacted rural healthcare providers' confidence and competency to manage trauma care in rural healthcare settings thus improving the quality of life for patients. Kenya's patient rights charter gives a patient right for emergency care and a study on implementing and evaluating the Maternal and Neonatal Emergency program showed that there was an improvement in various components of knowledge, such as knowledge of teamwork principles, effective communication, clinical governance and risk management, eclampsia management, knowing how to escalate and access help, knowledge of post-partum hemorrhage management, leadership and delegation and knowledge and understanding of performing newborn resuscitation. The results also showed that this program was effective in enhancing confidence in healthcare providers in managing eclampsia, post-partum hemorrhage and newborn resuscitation and also showed positive behavioral outcomes (Christiansen, *et al.*, 2023).

Several studies have also reinforced the need to engage patients in changing the culture of the healthcare providers and the healthcare settings. For instance, some studies have reported a shift in organizational culture promoting further patient participation in service design and delivery achieving collaboration and mutual learning and sharing or neutralizing power among patients and providers or staff as well as developing new competencies and negotiating for service changes (Halawany *et al*., 2016).

In Kenya, Satisfaction with healthcare services has for long been reported as low and many reasons including cost of services has been given as one of the reasons for dissatisfaction with the services. Similarly, incidences of unfriendly healthcare workers as well as poor treatment of pregnant mothers in public health facilities have been demonstrated to be a barrier in maternal healthcare seeking behavior (Abuya *et al.,* 2015).

2.7 Educational Intervention on Patients' Rights Awareness

There have been varied receptions for the implementation of patient rights charter across the region to address patient awareness gaps. Educational interventions have demonstrated significant potential in patient rights awareness and empowering women to advocate for better maternal care. Most educational interventions involve structured training sessions, workshops, use of informational materials, or digital tools delivered during ANC visits, aiming to enhance knowledge of rights such as informed consent, privacy, non-discrimination, and access to health information on nutrition and pregnancy practices. By addressing awareness gaps, they mitigate unintended consequences like timely attention to emergency pregnancy situations like hemorrhage, balanced diets that may lead to birth defects i.e. folic acid, underweight or overweight impacts that are prone to morbidity, and maternal mental health concerns like postpartum depression (Levin *et al*.,2014).

Globally, a systematic review to highlight the efficacy of an educational intervention for midwives and nurses found that targeted training programs improved tremendously the respectful maternal care practices reducing instances of mistreatment and abuse by 15-30% and enhancing the perception of women to dignified care. The programs observed including the use of case studies, rights-based curricula and role-play resulted to a better patient-provider communication and increased patient rights awareness among women. This study reported improved health behaviors like adherence to nutritional guidelines to prevent neonatal deformities and maternal stress (Buciu *et al.,* 2025). This study also showed adverse effects of preeclampsia on neonatal well-being, birth weight, and gestational age at birth was partially mitigated by maternal education. Birth weight. These findings underscore the importance of incorporating maternal education into prenatal care programs to improve perinatal outcomes, with a special focus on high-risk pregnancies. World health organization has also emphasized the need to incorporate multi-component strategies which includes community education by fostering

accountability and empowering women to report violations, ultimately lowering maternal morbidity and other mortality risks (WHO, 2023).

Various studies in LMICs have shown greater impact due to baseline low awareness. A study in Ethiopia explored respectful maternal care training for healthcare providers revealed that participant's perceptions shifted positively with women reporting less neglect and better access to information on pregnancy nutrition thereby reducing risk of overweight's and underweights for babies and prolonged infant suffering (Gibson *et al.,* 2020). Another study that utilized quasi-experimental study using online educational interventions showed a 25% improvement of respectful maternal care and advocacy in clinical settings.

According to some studies (Alzeftawy et al., 2018), the effect of the educational intervention had a significant difference between both study before and after intervention, and this emphasizes the importance of education for nurses and other healthcare providers about patient rights. These findings are in agreement with a study done in Iran (Rostami-Moez *et al*., 2021) that showed high scores of all aspects of the patients' rights being higher in after training than before training. Significant differences in the desirable services domain indicated that teaching the patient rights charter to midwifery students had a positive effect on their compliance with patients' rights. Awareness of the desirable services can lead to compliance with this right. Several other studies have reported the same findings by scoring higher score in awareness and practice by nurses that received educational intervention compared to the control group is similar to results of studies that show educational programs can change practice of nurses and ultimately lead to improved quality of care services (Onyambumasese *et al*.,2016). Promoting patient rights is among the priorities of healthcare providers and is considered as an indicator of health state in every community. One of the examples pointed out was the impact of visible display of posters in health facilities. The healthcare recipients became more mindful of the rights and responsibilities of the patients and even how they responded to their questions. This had a direct impact on

utilization of services, patient perceptions and improved knowledge of the rights among the providers.

In Kenya, evidence has supported tailored interventions. A Heshima project study by Abuya *et al.,* (2017) carried out a participatory-based approach across 13 facilities where they integrated RMC training and community education, resulting in increased knowledge and improved practices among providers for understanding client rights, client-centered care, and positive attitudes towards and a 15–25% decrease in mistreatment and improved maternal satisfaction, highlighting the role of participatory approaches in addressing cultural barriers. Different perspectives from the Kenyan healthcare providers as recorded in a 2022 study emphasized the need for continuous training through continuous medical education, seminars and mentorships to sustain quality maternal care, with interventions also focusing on gender-sensitive education to reduce stigma and discrimination (Gitobu *et al.,* 2018). Some healthcare providers thought the charter had helped to improve the quality of care, understood in such terms as giving more time to patients, showing more respect, or having greater compassion. Some saw it as an instrument that could enable them to learn new things about patient care. On the other hand, these positive effects might be short-lived since many staff noted that once they had read the charter, they seldom looked at it again. Similarly, patient rights charters can be a significant tool for motivating healthcare workers, especially by rewarding those who adhere to these rights (Olwanda *et al*., 2024).

The human rights approach calls for an accommodative provider-patient relationship. Ideally, this would guarantee the patient the right to autonomy, free expression, self-determination, information, personalized attention, and non-discrimination (Tura *et al.,* 2020). Healthcare providers routinely engage in acts that hamper the realization of patients' rights. The majority of patients are not aware of their rights. Many patients simply do what the physician tells them to do. Some patients do not even ask questions because they do not want to take up the doctor's or nurse's time or appear ignorant while some may not know which questions to ask (Mosadeghrad *et al.,* 2016). The quality of

the relationship between nurse and patient is an important factor in patients' satisfaction and in turn affecting their commitment in the treatment and improving outcome.

2.8 Theoretical Framework

This study employs two major theories: The Health belief Model (HBM) and Bio-Psychosocial Model. These theories provide a solid foundation for investigating the factors that affect the awareness of patient rights awareness and the impact of health education interventions. The patient-centered approach, commonly referred to as the Bio-Psychosocial Model (BPM), emphasizes person-centered care. This model underscores the connection between patient care and patient rights. Patient-centered care is influenced by multiple factors, including those related to healthcare providers as well as patients themselves. Furthermore, patient involvement in decision-making regarding their own treatment is a key indicator of quality care. The characteristics of healthcare professionals involved in the patient-centered paradigm, such as honoring the patient's specific preferences and requirements and ensuring that the patient's values lead to all therapeutic decisions, are enshrined in the Patient's Bill of Rights. Patients' rights to knowledge, informed consent to treatment, dignity, and options, including the ability to select a healthcare practitioner, decline treatment, obtain emergency treatment at any healthcare institution, and be informed of any health plan terms or health insurance policy, access to and opinion, and the right to privacy in healthcare opinions, questions, and complaints about healthcare, are all part of the patient-centered model of care (Guillemin & Barnard, 2015).

Key attributes of healthcare professionals within the patient-centered approach include respecting individual patient preferences and needs and ensuring that patients’ values guide all treatment decisions. These principles are reflected in the patient’s bill of rights. Patients' rights to knowledge, informed consent to treatment, dignity, and options, including the ability to select a healthcare practitioner, decline treatment, obtain emergency treatment at any healthcare institution, and be informed of any health plan

terms or health insurance policy, access to and opinion and right to privacy in healthcare opinions, questions, and complaints about healthcare, are all part of the patient-centered model of care (Guillemin & Barnard 2015).

Researchers have developed various models to provide a framework for upholding patients' rights by identifying and addressing the challenges they face when seeking healthcare services. One such model is the Bio-Psychosocial Model (BPM), which promotes person-centered care. It outlines the range of factors influencing patient-centered care, including those related to both patients and healthcare providers, and highlights the link between patient rights and patient care.

Another model that has been employed by the researcher is the Health Belief Model that emphasizes that individuals' health behaviors are influenced by their perceptions of susceptibility to health issues, the severity of those issues, the benefits of taking preventive action and the barriers to taking that action.

The Health Belief Model (HBM) provides a useful framework for understanding patient rights awareness by explaining how individuals' beliefs influence their health-related behaviors. According to the model, a patient is more likely to seek information about and exercise their rights when they perceive themselves to be at risk of poor treatment (perceived susceptibility) and believe that the consequences of not knowing their rights are serious (perceived severity). Awareness is further strengthened when patients recognize the benefits of understanding their rights, such as improved quality of care and informed decision-making, while minimizing perceived barriers like lack of information or fear of questioning healthcare providers. Cues to action, such as health education, provider communication, and media campaigns, also play a key role in prompting patients to become more aware and assertive. Additionally, self-efficacy, or the confidence in one's ability to claim these rights, is essential in ensuring that awareness translates into active participation in care.

CHAPTER THREE

MATERIALS AND METHODS

3.1 Introduction

This chapter describes the study area, research design, the sample population, the sampling method, data collection instruments, methods of data analysis for the pre- and post-intervention phases, data quality control, limitations of the study and ethical considerations of the study.

3.2 Study Site

The study was carried out in Kirinyaga County in selected primary health facilities namely Kagumo health Centre and Mutithi Health centers. The County borders Embu County to the East and south, Murang'a County to the West and Nyeri County to the Northwest. Administratively, the County has 5 sub counties: Kirinyaga East, Kirinyaga West, Kirinyaga central, Kirinyaga North and Kirinyaga south. The County has a total population of 590,635 (KNBS, 2009). It covers an area of 1,479 km2, most of which lies on the southern slope of Mount Kenya, while the southern part (Mwea), are plains that are part of the Tana River basin.

The County lies on the windward side of Mount Kenya and receives adequate rainfall. The main socio-economic activities in this county are agriculturally based and include rice farming, small scale tea farming, coffee farming and horticulture. The population growth rate was projected at 1.6% (CHIS, 2014). Service delivery in Kirinyaga County is offered from Level 1 to 4 and there is a total of 238 Health Care Facilities inclusive of public health facilities, faith-based institutions, and private health facilities. On average the population can access a health facility within a radius of about 5km. The main public health concerns include both communicable and

and non-communicable conditions contributing significantly to morbidity and mortality. HIV prevalence in the county stands at 3.3% (~12,654 people), slightly below the national average of 4.5%, while TB notification rates are 245 per 100,000, above the national average of 222 per 100,000. Non-communicable diseases are on the rise, with an estimated 13.3% of residents living with hypertension compared to 24% nationally, and about 0.8% with diabetes versus 2–3% nationally, though under-diagnosis remains a challenge. Injuries, especially among motorcyclists, are disproportionately high, with 38% reporting crashes annually in Mwea against a 15% national injury prevalence. In addition, violence against women is a major public health concern, with national data showing 39% of women experience physical violence and 20.6% sexual violence, patterns likely mirrored in Kirinyaga county (Kirinyaga County, CAIP).

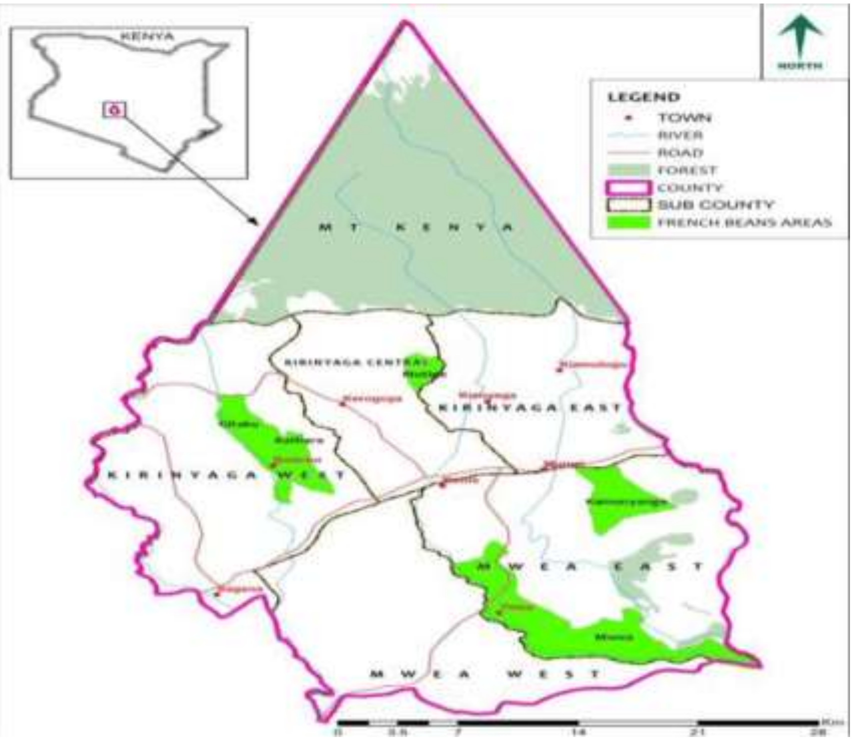


Figure 3.1: Kirinyaga County Map

3.3 Research Design

This study adopted a mixed method design with quasi-experimental quantitative arm employing non-equivalent group design where one group was assigned as an intervention site while the other a control site. In both groups, exit questionnaires and matching of respondents was done to control for confounding factors - excluding patients who discuss with other patients and clinicians about patients' rights in the control arm (Hansen & Klopfer, 2012). Both quantitative data and qualitative data using convergent parallel designs were collected at pre-intervention and post intervention, and its findings were analyzed.

3.4 Study Population

The study population were pregnant women attending antenatal clinics in Kagumo and Mutithi Health Centers.The target population were pregnant women within the first to second trimester but less than 20 weeks of pregnancy. Since women generally seek antenatal services towards the end of the first trimester, this period presents a practical opportunity to enroll participants (Ifenne & Utoo, 2012). Women in the third trimester were excluded due to the four-month duration of the intervention and hence they will deliver before the completion of the intervention period. Therefore, only women in their first and second trimesters were included, as this timing allowed sufficient follow-up to fully implement the intervention before delivery.

3.4.1 Inclusion Criteria

All pregnant women attending antenatal clinics aged between 18-49years between first and second trimester but not after 20weeks of pregnancy in the two selected facilities and those who consented to participate were included in the study.

3.4.2 Exclusion Criteria

All pregnant women attending antenatal clinics who did not consent to be enrolled to the study were excluded. Also, pregnant women who were ill were excluded because their condition could complicate or influence their participation or may force the participant to drop out of the study.

3.5 Sample Size Determination

Table 3.1: Sample Size Determination

Indicator	Information
α = Level of significance	0.05
n_1 = Sample size for Facility 1	80
n_2 = Sample size for Facility 2	60
Sample size for both facilities (n1+n2)	140
Attrition (%)	20
Total sample size (with attrition)	168
Sample size for HCPs (5 for each site)	10
Total Sample to be included in the study	178

*The sampled population was stratified and proportionally distributed between the two sampled primary health care facilities.
*A sample total of 140 participants and adjusting for loss to attrition at 20%, a total of 178 respondents participated in the study. Kagumo Health Centre – 96 participants and 5HCPs while Mutithi Health Centre – 72 participants and 5 HCPs
*For the determination of the facility healthcare provider's sample, purposive sampling was used where all were included in the study.

The study utilized Yamane's Simplified Sample Formula for proportions which is suitable for small population and reducing the sample size slightly as revised by Blair and Blair (2015). The total target population was 215 women from the two facilities.

$n=N/(1+N(e2))$

Where;

n is the sample size. N is the population size while e is the margin of error.

$n1 = 215/(1 + 215(0.05)2)$

$n1 = 140$

3.6 Sampling Procedure

There are five sub-counties in Kirinyaga County and the two sub counties with the highest antenatal care visit indicators were identified as Kirinyaga South and Central sub-counties. One facility in Kirinyaga South sub county - Mutithi Health Center, was selected for control study while one facility in Kirinyaga Central – Kagumo Health Center, was selected for the intervention study. The two facilities are strategically placed within Kirinyaga County, and they receive the highest numbers for antenatal care visits in any month as per the antenatal care registers. The two facilities were purposively selected due to their numbers of pregnant women attending antenatal care clinics. Ten health care providers (10) of the two facilities were conveniently sampled. Convenience sampling method was used to sample pregnant women at the health facility for baseline study in both primary health care centers. This infers that ANC clients who turned up in each facility for an antenatal care visit were recruited, and the recruitment continued until the sample size was attained. The sample size (168) was divided proportionately by percentage of the total population (215). This approach was deemed appropriate due to time and resource constraints, as well as the need to enroll eligible participants within a defined intervention timeline. The method also allowed for efficient recruitment of participants who met the inclusion criteria. However, it is acknowledged that convenience sampling may introduce selection bias and limit the generalizability of the findings. To mitigate this, clear eligibility criteria and standardized data collection procedures were applied to enhance the validity and reliability of the study outcomes.

3.7 Data Collection Methods and Tools

The researcher integrated both qualitative and quantitative data collection techniques to provide a comprehensive approach to research, allowing for a more nuanced understanding of the subject under research. The researcher was responsible for development and refinement of data collection tools, including structured questionnaires and interview guides, ensuring alignment with the study objectives and conceptual framework. Mixed method approach is becoming more valuable because it can potentially capitalize on the respective strengths of both approaches.

3.7.1 Quantitative Technique

Quantitative data was collected using interviewer led semi-structured questionnaires. Quantitative data is a systematic empirical investigation which focuses on quantifying data and generalizing results from a sample to the population of interest and it's effective in this study to determine the relationships and trends of the educational intervention on patient rights awareness of the respondents (Östlund *et al*., 2011).

3.7.2 Qualitative Technique

Qualitative data techniques helped to understand the social phenomena from the perspectives of the healthcare providers since they share the information from their experiences. The researcher used key informant interviews and focus group discussions guide to collect this kind of data. This approach was valuable in exploring complex issues in depth and gaining insights on the health care providers' experience in implementation of patient rights charter.

3.7.3 Data Collection

Both qualitative and quantitative data were collected. For quantitative data collection, at the pre-intervention phase, data was collected using the semi-structured questionnaire

(Appendix II). The questionnaire addressed issues such as socio-demographic characteristics of the respondents, level of patient rights awareness, and the source of information at the facility. The questionnaire utilized Linkert scale.

The intervention phase entailed administering educational intervention through health talks and bookmarks. The researcher oversaw the delivery of health education sessions (educational talks and distribution of informational materials) to ensure fidelity to the intervention design. This included ensuring that content was delivered consistently across participants and settings. Healthcare providers conducted a series of educational sessions in the waiting room during routine antenatal care clinics to pregnant women. Following the sessions, participants received a bookmark summarizing patients' rights and responsibilities as detailed in the patient rights charter. To ensure accessibility, the bookmark presented patient rights in both English and Kiswahili, accommodating those who were not proficient in English. On the subsequent antenatal clinic days, the healthcare providers discussed the patients’ rights using standardized messages in the hospital antenatal care waiting area for a follow-through of their knowledge. Questions and answer sessions were also done routinely to ensure that the participants understood the domains of patient rights.

On a monthly basis, the researcher would ensure that the educational talks are done and the participants are well informed. After four months of successful administration of the intervention, semi structured questionnaire was used to assess the level of awareness of patient rights on the participants. The researcher led the administration of the questionnaire, the data was analyzed, and findings documented.

For qualitative study, key informant interviews were conducted using KII guide (Appendix III) among ten nurses who serve at the facility which addressed issues such as knowledge of patient rights, attitudes of and practices of patient rights. The interviews were conducted upon agreed time, venue and the appointments. The key informant interviews and guides were conducted in English as all the health providers were

proficient in the language. The researcher moderated the interviews, and the proceedings were tape recorded and additional notes taken on non-verbal cues. These were carried out at the beginning of the intervention period.

Four focus group discussions of 8-12 respondents each were conducted among pregnant women using a focused group discussion guide (Appendix III). Women attending antenatal clinics who qualified were targeted for the study. Pregnant women were grouped by age and data collected until saturation was achieved. FGD guide captured issues such as awareness of the patient rights and quality of services at the facility. In this category, the respondents obtained were maintained for both the pre-intervention and post-intervention phases. The researcher moderated the discussions with help from the research assistant for note taking and tape recording.

3.8 Reliability

The reliability of the test is the extent to which the data collection techniques and analysis is set to yield consistent findings. To ensure that the results of this study are highly reliable, a couple of measures were taken. This was achieved through pretesting the concept and objectives and making the necessary amendments. Standard operational terms were used throughout the proposal and were defined at the begining of the study. Resarch assistants were also be trained to ensure they collect correct information and ask the questions in a consistent and standadized manner.

The reliability and validity of the findings were maintained during the study. The Cronbach's Alpha levels of all the variables were all above 0.70 indicating a reliable internal consistency.

3.9 Validity

The validity of an instrument refers to its ability to test what it has set out to find. The research instrument was tested for face and content validity by giving the instrument to

an independent health systems research expert and a statistician to evaluate for conceptual and investigative bias. The focus was on the content validity, assessing the accuracy with which an instrument measures the factors under study.

The threats to internal validity of the study were minimized by doing the following:

a) Follow-up re-training of the HCPs on the patient rights charter in the health facilities was done at the beginning and after two months into the study. This helped sort out any bias that may be introduced by healthcare providers in the facilities in the intervention group.
b) The researcher led team meetings regularly to review the progress of research and ensure strict adherence to the study procedures.

3.10 Training of Research Assistants

Fieldwork was led by the researcher with the help of research assistants. The research assistance helped with the administration of questionnaire and taking notes with full supervision of the researcher. The researcher trained and supervised research assistants on study procedures, ethical considerations, and administration of the tools to ensure standardization across both intervention and control groups. The researcher also coordinated the logistics of data collection, including scheduling visits to health facilities and liaising with facility staff to facilitate smooth execution of the study. The researcher also performed quality assurance throughout the process.

3.11 Pre-Testing of Data Collection Tools

Pre-testing of the study instrument was conducted in Thiba Health Center situated in Kirinyaga County. The researcher facilitated pre-testing of the tools to assess clarity, reliability, and appropriateness, and incorporated necessary amendments prior to full-scale data collection. The pretesting aimed to evaluate the logic and clarity of the instruments. 20 participants were picked to represent 10% of the study sample because

they resembled the intended participants, according to Rudolph, JE *et al*., (2023). The participants were invited to give feedback and ideas, which were utilized to refine the items, such as the sampling procedure, conceptual framework and collection methods. After analysis of the pre-testing data, problem statement, study objectives, administration of the intervention were reviewed and adjustments made. Consent and from the hospital administration were sought to conduct pre-testing and analysis of data.

3.12 Educational Intervention module

The healthcare provider led educational module covered the various rights and responsibilities of a patient as envisaged in the patient rights charter, the importance of each right and the strategies into which the health care providers would be using the deliver the content. Initially the researcher had registered the providers with a clear understanding of the rights and took them through a training at the intervention site for one week. The selection criteria of the nurses to be taught were registered health care providers employed by the government and working in the antenatal care clinic in the health facility. In this study, the healthcare provider provided health education to the antenatal care women based on the training module without interfering with the routine services in the health facility.

The trained health care provided conducted at least two teaching sessions per week for four months. Firstly, the trainer introduced themselves, introduced the intervention module core topics and educated them on the significance of each of their patient rights and responsibilities. Adult learning methods were also employed such as storytelling, discussions, role plays and demonstrations were used to emphasise on the modules. Educational materials i.e. brochures were provided to the pregnant mothers to act as reminders of the key messages and references. None of these were done in the control groups.

The content of the training adopted were as follows:

a) Module 1: Patient rights charter: This entails the 14 patient rights in detail, how its applicable in the facilities (page 5 in the patient rights charter)
b) Module 2: Patient responsibilities: The participants were taken through their responsibilities (page 6 in the patient rights charter)
c) Module 3: Dispute resolution. In the course of discharging duties and responsibilities, and also receiving services, disputes may arise between patient and health care providers. Participants were imparted knowledge on how they can lodge their disputes and the procedures for dispute resolution (page 7 of the patient rights charter)

The content of the module was developed and validated against the Kenya National Patient Rights Charter (2013), WHO recommendations on respectful maternity care and published literature on patient rights and health education interventions. This ensured that the information provided was evidence-based and standardized.

3.13 Analysis

3.13.1 Data Analysis

A five-point Likert scale for each variable was utilized from which descriptive and inferential statistics were derived. The awareness of the patients' rights and responsibilities was assessed using a semi structured questionnaire with a response of 5-point Likert scale categories ranging from "strongly disagree" coded with 1 and "strongly agree" coded with 5. The total awareness of patient rights score was calculated by adding all the items in the questionnaire. A score ranging from 15 to 75 points was generated, a higher score indicates a higher awareness of the patient's rights and responsibilities. By using blooms taxonomy scores to determine the level of awareness, 75-100% were categorized as good awareness, 50-74% as moderate awareness and below 50% as poor awareness. For quality of services, the same structure as above where Likert scale was adopted where very dissatisfied were coded with 1 and very satisfied coded with 5. The results of each participant group were presented separately

based on research questions. Descriptive statistics for each of the items on the questionnaire were summarized in categories and displayed as means and percentages. A variable combining the respondents; demographic data of age, marital status, income level and level of education was created as a covariate to moderate specific non-parametric tests.

Re-coding data under the dependent and independent variables was done and analyzed. Cohen d effect of size test was calculated based on the following formula and to estimate the effect based on the standard deviation. For comparison of baseline characteristics between intervention and control groups, categorical variables were analyzed using Pearson chi-square tests. Mean scores for awareness of patient rights were tested among two groups using student t-tests. Difference in difference analysis test was used to test the change between pre & post in the intervention and control group. The effect of the intervention was determined by odds ratio generated from logistic regression analysis. Statistical significance was interpreted at 0.05 level ($p<0.05$). All the quantitative data analysis was cleaned, coded and underwent data management procedures.

For Qualitative data, field notes together with tape recorded data from FGDs and KIIs were transcribed verbatim into Microsoft word and exported into NVivo version 12 and were subjected to the following five (5) stage-thematic analytical framework as recommended by Braun & Clarke (2021).

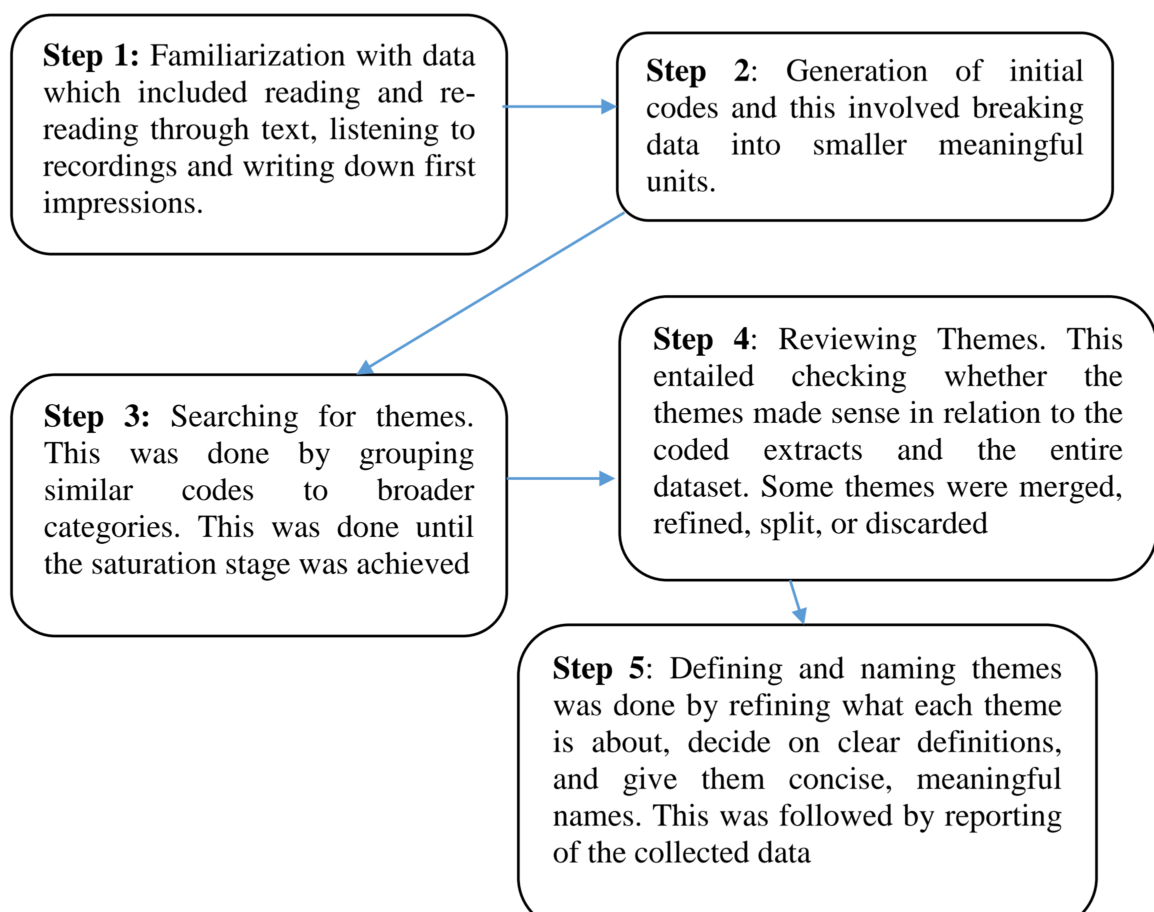


Figure 3.2: Thematic Analytical Approach for Qualitative Data

Themes were identified post hoc through thematic content analysis. Codes were also developed manually, and direct quotes and notes were used to illustrate the findings. Inductive approach was adopted in developing new themes, categories and theories from the scripts through a bottom-up process. Findings were presented in descriptive summaries and process maps based on themes, patterns, and supported by verbatim.

In Step 1 above, data preparation and familiarisation were done. All qualitative data were first transcribed verbatim from field notes and interview recordings. Where necessary, responses were translated into English while maintaining the original

meaning. The transcripts were reviewed multiple times to ensure accuracy and to allow the researcher to become familiar with the content.

In Step 2, an inductive coding process was employed, where codes were generated directly from the data. Segments of text relevant to the study objectives—such as knowledge of patient rights, experiences during ANC visits, and perceptions of care—were identified and assigned descriptive codes. Coding was conducted manually (or using qualitative analysis software, if applicable).

In Step 3, in the development of themes and categories, similar codes were grouped together into broader categories based on patterns and relationships observed in the data.

While in Step 4, Categories were further analysed to develop overarching themes that reflect key aspects of patient rights awareness and experiences. The major themes identified included: awareness and understanding of patient rights, experiences of respectful and disrespectful care, barriers to exercising patient rights, impact of health education on knowledge and confidence. These themes were aligned with the study objectives and conceptual framework.

Finally, in Step 5 on thematic analysis and interpretation, each theme was analyzed in depth to understand its meaning and implications. Patterns across participants were examined, and similarities and differences between pre- and post-intervention groups were explored. The findings were interpreted in relation to the study objectives and supported by relevant literature. The results were presented in a narrative format organized by themes and sub-themes. Representative verbatim quotes from participants were included to illustrate key findings and provide context. This approach enhanced the richness and credibility of the data.

3.14 Ethical Considerations

Ethical approval to conduct the study was obtained from the Scientific and ethical Review Unit – (SERU) at the Kenya Medical Research Institute (Nairobi, Kenya). At the national level, a research permit to conduct the study was obtained from The National Commission for Science, Technology and Innovation (NACOSTI). While approval of the proposal was provided by JKUAT. Authorization to conduct the study was sought from the Kirinyaga County Department of Health.

Informed consent (Appendix I) was sought from all the respondents before being enrolled in the study. Relevant information pertaining to the study was given to the respondents and this included the purpose of the study, any risk and discomfort that they were likely to face, their right to participate, withdraw or not participate in the study, and assured confidentiality, among other issues.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter presents the results and findings of the study based on the study objectives for the pre-intervention and post-intervention phases of the study. The study sought to determine the effect of an educational intervention on patient rights awareness among pregnant women attending antenatal care clinics in Kirinyaga County. Findings from both qualitative data and quantitative are presented. The post intervention findings were recorded after implementing an educational intervention in the intervention arm.

4.2 Response Rate

The study recruited 168 participants, with the control arm having 72(43%) participants and 96(57%) participants in the intervention arm. At post intervention, 67(40%) participants and 90 (54%) participants were enrolled in control and intervention arms respectively, representing 94% response rate.

4.3 Socio-Demographic Characteristics of Respondents

Majority of the respondents were between the ages of 18-30years 66(68.8%) in intervention and 49(68.1%) in control group. Most respondents were married with 56(77.8%) in the control group and 74(77.1%) in the intervention group. In terms of education, most of the respondents had attained secondary education with 54(56.3%) in the intervention and 46(63.9%) in the control group. Table 4.1 below shows more details.

Table 4.1: Socio-Demographic Characteristics of Participants at Baseline

Variable	Pre-intervention		Post-intervention	
	Intervention	Control	Intervention	Control
	n=96(%)	n=72(%)	n=90(%)	n=67(%)
Age group				
18-30	66 (68.8)	49 (68.1)	61(67.8)	44 (65.7)
31-40	25 (26.0)	19 (26.4)	24 (26.7)	19 (28.4)
41-49	5 (5.2)	4 (5.6)	5 (5.6)	4 (6.0)
Employment status				
Employed	17 (17.7)	10 (13.9)	16 (17.8)	9 (13.4)
Self-employed	34 (35.4)	28 (38.9)	32 (35.6)	26 (38.8)
Not Employed	45 (46.9)	34 (47.2)	42 (46.7)	32 (47.8)
Monthly Income				
1000-2999	40 (41.7)	32 (44.4)	37 (41.1)	29 (43.3)
3000-4999	28 (29.2)	21 (29.2)	27 (30.0)	20 (29.9)
5000-10000	28 (29.1)	19 (26.4)	26 (28.9)	18 (26.9)
Level of education				
Primary or less	7 (7.3)	5 (6.9)	5 (5.6)	5 (7.5)
Secondary	54 (56.3)	46 (63.9)	53 (58.9)	43 (64.2)
Tertiary	37 (36.5)	21 (29.2)	32 (35.6)	19 (28.4)
Marital status				
Single	19 (19.8)	12 (16.7)	17 (18.9)	11 (16.4)
Married	74 (77.1)	56 (77.8)	70 (77.8)	53 (79.1)
Others+	3 (3.1)	4 (5.6)	3 (3.3)	3 (4.5)
No Children				
0	30 (31.3)	20 (27.5)	29 (32.2)	19 (28.4)
1	31 (32.3)	25 (34.7)	30 (33.3)	20 (29.8)
2+	35 (36.5)	27 (37.5)	31 (34.4)	28 (41.8)
No. of ANC Visits				
1	26 (27.1)	20 (27.8)	25 (27.8)	17 (25.4)
2	30 (31.3)	21 (29.2)	28 (31.1)	19 (28.4)
3+	40 (41.6)	31 (43.0)	37 (41.1)	31 (46.2)

4.4 Participant Description for Focus Group Discussion

A total of 4 focused group discussions among pregnant women, consisting of eight to twelve participants were conducted. Respondents were grouped based on age and data was collected until saturation was achieved. Two groups were conducted in the 31-40

age group stratum. Across the stratums, majority 25(61%) of the women had attained secondary education and 22(54%) had attended more than 3 ANC visits.

Table 4.2: Description for Focused Group Discussions

	FGD1 18-30, n=8	FGD2 31-40, n-11	FGD3 31-40, n=10	FGD4 41-49, n=12	Total n=41
Education					
Primary or less	2	2	0	1	5(12%)
Secondary	5	7	5	8	25(61%)
Tertiary	1	2	5	3	11(27%)
No. of ANC visits					
1	1	2	2	3	8(20%)
2	4	1	3	3	11(27%)
3+	3	8	5	6	22(54%)

4.5 Socio-Demographic Factors Associated with Patients' Rights Awareness

The analysis of demographic factors influencing patient rights awareness presents the findings as shown in the table below (table 4.3). The table shows that education status showed as a strong predictor of awareness. Participants with tertiary-level education showed markedly higher levels of good awareness compared to those with secondary or no formal education. The number of ANC visits was significantly associated with awareness. Women who attended three or more ANC visits were more likely to have good awareness of patients' rights compared to those with fewer visits. This finding emphasizes the role of ANC as an entry point for patient education and advocacy. Regular contact with healthcare providers likely increases exposure to rights-related information and reinforces understanding. Other socio-demographic factors—including age, employment, income, marital status and parity—did not show significant associations with rights awareness. This suggests that while individual characteristics may influence health experiences, structural factors such as education, frequency of health system interaction, and programmatic interventions are more critical in shaping patients' knowledge of their rights.

Table 4.3: Awareness Levels by Socio-demographic Factors in Control and Intervention Group

Variables	Study group		<50-Poor awareness	50-74 moderate awareness	>75 good awareness	X^2	df	p-value
Age group	Intervention group	18-30	2(3.0)	36(53.7)	29(43.3)	1.09	2	0.057
		31-40	0(0.0)	18(56.0)	12(44.0)			
	Control group	18-30	2(4.2)	35(72.9)	11(22.9)	2.12	2	0.346
		31-40	0(0.0)	16(84.2)	3(15.8)			
Employment status	Intervention group	Employed	0(0.0)	11(61.1)	7(38.9)	7.91	4	0.95
		Self-employed	0(0.0)	24(70.6)	10(29.4)			
		Not Employed	2(4.4)	19(42.2)	24(53.3)			
	Control group	Employed	0(0.0)	8(88.9)	1(11.1)	2.793	4	0.593
		Self-employed	0(0.0)	22(78.6)	6(21.4)			
		Not Employed	2(5.9)	25(73.5)	7(20.6)			
Income level	Intervention group	0-3000	0(0.0)	19(47.5)	21(52.5)	8.066	4	0.089
		3000-5000	2(7.1)	18(64.3)	8(28.6)			
		Above 5000	0(0.0)	17(58.6)	12(41.4)			
	Control group	0-3000	1(3.1)	22(68.8)	9(28.1)	3.587	4	0.465
		3000-5000	1(4.8)	17(81.0)	3(14.3)			
		Above 5000	0(0.0)	16(88.9)	2(11.1)			
Education level	Intervention group	Primary	0(0.0)	2(28.6)	5(71.4)	11.268	4	0.187
		Secondary	2(3.7)	35(64.8)	17(31.5)			
		Tertiary	0(0.0)	17(47.2)	19(52.8)			
	Control group	Primary	0(0.0)	2(40.0)	3(60.0)	8.718	4	0.367
		Secondary	2(4.3)	37(80.4)	7(15.2)			
		Tertiary	0(0.0)	16(80.0)	4(33.3)			
Marital status	Intervention group	Single	0(0.0)	11(57.9)	8(42.1)	1.436	4	0.964
		Married	2(2.7)	41(54.7)	32(42.7)			
		Others	0(0.0)	2(66.7)	1(33.3)			
	Control group	Single	0(0.0)	11(57.9)	1(8.3)	2.456	4	0.873
		Married	2(3.6)	41(74.7)	12(21.8)			
		Others	0(0.0)	3(75.0)	1(25.0)			
ANC visits	Intervention group	0	0(0.0)	18(69.2)	8(30.0)	9.808	4	0.079
		1	2(6.5)	15(48.4)	14(45.2)			
		2+	0(0.0)	21(52.5)	19(47.5)			
	Control group	0	0(0.0)	17(85.0)	3(15.0)	10.905	4	0.091
		1	2(10.0)	16(80.0)	2(10.0)			
		2+	0(0.0)	22(71.0)	9(29.0)			

Table 4.4: Adjusted Odds Ratios showing associations between baseline demographics and awareness levels

Variable	Adjusted OR (95% CI)	P value
Age group		
18-30	1.8 (0.1-24.1)	0.664
31-40	0.52 (0.2-91.1)	0.026
41-49	1	
Employment status		
Employed	1.1 (0.1-8.9)	0.964
Self-employed	0.5 (0.1-1.8)	0.263
Not Employed	1	
Income level per month		
0-3000	1.0 (0.2-5.7)	0.99
3000-5000	0.6 (0.1-4.7)	0.657
Above 5000	1	
Level of education		
Primary	1	
Secondary	1.81 (1.05-3.061)	0.031
Tertiary	2.24 (1.0-5.71	0.002
Marital status		
Single	1	
Married	0.6 (0.1-3.3	0.516
Others	2.4 (0.1-110.9)	0.893
No. of Children		
0	1.0 (0.0-29.3)	0.999
1	0.3 (0.0-8.7)	0.468
2+	0.3 (0.0-11.7)	0.86
ANC visits made		
1	1	
2	0.8 (0.2-3.8)	0.788
3+	0.2 (0.0-1.1)	0.008

AOR; adjusted odds ratio, 95%CI; 95% confidence interval, Ref; reference

Both secondary (OR = 1.81, 95% CI: 1.05–3.061, p = 0.031) and tertiary education (OR = 2.24, 95% CI: 1.0–5.71, p = 0.002) show significant associations with the outcome compared to primary education. Participants with 3+ ANC visits have a significantly lower odds of the outcome (OR = 0.2, 95% CI: 0.0–1.1, p = 0.008) compared to those with 1 visit and thus shows statistically significant associations with the outcome, with higher education linked to increased odds and more ANC visits linked to decreased

odds. The 31–40 age group has a significantly lower odds of the outcome (Adjusted OR = 0.52, 95% CI: 0.2–91.1, p = 0.026) compared to the 41–49 reference group, suggesting a potential difference in awareness or outcome likelihood in this age range. The 18–30 group (OR = 1.8, p = 0.664) shows no significant association.

4.6 Level of Patient Rights Awareness

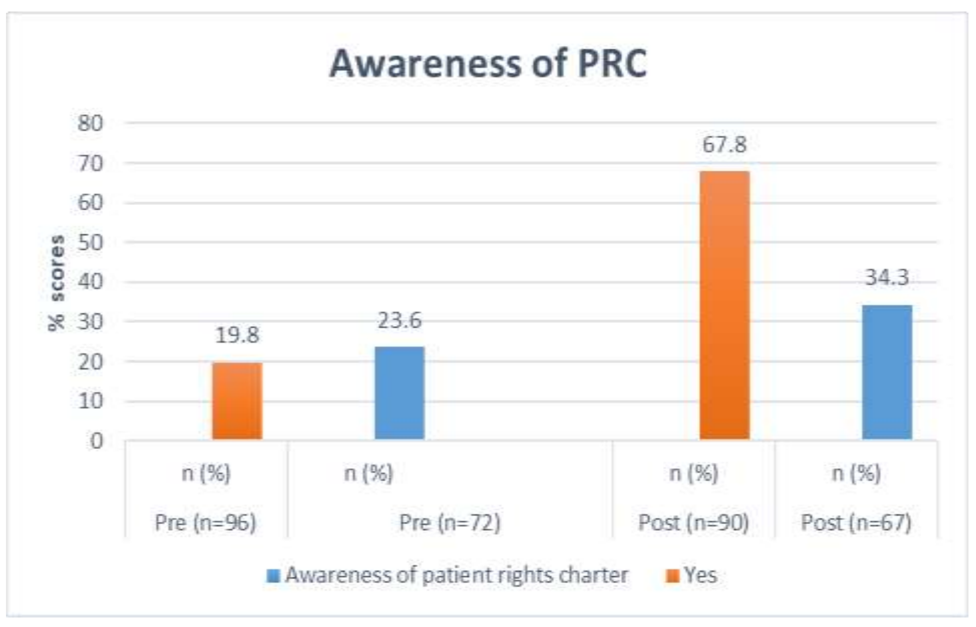
The table below (Table 4.5) shows the proportions of participants who had knowledge about their patient rights during the pre-intervention and post-intervention. The level of awareness of patient rights among antenatal care mothers at baseline was 19.8%. Additionally, the composite scores for patient rights for good awareness increased from 40(41.7%) to 82(91.1%). The composite mean score for patient rights improved from 13.5 to 8. Majority of the respondents (68%) also mentioned healthcare providers as the main source of information on patient rights.

Table 4.5: Level of Awareness of patient rights

Variable	Intervention group		Control group	
	Pre (n=96) n (%)	Post (n=90) n (%)	Pre (n=72) n (%)	Post (n=67) n (%)
Awareness of PRC				
Yes	19 (19.8)	61 (67.8)	17 (23.6)	23 (34.3)
No	77 (80.2)	29 (32.2)	55 (76.4)	44 (65.7)
Ever received an education on PRC				
Yes	3 (3.1)	64 (71.1)	2 (2.8)	12 (17.9)
No	93 (96.9)	26 (28.9)	70 (97.2)	55 (82.1)
Parents' rights awareness				
Mean score (SD)	73.1 (13.5)	84.0 (8.0)	66.8 (8.3)	69.4 (6.8)
Category, n (%)				
Poor	2 (2.1)	0	2 (2.8)	0
Moderate	54 (56.3)	8 (8.9)	55 (76.4)	50 (74.6)
Good	40 (41.7)	82 (91.1)	15 (20.8)	17 (25.4)
Source of the patients' rights charter information				
Healthcare provider	13 (6843)	60 (98.4)	12 (70.6)	14 (58.3)
Hospital (Posters, placards)	6 (31.6)	11 (18.0)	8 (47.1)	9 (37.5)
Media (social media,	9 (47.4)	15 (24.6)	8 (47.1)	11 (45.8)

Variable	Intervention group		Control group	
	Pre (n=96) n (%)	Post (n=90) n (%)	Pre (n=72) n (%)	Post (n=67) n (%)
TV etc)				
Others (Relatives)	3 (15.8)	4 (6.6)	2 (11.8)	2 (8.3)

The graph below shows the awareness of patient rights among ANC mothers in the intervention group compared to the control group



**PRC- Patients rights charter.*

Figure 4.1:Level of Awareness of Patients Rights Charter

Also, at pre-intervention, 3(3.1%) of the respondents had received education and this increased significantly to 64(71.1%) post intervention.

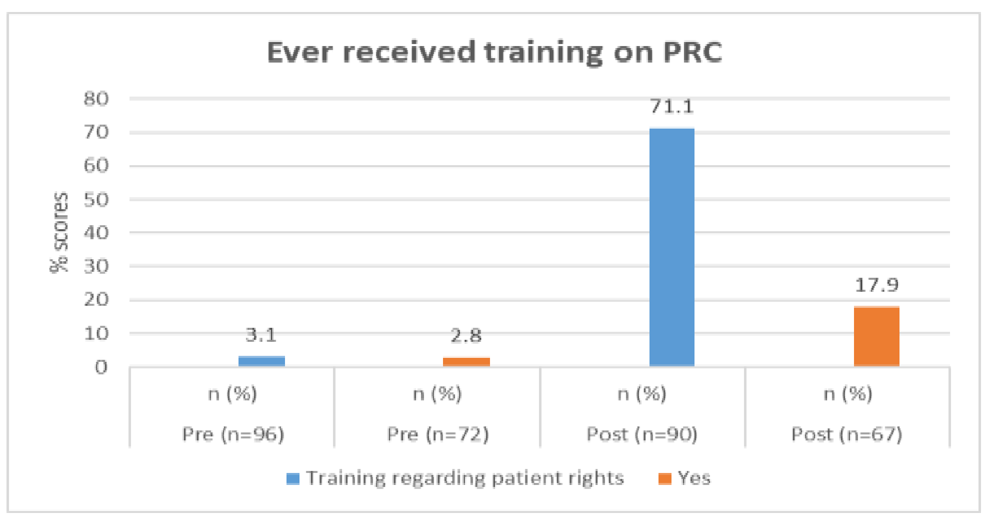


Figure 4.2:Changes in Training Pre & Post-intervention among Participants

Further, respondents who had good awareness improved from 40(41.7%) to 82(91.1%). Improved level of awareness indicates a good understanding with clarity and recognition of patient rights, hence good knowledge.

The qualitative findings show that there was no committal consensus on the general opinion regarding the knowledge and education of respondents on their patients' rights.

Majority of the respondents observed that they had not interacted with the patient rights charter, and no healthcare provider had educated them during their interactions.

> *"...No one has ever taught us about rights and have never interacted with the patient rights charter, in fact, I am hearing about these rights today for the first time.*" (FGD 2;3;4)

> *'The healthcare providers, especially nurses, should be on the forward in educating us on patient rights, but we haven't seen any initiative in our facility. Maybe we have a right to medical attention since we get treatment when we visit the facility, that's all" (*FGD 1;2;3)

A few respondents expressed themselves to have been made aware of some of the patient rights items by a community health care worker however the majority reported not to be aware of patient charter showing the opinion of the majority.

> *"A community health worker once explained about the patient's rights to treatment during their routine visits but since then, no follow up or further education has been received"* (FGD 1; 2)

> *".... We have not seen any flier or poster in the health facility with patient rights information"* (FGD 2;3;4)

4.7 Sources of Information

The study sought to establish the sources of information on patient rights as reported by the participants. In the two facilities, the patient rights charters had been clearly displayed on hospital boards. At pre-intervention, 13(68.4%) and 12(70.6%) reported that the source of information was healthcare providers while at post intervention, 60(98.4%) and 14(58.3%) reported healthcare providers as their source of information.

Table 4.6: Source of the Patients' Rights Information

Variable	Intervention group		Control group	
	Pre (n=96) n (%)	Post (n=90) n (%)	Pre (n=72) n (%)	Post (n=67) n (%)
Healthcare Provider(nurses)	13 (68.4)	60 (98.4)	12 (70.6)	14 (58.3)
Hospital boards (Posters, placards)	6 (31.6)	11 (18.0)	8 (47.1)	9 (37.5)
Media (social media, TV etc)	9 (47.4)	15 (24.6)	8 (47.1)	11 (45.8)
Other (Relatives)	3 (15.8)	4 (6.6)	2 (11.8)	2 (8.3)

The intervention significantly showed that the healthcare providers as the primary awareness source of information to patients (χ^2=34.6, p<0.0001) enhancing patients' rights uptake.

Table 4.7: Univariate Analysis for Source of Information

Source of information	Group	Pre Yes/No (%)	Post Yes/No (%)	χ^2	df	p-value
Healthcare Providers	Intervention	13(68.4%)	60 (98.4%)	34.6	1	**<0.0001**
	Control	12 (70.6%)	14 (58.3%)			

From the qualitative data, most of the participants emphasized that being treated with respect and empathy by the healthcare provider is a critical measure for good quality care. They noted that even when resources are limited, a respectful attitude satisfies their expectations.

> *"…We don't ask too many questions; don't get answers or its ignored, it may be a waste of time for everyone. This makes us to feel bad because we cannot express ourselves fully during our interaction with the healthcare provider" (*FGD 1;3)

Many respondents associated quality care with availability of essential medicines, medical tests, and equipment**.** Majority of the respondents reported stock out of essential drugs and tests being done outside the facility

> *"…We get referred to other hospitals for tests and we buy some essential medicines from the pharmacies around*" (FGD 1;3;4)

Majority of the respondents reported that their waiting times to see a healthcare provider can sometime exceed 20mins. Waiting times influences the perceived quality of services from a patient perspective.

> "*We sometimes wait to see a healthcare provider for more than 20mins, especially during clinic days due to the long ques. It's a bit discouraging*" (FGD 3;4)

4.8 Knowledge, Attitude and Practices on Patient Rights

4.8.1 Knowledge of Patient Rights

The majority of healthcare providers demonstrated good knowledge of fundamental patient rights—specifically, informed consent, the rights to provision of information to patients, respect and dignity during treatment and ensuring patient records are accessed by healthcare providers only at the facility**.** Even though the majority mentioned not having been trained on these rights, they could list at least the core rights indicating that these core concepts are well understood and practices at all times in their practice.

> "*...The healthcare providers are aware of the patients' rights charter However there is need for refresher courses to motivate them"* (KII, 2).

The respondents also reported that patient rights and responsibilities charter were available in the facility.

> *"…We have patient rights charters available in the facility hospital boards, and they are accessible to all. What we haven't done is to have sensitization sessions with the healthcare providers, but I am sure they know the contents of it already"* (KII, 10)

Whereas the healthcare providers have adequate knowledge and access to information regarding the patient rights charter, this does not guarantee good practice and hence the health systems must reinforce rights-based care through supportive environments and accountability mechanisms.

4.8.2 Attitude towards Patient Rights

A majority of the respondents showed a clear consensus that patient rights underpin high quality care especially to pregnant mothers and that respecting their rights is fundamental. This positive disposition was consistent among all the interviewees.

> "*… it's important to note that most of the healthcare providers understand that prioritizing our patient needs is non-negotiable and embedding trust in our services really boost the patient satisfaction and so that forms our foundation, however at the very least our healthcare providers should be trained*" (KII, 8)

However much the show of this attitude towards patient rights, there are several barriers that hinder the implementation of these rights. The majority view that due to high patient volumes, high workload and limited resources, it's almost impossible to achieve implementation effectively.

> "…We *have a huge workload a time and we may not have adequate time to attend to all patients in a timely manner*" (KII, 3)

Respondents were also divided on the facility-based factors affecting the implementation of patient rights. Some mentioned that management bears a major responsibility and their lack of involvement specifically in advancing meetings with staff, providing updates, conducting orientation on implementation, regular reviews and quality assurance affects greatly their success and hence performance.

> *"... Most of us are overwhelmed with work, and we do not have any other support like meetings, trainings from the management. You may have witnessed today the long queues in this facility. We are not sure how we should implement this since we are not aware on the implementation framework" (*KII, 2)

4.8.3 Practice of Patient Rights

A majority of the respondents agreed that sensitizations always occur during treatment rather than following a systematic approach every time or on each visit by patients. The responsibility of supervising the implementation of patient rights and responsibilities also was the role of the facility-in-charges. Even though they understand that it's their role, the actual day-to-day practice could not be validated due to lack of guidance documents from the two facilities. The frequency on sensitization on the same and dissemination to patients were also not defined in any document.

"We talk to our patients especially during examinations and this happens every time during clinic days. Even though we ensure they know about their privacy, ensuring that privacy can be difficult due to unavailability of facilities" (KII, 1)

A majority of them agreed on the benefits of having standardized checklist especially during orientation and this quick reference would be useful for briefing the patients during examination. This was echoed universally as a facility weakness, and this shortfall falls within the management docket.

*"…We always refer to the PRC for guidance at least for the items we can practice. Those rights are quite elaborate and having it as a quick reference, more of an SOP or a pocket guide would go along way" (*KII, 7)

4.9 Effect of Educational Intervention on Patient Rights Awareness

The table below (table 4.6) presents the multiple linear regression model analyzing the effect of an intervention on patient rights awareness of ANC clients. The regression model explains 57.3% of the variance in the outcome ($R^2 = 0.573$, Adjusted $R^2 = 0.344$), indicating a moderate fit. The overall model is statistically significant ($F (14, 310) = 13.146$, $p < 0.001$), suggesting that the variables collectively influenced the patient rights awareness. The intervention group is associated with a 6.314-unit increase in the outcome, with p-value (<0.001) indicating high statistical significance, and the 95% CI (3.314, 9.314). The difference-in difference for the intervention group interaction over time is associated with a 6.806-unit increase in the outcome, with a significant p-value (0.004) and 95% CI (2.214, 11.399). Higher education levels increase the outcome by 1.643 units per level and significant p-value (0.001). More antenatal care visits increase the outcome by 1.770 units per visit, with a significant p-value (0.002) and 95% CI (0.639, 2.901). Better perceived quality of service increases the outcome by 0.845 units per unit increase in quality score, with high significance ($p < 0.001$) and 95% CI (0.647, 1.045).

Table 4.8: Regression Coefficients on the Effect of Intervention on Patient Rights Awareness

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% Confidence Interval for B	
		B	Std. Error	Beta			Lower Bound	Upper Bound
1	(Constant)	73.513	6.459		11.382	.000	60.805	86.221
	Study_group	6.314	1.525	.265	4.141	.000	3.314	9.314
	Time	2.216	1.649	.094	1.344	.180	-1.029	5.462
	Intervention Time 2	6.806	2.334	.258	2.916	.004	2.214	11.399
	Age_group	.946	.983	.o47	.962	.337	-.9892	2.881
	Employment_status	.785	.924	.049	.850	.396	-1.032	2.602
	Income_Level	-.919	.792	-.064	-1.161	.247	-2.477	.639
	Educational_Level	1.643	.136	.359	12.066	.001	1.376	1.910
	Marital_status	-2.332	1.019	-.107	-2.289	.023	-4.336	-.327
	No._of_children	.071	.548	.007	.130	.897	-1.008	1.150
	ANC_visits	1.770	.575	.160	3.080	.002	.639	2.901
	Quality_of_Service	.845	.103	.234	8.347	.000	0.647	1.045
	Knowledge_of_PRC	.678	1.731	.028	.392	.696	-2.729	4.084
	Ever_received_education_on_PRC	-3.364	2.201	-.123	-1.528	.128	-7.696	.968

Coefficients a

Dependent Variable: right_score_percentage

4.10 Factors Influencing Patient Rights Implementation

The qualitative findings as shown in the table below (table 4.8) show that access to information, provider interactions and perceived quality of care are the main drivers to successful implementation of patient rights.

Table 4.9: Summary of Factors Influencing Patient Rights Implementation

Theme	Sub-theme	Word counts	Description	Quote
Knowledge and awareness of patient rights	Access to information	21	Most participants emphasized that with good knowledge on patient rights, they can demand for better services which will result to good quality of care	'*...We haven't seen the patient rights charter anywhere' (FGD 2;4)*
	Education and training experience	10		*'No trainings have been conducted in the past (FGD 3)*
	Knowledge gaps and misconceptions	8		'*Sometimes if you start questioning the nurse can stay that is politics and you can be marked; we don't want that to happen (FGD 4)*
Barriers to	HCP related	12	There was a	*'We don't know why they shout a*

Theme	Sub-theme	Word counts	Description	Quote
accessing patient rights	barriers		consensus on the role of healthcare providers in	*times, they give you a bad look and may seem to show a bad attitude (FGD 2)*
	Patient related barriers	8	enhancing the patient-provider relationships which in	*'…Ofcourse when you don't have bus fare you can't come for clinics' (FGD 3)*
	Facility related barriers	3	turn improves patient satisfaction and delivery of services	*'Waiting in this facility sometimes exceed 20minutes and when we ask we are told that the nurses are few and we are many'(FGD 1;2)*
Perceived quality of care and provider interactions	Perceptions of quality of care	20	Majority of the respondents reported that their waiting times to see a healthcare provider	*'Most oftenly you hear there are no medicines and sometimes you are asked to buy, it's really disheartening especially in this economy' (FGD3;4)*
	Patient experiences	10	exceeded 20mins. Waiting times influences the perceived quality of services from a	*'We expect nurses to speak with a lot of sensitivity; we overheard a patient's being told to stop having more children…. It's not okay' (FGD 4)*
	HCP contributions to care	11	patient perspective	*'...Some nurses are really nice and speaks with a lot of empathy, those are the ones we like, we feel loved and cared for' (FGD 1)*

4.10.1 Knowledge of, and Patient Rights Awareness

Majority of the antenatal women expressed that they were unable to access information regarding patient rights. They were neither educated nor formally trained on the importance of practicing them. Majority agreed that the healthcare provider would be the best source of information for efficiency due to their regular visits to the facility though none had explored other sources including social media and relatives. Even though the patient rights charter is placed in most facility hospital boards, few of the respondents had taken note of its contents.

> *"...It would be useful to place these patients' rights charters in visible places, or we can have taken home pamphlets translated to our local language or even Kiswahili otherwise before today, I had not seen where it is put at the facility. You see you cannot demand for something you don't know; this document will help us know what is right for us" (FGD, 1)*

The relationship between the subthemes and themes are below represented by figure 4.0, a visual representation from NVIVO analysis.

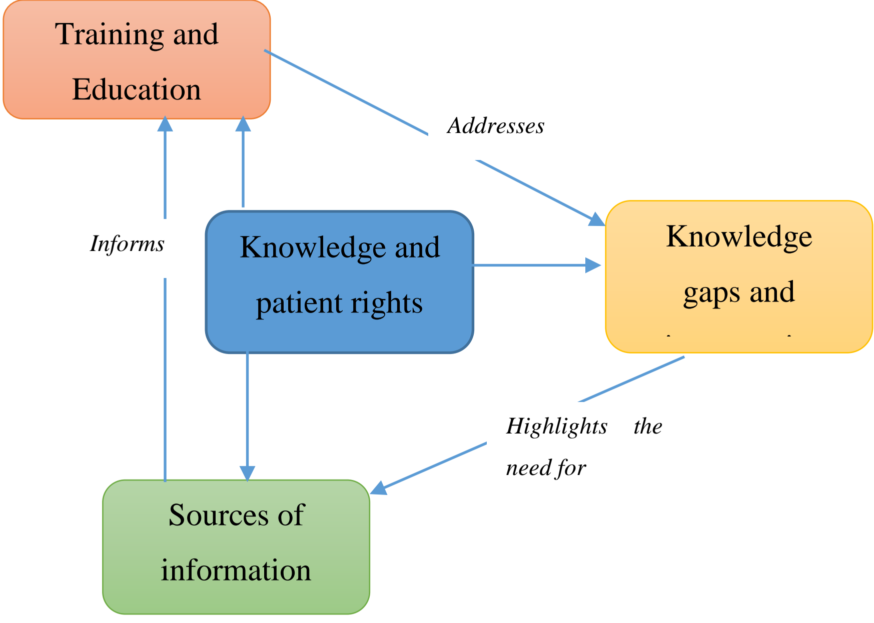


Figure 4.3: Knowledge and Patient Rights Awareness

4.10.2: Barriers to Accessing Patient Rights

Majority of the respondents highlighted the need to address health care provider workload and burn out as this affects the satisfaction of the patients. Shortages of staff and huge workload demotivate the provider thus resulting in a strained relationship between the provider and the patient. Effective communication helps build trust and ensures that there is clarity during treatment and diagnosis and hence a critical factor in informed consent. Staff attitude plays a key role in ensuring patient satisfaction and hence compliance. Patients may perceive positive or negative attitudes depending on how they have been treated.

> *"…you cannot complain to an already tired nurse. Many times, you say thank you as you leave even if you had other clarifications to make. We don't know who can come to our rescue because we pity the nurses. I think some of the issues are beyond them" (FGD 3,4)*

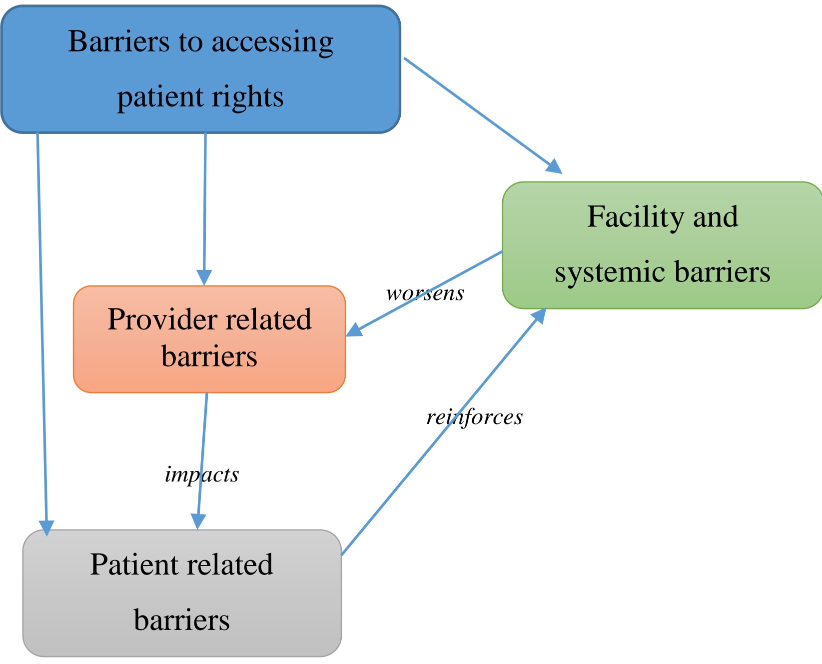


Figure 4.4: Barriers for Accessing Patient Rights

4.10.3: Perceived Quality of Care

When probed on the factors that contribute to quality of care, respect from healthcare providers, sufficient waiting time and time spent at the provider was top of the list. Respect from the healthcare providers is a cornerstone of a patient centered care. Majority of the respondents reported that the healthcare provider contributes to a big portion in enhancing quality of care.

> *'…It is better to be attended by a certain person, but you can't reach a facility and ask for this specific person, but we know why we would prefer this other person, she is kind and polite, takes time to explain processes especially when you are a first-time mother. But since we have no choice but to refuse or pick a favorite provider, you just get attended and go home'* (FGD 2;4)

When the consultation time is insufficient, the patient may feel that their needs were not met or misunderstood. Patients' experiences influence the perceived quality of care. Due to the challenges faced at the facility like shortage of staff, waiting times may be long hence affecting negatively the perceived efficiency and responsiveness of healthcare services.

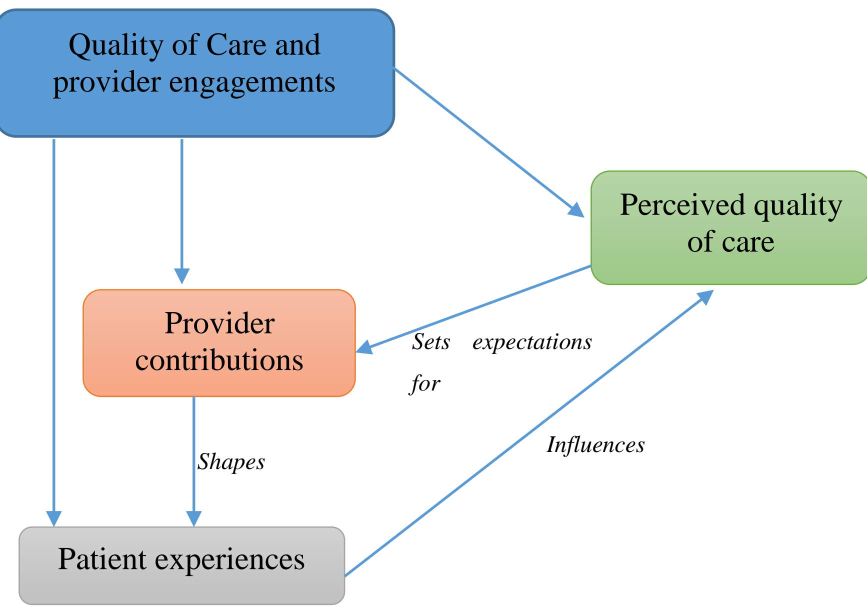


Figure 4.5: Perceived Quality of Care

4.11 Challenges with Implementation of Patients' Rights

Several challenges that were identified by respondents are associated with the implementation of the patient rights charter at the facilities. Respondents gave varied views as challenges regarding the issues identified and grouped as the themes and subthemes as shown in the table below (table 4.10).

Table 4.10: Summary of Factors Associated with Implementation of Patients' Rights

Theme	Subthemes	Description

Healthcare provider related challenges	- Training and Knowledge deficits - Lack of resources - Workload, burnout and staff turnover - Practices and attitudes	Respondents universally agreed that integration of services would enhance effectiveness in implementation process.
Institutional and Systemic Barriers	- Policy and regulation gaps - Resource limitations - Language barrier of the patient rights charter - Bureaucratic processes. - Lack of monitoring and evaluation mechanisms	Majority of the respondents reported that patient rights charter was available in the facility though the language may not be appropriate for the local population.
Patient related barriers	- Literacy challenges - Patient attitudes, cultural norms and - Socio-economic disparities.	Majority of the respondents agreed that patient's literacy levels is the key to successful implementation of patient rights. It empowers women to exercise their rights.

4.11.1 Healthcare Provider Related Challenges

Health care providers lack knowledge of how to disseminate information on patient's rights charter, since most of them have never been formally trained. Capacity building health care providers improves their confidence in service delivery and enhances health promotion and quality of services to the antenatal clients.

> *"The health talks are done routinely but, in most cases, they do not include patient rights awareness talks. We disseminate useful information concerning conception and delivery" (*KII, 2)

Lack of resources and continuous training is a challenge in the implementation of patient rights charter. Healthcare providers experience burnouts due to huge workload and continuous working which demotivates them.

> "*…Sometimes nurses experience burnout related to work and workload and sometimes related to outcomes like a maternal death. And it would put them in a*

situation where they are not able to cope. We have not seen any materials to conduct trainings on patient rights charter. These materials in my opinion should be standardized so that the same message is passed across all facilities (KII, 6;7;8)

Most of the patients also expect nurses to perform optimally regardless of the systemic barriers and hence most of their expectations are met. Such barriers affect the practice and attitudes of healthcare providers and this effect delivery of services.

"…Women expect too much from the providers, if the provider does not provide curtains or examination beds during examinations, they can do nothing to ensure comfort and privacy yet that's not their key mandate. We do not have adequate budgetary allocations to cover patient needs (KII, 7,9,10)

4.11.2 Institutional and Systemic Barriers

Whilst the respondents agreed they are aware of the patient rights charter and should be disseminated during patient - provider interactions, they cited challenges including gaps in the policy and guidelines of the existing frameworks that support patient rights charter implementation. There are other factors that should also be considered including the integration of the implementation with other health care systems. Parallel implementation has resulted in wasteful resources and unaccountability of the scares resource.

Key informant participant observed that.

*"…Even though the health facilities report to have continuous medical education sessions (CMEs) which are held once in a month, the dissemination of patient rights charter is never put as top of priority since there are many other items to be discussed. Integration should be emphasized to ensure that all topics are covered adequately. These are gaps that needs to be addressed by policies and hospital guidelines as well as having the health facilities be sensitized on the significance of the patient rights charter" (*KII, 5)

Other challenges affecting the implementation of the patient rights policy include insufficient management support, lack of knowledge about the bill, staff dissatisfaction,

heavy workload and inadequate resources. In addition, having a grievance redress mechanism tool to document and monitor patient complaints can be effective in analyzing patient experiences and consequently their satisfaction. Lack of this mechanism has greatly affected the implementation of patient rights among patients.

> *"Some concerns are addressed immediately as they are raised so no need to document due to HCP shortages, even those that are documented are not exhaustively addressed so its work in vain. Most of those concerns if you check revolves around the common issues that we encounter like lack of medicines, long waiting times etcetera" (*KII, 4)

Monitoring the patients' grievances is important are they are a source of improvement and ensuring quality of services. The respondents agreed that while the health care provider is mandated to ensure the patients' rights are implemented and monitored, they should be facilitated to effectively perform their duties.

Feedback should be relayed back to the client to ensure satisfaction of services and whilst it's important to do this, the respondents reported challenges hence contributed to non-responsiveness of patient needs. Issues on lack of essential medicines and lack of critical services should be handled by the county health management together with the facility in charges.

For sustainability on the implementation of these patient rights, Mastaneh *et al.,* (2013) in her studies noted that establishment of patient right committee for supervision and monitoring of informing and observance of patients' rights is also recommended.

4.11.3 Patient-Level Related Challenges

Patient's literacy levels greatly affect the success of patient rights implementation. Low levels of knowledge lead to underreporting violations of their rights or any form of abuse or reluctance to acknowledge the violations.

"I observed an issue of negligence and abuse a while ago, and upon interrogating the patient, I could tell that she had been mishandled in another facility and she was not willing to report the complaint. The patient also alluded that most of the nurses do not really care about their feelings and unfortunately could not convince her that it was an isolated case. The condition had really affected her and being a pregnant woman, it was posing a risk to the patient. Such issues can affect ANC attendance and ultimately the pregnancy outcome" (KII,1)

Results from this qualitative study also show the financial constraints and cultural norms strains the realization of successful implementation. While there is an expectation of at least 8 ANC visits before delivery, some women depend entirely on their partners to provide finances and consent to visit the facilities, which limits their exposure and their ability to exercise their rights.

"*…We always encourage the ANC patients to attend all ANC clinics amidst challenges of finances, emphasizing the need to come with their spouses though in this part of the region, men hardly accompany their spouses due to cultural norms. It's even difficult when they are not working and have to borrow money every time for transport and meals"* (KII, 10)

CHAPTER FIVE

DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter discusses the findings in accordance with the study objectives, appropriate postulates and comparison with previous studies. A mixed method design with quasi-experimental quantitative study arm was used to evaluate the effects of an educational intervention on patient rights and responsibilities awareness among pregnant women attending antenatal clinics in Kirinyaga's primary health centers. In addition, the study also focused on the social demographic factors influencing patient rights awareness in control and the intervention site. This study also includes recommendations for policy, practice and future research are made.

5.2 Discussion

5.2.1 Socio-demographic and Economic Factors Influencing Patient Rights Awareness

The socio demographic and economic factors have a significant bearing on the level of patient rights awareness globally. From the study, most respondents fall into the age group 18-30 years, where majority of them were married, with secondary education were are not employed. Although age of the respondent not statistically significant younger women had higher levels of good awareness compared to older age groups. This trend reflects national survey data showing that younger women tend to have greater exposure to media and digital information platforms (KNBS & ICF, 2022). Regionally, studies from Nigeria and Ethiopia have similarly documented that younger ANC clients are more receptive to health information than older women (Alemayehu *et al.*, 2019; Ifenne & Utoo, 2012). In contrast, findings done in South Africa found that knowledge of patient rights and preferences for participation in healthcare decisions may

not be significantly influenced by socio-demographic or economic factors but underscored the importance of implementing universal health education strategies that are inclusive and accessible to all patients, regardless of their background. (Vermaak, *et.al*., 2021).

Educational level was strongly associated with patient rights awareness. Women with tertiary education had the highest proportion of good awareness (41.1%), while those with only primary education had much lower awareness. This finding is consistent with the KDHS (KNBS & ICF, 2022), which shows a direct relationship between women's education and utilization of maternal health services. Regionally, studies from Ghana and Malawi have similarly found that higher educational attainment improves knowledge and demand for respectful maternity care (Iwelunmor, *et al*., 2016). Other studies done by Morgan *et al*., (2018) support this study as it found that health seeking behavior of patients with a higher educational level was associated with better health outcomes. This is also reported by Abiiro *et al*., (2020) where it found that tertiary education was significantly associated with higher likelihood of awareness of patients' rights and responsibilities. Globally, women with higher education are consistently more empowered to exercise their health rights, reflecting broader evidence linking literacy with health outcomes (WHO, 2015).

Employment status showed a borderline association with rights awareness with unemployed women having higher proportions of poor awareness compared to employed or self-employed women. These patterns are consistent with Kenyan data linking socioeconomic status with access to health information and service utilization (MOH, 2021). Studies by Sando *et al*., (2016) reported that economic empowerment enhances women's ability to demand quality care and exercise health rights. According to WHO, socioeconomic inequalities remain to be a major barrier to patient rights awareness, particularly in low- and middle-income countries (WHO, 2019).

Antenatal care visits showed a strong association with awareness, increasing significantly as the number of visits increased. This aligns with Kenyan policy guidelines (MOH, 2016) that emphasize multiple ANC contacts as opportunities for continued health education, including sensitizations on patient rights. Similar findings have been reported in Ethiopia and Tanzania, where frequent ANC visits improved women's health literacy on reproductive health rights (Alemayehu *et al*., 2019; Sando *et al*., 2016). WHO's focused ANC model highlights multiple visits as critical for reinforcing rights and responsibilities (WHO, 2016).

To promote awareness of patient rights and responsibilities, advocacy and public education using the mass media and community engagement should be intensified especially within the areas where primary healthcare facilities are located in the communities.

5.2.2 Patient Rights Awareness

This study showed that awareness of patient rights and responsibilities was at quite low at 19.8% and increased to 67.8% after educational intervention. This study aligns with another study by Rose *et al*., (2019) where only 34.4% of the respondents reported to be aware of their right to access maternal health services. The study also added that women who were aware of their rights of access were almost 5 times more like to use skilled birth attendants compared to those who were not. This study recommended the government and partners to prioritize provision of information, increase communication and education on women human rights including the right to access the best quality maternal health services especially to women in rural areas.

Similar studies also showed that 92% of patients were not aware of their patient bill of rights, 1.8% had good awareness while 7.2% had only average awareness. From this study, 92% of the patients had fair access to the services while 95.2% of patients declared that they had not received necessary information concerning their patient bill of

rights either in writing or verbally. Alyah's study indicated patient awareness rate about their own rights was at 25.2%. Another study by Merakou *et al*., (2010) reported patient awareness rates concerning patient bills of rights was 16%, where 84% of the patients were not aware of their rights. These differences could be due to the positive effect of educational programs performed in recent years. Yousuf *et al*., (2021) concluded that 90% of patients were not aware of their rights, 85% were aware of their illness and treatment methods used. Some of the patients 65% of patients gained medical information during their hospitalization period and 92% of patients in surgery and dialysis units were satisfied with their physicians. These values are greater than those reported in this study. The reason for these differences could be due to the negligence of service providers and lack of information sharing with patients and healthcare providers concerning the patient bills of rights.

Healthcare providers are entrusted with management in ensuring that the patients have well sensitized to their rights and responsibilities. According to a study by Abedi *et al*., (2017) who reported that given the role of nurses as patient advocates and educators, low level of knowledge on aspects of patient rights among them may also be associated with low patient rights awareness among patients themselves. Nonetheless, a high level of knowledge does not guarantee implementation in practice, as several barriers may exist, including lack of implementation framework and shortages of staff.

Unfortunately, there is inadequate systems of checks and balances on the practice of patients' rights at the primary health care facilities to both patients and healthcare providers, contrary to provisions in the Constitution that the State will take all efforts to ensure provision of health services to its population. Some of the issues cited by the health care providers during the qualitative study include high workload, poor monitoring systems at the facility, lack of support from management, lack of time to engage with patients, lack of proper knowledge and skills to disseminate the patient rights charter and improper implementation mechanisms at the facilities.

According to this study, the educational intervention likely introduced notable changes that significantly enhanced participants' perceptions of care quality in the intervention group compared to the control group. The most notable improvements were in consultation and waiting times, communication with healthcare providers, facility cleanliness, and privacy during examinations. The availability of services and drugs showed a weaker but still notable effect. These findings show that the ANC clients were satisfied by the outcomes after the intervention and this could be due to resources, training and process improvements that the healthcare providers invested during the intervention period. The availability of services and drugs could not have satisfactorily improved due to the limitations that the healthcare providers have in terms of purchases of drugs and other specialized services that can be provided in the health centre. Similar studies have been reported in Ghana where the study reported an improved antibiotic prescription for urinary tract infections from 49% to 68%, $p<0.001$ after an educational intervention through guideline training and peer reviews (Owusu *et al.*, 2017). This study highlighted the efficacy of low-cost, onsite and targeted training in resource-limited settings. Another evidence-based practice study for nurses identified a multifaceted strategy, for instance mentoring and tutoring as effective in improving EBP competences and patient perceptions mirroring the current study in related domains in communication and availability of staff (Iltanen , *et al.*,2012).

Unlike the current study's comprehensive improvements across domains, a 2014 global review noted that quality metrics for acute illnesses in ambulatory settings often lag, with interventions showing variable success due to implementation barriers (e.g., provider resistance). The current study's success may reflect stronger stakeholder engagement or context-specific design. A 2016 study in Kenya and Namibia (Khalaf *et al.*, 2014) found that patient perceptions of care quality were not consistently associated with clinical quality, unlike the current study's alignment between perceived and measurable improvements (e.g., cleanliness, privacy). This suggests the intervention effectively bridged perception and reality.

5.2.3 Source of Information on Patients' Rights

The importance of sources of information regarding patients' rights and the ways to increase awareness were also addressed by the researcher in this study. Patients were asked where they have ever heard about patient rights from, and varied responses were recorded. In this regard, the most commonly known sources of patient rights information were healthcare providers including doctors and nurses and social media (TV, newspaper, and radio) while posters and Pamphlets was the least source of the patients. The researcher also made observations that having healthcare providers as sources of patient rights information significantly improved awareness levels.

The source of information from healthcare providers increased significantly from 68% pre-intervention to 98% post-intervention in the intervention group. The respondents were also allowed to choose more than one source of information. From the focused group discussion, the current responsive strategies to the Kenya's Patients' Charter through use of posters on notice boards remains limited and remote from points of care; is inaccessible to many patients and health care providers because it's too cluttered and only in English language. Healthcare providers rarely engage in community-based patients' rights activities which may seem to be a better way to disseminate patient rights (Madula *et al*., 2018).

Such strategies have been found to be largely ineffective as many patients and healthcare providers were not aware of their contents. There is also lack of a clear system for patients to seek redress and guide access to their rights. The system is perceived as reactive rather than proactive and only comes into place when patients' rights have been grossly violated. Responsiveness has been strained by the so many institutional and healthcare factors on which the hospital operates and thus largely depends on posters to create awareness, a mechanism that is ineffective and not sustainable (Mastaneh *et al*., 2013). There is therefore a need for the ownership and integration of a patient's rights approach in patient care.

Some similar studies have documented the same findings and in most of them healthcare providers have been cited as the main sources of patient rights information and have been well documented in the literature with social media being the secondary source. A study done in South Africa (Tabassum *et al.,* 2016), patients demonstrated lack of awareness about the patients' rights Charter, and they were unable to mention any rights they are entitled to as patients. Lack of sources of information was cited as the main challenge by the patients in getting adequate education about their rights. Moreover, in terms of the effective means of raising awareness, 34.6% of patients indicated that the most effective ways were about making videos or websites and posting them on the internet. This could be attributed to infiltration of social media as a source of information. Findings from this study further suggest that this method could lead to a significant improvement in patients' awareness of their rights. This was followed by a stationed office in every hospital to address the lack of education about patients' rights (23.4%) and providing education and evaluation of the healthcare providers in relation to giving respect to patients' rights (16.9%), other mentioned means were inclusion of this topic at school or university curriculum (15.9%) and increase promotion through leaflets and pamphlets in the facilities waiting area (9.2%).

5.2.4 Knowledge, Attitudes and Practice on Patients' Rights Awareness

The research findings show a positive attitude towards the practice of patient rights and responsibilities. The practice and attitudes of healthcare providers toward patient rights awareness are crucial in shaping a respectful and ethically sound healthcare environment. Patient rights encompass various aspects, including the right to privacy, informed consent, dignity, and access to accurate information about one's health. According to a study by Ghasemi, *et al*., (2019), the study findings showed that a significant number of healthcare providers, although aware of patient rights in principle, often struggle to fully implement them due to constraints such as time pressure, facility-based factors, existing institutional policies, and lack of resources**.** Healthcare providers, as the primary agents of patient interaction, are responsible for ensuring these rights are

upheld at all times. Studies have shown that while many healthcare providers understand the importance of these rights, practical implementation can be challenging due to factors affecting the health care providers themselves including heavy workload, inadequate training and lack of personnel. Consequently, there is often a disparity between knowledge and practice, with healthcare providers sometimes unknowingly compromising patient rights due to these pressures.

In a survey conducted by Joolaee *et al.,* (2012), conducted among physicians and nurses, 52% reported to routinely informing patients about their rights while majority (76%) acknowledging the importance of disseminating the same information to patients. Whilst this is alarming, the same findings have been extrapolated in this study since 100% of the healthcare providers acknowledged knowing the patient rights but adherence to the various items is varied. Healthcare providers' attitudes toward patient rights significantly influence their practice and subsequently influences the relationship with their patients. Providers with positive attitudes towards patient rights are more likely to respect and advocate for them in daily clinical engagements. However, research indicates that some healthcare providers may view patient rights as secondary to clinical outcomes, especially in high-stress environments like emergency departments. This perspective can lead to a paternalistic approach, where providers make decisions without fully involving patients. Moreover, in settings where patients may lack knowledge about their own rights, healthcare providers might not feel pressured to uphold these standards consistently, potentially limiting patients' autonomy and informed decision-making.

In areas where the stress levels are high or quite constraints as it is in the primary health facilities, the healthcare providers may not fully uphold these patients' rights owing to pressure to clear queues due to exhaustion and hence some critical rights like informed consents may be bypassed. These findings were also reported by Moradian *et al.,* (2019) in their study in Iran**.**

Most institutions and countries have scaled up efforts to improve healthcare providers' practices regarding patient rights and have focused majorly on education, training, and policy enforcement. According to a study done in Iran by Bagheri *et al.,* (2018), health care providers with positive attitudes toward patient rights, especially those who received specific training, were twice as likely to involve patients in decision-making processes compared to those without such training. Training programs that emphasize the ethical and legal aspects of patient rights can enhance providers' understanding and commitment to these principles. Additionally, clear institutional policies that promote accountability and support healthcare providers in practicing patient rights can foster a more patient-centered culture. Ultimately, aligning healthcare providers' practices and attitudes with patient rights standards benefits both patients and providers, creating a healthcare environment based on trust, respect, and shared decision-making. Studies by Almoajel *et al., (*2012) showed that over 60% of participants reported that patient rights were not regularly enforced in their institutions, indicating a need for stronger policy measures.

5.2.5 Effectiveness of an Educational Intervention on Patient Rights Awareness

Awareness of patient rights improved from baseline post-intervention in the intervention group with the regression model supporting the effect of the educational intervention. Higher educational attainment was strongly associated with a 1.643-unit increase in quality-of-service score per education level (e.g., primary to secondary or tertiary; 95% CI: 1.376–1.910). With the largest effect size in the model, it suggested that more educated participants may have higher expectations or better ability to recognize and appreciate quality of service improvements. This finding corroborates earlier baseline odds ratio data, where secondary (OR = 1.81, p = 0.031) and tertiary education (OR = 2.24, p = 0.002) were linked to better outcomes. In the intervention context, education likely amplified the program's effects, as seen in awareness distributions where tertiary-educated individuals in the intervention group had 19(52.8%) good awareness (>75 score) versus 4(33.3%) in the control group. Each additional ANC visit increased quality

of service perception by 1.770 units (95% CI: 0.639–2.901), with a moderate effect size. This indicates that frequent healthcare interactions foster familiarity and trust, enhancing quality of service ratings. Baseline data showed borderline significance for ANC visits in both groups ($p = 0.091$ control, $p = 0.079$ intervention), but the regression highlights its independent role. In the intervention group, those with 3+ visits had 19(47.5%) good awareness, suggesting synergies between ANC exposure and intervention efficacy.

This study has shown the need for low-cost sustainable sensitizations of patients and patient rights must be observed and protected. These finding aligns with studies in Kenya and Uganda, which reported that structured health education sessions improved women's knowledge of their health rights entitlements and enhanced their capacity to demand respectful care (Sando *et al*., 2016; Tura *et al*., 2020). Similarly, a systematic review by Bohren *et al.*, (2015) found that targeted community and facility-based interventions significantly increased awareness of patients' rights and reduced mistreatment during maternity care.

However, some contrasting evidence exists. In Ethiopia, Alemayehu *et al*., (2019) reported that awareness campaigns alone had limited impact when not supported by institutional accountability mechanisms. This suggests that while educational interventions are crucial, they may need to be reinforced by system-level changes to ensure sustained improvements.

The increase in knowledge of patient rights from baseline to post intervention is consistent with findings by McMahon *et al*., (2014), where training and educational outreach significantly raised women's knowledge of their rights and responsibilities during antenatal visits. This also aligns with WHO efforts that emphasized the role of patient education as a cornerstone of people-centered health systems, reinforcing the value of such interventions (WHO, 2015).

Global evidence has shown that education not only enhances knowledge of rights but also fosters a stronger sense of responsibility among patients, thereby strengthening the provider-patient relationship (Kruk *et al*., 2018; WHO, 2016). In contrast, studies in South Asia have shown that while rights awareness may increase, patient responsibility is often less emphasized, reflecting cultural contexts where health decision-making is primarily provider-driven (Sharma *et al*., 2017). Nonetheless, evidence by Okafor *et al*., (2018) suggests that knowledge gains may diminish over time without continued sensitizations, indicating the need for ongoing patient education as part of routine antenatal care which is possible with pregnant women due to their repeated antenatal care visits.

This study shows that despite provisions for the practice of patients' rights in the Bill of Rights in Kenya's constitution, awareness of and practice of patients' rights remain limited at primary health care facilities in Kirinyaga County. Patients encounter challenges in accessing their rights.

Similar studies have reported that despite the existence of laws, Kenya's public health system inadequately promotes and protects and frequently violates the rights of patients seeking care. Some human rights networks have attributed this to the poor socio-economic status of patients who are vulnerable to abuse and resource constraints to meet the health care needs of public hospitals due to poor funding, poor remuneration of healthcare workers and high patient turnover. These factors facilitate unethical behavior and patient exploitation, such as non-observance of patient rights and denying patients their right to health

Educational interventions to enhance patient rights awareness have proven effective across various contexts, including Africa and other parts of the world. These educational interventions align with Sustainable Development Goal 3, which aims to ensure healthy lives and promote well-being for all ages, and SDG 5, which emphasizes gender equality and the empowerment of all women and girls. Specifically, the goal to reduce global

maternal mortality relies on creating a healthcare environment where women are informed of their rights and can receive quality, respectful care without discrimination (UN, 2022). By improving antenatal patients' understanding of their rights, educational programs support better maternal health outcomes and address gender inequalities within healthcare settings. Furthermore, these interventions promote a culture of accountability among healthcare providers, contributing to SDG 16’s target to build inclusive institutions by fostering trust and transparency within the health sector. Together, these outcomes illustrate that patient rights awareness is not only beneficial for individual patients but is also essential for achieving broader public health and social equity goals.

These interventions typically focus on improving patients' understanding of their rights regarding consent, confidentiality, access to care, redress to grievances and participation in decision-making. Studies indicate that patients who are more aware of their rights are more likely to engage actively in their care, leading to better health outcomes and increased satisfaction with the healthcare system Haque *et al.,* (2021). According to the World Health Organization, effective educational interventions often combine informational sessions, printed materials, and digital resources, helping to increase awareness and understanding of patient rights universally (WHO, 2022).

In Africa, research highlights that many patients have limited awareness of their rights due to socio-economic challenges, inadequate health literacy, and systemic issues within healthcare systems. For instance, a study conducted in Ghana by Boadu *et al.,* (2018) found that educational programs significantly improved patients' understanding of their rights to information and participation in treatment decisions. Similar studies in Nigeria and South Africa demonstrated that targeted educational interventions, such as workshops and patient information leaflets, were effective in improving knowledge and fostering a stronger patient-provider relationship (Okoronkwo *et al*., 2019). These findings underscore the need for ongoing education to address the gaps in patient rights awareness across African healthcare settings.

Globally, educational interventions have shown promising results in enhancing patient rights awareness, particularly in low- and middle-income countries (LMICs) where healthcare literacy is often low. Research from India and Brazil reveals that community health programs that educate patients on their rights and responsibilities improve trust in the healthcare system and empower patients to make informed health decisions Desai *et al*., (2019); Paim *et al*., (2020). In developed countries, interventions like informational campaigns, workshops, and online educational tools have also proven effective. A systematic review by Shrestha *et al*., (2021) indicated that patient education on rights in hospitals across Europe and the U.S. was linked to increased compliance with treatment, fewer conflicts with healthcare providers, and overall improved patient satisfaction.

The effectiveness of these interventions depends on their adaptability to local cultures and health literacy levels. While global studies underscore the value of tailored educational approaches, they also highlight challenges, such as resource limitations and varying patient engagement levels, that impact intervention success in specific regions (Beyene & Alemu, 2021). Implementing consistent and culturally sensitive educational initiatives could bridge these gaps, ensuring that patients worldwide understand their rights and responsibilities, contributing to more equitable healthcare outcomes (WHO, 2022). These studies collectively reinforce that patient rights education can lead to improved health outcomes and greater satisfaction, particularly when interventions are designed with local context in mind.

Educational interventions to raise patient rights awareness among antenatal patients have shown to be instrumental in improving both patient empowerment and the quality of maternal healthcare services. Awareness of rights, including the right to informed consent, privacy, and respectful care, is particularly critical for antenatal patients, who are often vulnerable to inequities in service delivery. Studies demonstrate that antenatal patients who receive education about their rights experience improved healthcare interactions and are more likely to advocate for their preferences and participate actively in decision-making regarding their care Mukamurenzi *et al*., (2021). In Rwanda, an

educational program for pregnant women on their rights resulted in significant improvements in both patient satisfaction and adherence to antenatal care visits, suggesting that informed patients are more engaged and likely to follow medical advice (D'Souza *et al*., 2012). Increased patient engagement directly impacts the quality of service provided, as healthcare providers respond positively to informed patients, resulting in more respectful and transparent interactions, which are essential for maternal health.

A potential limitation of this study is the influence of social desirability bias, particularly in the post-intervention phase. Following exposure to the educational sessions through health talks and use of information materials, participants may have been more inclined to provide responses they perceived as desirable or aligned with the expected outcomes of the study, rather than reflecting their true experiences, knowledge or attitudes. This is especially relevant in facility-based settings where participants may associate the research team with healthcare providers, potentially leading to overreporting of patient rights awareness or positive experiences from participants. As a result, the observed improvements in awareness scores may partly reflect response bias rather than solely the effect of the intervention.

To mitigate this bias, the researcher undertook several measures to implement and are recommended for future studies. First, efforts were made to assure participants of confidentiality and anonymity, emphasizing that their responses would not affect the care they receive in the current times and future services at the facility. Secondly, research assistants were trained to maintain neutrality and create a non-judgmental environment to reduce pressure on participants to provide socially acceptable answers. Third, the use of mixed methods, including qualitative data, allowed for triangulation and deeper exploration of participant responses beyond structured questionnaires. Additionally, future studies could strengthen validity by incorporating indirect questioning techniques, self-administered tools where literacy allows, or blinded outcome assessment to further minimize interviewer influence. Conducting follow-up

assessments after a longer interval may also help distinguish between short-term response bias and sustained knowledge gains.

5.3 Conclusions

This study makes the following conclusions.

1. Both at pre-intervention and post-intervention, socio-demographic characteristics including education levels and income levels have been documented to be significant and associated with improved knowledge on patient rights and responsibilities; employment status and level of education remained to be strong predictors. The study demonstrates that higher education of respondents, and frequent ANC visits are key drivers of patient rights awareness. The main source of information on patient rights was recorded as healthcare providers and social media. This calls for more efforts to be directed towards increasing awareness among health care providers. From the focused group discussions, it’s noted that women interact better at social gatherings and awareness could be extended to through social groups. Also, even though the charters could be available at the hospital notice boards, accessibility of information because of language barrier and information overlaps.
2. The study findings showed that healthcare providers were knowledgeable about the patient rights and had a good understanding of what is required of them to do. From the qualitative findings, the healthcare providers practised patient rights in their engagements with health care recipients. Even though they were aware of the rights, they had never been formally trained, no implementation policies in place and no documentation as evidence on how the patient rights are being implemented.
3. The intervention of educational talks to patients had a statistically significant influence in the awareness levels in the intervention site likened

to the control site. The educational intervention was associated with a 6.314 unit increase in the outcome therefore participants in the intervention group were more aware of their patient rights when compared with the those in the control group.

5.4 Recommendations

This study makes the following recommendations.

1. It is crucial to implement programs that improve access to education and as such the Ministry of Health in collaboration with county governments should implement regular sensitizations for patients to improve their overall knowledge on patient rights and awareness. Sensitizations can be carried out through healthcare providers, social media and other avenues that patients can access. County governments should enhance the utilization of Educational Materials: This research has also shown the impact of utilization of print materials in enhancing knowledge on patients' rights. The development and distribution of user-friendly educational materials (e.g., pamphlets, posters) in healthcare settings to ensure women and other healthcare recipients are continuously informed about their rights.

   Kenya National Patients' Rights Charter should be translated to local languages by the Ministry of Health together with other stakeholders to ensure that patients' rights are understood, practiced, and protected

2. Governments and stakeholders in the policy making spaces should also institutionalize continuous training for healthcare providers. Policy implementation at primary health care settings requires an understanding of the setting, attitudes and the culture of the health care providers to enable the process of implementation to be tailored to the context. Also devise effective strategies to monitor implementation to support healthcare providers to fulfil patients' needs

as well as maintaining documentation to ensure that healthcare providers attitudes and practices are sustained.

3. The Ministry of Health should champion policy reforms that integrate patient rights education into antenatal care initiatives. This study highlights the need for advocacy at the policy level to embed patient rights education within antenatal care programs in a manner that is structured, practical, and sustainable.

5.4.1 Recommendation for Further Research

There is need for further research to explore the long-term impact of educational interventions on patient rights awareness and to assess the effectiveness of various educational strategies across different demographics and regions. Further research is recommended on the patient level awareness of patient rights of the general population of healthcare recipients.

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APPENDICES

Appendix I: Informed Consent Form

Study Title:	Effect of an Educational Intervention on Patients' Rights Awareness among pregnant women attending Antenatal Care Clinics in Kirinyaga County, Kenya
Investigator:	Egla Chepkorir

This Informed Consent Form has two parts: -

• Information Sheet (to share information about the study with you)

• Certificate of Consent (for signatures if you choose to participate)

Part 1: Information Sheet

We are conducting research to investigate the effects of educational intervention on patients' rights to pregnant women attending antenatal care clinics in this facility. The researcher will conduct interviews using a questionnaire as clients leave the facility. The study seeks to establish the level of awareness of patient's rights, to assess the practice and knowledge of health care providers towards patient rights from the patients' perspective as well as to determine the degree of adherence of these rights by the healthcare providers. The researcher intends to utilize the services of a healthcare provider by providing health talks during antenatal care sessions and provision of bookmarks which the patients will carry home as ways to improve knowledge on patients' rights.

This study will not interfere in any way with your treatment, and your participation is purely voluntary. Should you choose not to participate, your services will not be affected in any way. Before participating, you are requested to go through the form and understand the aim and purpose of the study. You are free to ask questions and clarifications where necessary before proceeding to consent to the study.

Purpose of the study

The purpose of this study is to determine the effect of educating patients on their rights as stated in the patients' rights charter. Patients, especially pregnant women are vulnerable to abuse and violence at the health facility and enlightening a patient to know what she is entitled to empowers them to demand services that respect her dignity, ethical and of good quality. This then promotes the patient's satisfaction.

The target population

The study targets pregnant women attending this facility and meet the inclusion criteria. Pregnant women of less than 20weeks pregnancy will be eligible for this study. They will be required to consent before commencement of the study.

Length of the study

This study takes place over a period of about four months.

In the first month of the study, initial data will be collected and for the following months, the healthcare provider will conduct health talks at the facility as well as provide bookmarks with a summary of patients' rights. The health talks will take place during the routine antenatal clinics. During the last month of the study, data shall be collected as well using a questionnaire.

Discomfort and Risks

There are minimal risks to you in this study. If you find some of the questions too personal or that creates discomfort or risks with which you are uncomfortable, you may choose not to answer or withdraw from the study at any stage.

Benefits

There will be no monetary or any other direct benefit to you because the research assistants shall be collecting this data during your routine ANC clinics and compensation may be construed as an inducement to provide consent. Your participation is likely to help us find out more about how to increase knowledge about patients' rights and hence contribute to your services satisfaction and improve quality of care amongst pregnant women in your community.

The findings will also help to attain national health objectives as articulated in different strategies and vision 2030 hence contributing to the achievement of sustainable development goals.

Confidentiality

During data collection, critical information like identity of respondents shall not be noted but will assign codes for purposes of analysis. All data from the study will be stored in a secure location.

Data management

The findings from this research will be used by the researcher in her doctoral thesis for the award of a PhD degree in International Health. Findings from the study will also be shared with the county government.

Will to withdraw from the study

Your participation in this research is voluntary. If you choose not to participate, you will continue to receive all the normal services that you usually get, and nothing will change.

Person to contact.

If you have any questions at this moment, you can ask anyone from our team. If you have questions later, you can contact:

Egla Chepkorir, +254720912758

Study Approvals

The relevant ethical bodies have approved the study: - KEMRI Scientific and Ethics Review Ethics National Commission of Science, Technology, and Innovation (NACOSTI), JKUAT Graduate School, The County Government of Kirinyaga (County Director of Health) and the two health Facilities. If you have questions regarding the study or complaints, you may contact:

The Committee Chairperson- KEMRI

KEMRI Scientific and Ethics Review Unit

Telephone numbers: 020-2722541, 0717719477.

P. O. Box 54840-00200, Nairobi, Kenya

Email address: seru@kemri.org

Part 2: Statement of Consent

The above statements and requirements of the study have been read to me in a language I understand, and they are clear to me. I have been informed that my participation in this study is voluntary with no rewards whatsoever, and that any information I provide will be kept safe and confidential, and used only for academic purposes. I also understand

that I can withdraw from study at any stage without victimization.

I also understand that by signing this form, I agree to participate in the study under the contents of this letter as read to me.

Signature…………………………. ……. Date......../……/20….

Statement by the researcher/person taking consent.

I have accurately read out the information sheet to the potential participant (pregnant women), and to the best of my ability made sure that the participant understands the study and what will be expected of them.

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent was given freely and voluntarily.

Researchers Name: ……………………………………………………………..

Signature………………………………. Date……/……/20……

Appendix II: Questionnaire for Pregnant Women

Study title: The Effect of an Educational Intervention on Patients' Rights Awareness among pregnant women attending Antenatal Care Clinics in Kirinyaga County, Kenya

SECTION 1: Sociodemographic Characteristics

1. What is your age (in complete years)?

Age bracket	Please tick
18-30	
31-40	
41-49	

2. What is your employment status?

Status	Please tick
Employed(salaried)	
Not employed(housewife)	
Self-employed (farmer, businesswoman)	

3. What is your income level per month? ……

Salary range	Please tick
1000 – 2999	
3000- 4999	
> 5000	

4. What is your level of education?

Education level	Please tick
Primary or less	
Secondary	
Tertiary	

5. What is your marital status?

Single	Married	Others (widowed, divorced, etc)

6. How many children have you had before this one?

# of children	Please tick
None	
1	

2	
More than 3	

7. How many visits have you done for antenatal care during this pregnancy?

No of visits	Please tick
1	
2	
More than 3+	

Part 2: Level of awareness of patients' rights charter

8. *Knowledge on Patient rights awareness*
   a. Do you understand your patient rights as an ANC patient at this facility?
      1. Yes……………………………2. No…………………

   b. Have you ever been trained or educated on your patient rights as an ANC patient at this facility?
      Yes……………………………No…………………

   c. Patient rights awareness questions, please tick on the boxes below.

No	Patients' rights	SA	A	N	D	SD
a)	**Quality of Care**					
	The patient has a right to the best quality and safest healthcare services available.					
	The patient has a right to emergency health services during an emergency.					
	The patient has a right to a safe and hygienic environment.					
b)	**Privacy and confidentiality**					
	The patient has the right to confidentiality. The information a patient reveals to a health care provider is private and sensitive					
	The patient has a right to be asked for permission prior to examination.					

	The patient has the right to privacy during clinical examination					
c)	**Dignity and Respect**					
	The patient has the right to receive empathetic and respectful care at all the times					
	The patient has the right to be provided with appropriate medical services available in the facility irrespective to gender, age, religion.					
d)	**Choice of care**					
	The patient has the right to refuse or discontinue treatment after a thorough explanation by his/her healthcare provider about the consequences and/or outcomes of his/her decision					
	Patients have the right to seek a second opinion from another healthcare provider					
e)	**Access to Information and informed consent**					
	The patient has a right to accept or refuse to participate in any medical research and any refusal will not negatively affect the medical services provided					
	The patient has a right to be informed about his/her rights and responsibilities in a manner that he/she can understand					
	The patient has the right to receive a full explanation of his/her case and any unanticipated outcomes of care and treatments					
	Patients or parents has a right to sign an informed consent form before any medical procedure					
	Patients have a right to receive the copy of their medical records					
f)	**Participation in decision making**					
	The patient has the right to know the identity/name of health care provider and other persons involved in his/her care					
	The patient has the right to participate in care decisions to the extent they wish, and in choosing the treatment plan					

g)	**Redress of grievances**					
	The patient has the right to file a complaint regarding any concerns related to confidentiality or the quality of his/her health care and to be informed about the results of such complaints.					

Part 3: Quality of care at the facility

9. *Self-reported quality of care as reported by ANC clients*

   How would you rate the overall quality of services (*cleanliness of the facility, Privacy during treatment, Communication, Staff availability, availability of services and drugs, Consultation and waiting times*) you received in this facility?

Satisfaction element	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied
Consultation time and waiting times)					
Communication by HCP					
Staff availability					
Cleanliness of the facility					
Privacy during examination					
Availability of services and drugs					

Part 4: Sources of information on patient rights and responsibilities

12: Sources of patient rights information for ANC

1. What are your sources of information on patient rights and responsibilities?

Source	**Please tick**
Health care provider (nurse, doctor, clinician)	
Hospital posters, pamphlets, charters	
Social media (TV, newspaper, radio)	
Others (Relatives &friends)	

Appendix III: Key Informant Interview Guide for Healthcare Providers

Age group…………. Education level……………….no of years worked……….

Introduction: May I take this opportunity to welcome you to this interview where we shall be discussing some issues regarding patient rights awareness. The main goal of this discussion is getting your professional perspective to issues that I will be putting to you for clarification. This study has received all the approvals from the national to county offices. Feel free to provide your views/perspectives in whichever manner you may wish under my guidance. Moreover, feel free to interject by raising your hand up. This interview is anticipated to take about 45 minutes.

Welcome.

Start time : ……………………………… **End time:**………………………..

1. Can you describe your understanding on patient rights, how it's being disseminated and implemented?

   ***Probe**: Patient rights items, knowledge gaps, plans on patients' rights dissemination; how they are implemented (processes, who is involved)*
2. What is the current practice for patient rights, monitoring and implementation for patients' rights?

   ***Probe**: Patients' rights charter, M&E framework, policies & guidelines, sources of information*
3. What is your suggestion on how the implementation of patient's rights and responsibilities can be improved?

   ***Probe:** Gaps in the present framework, what can be improved, what educational initiatives can improve the awareness*
4. In your views, what is the role of nurses in promoting patient rights among ANC clients?

Probe: *Attitudes among HCPs, barriers, pregnancy outcomes, integration to daily practices, challenges in implementation*

5. Please share your experiences on how patient complaints are documented, addressed and feedback mechanisms?

   Probe: *SOPs, registers to document complaints, how feedback on complaints*

6. In your own opinion what steps should be taken to enhance awareness to patients about patient rights charters?

   Probe: Training, resources, integration plans

Appendix IV: Focus Group Discussion Guide for Pregnant Women

FGD No…Age group…………Education level:…………………….No of ANC visits………

May I take this opportunity to welcome all of you to this discussion where we shall be discussing some issues regarding patient rights awareness. The main goal of this discussion is get your professional perspectives. This study has received all the approvals from the national to county offices. Each one of you will get an opportunity to speak to any of the issues I will be putting to you. Feel free to provide your views/perspectives in whichever manner you may wish under my guidance. Moreover, feel free to interject by raising your hand up. I anticipate that this discussion will take about 45 minutes.

Welcome.

Start time : …………………………….End time…………

1. Can you share your knowledge on patience rights and experiences with any form of education or training you have received on patient rights.

   Probe: *knowledge on PRC, name any of the rights, topics covered during trainings if any, mode of delivery, the person who delivered and the impact.*
2. From your experience, where can one get information on patient rights?

   Probe: *location of PRC in the facility, sources i.e. HCPs, social media, friends*
3. What are the challenges to accessing patient rights?

   Probe: *language barrier, clarity & understanding, practice of PRCs i.e– Complaints filing and redress, feedback-experience and how long it took*
4. What do you think are the contributions of healthcare providers in of patient rights implementation?

   Probe: *any interaction with HCP on PRCs***,** *HCP attitudes***,** *examples of positive or negative contribution, areas of collaboration with HCP*
5. What does quality of services and care look like from your understanding?

   Probe: *cleanliness of facility, availability of medicines and tests, treatment with dignity and respect, privacy, communication with the HCPs, waiting times*

6. What are some of the experiences interacting with health facility providers whilst accessing health services?

    Probe: *violations, support, kinds of abuse, effect on treatment outcomes*

Thank the respondents for their time and cooperation

Appendix V: SERU Approval

KENYA MEDICAL RESEARCH INSTITUTE

OFFICE OF THE DIRECTOR RESEARCH & DEVELOPMENT

Tell: +254 020 2722541, 2713349,
0722 205 901, 0733 400 003

P.O. Box 54840-00200,
Nairobi Email:
ddrt@kemri.go.ke
Website: www.kemri.go.ke

KEMRI/RD/22

October 02, 2023

TO: **EGLA TONUI CHEPKORIR,**
PRINCIPAL INVESTIGATOR.

THROUGH: **THE DEPUTY DIRECTOR, CPHR,**
NAIROBI.

Dear Madam,

RE: **PROTOCOL NO. KEMRI/SERU/CPHR/57-4-23/4763 *(RESUBMISSION II OF INITIAL SUBMISSION)*: PATIENT RIGHTS AWARENESS OF EXPECTANT MOTHERS ATTENDING ANTENATAL CLINICS IN THE CONTEXT OF AN EDUCATIONAL INTERVENTION IN KIRINYAGA COUNTY *(PROTOCOL VERSION 4.0 DATED SEPT 2023)***

Reference is made to your letter dated September 20, 2023. The KEMRI Scientific and Ethics Review Unit (SERU) acknowledges receipt of the following revised study documents on September 20, 2023;

1. Study protocol version 4.0 dated Sept 2023

This is to inform you that the Committee determined that the issues raised during the 337th Committee A meeting of the KEMRI Scientific and Ethics Review Unit (SERU) held on **July 11, 2023** have been adequately addressed.

Consequently, the study is **granted approval** for implementation effective this day, **October 02, 2023** for a period of **one (1) year**. Please note that authorization to conduct this study will automatically expire on **October 01, 2024.** If you plan to continue with data collection or analysis beyond this date, please submit an application for continuation approval to SERU by **August 20, 2024.**

Please note that only approved documents including (informed consents, study instruments, Material Transfer Agreement) will be used. You are required to submit any proposed changes to this study to SERU for review and the changes should not be initiated until written approval from SERU is received. Any unanticipated problems resulting from the implementation of this study should be brought to the attention of SERU and you should advise SERU when the study is completed or discontinued.
Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) https://oris.nacosti.go.ke and also obtain other clearances needed.

Yours faithfully,

ENOCK KEBENEI,
THE ACTING HEAD,
KEMRI SCIENTIFIC AND ETHICS REVIEW UNIT.

Appendix VI: NACOSTI Research Approval

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **106785**

Date of Issue: **16/January/2024**

RESEARCH LICENSE

This is to Certify that Ms.. Egla Chepkorir of Jomo Kenyatta University of Agriculture and Technology, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Kirinyaga on the topic: THE EFFECT OF AN EDUCATIONAL INTERVENTION ON PATIENTS' RIGHTS AWARENESS AMONG EXPECTANT MOTHERS ATTENDING ANTENATAL CARE CLINICS IN KIRINYAGA COUNTY, KENYA. for the period ending : 16/January/2025.

License No: **NACOSTI/P/24/32465**

106785

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

See overleaf for conditions

Appendix VII: County Approval

COUNTY GOVERNMENT OF KIRINYAGA

DEPARTMENT OF MEDICAL SERVICES, PUBLIC HEALTH AND SANITATION

E- mail: directorhealth@kirinyaga.go.ke or dmohkirinyaga@gmail.com

COUNTY DIRECTOR OF HEALTH
KIRINYAGA,
P. O. BOX 260 - 10304
KUTUS

When replying please quote:

REF: CDH/RES/VOL.III (2) 57

11th January 2024

To
Egla Tonui Chepkorir
Principal Investigator

Dear Egla,

Subject: No Objection Letter for research titled: Patient Rights Awareness Of Expectant Mothers Attending Antenatal Clinics In The Context of an Educational Intervention In Kirinyaga County

We acknowledge your request to conduct the research titled; Patient Rights Awareness of Expectant Mothers Attending Antenatal Clinics in The Context of an Educational Intervention in Kirinyaga County. The research is part of the requirements of your PhD program at Jomo Kenyatta University of Agriculture and Technology.

After careful review of the research documents package, we are pleased to inform you that all necessary permits and research requirements are in order and the county department of health has no reservations for the study.

This official letter serves as a no-objection approval to undertake the study. We expect that you and your team will strictly adhere to all ethical and scientific principles governing human subjects' involvement in research. We also request that you provide regular written progress reports to the County Director of Health.

Should you require any further assistance or clarification, please do not hesitate to contact the County Health Research Focal Person. We look forward to the successful study and the positive impact it will have on the health and well-being of mothers in Kirinyaga County.

Sincerely,

COUNTY DIRECTOR OF HEALTH KIRINYAGA COUNTY
11 JAN 2024
P.O. Box 24 - 10300, KERUGOYA

Dr. Esbon Gakuo
Director
Department of Medical Services, Public Health, and Sanitation Kirinyaga County

- **CECM Health**
- **Chief Officer Health**