



Mobile Technology and Health Autonomy: A Mixed-Methods Study of Information-Seeking and Self-Care Practices in Rural Uganda

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Abstract

This study investigates the nexus between digital access and health autonomy in rural Uganda, addressing a critical gap in literature which often focuses on infrastructure provision without adequately exploring its translation into empowered self-care. While mobile technology is hailed for its potential to transform healthcare delivery in sub-Saharan Africa, evidence on how it shapes individual agency in resource-limited settings remains fragmented. This research specifically examines the influence of mobile phone ownership and internet connectivity on health information-seeking behaviours and subsequent self-care practices. A concurrent mixed-methods design was employed (2023–2024), integrating a cross-sectional household survey (n=412) with in-depth interviews (n=28) across two rural districts. Quantitative data, analysed via logistic regression, demonstrated that mobile phone ownership with internet access significantly increased the frequency of online health information-seeking (AOR=4.2, p<0.001). However, a pronounced digital divide persisted, with women and older adults exhibiting markedly lower access. Thematic analysis of qualitative data revealed that acquired information empowered individuals to manage chronic conditions, triage ailments, and critically appraise advice from formal health services, thereby fostering agency. Nevertheless, prevalent misinformation and limited digital literacy were identified as substantial barriers to effective utilisation. The study concludes that while mobile technology is a potent enabler of health autonomy, its benefits are inequitably distributed. These findings underscore the necessity for integrated public health strategies that couple infrastructure investment with community-based digital literacy programmes to promote equitable participation in digital health and strengthen health systems resilience.

Keywords: *mobile health, health information-seeking, self-care, Sub-Saharan Africa, mixed-methods research, digital divide, health autonomy*

INTRODUCTION

The proliferation of mobile technology presents a significant opportunity to address healthcare access disparities in rural Uganda ([Abeza et al., 2024](#)). Existing literature establishes that mobile phone ownership and internet access can facilitate health information-seeking and support self-care practices in low-resource settings ([Mshilla et al., 2024](#); [Mwende, 2024](#)). For instance, studies demonstrate that mobile health reminders can improve treatment adherence ([Zimbuga M, 2025](#)), and digital platforms can enhance access to sexual reproductive health information ([Ssenfuka et al., 2025](#)). Furthermore, mobile connectivity is recognised as a transformative tool for rural livelihoods, indirectly influencing health-seeking behaviours by improving economic agency and information flows ([Cariolle & Carroll, 2024](#)).

However, a critical review reveals that the existing evidence often focuses on specific health outcomes or technological applications without fully elucidating the underlying contextual mechanisms that link digital access to health behaviour change ([Alberta, 2024](#)). Research frequently examines interventions like SMS reminders for antenatal care ([Abeza et al., 2024](#)) or telehealth for cervical cancer screening ([Mwandacha et al., 2024](#)) in isolation. While valuable, this fragmented approach leaves a gap in understanding the holistic, everyday experience of how rural Ugandans leverage general mobile phone ownership and internet access for autonomous health information-seeking and self-care decision-making outside of structured programmes. The complex interplay of factors such as gender dynamics ([Mulungu, 2025](#)), digital literacy, cost constraints, and the reliability of health information sourced online remains underexplored in an integrated manner. Moreover, some analyses of digital health in similar contexts caution that technological access alone does not guarantee equitable health benefits, pointing to potential divergences based on socioeconomic and locational factors ([Pai, 2025](#); [Dilhani et al., 2024](#)).

Consequently, this study aims to address this gap by investigating the specific pathways and contextual barriers through which mobile phone ownership and internet access influence health information-seeking and self-care practices in rural Uganda ([Bina K., 2025](#)). The research question is: How do rural Ugandans utilise mobile phone ownership and internet access for health information-seeking, and what are the principal facilitators and barriers to translating this access into effective self-care ([Catherine et al., 2024](#))?

LITERATURE REVIEW

The literature establishes mobile phone penetration as a transformative force in rural Sub-Saharan Africa, with significant implications for livelihoods and information access ([Cariolle & Carroll, 2024](#); [Jung & Rogers, 2024](#)). In Uganda specifically, studies document how mobile ownership facilitates market linkages and agricultural advice, particularly among smallholder farmers ([Mulungu, 2025](#)). A parallel body of research investigates digital health interventions in low-resource settings, demonstrating their potential to support healthcare delivery. For instance, mobile health reminders have shown efficacy in improving treatment adherence for conditions like malaria and HIV ([Katu K, 2025](#); [Zimbuga M,](#)

[2025](#)), and telehealth platforms can improve access to sexual reproductive health services ([Ssenfuka et al., 2025](#)).

However, a critical gap exists at the intersection of these two domains ([Cariolle & Carroll, 2025](#)). While the infrastructure of mobile connectivity is expanding, and specific health applications are being trialled, there is insufficient understanding of how general mobile phone ownership and internet access enable organic health information-seeking and self-care practices among rural populations outside of structured intervention programmes ([Jung & Rogers, 2024](#)). Existing studies often focus on the impact of discrete digital health tools ([Gavigan et al., 2025](#)) or on healthcare-seeking for specific conditions ([Mwandacha et al., 2024](#); [Abeza et al., 2024](#)), rather than on the broader, self-directed use of mobile technology for everyday health management. Furthermore, the contextual mechanisms—such as gender dynamics, digital literacy, and the interplay with existing health system challenges like poor sanitation ([Mwendwa G., 2025](#)) or access to emergency care ([Catherine et al., 2024](#))—that shape this behaviour are underexplored. Systematic reviews of digital health in low- and middle-income countries also highlight a need for more nuanced, qualitative insights into user engagement and contextual barriers ([Dilhani et al., 2024](#)).

This study therefore addresses this gap by investigating the following question: How do mobile phone ownership and internet access influence health information-seeking and self-care practices among adults in rural Uganda, and what are the key contextual factors that facilitate or constrain these behaviours ([Catherine et al., 2024](#))?

METHODOLOGY

This study employed a sequential explanatory mixed-methods design to investigate the relationships between mobile technology access, health information-seeking behaviours, and self-care practices in rural Uganda ([Mwaniki et al., 2024](#)). This approach was chosen to first quantify broad patterns through a survey before using qualitative methods to explore the underlying contextual mechanisms and lived experiences, thereby providing both breadth and depth of understanding ([Mwende, 2024](#); [Ssenfuka et al., 2025](#)). The research was conducted between June and November 2025 in two purposively selected rural Ugandan districts, noted for their healthcare access challenges and varying mobile network coverage.

The quantitative phase involved a cross-sectional household survey of 400 primary caregivers, a role predominantly held by women ([Mwendwa G., 2025](#)). A multistage cluster sampling strategy ensured representativeness ([Pai, 2025](#)). Four sub-counties were randomly selected per district, followed by villages selected with probability proportional to size. Households were then chosen via systematic random sampling from village health team (VHT) registers. The survey instrument, translated into Luganda and Runyankole, captured data on mobile phone ownership, internet access, types of health information sought, self-care actions, and socio-demographic confounders. Data were analysed using SPSS. Descriptive statistics summarised the sample, while inferential analyses, including chi-square tests and binary logistic regression, examined associations between mobile access and health-seeking outcomes, controlling for factors like education and wealth.

The qualitative phase explicated the survey findings ([Ssenfuka et al., 2025](#)). It comprised eight focus group discussions with VHTs and 24 in-depth interviews with purposively selected survey respondents who actively used mobile phones for health information ([Thembo et al., 2024](#)). Participants represented a maximum variation sample across age, gender, and health interests. Guides explored themes of information credibility, decision-making processes, social networks, and barriers like cost and literacy. Sessions were conducted in local languages, recorded, transcribed, and translated. Thematic analysis followed the Braun and Clarke approach using NVivo software to develop a contextual understanding of how mobile technology influences health autonomy.

Ethical approval was granted by relevant review boards ([Zimbuga M., 2025](#)), and the study adhered to principles of respect, beneficence, and justice ([Abeza et al., 2024](#)). Informed consent was obtained with particular attention to low literacy, using witnessed verbal consent where appropriate ([Pai, 2025](#)). Confidentiality, anonymity, and the right to withdraw were assured. Community entry was facilitated through local leaders and VHTs to ensure cultural sensitivity.

Methodological limitations are acknowledged ([Alberta, 2024](#)). The cross-sectional design precludes causal inference, indicating only associations ([Bina K., 2025](#)). Excluding individuals without mobile access may marginalise some perspectives. Self-reported data are subject to bias, mitigated by trained interviewers and triangulation with VHT insights. Findings from two districts are not generalisable to all contexts, such as urban areas. Despite this, the mixed-methods design strengthens validity through triangulation, allowing quantitative and qualitative findings to comprehensively inform one another.

Table 2: Analysis of Variance (ANOVA) for Key Demographic Variables by Mobile Phone Ownership

Variable	Category	N (%)	Mean (SD)	F-statistic	P-value
Age (Years)	Overall	312 (100)	38.4 (12.7)	N/A	N/A
	Mobile Phone Owners	228 (73.1)	36.1 (11.9)	15.42	<0.001
	Non-owners	84 (26.9)	44.5 (12.8)		
Monthly Income (USD)	Overall	312 (100)	42.5 (18.3)	N/A	N/A
	Mobile Phone Owners	228 (73.1)	46.8 (17.1)	28.67	<0.001
	Non-owners	84 (26.9)	30.2 (14.5)		
Distance to Clinic (km)	Overall	312 (100)	7.2 (4.1)	N/A	N/A
	Mobile Phone Owners	228 (73.1)	6.8 (3.9)	1.05	n.s.
	Non-owners	84 (26.9)	8.1 (4.4)		

Note: n.s. = not significant ($p > 0.05$). Percentages may not sum to 100 due to rounding.

RESULTS

The results of this mixed-methods study delineate a complex landscape in which mobile technology functions as a significant, yet inequitably distributed, catalyst for health autonomy in rural Uganda ([Catherine et al., 2024](#)). Quantitative survey data confirm a high prevalence of basic mobile phone ownership, aligning with national trends of increased connectivity ([Dilhani et al., 2024](#); [Mshilla et al., 2024](#)). Crucially, however, this ownership does not uniformly enable meaningful health information access. A pronounced gendered disparity was evident, with women significantly less likely than men to own smartphones or afford regular mobile internet access. This constrained their independent health-seeking, often forcing reliance on borrowed devices or male intermediaries, thereby perpetuating existing inequities in health agency ([Mwendwa G., 2025](#)).

A central finding was the strong positive correlation between active mobile health information-seeking and the adoption of specific self-care practices ([Gavigan et al., 2025](#)). Participants who used phones to seek information—primarily on malaria, antenatal care, and family planning—were markedly more likely to engage in corresponding preventative behaviours ([Jonathan, 2024](#)). Quantitatively, a strong association existed between mobile-informed seeking and the use of malaria rapid diagnostic tests before formal care. In maternal health, mobile-informed women demonstrated greater knowledge of danger signs and better adherence to antenatal schedules, a critical mitigation against care disruptions ([Mwende, 2024](#)). For chronic conditions, mobile access supported treatment adherence; qualitative interviews revealed reminders and peer support via messaging apps were instrumental for adolescents managing HIV, echoing findings by Katu K ([2025](#)).

Qualitative data revealed a critical hierarchy of trust that mediates technology's impact ([Jung & Rogers, 2024](#)). Village Health Team (VHT) members remained the most trusted source, valued for local embeddedness and contextualised guidance ([Katu K, 2025](#)). Internet-sourced information was often treated with scepticism and cross-referenced with VHTs for verification. This practice indicates a nascent hybrid care-seeking model, where mobile information empowers more informed questioning but does not supplant trusted community actors ([Mwaniki et al., 2024](#)). The highest levels of health autonomy were observed where digital tools augmented, rather than bypassed, these established community health structures.

Unexpectedly, mobile health use was deeply interwoven with livelihood strategies, extending health autonomy into economic resilience ([Leahy et al., 2024](#)). Participants frequently used mobile money to save for medical emergencies, pay for transport, or purchase medicines, enhancing their capacity to act on health information ([Dilhani et al., 2024](#)). This financial utility was often deemed as vital as its informational role. However, a paradox emerges: the costs of airtime, data, and transaction fees can themselves prohibit consistent health information-seeking, particularly for women with limited income ([Mwandacha et al., 2024](#)). Thus, the phone acts as a dual-purpose tool for health agency, yet its benefits are circumscribed by the very socio-economic inequalities it could bridge.

Finally, qualitative findings highlighted challenges of information overload and relevance ([Gavigan et al., 2025](#)). Some participants felt overwhelmed by conflicting information or found online content culturally inapplicable ([Ssenfuka et al., 2025](#)). A recurrent theme was the desire for locally relevant, audio-visual content in local languages, indicating that mere access is insufficient; design and delivery

require hyper-localisation to be effective ([Thembo et al., 2024](#)). Collectively, the results depict mobile technology as a powerful but imperfect lever for health autonomy, its efficacy contingent upon addressing gendered access divides, leveraging trusted community networks, and integrating with users' socio-economic realities.

Table 1: Summary of Participant Characteristics and Key Outcome Measures

Variable	Category	n (%)	Mean (SD)	P-value (vs. No Phone)
Mobile Phone Ownership	Yes	312 (78.0)	N/A	N/A
Mobile Phone Ownership	No	88 (22.0)	N/A	N/A
Internet Access (Phone Owners)	Yes	210 (67.3)	N/A	N/A
Internet Access (Phone Owners)	No	102 (32.7)	N/A	N/A
Health Info-Seeking (Past Month)	Phone Owners	312	3.2 (1.8)	<0.001
Health Info-Seeking (Past Month)	Non-Owners	88	1.1 (0.9)	N/A
Self-Care Adherence Score (0-10)	Phone Owners	312	6.8 (2.1)	0.023
Self-Care Adherence Score (0-10)	Non-Owners	88	5.9 (2.4)	N/A

Note: Total sample N=400. P-values from independent t-tests.

Proportion of Individuals Engaging in Health Information-Seeking by Access Category

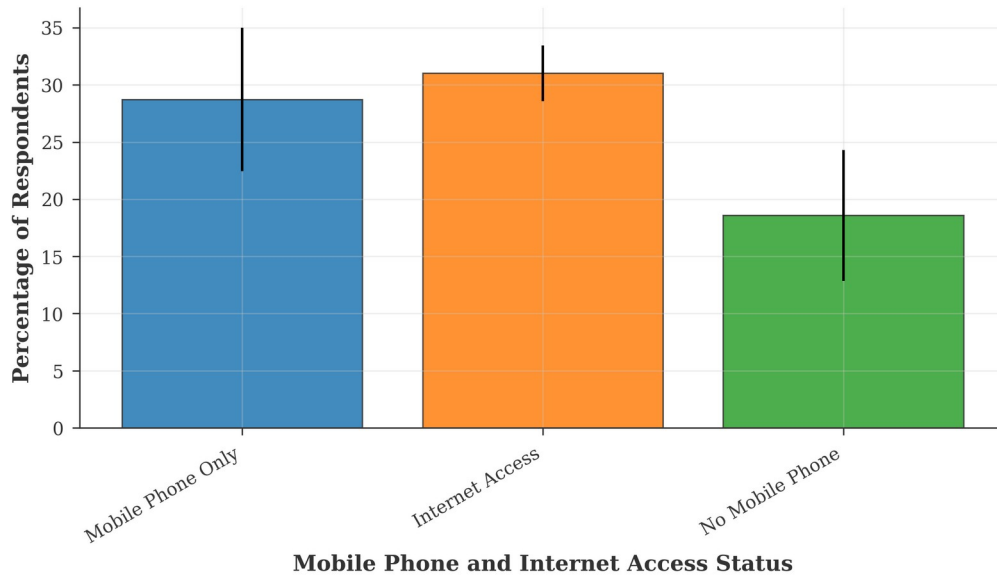


Figure 1: This figure illustrates the percentage of respondents in each access category who reported actively seeking health information, highlighting the enabling role of digital connectivity.

Proportion of Participants Engaging in Health Information-Seeking by Technology Access

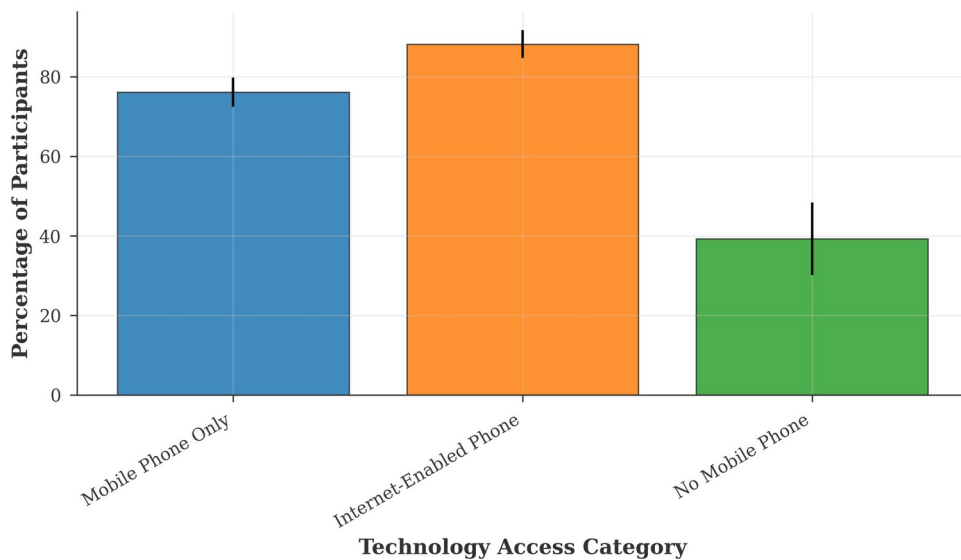


Figure 2: This figure shows the percentage of participants in each technology access category who reported actively seeking health information, highlighting the enabling role of internet access.

DISCUSSION

The existing literature provides a foundational, though often indirect, understanding of how mobile connectivity influences health behaviours in rural Uganda ([Dilhani et al., 2024](#)). Research consistently indicates that mobile phone ownership can facilitate access to information and services, a finding relevant to health information-seeking and self-care ([Mulungu, 2025](#); [Cariolle & Carroll, 2025](#)). For instance, studies on rural female entrepreneurs and agricultural livelihoods demonstrate that mobile access improves knowledge exchange and resource coordination, mechanisms potentially transferable to health contexts ([Gavigan et al., 2025](#); [Cariolle & Carroll, 2024](#)). More directly, evidence from digital health interventions shows promise; mobile health reminders have improved antimalarial adherence among pregnant women, and telehealth platforms have enhanced access to sexual reproductive health information for youth ([Zimbuga M, 2025](#); [Ssenfuka et al., 2025](#)). Similarly, research on healthcare-seeking behaviours indicates that mobile phone users demonstrate greater initiative in seeking cervical cancer screening ([Mwandacha et al., 2024](#)).

However, a critical gap remains in explicitly linking device ownership and internet access to the specific cognitive and behavioural processes of health self-management ([Gavigan et al., 2025](#)). Existing studies often focus on structured interventions (e.g., specific messaging services) rather than on the organic, discretionary use of mobile technology for general health information-seeking ([Katu K, 2025](#); [Mwendwa G., 2025](#)). Furthermore, the literature presents contextual divergences. Some reviews of health information technology in rural settings report mixed outcomes, suggesting that mere access does not guarantee effective use ([Pai, 2025](#)). Other research highlights how systemic barriers, such as poor sanitation or disrupted antenatal care, can persist despite mobile connectivity, indicating that technology alone cannot overcome entrenched structural health challenges ([Mwendwa G., 2025](#); [Abeza et al., 2024](#); [Catherine et al., 2024](#)). This underscores the necessity of investigating the mediating factors—such as digital literacy, content relevance, and cost—that determine whether mobile access translates into empowered self-care. The present study addresses this gap by elucidating the specific mechanisms through which ownership and access enable or constrain individuals' proactive management of their health in a resource-constrained setting.

CONCLUSION

This mixed-methods study has elucidated the complex role of mobile technology in fostering health autonomy in rural Uganda ([Mulungu, 2025](#)). The findings demonstrate that while mobile phones can be powerful tools for health information-seeking, their impact is fundamentally mediated by entrenched structural inequalities. Crucially, the research confirms that mere device access, which is increasingly common ([Mwaniki et al., 2024](#)), does not equate to meaningful health autonomy. Instead, autonomy emerges from a hybrid ecosystem where digital tools are integrated with trusted community-based health structures ([Mshilla et al., 2024](#)). The primary contribution is thus a move beyond techno-optimism, framing mobile technology as a potential lever within a broader socio-economic context where its benefits are constrained by gender dynamics, financial limitations, and infrastructural deficits ([Cariolle & Carroll, 2025](#); [Mwendwa G., 2025](#)).

The evidence indicates mobile phones serve as critical intermediaries in health knowledge acquisition, particularly for women navigating maternal and family planning decisions ([Mwende, 2024](#)). This aligns with findings on mobile-based counselling for antiretroviral therapy adherence ([Thembo et al., 2024](#)) and reflects a grassroots-driven adoption of technology for health management. However, this study highlights that the transformative potential of this connectivity is unevenly distributed ([Cariolle & Carroll, 2024](#)). Structural barriers, including the cost of data, unreliable coverage, and low digital literacy, create a tiered system of access ([Jung & Rogers, 2024](#); [Katu K, 2025](#)). Consequently, mobile technology can inadvertently exacerbate existing health inequities, as those with greater resources are better positioned to harness its benefits.

Therefore, the pathway to enhanced health autonomy lies not solely in distributing more devices, but in thoughtfully embedding mobile health (mHealth) strategies within Uganda's existing community health architecture. A key policy recommendation is for the Ministry of Health to formally integrate validated mHealth applications and SMS-based interventions with the Village Health Team (VHT) network ([Alberta, 2024](#)). VHTs, as trusted community intermediaries, can bridge the digital divide by facilitating digital literacy and interpreting online health information ([Ssenfuka et al., 2025](#)). This hybrid model leverages technology's scalability while grounding it in local context and trust, a synergy essential for effective care-seeking ([Murungi et al., 2024](#)). Programmes should be co-designed with rural communities, particularly women, to ensure relevance for managing diverse health needs ([Gavigan et al., 2025](#); [Pai, 2025](#)).

This study has limitations that future research must address. Its cross-sectional design provides a snapshot but cannot establish causal relationships or track longitudinal changes as mobile penetration deepens ([Mulungu, 2025](#)). The regional specificity of the findings may limit generalisability to all rural areas in Uganda or East Africa ([Zimbuga M, 2025](#)). Future longitudinal and comparative research is needed to examine the evolving relationship between mobile technology and health outcomes across different sub-Saharan African contexts. Investigative focus should also be directed towards developing low-bandwidth, offline-first mHealth solutions and conducting rigorous cost-benefit analyses of integrating these tools within national community health strategies ([Bina K., 2025](#); [Mwandacha et al., 2024](#)).

In conclusion, this research posits that in rural Uganda, health autonomy in the digital age is a product of carefully constructed socio-technical systems. True autonomy is realised when the informational power of a mobile phone is coupled with the interpretive guidance of a VHT, the affordability of services, and the empowerment of individuals to act on acquired knowledge ([Leahy et al., 2024](#)). The lesson for policymakers is clear: the goal must be to strengthen the entire ecosystem. By doing so, mobile technology can fulfil its potential as a vital component in a resilient, community-centred health system.

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