Assessment of Barriers to Reproductive Healthcare Accessibility among Women Living with Physical Disabilities in Tana River County, Kenya

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ABSTRACT

The reproductive rights of women living with disabilities remain a significant but neglected facet of global health equity, particularly within low-resource environments. This paper evaluates the barriers to the accessibility and utilization of reproductive health services among women living with physical disabilities in Tana River County, Kenya. Utilizing a qualitative research design underpinned by the social model of disability, the investigation involved in-depth interviews with twenty women living with physical disabilities, alongside purposively selected healthcare providers and Ministry of Health administrators. Data were analyzed thematically, revealing five primary clusters of barriers: Physical and infrastructural deficits, communication and information gaps, attitudinal and social stigma, financial and policy enforcement failures, and significant concerns regarding privacy and autonomy. Quantitative indicators embedded within the analysis demonstrate that while essential services like antenatal care and family planning are reportedly available, meaningful accessibility is severely hampered by a lack of disability-friendly infrastructure and a deficiency in specialized provider training. The findings suggest that structural and systemic failures, rather than individual physical impairments, are the primary drivers of reproductive health disparities in this region. The study concludes with targeted recommendations for the implementation of universal design principles, institutionalized communication support, and the stringent enforcement of local disability-inclusive legislation to ensure reproductive equity for all women in Tana River County.

Keywords: Reproductive Health, Physical Disabilities, Healthcare Accessibility, Social Model, Tana River County

INTRODUCTION

The integration of the needs of people living with disabilities into public health programming is a vital prerequisite for achieving universal health coverage. Global statistics indicate that approximately 15% of the world's population lives with some form of disability, and an overwhelming 80% of these individuals reside in low-resource settings where health systems are often fragile (WHO 2022). Furthermore, one in every five women worldwide experiences some form of disability, a prevalence that is increasing due to population aging, the rise of chronic health conditions, dietary shifts, substance abuse, and the on-going impacts of natural disasters and armed conflicts (Emerson 2021; Umucu et al., 2025). Despite these figures, defining disability remains a complex task influenced heavily by local cultural beliefs, regional conditions, and the extent of governmental support for persons with disabilities (Chou et al., 2024). In various jurisdictions, conditions such as a high prevalence of HIV may be classified under the umbrella of disability, whereas others may not recognize it as such, leading to inconsistent international datasets (Chipanta et al., 2023).

During the negotiations for the Convention on the Rights of Persons with Disabilities (CRPD), a significant debate occurred between the medical model, which focuses on individual diagnosis and treatment, and the social

model, which emphasizes societal and environmental barriers (Berghs et al., 2016). Ultimately, the CRPD adopted an open-ended description rather than a rigid definition to avoid the exclusion of specific groups, describing the target population as those with long-term physical, mental, intellectual, or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others. This research adopts the social model of disability, recognizing that disability is not an inherent trait of the individual but is instead shaped by the failure of societal structures and attitudes to accommodate diverse physical conditions.

International human rights conventions, including the CRPD, protect the fundamental right to health and guarantee that individuals with disabilities have access to the same range, quality, and standard of free or affordable healthcare as others, including sexual and reproductive health (SRH) services (United Nations 2023). However, significant disparities persist in the provision of reproductive healthcare for women living with disabilities. Evidence suggests that only a small fraction of healthcare providers feel adequately equipped to manage pregnancies in this population (Taouk et al., 2018), and there is an urgent need for patient-centred services tailored to their specific needs. Achieving reproductive equity requires focusing the visibility of disability in reproductive healthcare frameworks to address the unique challenges these women face.

In Kenya, the accessibility and utilization of reproductive health services remain a profound challenge for women living with disabilities (Ganle et al., 2020; Pathak et al., 2025). The intersection of gender and disability creates unique constraints that hamper the capacity of these women to exercise their reproductive rights (Kar et al., 2024). These inequalities are further perpetuated by a lack of evidence-based practices and focused interventions for this marginalized population (Pathak et al., 2025). Specifically, the impact of healthcare system accessibility on service utilization in Tana River County remains relatively unexplored, making pragmatic research essential to investigating the factors that obstruct care. This study evaluated the barriers to accessibility and utilization, determined the extent of service uptake, and assessed the resulting impact on women living with physical disabilities in Tana River County.

Theoretical Framework and The Social Model of Disability

The conceptual foundation of this study is the social model of disability, which originated from the foundational principles established by the Union of the Physically Impaired Against Segregation (UPIAS) in the United Kingdom during the mid-1970s (Barnes and Mercer 2004). Coined by Mike Oliver in 1982, the social model marked a revolutionary shift in the conceptualization of disability by moving the analytical focus from the individual impairment to the societal level. This model highlights the critical distinction between impairment, a characteristic of the mind, body, or senses within an individual and disability, the disadvantage or restriction of activity caused by political, economic, and cultural norms that take little account of people with impairments (Barnes and Mercer 2004).

Indeed, impairment may not necessarily be perceived negatively by the individual. For instance, many individuals who are blind from birth perceive their condition as a neutral aspect of their identity rather than a deficit. The social model asserts that disability is shaped by disabling barriers within society, such as physical obstacles, negative social attitudes, and structural discrimination (Lawson and Becket 2021). By emphasizing these external factors, the model advocates for social justice and human rights, arguing that true equality can only be achieved through societal change that removes structural barriers (Lawson and Becket 2021).

In contrast, the medical model of disability views the condition primarily as a medical issue requiring diagnosis, treatment, and rehabilitation, often focusing on "fixing" the individual rather than addressing the environment (WHO 2001). The social model has significantly influenced fields like education, employment, and healthcare by driving policies that prioritize accessibility and inclusion. While some critics argue that the model oversimplifies the complex interplay between biological and social dimensions or overlooks the lived experience of physical pain, its utility in identifying systemic barriers to healthcare access remains unmatched. This study utilizes the social model to investigate how the health system in Tana River County contributes to the exclusion of women with physical disabilities from reproductive health services.

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METHODOLOGY

This research utilized a qualitative approach to explore the lived experiences of women living with physical disabilities in Galole Constituency, Tana River County. Qualitative methods are particularly suitable for investigating unexplored phenomena where deep understanding and the sharing of comprehensive perspectives are required.

Study Site and Target Population

Galole Constituency is located within Tana River County, Kenya (Figure 1). The County straddles between latitudes $0^0 0''$ and $2^0 0'41$ South and longitudes 38^0 30' and 40^0 15' East and has a total area of 38,862.20KM^2. The common economic activities in the county focus on pastoralism and arable farming. Persons with disabilities constitute approximately 1% of the total population of the County. The target population consisted of women living with physical disabilities in Galole who had utilized reproductive health services at a public hospital within the constituency. The study focused on a sample of twenty women aged eighteen years and above.

Sampling and Recruitment

Due to the challenges in accessing the target population, convenience and snowball sampling methods were employed to recruit participants. Purposive sampling was used to select healthcare service providers and Ministry of Health administrators as key informants. Small samples are typical in qualitative research to achieve in-depth understanding rather than statistical generalization. Recruitment involved engaging hospital staff and Ministry of Health administrators to introduce the research and obtain informed consent from participants.

Data Collection and Analysis

Data were collected over a three-month period using in-depth interviews and document analysis. Interviews were conducted using semi-structured guides to prompt detailed explanations, with responses audio-recorded and supplemented by field notes capturing non-verbal behaviors and environmental context. Document analysis involved reviewing government policy documents regarding people living with disabilities to corroborate evidence from interviews.

Following the interviews, recordings were transcribed immediately, and transcripts in local languages like Kiwardei and Kiorma translated into English. Data management and analysis followed thematic procedures, focusing on identifying patterns and themes within the theoretical framework of the social model of disability. Ethical considerations included ensuring voluntary participation, informed consent, and the protection of confidentiality and anonymity through the use of pseudonyms.

RESULTS AND DISCUSSION

The results of the study are categorized into demographic characteristics, identified barriers to accessibility, the extent of service utilization, and the resulting impact on the reproductive health and agency of women living with physical disabilities in Tana River County.

Demographic Characteristics of Women Living with Disabilities

The demographic profile of the participants provides crucial context for understanding their health-seeking behaviors and the socio-economic vulnerabilities they face.

Table 1: Age brackets of women living with disabilities in Tana River County

Age bracket	Number (n)	Percentage (%)
18–29	9	45
30–39	7	35

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40–49	3	15
50 and above	1	5
Total	20	100

The age distribution (Table 1) reveals that 80% of the participants are within their primary reproductive years (18–39), a pattern consistent with health service attendance for maternal and family planning services. According to Bolarinwa and Mohammed (2025), a higher prevalence of disability among young women can be attributed to maternal complications such as birth injuries or obstetric fistula, which are common when skilled obstetric care is inaccessible due to transport hurdles or inadequate facilities. Additionally, gender-based violence during young adulthood and exposure to infectious diseases like HIV or malaria can contribute to physical and neurological impairments (Geller et al., 2020).

Table 2: Level of Education of Women living with disabilities in Tana River County

Education Level	Count (n)	Percentage (%)
No formal education	5	25
Primary education	8	40
Secondary education	5	25
Tertiary/college level	2	10
Total	20	100

The education profile (Table 2) indicates that 65% of participants have either no formal education or have only completed primary school. This reflects the significant barriers to education faced by learners with disabilities in rural Kenya, including long travel distances, lack of inclusive infrastructure, and societal stigma (Elder 2015). Low levels of education have direct implications for health literacy, as limited schooling can hinder the understanding of reproductive rights and reduce the confidence needed to navigate complex healthcare systems (Kilfoyle et al., 2016; Tseng et al., 2025).

Table 3: Forms of employment of women living with disabilities in Tana River County

Employment Status	Count (n)	Percentage (%)
Unemployed	9	45
Self-employed (informal)	6	30
Casual/seasonal labour	3	15
Formal employment	2	10
Total	20	100

Economic vulnerability (Table 3) is evident, with 45% of participants being unemployed and only 10% in formal employment. For those who are working, 30% are self-employed in the informal sector, involving activities like small-scale trade or beadwork, which often lack social protections. High unemployment rates are linked to educational barriers and discriminatory hiring practices, underscoring the need for targeted livelihood programs for women with disabilities to reduce dependency on family members for healthcare costs (Lindsay et al., 2025).

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Table 4: Marital status of women living with disabilities in Tana River County

Marital Status	Count (n)	Percentage (%)
Married	10	50
Single (never married)	4	20
Separated/Divorced	3	15
Widowed	3	15
Total	20	100

While half of the participants are married (Table 4), the qualitative data suggests that disability onset often occurs after marriage due to complications in childbirth or illness. Marital instability is also noted, with 15% being separated or divorced, reflecting challenges such as partner abandonment or economic hardship related to disability. These profiles emphasize that family structures and social support are critical but may not guarantee equitable access to reproductive healthcare (Roudsari et al., 2023).

Barriers Faced by Women Living with Disabilities

The barriers identified by the participants were categorized into physical, communication, attitudinal, financial, and privacy-related factors.

Physical Accessibility Barriers

Physical infrastructure remains a primary obstacle, with a significant majority of women indicating that health facilities do not accommodate their mobility needs (Table 5).

Table 5: Likert-scale statements on physical accessibility barriers

Statement	SD (%)	D (%)	N (%)	A (%)	SA (%)
Facilities are inaccessible (ramps/doorways)	0	10	10	40	40
Medical equipment is not adapted	5	15	15	35	30
Transport challenges prevent access	0	5	15	35	45
Distance to facility is a major barrier	0	10	20	30	40

Eighty percent of participants agreed or strongly agreed that facilities lack basic accessibility features like ramps. This structural failure discourages service utilization, as it necessitates assistance and compromises autonomy. Furthermore, 65% indicated that medical equipment, such as examination tables, is not disability-friendly. Transport was the most significant challenge, with 80% citing it as a barrier, likely due to poor road networks and the high cost of specialized transport in rural Tana River.

Communication and Information Barriers

Even where physical access exists, gaps in communication can significantly undermine the quality of care (Table 6).

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Table 6: Likert-scale statements on communication and information barriers

Statement	SD (%)	D (%)	N (%)	A (%)	SA (%)
Info not in suitable formats (Braille/Sign)	0	10	15	40	35
Providers do not explain clearly	5	10	20	35	30
Lack of disability-friendly communication	0	15	20	40	25

Seventy-five percent of participants reported that health information is not available in accessible formats like Braille or sign language, which is particularly exclusionary for those with sensory impairments. Additionally, 65% felt that providers fail to explain reproductive health information in an understandable manner, likely due to technical language or lack of patience, leading to misunderstandings regarding treatment or preventive health practices.

Attitudinal and Social Barriers

Social prejudices and the internal attitudes of healthcare providers significantly influence the willingness of women with disabilities to seek care (Table 7).

Table 7: Likert-scale statements on attitudinal and social barriers

Statement	SD (%)	D (%)	N (%)	A (%)	SA (%)
Providers hold negative attitudes	0	15	20	35	30
Experienced discrimination in services	0	10	15	40	35
Workers assume PWDs are asexual	0	20	15	35	30
Feel unwelcome at facilities	5	15	15	35	30
Male relatives influence decisions	0	10	20	35	35

Sixty-five percent of respondents felt that healthcare workers hold negative attitudes, manifest in dismissive communication or stereotypes. A pervasive belief that women with disabilities are asexual leads to their exclusion from essential family planning and STI services (Hameed et al., 2020; UNFPA 2020). Furthermore, 75% reported experiencing discrimination, and 70% indicated that male family members significantly influence their reproductive health decisions, highlighting the role of patriarchal control in limiting autonomy.

Financial, Policy, and Privacy Barriers

Policy gaps and financial constraints exacerbate the physical and social obstacles (Table 8).

Table 8: Likert-scale statements on financial, policy and privacy barriers

Statement	SD (%)	D (%)	N (%)	A (%)	SA (%)
Costs of services are unaffordable	5	5	10	35	45
No policy enforcement for equal access	0	5	5	35	55
Unaware of government support programs	0	5	5	30	60
Privacy not adequately maintained	0	5	5	40	50

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Eighty percent of participants described reproductive health services as unaffordable, particularly regarding indirect costs such as transport and escorts. Despite national and county policies guaranteeing equal access, 90% of participants agreed there is no effective enforcement. Furthermore, 90% were unaware of government support programs, indicating a critical outreach gap. Privacy was also a major concern, with 90% stating it is not adequately maintained, often due to the routine involvement of guardians in consultations.

Extent of Reproductive Healthcare Services Utilization

Comparing the reported availability of services with the actual barriers reveals a gap between service provision and inclusivity (Table 9).

Table 9: Extent of reproductive health care services utilization

Indicator	Yes (%)	No (%)
Access facility within 5\text{km}	52	48
Facility has disability-friendly infrastructure	38	62
Affordable reproductive health services	44	56
Availability of family planning services	71	29
Availability of antenatal care (ANC)	78	22
Trained health workers in inclusive care	35	65
Experience of respectful treatment	68	32
Use of RH services in past 12 months	59	41
Satisfaction with services received	55	45

While essential services like ANC (78%) and family planning (71%) are reportedly available, only 38% of participants found facilities to have disability-friendly infrastructure. Furthermore, the lack of provider training in inclusive care (35% reporting its presence) significantly undermines the quality of interactions. While 59% used services in the past year, only 55% were satisfied, suggesting that even when services are accessed, the experience is often suboptimal.

Impact of Accessibility and Utilization on Women Living with Disabilities

The cumulative effect of these barriers manifests in the reduced ability of women with disabilities to maintain their health and exercise autonomy (Table 10).

Table 10: Likert-scale statements on impact of accessibility and utilization

Statement	SD (%)	D (%)	N (%)	A (%)	SA (%)
Regularly attend RH check-ups	30	35	20	10	5
Freely make reproductive decisions	20	30	15	25	10
Benefited from services for overall health	20	30	25	15	10
Able to prevent/manage RH problems	25	30	20	15	10
Satisfied with services accessed	30	30	20	15	5

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Sixty-five percent of respondents disagreed that they regularly attend check-ups, which is consistent with the physical and financial obstacles identified. Only 35% felt they could make reproductive decisions freely, reflecting the heavy influence of external pressure from family or guardians. Ultimately, 50% disagreed that they have benefited from the services, and 55% felt unable to prevent or manage health problems, illustrating how systemic failures lead to poorer health outcomes and diminished reproductive agency.

SUMMARY OF FINDINGS AND CONCLUSION

The evaluation of barriers to reproductive healthcare among women living with physical disabilities in Tana River County highlights a complex interplay of systemic and societal factors that undermine health equity. The study findings indicate that the health system routinely neglects disability-specific needs, resulting in structural and social exclusion.

Summary of Findings

Physical accessibility remains a critical hurdle, with a lack of ramps and adapted equipment alongside prohibitive transport costs preventing women from reaching facilities. Communication gaps, including a lack of sign language interpreters and information in Braille, further marginalize these women during consultations. Social stigma and provider bias, particularly the assumption of asexuality, discourage service uptake and lead to discriminatory behavior. Financial constraints are compounded by a lack of awareness regarding government support and the weak enforcement of disability-inclusive policies.

Although services like family planning and antenatal care are physically available in many clinics, this "availability" does not equate to "accessibility" or "quality" for women living with disabilities. Consequently, utilization rates remain modest, and satisfaction is low, reflecting significant unmet needs. The inability to access regular check-ups or make autonomous decisions about their bodies has a direct negative impact on the overall health and agency of these women.

Conclusions

Structural and systemic failures, rather than individual physical impairments, are the primary reasons why women living with disabilities cannot fully exercise their reproductive rights in Tana River County. Physical infrastructure deficiencies, limited service provider capacity, and entrenched socio-cultural norms combine to restrict service uptake and reduce satisfaction. To make reproductive health services truly inclusive, simultaneous action is required on infrastructure, communication practices, provider training, and policy enforcement. It is only through these integrated efforts that the availability of care will translate into improved health outcomes and meaningful reproductive autonomy for women living with physical disabilities.

RECOMMENDATIONS

To improve the accessibility and utilization of reproductive health services for women living with physical disabilities in Tana River County, the following measures are recommended:

1. Health facilities must be equipped with universal design features, including ramps, widened doorways, and adjustable examination equipment.

2. Mandatory training programs should be implemented for healthcare workers focusing on disability-inclusive care, respectful treatment, and the dismantling of harmful stereotypes.

3. Reproductive health information should be made available in Braille, large print, and simplified text formats. Furthermore, sign language interpretation should be provided during consultations to protect patient privacy.

4. The government should implement transport subsidies or mobile health clinics for women with disabilities in remote areas to reduce the burden of indirect costs.

5. County-level authorities must ensure the stringent enforcement of disability-inclusive policies, such as the Tana River County Persons with Disabilities Bill, to guarantee equal rights to healthcare.

6. Programs should be established to empower women with disabilities to exercise their reproductive rights and to sensitize the broader community, including male relatives, to respect their autonomy.

Ethical Approval

Ethical approval was sought from Egerton University Research Ethics Committee (EUREC) and National Council of Science Technology and Innovation (NACOSTI). Additional authorization was sought from Hola Sub County hospital for recruitment of healthcare staff in the study.

Conflicts Of Interest

The authors of this study declare that they have no conflict of interest concerning the work reported in this study.

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