

Health Challenges of Women with Disabilities: A Focused Study of Rajouri District, Jammu and Kashmir

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ABSTRACT:

This paper examines the challenges faced by women with disabilities in the Rajouri district of Jammu and Kashmir; it relies on qualitative research design. One hundred and fifty respondents were sampled using snowball sampling method and were able to give in-depth information by participating in structured interviews. The most critical aspects under study are the availability of health infrastructure, health and hygiene awareness, doctors and nurses supply, cost-effectiveness of health and medical costs as well as satisfaction with medical care. The results indicate that there is a tremendous setback that women with disabilities face in accessing healthcare due to poor infrastructure, awareness and delivery in services. Answers analysis shows that most women do not know their rights to health, are unhappy with health services and face physical and social barriers to seeking health care. The level of education and awareness is strongly related to the knowledge of reproductive and general health requirements. Findings of the study warn that specific efforts to address the health access issue among disabled women should be put in place by focusing on disability-friendly infrastructure, community-level awareness, and medical personnel training. It is also important to make sure that the Rights of Persons with Disabilities Act is executed correctly. Along with the contributions, the study is aware of the limitations, small sample size and the use of self-reported data. A larger scale study under a mixed-methodology is possible in the future and can provide greater information and advise more extensive health policy actions.

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1. Introduction

Unhealthiness is one of the most sensitive human rights, as well as the basis of social justice and human welfare. Nevertheless, the gap in the

ability to receive quality health has been eminent and rooted, especially with the marginalized groups, including women with disabilities.

Globally, people with disabilities have poorer health and access to services, reduced access to healthcare services, and health systems discrimination. Women particularly have to bear these burdens combined with many other drawbacks depending on their gender, socioeconomic circumstances, or even physical or mental incapacities. It is critical to know these barriers and deal with them in order to promote inclusive and equitable systems within healthcare.

Global experiences have shown that women with disabilities are more likely to experience unmet needs with regards to health, discriminatory attitude towards health professional and find it harder to access reproductive and maternal health services. To give an example, the systematic review conducted by Matin et al. (2021) identified several obstacles to accessing the health facilities (in terms of physical access and availability of medical services), as well as the presence of attitudinal barriers and the absence of individualized care when it comes to female individuals with disabilities. The same has been noted in report by Hughes et al. (2022), where the researchers highlighted the lack of access to services and information on health as being the central problem of women with disabilities.

The above problems are more acute in the rural areas and the conflict-affected areas of India such as Jammu and Kashmir, where the healthcare infrastructure is not fully developed and awareness of the patients and the providers is also less. According to Saikia et al. (2016), based on Census sources, disabled women in India are underprivileged with regard to health, education, employment, and have limited access to the most basic services. Local research including Tak (2022) have highlighted how the disabled women in Jammu and Kashmir have been excluded in the official healthcare infrastructure, in spite of legislative initiatives including the Rights of Persons with Disabilities Act (2016).

There is little progress in applying the same policy in the real world, despite all the improvements in the policy. In rural locations like Rajouri district, there is not only a problem in infrastructure but also the absence of professionals who have been

trained and moreover, ignorance on a very large scale affecting women with disabilities in a very bad way. The World Health Organization (1986) states that health should not just be considered as lack of illness but the capacity to live a socially and economically satisfying life. Yet, this dream has been beyond the reach of other disabled women especially in underserved regions.

Adoption of such disparities necessitates context-specific research as a way of generating and defining unique problems that are experienced by these women to influence the interventions. This paper will be an addition to this body of knowledge because it examines the lived health experiences of women with disabilities in Rajouri district. The hindrances revealed in the study through the use of a qualitative research design are restrictions through infrastructure inaccessibility, unawareness, professional insensitivity, and money-related limitations. The focus on the voices of disabled women in this study implies the necessity of immediate comprehensive measures to include the voices of all people in the health system, implement specific policies, and organize awareness campaigns at the local level to reduce the health equity disparity.

2. Literature Review

The well being and lives of women with disabilities has become major area of concern in the international health discourse especially in low-income and war-torn areas. Literature has concurrently reported that women with disabilities experience multidimensional obstacles to healthcare such as infrastructural inaccessibility, economic dependence, stigma, awareness gap, and discrimination by health personnel. They do not only bring about difficulties in terms of the physical health outcomes but also lead to social exclusion and inequality in the long term.

Pal and Vishwakarma (2018) have revealed that most of the women with disabilities are not included in mainstream health programs and do not access basic reproductive healthcare services as part of a pan-India analysis. They are additionally discriminated against in the rural

settings, where health infrastructure has not done a lot, and the cultural stigma is still effective. The paper has highlighted the high priority requirement of inclusive legislation and sensitivity in the institution aimed at addressing the nexus of gender and incapacitation in access to health.

An international scoping analysis by Greaux (2023) on health equity interventions involving persons with disability indicated that disability-inclusive infrastructure and communication are key factors that have to be addressed as a major inhibitor of health equity among persons with disabilities in developed and in the developing nations. In this review, among the needs that are not met, despite the existence of services, it was noticed that they are not often linked to the specificities of needs of women with disabilities, especially in rural or less developed areas.

Wolbring and Deloria (2024) in a qualitative study of women with disabilities and their experience in receiving healthcare singled out the autonomy issue in health decisions and provider discrimination, which play a role in low satisfaction and health-seeking behavior. The analysis recommended awareness projects at the community level and training programs that should be specialized to assist healthcare professionals in order to minimize stigma and provide better outcomes.

It was observed that using mixed methods, Piotrowski (2007) has investigated the impact of disability and its effect on health needs throughout the lifespan and ascertained that barriers are cumulative-disabled women face special challenges throughout the lifespan, presenting issues that are quite demanding related to sexual and reproductive health education, mental health support, chronic disease management, etc.

A locally based article by Singh (2024) depicted a segment of severely inaccessible status to disabled women in Jammu and Kashmir and especially in the distant districts. Many cannot travel physically to the hospitals or clinics and when people manage to reach there infrastructure is hardly accessible (ex., ramps, accessible toilets).

The research paper focused on the fact that even though there have been legislative safeguards, there is an underrepresentation of implementation.

Also identified to affect access to health is digital literacy and the socioeconomic status. Seiko et al. (2016) also proved that women with disabilities cannot enter a health scheme, even government-funded, due to poverty, immobility, and illiteracy. The authors proposed the need to strengthen the use of digital technology access and outreach to women with a visual and cognitive disability.

The collection of this literature, in summary, reveals the ubiquitous incursion and stratum of health differences that women with disabilities encounter. Although their rights are recognized at the national and international levels, the local studies, especially at the less studied localities such as Rajouri, are crucial in the implementation of what is on paper in the policy.

Hypotheses

- **H1:** Women with disabilities in rural areas such as Rajouri district face significant health access challenges, primarily due to inadequate infrastructure, lack of trained health professionals, and limited awareness of health rights.
- **H2:** Educational attainment and health awareness are significantly associated with access to and utilization of healthcare services among women with disabilities.
- **H3:** Targeted interventions—such as disability-sensitive health training for professionals, community-level awareness campaigns, and barrier-free infrastructure—can significantly improve the healthcare experiences and outcomes of women with disabilities.

3. Methodology

The research background takes a qualitative research design layout to determine the health issues affecting women with disabilities in Rajouri district, Jammu and Kashmir. Qualitative approach is effective when it comes to deciphering the intricate nature of social existence and realities in general, and in the

understudied population groups in particular. In gathering valuable, detailed information about the experiences of disabled women using in-depth interviews, the research is aimed at identifying patterns, themes, and factors that influenced healthy disparities among vulnerable groups of women in the population.

Participants have been identified and recruited through purposive snowball of people. This non-probability method is appropriate on the hard-to-reach population like the women with disabilities, and they could probably not be reached easily through the random sampling method. The researcher started with his or her established contacts and his or her initial respondents to get other respondents through referrals. Fifteen women with disabilities aged between 18 and 70 years belonged to different social-economic statuses were included in the study. Every participant was a resident of rural or semi-urban communities of Rajouri, and all of them had attended health institutions in December 2024 or January 2025.

This study was based on major variables established in extant literature and framed based on a few main themes, namely, access to medical infrastructure, health and hygiene awareness, presence of qualified medical workers, affordability of care, and satisfaction with medical services. These variables capture some systemic challenges as well as challenges at individual levels, which informed the development of a schedule with questions to address them.

The information gathering was conducted through structured interview schedule; both open-ended and close ended questions were used. This enabled uniformity of the interviews as well as providing time to the respondents to give details about their experiences. Amnesty interviews were carried out in a face-to-face manner either in the home of the participants or

in convenient places of the community and where there is less likelihood of probation as well as identification. The interviews took about 30 45 minutes.

Thematic content analysis was used to analyse the collected data since it is a method of analysis which is recommendable in qualitative data in determining trends and meaning. Responses were entered, coded and classified into themes that included infrastructure barriers, professional insensitivity, low health literacy, and financial constraints. The analysis sought to give an interpretive usage of the operations of these contributing factors play and their shaping of the healthcare experiences of women with disabilities.

Simple descriptive statistics were also used in the analysis of basic demographic data like the age, educational attainment and the level of awareness. These were given in the frequency tables in order to provide information to the qualitative results.

Despite this approach being small in scale because of a small number of participants and a geographic focus, it offers the underlying picture of the realities of healthcare access among disabled women in Rajouri. It is expected that the findings will be used in policy development, training and infrastructure development aimed at ensuring an inclusive healthcare service.

4. Results

4.1 Descriptive Statistics

The descriptive statistics provide an overview of the socio-demographic profile and key variables related to healthcare access among women with disabilities in the Rajouri district. Tables 1–4 summarize the age distribution, awareness of health and hygiene, educational level, and satisfaction with healthcare services.

Table 1: Age Distribution of Respondents

Age Group	Frequency	Percentage
21–25	3	20%
26–30	3	20%
31–35	4	27%
36–40	5	33%

The highest proportion of respondents (33%) were aged 36–40, followed by 27% in the 31–35 age group. This suggests that the study captures perspectives across adult age ranges, with a slight skew toward older participants.

Table 2: Awareness of Health and Hygiene

Awareness	Number of Women	Percentage
Yes	6	40%
No	9	60%

The data reveals that 60% of respondents are unaware of basic health and hygiene practices, highlighting a significant information gap in this population.

Table 3: Educational Attainment

Education Level	Frequency	Percentage
Graduate	2	13%
12th Pass	4	27%
10th Pass	9	60%

A majority of the women (60%) had only completed secondary education (10th grade), with only 13% attaining graduation. This reflects limited access to higher education among disabled women in the region.

Table 4: Satisfaction with Healthcare Services

Viewpoint	Frequency	Percentage
Satisfied	5	33%
Dissatisfied	10	66%

Only 33% of respondents expressed satisfaction with healthcare services, while 66% were dissatisfied, pointing to systemic issues in healthcare delivery.

4.2 Thematic Findings from Qualitative Analysis

Through thematic content analysis of the structured interviews, four major themes emerged regarding the healthcare challenges faced by women with disabilities:

1. Inaccessible Health Infrastructure

Many participants reported that healthcare facilities lacked ramps, wide doorways, elevators, or accessible toilets. This physical inaccessibility often deterred or prevented them from visiting clinics or hospitals independently.

“I had to be carried into the hospital because the stairs were too steep and there was no ramp.” – Respondent, 35 years old

2. Lack of Trained Health Professionals

Participants described insensitive or uninformed behavior by medical staff who lacked the training to appropriately address their needs. Several reported being overlooked or dismissed during consultations.

“Doctors don't listen to us properly. They think we are exaggerating or wasting their time.” – Respondent, 28 years old

3. Low Awareness and Health Literacy

Most women demonstrated limited understanding of reproductive health, preventive care, or available government schemes. Those with higher educational attainment showed slightly better awareness but still lacked detailed health knowledge.

"I don't know about health checkups or women's health schemes. No one told me." – Respondent, 40 years old

4. *Affordability and Economic Barriers*

Financial limitations were a significant obstacle, with women reporting that even subsidized care was out of reach due to travel costs, medication expenses, or lack of income support.

"I can't afford the medicines prescribed, so I don't buy them most of the time." – Respondent, 32 years old

An aggregation of these results brings out the fact that women with disabilities in the region of Rajouri face health issues that are not merely medical but also very structural and systemic. The research points out the dire importance of inclusive infrastructure, awareness campaigns, and capacity building in order to ensure equal access to health services among all healthcare professionals.

5. **Discussion**

This research indicates that the access and quality of health services of women with disabilities in the Rajouri area of Jammu and Kashmir are unequal. These gaps are in line with other available studies in the world and in the region where scholars have researched on areas of overlap of disability and gender as well as rural health challenges. Descriptive and thematic analysis disclosed barriers like inaccessible health infrastructure, shortage of trained health experts, health ignorance, financial limitations and disappointment with the ill health organizations. These results correspond with the studies that have identified disability as the cause of health inequities, especially in the low-resource areas (Lund & Emerson, 2017).

This study had another theme that was the inaccessibility of health infrastructure. Most women complained that access to hospitals was highly or completely impossible with or without help since they did not have ramps, accessible toilets, and assistive equipment. This was similar to the study done by Kroll et al. (2006) which revealed that women with mobility limitations

tend to take long to seek care or even avoid care altogether because of barriers in health facilities.

Most of the respondents also indicated having received negative or dismissive attitudes towards healthcare providers. According to respondents, doctors and nurses were usually lacking empathy or knowledge or interest in directly dealing with their particular requirements. This observation agrees with the findings of Shakespeare et al. (2009) who noted the significance that the disability competence training of medical professionals should take place in order to minimize the effect of implicit bias, as well as to improve the provider-patient communications.

Another commonality was low awareness of the essential health practices and entitlements. Those who are less educated were found to have little or no information on reproductive health or health schemes of government. The study of Ganle et al. (2016) confirms this fact by demonstrating how disabled women in general and women in rural communities in particular do not have access to sexual and reproductive health information.

The factors that were considered as a great challenge to accessing effective and sustainable healthcare were financial barrier. Affordability of the medicines and transport cost were identified as some of the most compelling factors that influenced most of the women to delay or prevent treatment based on responses of most of the women in this study. It correlates with the findings of Trani et al. (2015) who concluded that vulnerability in the economy and disability interact to form high levels of marginalization in health provision services.

The lack of satisfaction portrayed among the 66 percent of the respondents regarding healthcare services shows that there are systemic problems regarding service provision. These are untrained personnel, poor facilities and no follow-up. This follows other similar reports by Badu et al. (2021), who relayed how disability-inclusive healthcare is undermined by the lack of sufficient investments in healthcare.

Overall, the results of this research boost the knowledge that women with disabilities have multiple barriers to accessing care. These are physical, social, economic, and informational barriers, which aligns with an accumulating literature that proposes an intersectional perspective to health equity.

Implications

The results of the present study hold policy, practice and future research implications. Doing so will need an integrated and disability-friendly context comprising of institutional change, community sensitization, and infrastructural development to address the health issues of the women with disabilities in rural areas like the Rajouri.

The immediate implication is that there should be increased physical accessibility to health institutions. The answers by the respondents were categorical on issues of difficulty in locating in hospitals physically or the basics. The health systems should also be redesigned in line with the universal access rules, which involve the use of ramps, wide passages, accessible toilets, and signs in braille or audio form (Iezzoni et al., 2006).

Another high priority is healthcare workers training and sensitization. This paper revealed that habitus of healthcare providers tends to be a hindrance towards service usage. Healthcare organizations are supposed to include disability-consciousness in both the medical and nursing education. It is corroborated by the findings of Morris et al. (2014) according to which the improvement of patient satisfaction and behaviour of providers can be achieved with even short-term disability-sensitivity programmes.

Grass root awareness campaigns ought to be given priority as well. There were also numerous reportees who had no knowledge about hygiene, reproductive health and also about the available health schemes. ASHAs and Anganwadi workers are the examples of community health workers, whose health education and outreach could be decisive, just as Bright et al. (2018) proved the success of a community-based rehabilitation approach in rural settings.

The study was hit by the consistent and continuous issue of constraints in the financial area. There should be policy interventions like transport subsidies, free medicine programs and cash transfer to women with disabilities. Shopdman (2006) mentioned that the targeted financial incentives have a high positive impact on the healthcare utilization of the poor disabled population.

The other implication entails the necessity to enforce policies. Although the Indian Rights of Persons with Disabilities Act (2016) ensures the provision of health rights, they are not under implementation in all parts, particularly rural districts. Accountability in the system of public health delivery can be enhanced by solidifying monitoring systems and implementing feedback loops within the community.

To sum it up, the results have identified various implications that can be addressed by policymakers and healthcare administrators. To achieve health equity among women who have disabilities, it is important to invest in accessible infrastructure, sensitize the health workers, intensify their attention to community outreach, and deal with barriers to accessibility, such as affordability.

Limitations and Scope for Future Research

Although this study has contributed to a better understanding of the health experience of women with disabilities in Rajauri district, there are some limitations that need to be noted and also the areas to be studied in future. One of the main limitations is a small sample ($n = 15$), which does not allow covering the full range of experiences within the district or even the region. Becoming generalized is restricted by small samples that are non-random as observed by Schur et al. (2013). In further investigations, it is recommended to consider more people and a more varied sample with stratified or random sampling.

Another limitation to the study is its cross-sectional aspect. It gives a picture of the health problems, but does not reflect any seasonal change or time trend. Longitudinal research, such as carried out by Emerson et al. (2012), would be

of benefit in assessing the long term adjustments of interventions in access and outcomes of healthcare in women with disability.

The study was based on self-report data that can be recalled or biased during responses. Data that is gathered in interviews could be triangulated with health records or actual facility observations strengthening results. Kuper et al. (2014) stressed the need to validate disability studies by means of multiple sources of information. Moreover, the research also centered greatly on physical access and reproductive health with less attention paid to mental health. Since it is necessary to take into account the psychological load that disabilities and gender-based exclusion put on people, in future research, it would be worth taking into account such mental health variables and evaluating access to psychosocial support services (Hanass-Hancock et al., 2021). The other direction of additional research is the attitude of

healthcare providers and policymakers which was not considered in this study. It would provide a more comprehensive overview of system-level limitations and possibilities of change through the involvement of them. Finally, this research focused on the examine of a single district that reduced the regional applicability. Comparative analysis conducted at a district or state wide level may reveal the issues of regional, cultural, or conflict-related influences on health equality among women with any disabilities.

To sum up, even though this research represents one of the first pieces of evidence to support the claims regarding healthcare barriers to disabled women in Rajouri, by supplementing its evidence the research can be improved in multiple dimensions and on a longitudinal scale eventually resulting in more comprehensive findings which can be used to formalize the process of intervention efficiency.

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Conflict of Interest

The authors declare no conflict of interest.

Author Contributions

Azra Qureshi: Conceptualization, Data Collection, Methodology, Formal Analysis, Writing – Original Draft, Writing – Review & Editing, Validation

Ethics Approval

This study was conducted in accordance with the ethical standards of the institution. Informed consent was obtained from all participants.

Data Availability

The data supporting the findings of this study are available from the corresponding author upon reasonable request.

Abbreviation

PWD – Persons with Disabilities

UT – Union Territory

CEDAW – Convention on the Elimination of All Forms of Discrimination Against Women

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