

# Barriers to Health Care Access and Quality of life Assessment Among People with Disabilities in Makurdi, Benue State: Improving Healthcare Access.

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## ABSTRACT

People with Disabilities (PWD) continue to face significant barriers to accessing quality healthcare, which negatively impacts their quality of life (QoL). This study explored these barriers and assessed QoL among PWD during a medical outreach held on World Family Doctor Day 2023 at the Federal Medical Centre, Makurdi, Nigeria. Seventy consenting participants were recruited consecutively and interviewed using a structured questionnaire. Data were analyzed using SPSS version 23, with significance set at  $P < 0.05$ . The majority of respondents were aged 21–40 years (67.1%), male (51.4%), and married (54.3%). Mobility impairment was the most common disability (37.1%). Key barriers identified included the lack of disability-friendly transportation (35.5%), absence of ramps in healthcare facilities (27.9%), lack of communication assistance (40.3%), and poor interaction with healthcare providers (31.3%). Over half (51.2%) reported the unavailability of assistive devices, and 30.6% found hospital beds uncomfortable. More than half of the participants (52.9%) had poor QoL. Factors significantly associated with poor QoL were being female, residing outside Makurdi, having a chronic health condition, current use of medication, and infrequent healthcare visits. These findings highlight the urgent need for inclusive healthcare planning that addresses both structural and interpersonal barriers faced by PWD. Improving physical accessibility, enhancing provider communication skills, and ensuring availability of assistive technologies can significantly improve QoL. Policymakers and health system stakeholders must prioritize disability-friendly services and routinely engage PWD in healthcare program design to foster equity and improve health outcomes.

**Keywords:** Barriers, Healthcare, Accessibility, People With Disability, Quality of Life, WHOQOL-BREF.

## INTRODUCTION

Access to health care services and Quality of life (QoL) among People With Disability (PWD) are cardinal pointers to social inclusiveness, equitability in the distribution of health care services and are noteworthy Sustainable Developmental Goals.<sup>1</sup> Global trends have revealed that PWDs are vulnerable to being

excluded from accessing healthcare services which negatively affects their QoL.<sup>2</sup>

The World Health Organization defines disability as “any restriction or lack of ability to perform an activity in a manner or within the range considered normal for a human being”.<sup>3</sup> Types of disability include visual, hearing, speech, movement, mental impairment, and

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others like skin disorder.<sup>2-4</sup> About 1.3 billion people (16%) of the global population experience one or more forms of disabilities.<sup>5</sup> The prevalence of disability in Africa is higher compared to other regions of the world with Mali and Sierra Leone having about 1.7% and 17.1% respectively.<sup>6</sup> Approximately 25 million PWDs are in Nigeria and out of these, 3.5 million have severe functional difficulties reducing their QoL, especially the physical and social components.<sup>4,6</sup>

According to the World Health Organisation (WHO), QoL is defined as an individual's perception of their position in life in the context of the culture and value systems in which they live and about their goals, expectations, standards, and concerns.<sup>3,7</sup> Studies have revealed that both in developed and developing countries, disabilities, especially movement disability is significant in reducing QoL.<sup>2,3,7</sup> Stigmatization and discrimination against PWDs encourage social exclusion which impact negatively on QoL.<sup>8,9</sup> It is evident that employment opportunities and access to health care services are significant in the improvement of QoL though they may be limited or lacking among PWDs.<sup>3,10</sup> In addition, this special group is confronted with social isolation and lack of support which to a great extent results in individual low self-esteem and QoL.<sup>1,8</sup> There is documented evidence that disabilities could restrict physical and social participation which also contributes immensely to reducing QoL.<sup>11,12</sup> Other studies have also revealed that QoL is reduced when economic insecurity and poverty become prevalent, especially among vulnerable groups like PWDs.<sup>12</sup>

There are numerous challenges facing PWDs when accessing health care services in a health facility.<sup>3,13</sup> A range of physical barriers like narrow corridors, and lack of ramps and elevators have been cited in some studies as ensuing significant mobility difficulties.<sup>3,13,14</sup> Furthermore, unskilled healthcare providers and staff in a health facility may constitute significant communication barriers when interacting with patients having sensory or cognitive disabilities.<sup>13,15,16</sup> Additionally, PWDs may have difficulties assimilating health information when such information is not available in accessible formats like braille and large

print for those with visual impairment and audio-visual for those with hearing impairment.<sup>16</sup> Studies have indicated that financial barriers also had a significant role to play in preventing access to healthcare services.<sup>3,10,16</sup> Studies also report that people with disabilities are far less likely to be financially healthy due to financial exclusion, employment barriers, and public safety net constraints.<sup>16,17</sup>

There is paucity of data on barriers preventing access to health care services and assessment of QoL among PWDs. This study sets out to assess the barriers preventing access to health care services and QoL among PWDs in Benue State, Nigeria with the aim of exploring measures that would provide adequate health care and promote accessibility and inclusiveness to PWDs.

## MATERIALS AND METHODS

### Study area:

The study was conducted at the Federal Medical Centre, Makurdi during an outreach for PWDs on World Family Doctor Day (WFD) 2023. Federal Medical Centre, Makurdi is a four hundred bed tertiary hospital located in the capital of Benue State, North Central Nigeria.

### Study design and study population

The study was a cross-sectional descriptive study. The study population were consenting attendees of the medical outreach conducted for People With Disability who were invited through their registered welfare association, the Joint National Association of Persons with Disability, Benue State Chapter.

### Sampling techniques

A consecutive sampling technique was employed to recruit the 70 consenting respondents.

### Data collection

The questionnaire for data collection was interviewer-administered with four sections. The first section comprised the socio-demographic data. The second section comprised of history of disability, the third section explored barriers preventing access to health care services and the fourth section was the WHO quality of life (WHOQOL-BREF).<sup>18,19</sup> The WHOQOL-

BREF tool has 26 items scored on a Likert scale of 1 to 5, in a positive direction such that a lower score denotes low QOL and vice versa. Items 3,4 and 26 were also reversed in a positive direction (1=5, 2=4, 3=3, 4=2 and 5=1) transforming them into a positive phrase. A score  $\leq 78$  corresponding to an average score of 3 on each of the 26 items is categorized as poor quality of life. While a score of  $\geq 79$  is categorized as a good quality of life. The QOL tool has been validated in Nigeria, it has good internal consistency and high Cronbach alpha  $> 0.7$ .<sup>20</sup>

### Data analysis

The data was analyzed using SPSS version 23 (Chicago IL USA). The descriptive statistics generated were presented on frequency tables and bar charts. The association between variables were analyzed using the Pearson Chi-square test. The level of significance was set at  $P < 0.05$ .

### Ethical consideration:

The Health Research and Ethical Committee of Federal Medical Centre, Makurdi, granted ethical approval for

the research. Informed consent was obtained from the respondents following verbal, sign language, and written explanations.

## RESULTS

### 1. Socio-demographic characteristics of the respondents.

Table 1 revealed that overall, there were 70 respondents involved in the study. Most of the respondents 47(67.1%) were within the age range of (21-40) years. More than half 36(51.4%) were male and most of them 38(54.3%) were married. A high proportion 64(91.4%) stayed with their family members and more than half of the respondents 38(54.3%) were residing outside X. More than one third 27(38.6%) had secondary education, less than half 33(47.1%) were unemployed and majority of the respondents 57(81.4%) were of Tiv ethnicity. Most of the PWDs who were of female gender ( $X^2 = 5.803$ ,  $df=1$ ,  $P=0.016$ ) and living outside Makurdi ( $X^2 = 5.579$ ,  $df=1$ ,  $P=0.018$ ) had poor quality of life and the association was statistically significant.

Table 1: Socio-demographic characteristics

Variable	Total (%)	Quality of life grading		df	X <sup>2</sup>	p-value
		Poor	Good			
<b>Age</b>				4	8.080	0.089
≤20	7 (10)	4(57.1)	3(42.9)			
21-40	47(67.1)	21(44.7)	26(55.3)			
41-60	14(20)	11(78.6)	3(21.4)			
61-80	1(1.4)	1(100)	0(0)			
≥81	1(1.4)	0(0)	1(100)			
<b>Gender</b>				1	5.803	<b>0.016</b>
Male	36(51.4)	14(38.6)	22(61.1)			
Female	34(48.6)	23(67.6)	11(32.4)			
<b>Marital status</b>				2	6.200	0.484
Single	28(40)	16(57.1)	12(42.9)			
Married	38(54.3)	20(52.6)	18(47.4)			
Divorced	4(5.7)	1(25)	3(75)			
<b>Who do you stay with</b>				2	1.225	0.542
Family members	64(91.4)	34(53.1)	30(46.9)			
Caregiver	1(1.4)	0(0)	1(100)			
Others	5(7.2)	3(60)	2(40)			
<b>Where do you stay?</b>				1	5.579	<b>0.018</b>
Within Makurdi	32(45.7)	12(37.5)	20(62.5)			
Outside Makurdi	38(54.3)	25(65.8)	13(34.2)			
<b>Educational status</b>				3	7.348	0.062
Informal education	9(12.9)	7(77.8)	2(22.2)			
Primary education	9(12.9)	7(77.8)	2(22.2)			
Secondary education	27(38.6)	14(51.9)	13(48.1)			
Tertiary education	25(35.7)	9(36)	16(64)			
<b>Occupation</b>				4	5.566	0.234
Unemployed	33(47.1)	19(57.6)	14(42.4)			
Artisan	12(17.1)	4(33.3)	8(66.7)			
Farmers	8(11.4)	6(75)	2(25)			
Trader	10(14.3)	6(60)	4(40)			
Civil servant	7(10)	2(28.6)	5(71.4)			
<b>Ethnicity</b>				3	3.203	0.361
Tiv	57(81.4)	33(57.9)	24(42.1)			
Idoma	6(8.6)	2(33.3)	4(66.4)			
Igede	3(4.3)	1(33.4)	2(66.7)			
Others	4(5.7)	1(25)	3(75)			

**2. Quality of Life grading of the respondents.**

More than half of the people with disability 52.9% had poor quality of life while 47.1% had good quality of life.

**3. Relevant history of disability**

Table 2 shows the relevant history of disability. Most of the respondents 34(48.6%) had disability for the past (21-40) years and the most type of disability 26(37.1%) was that of mobility. More than half 40(57.1%) acquired disability through sickness and most of the respondents 38(54.3%) did not have chronic health issues. A high proportion of the respondents 37(54.3%) were not on

any medication and majority 44(62.9%) had frequent visit to health facilities. More than half 38(54.3%) affirmed that they experienced discrimination and the majority of the respondents 44(62.9%) had to queue in a health facility before accessing care.

Most of the PWDs who had chronic health issues ( $X^2 = 8.556$ ,  $df=1$ ,  $P=0.003$ ), those who were currently taking medication ( $X^2 = 9.892$ ,  $df=1$ ,  $P=0.002$ ) and those who did not visit health facilities frequently ( $X^2 = 6.787$ ,  $df=1$ ,  $P=0.009$ ) had poor quality of life with the association being statistically significant.

**Table 2: Relevant history of disability and status of quality of life among the respondents**

Variable	Total (%)	Quality of life grading		df	X <sup>2</sup>	p-value
		Poor	Good			
<b>Duration of disability</b>				3	3.587	0.310
≤20	32 (45.7)	20(62.5)	12(37.5)			
21-40	34(48.6)	15(44.1)	19(55.9)			
41-60	3(4.3)	2(66.7)	1(33.3)			
≥61	1(1.4)	0(0)	1(100)			
<b>Types of disability</b>				3	2.137	0.545
Visual	20(28.6)	11(55)	9(45)			
Mobility	26(37.1)	11(42.3)	15(57.7)			
Hearing Impairment	14(20.0)	9(64.3)	5(35.7)			
Skin disorder	10(14.3)	6(60)	4(40)			
<b>How disability was acquired</b>				2	0.975	0.614
Birth	25(35.7)	15(60)	10(40)			
Sickness	40(57.1)	20(50)	20(50)			
Accident	5(7.1)	2(40)	3(60)			
<b>Do you have any chronic health issue</b>				1	8.556	<b>0.003</b>
Yes	32(45.7)	23(71.9)	9(28.1)			
No	38(54.3)	14(36.8)	24(63.2)			
<b>Are you currently taking any medication</b>				1	9.892	<b>0.002</b>
Yes	33(45.7)	24(72.7)	9(27.3)			
No	37(54.3)	4(22.2)	14(77.8)			
<b>How frequent do you visit health facility</b>				1	6.787	<b>0.009</b>
Not frequent	26(37.1)	19(73.1)	7(26.9)			
Frequent	44(62.9)	18(40.9)	26(59.1)			
<b>Do you suffer discrimination in a health facility</b>				1	0.002	0.967
Yes	38(54.3)	20(52.6)	18(47.4)			
No	32(45.7)	17(53.1)	15(46.9)			
<b>Do you have to queue in a health facility</b>				1	0.746	0.461
Yes	44(62.9)	25(56.8)	19(43.2)			
No	26(37.1)	12(46.2)	14(53.8)			

#### 4. Barriers preventing access to health care services

Figure 1: Most of the PWDs (35.5%) revealed that difficulty to get disability-friendly transport was the most frequent challenge confronting them and the next in rank was absence of ramps (27.9%) in the health facility.

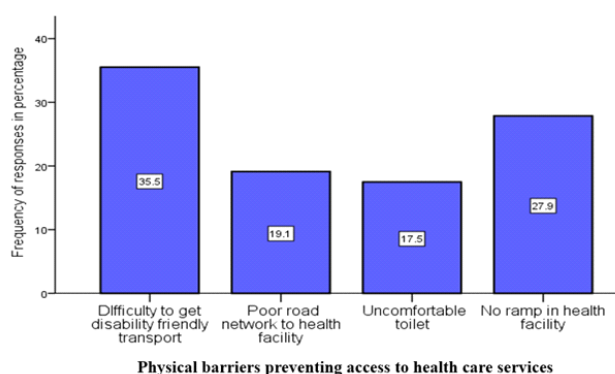


Figure 2 showed that most PWDs (40.3%) affirmed absence of disability assistance in communication while (31.3%) had difficulty in communicating with health care provider.

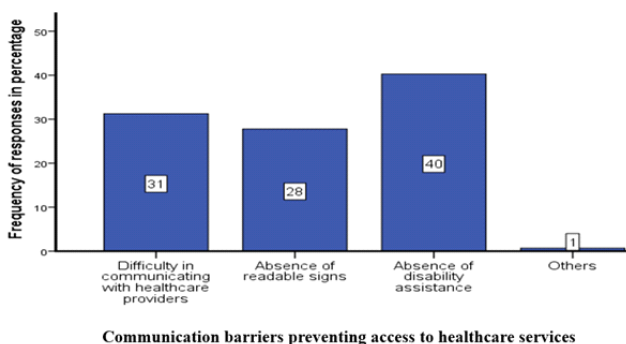


Figure 2: Communication barriers preventing access to healthcare services

Figure 3 shows medical barriers access which revealed that most of the PWDs (51.2%) attested that absence of assistive devices in health care facility was a barrier while (30.6%) complained of uncomfortable patient admission bed.

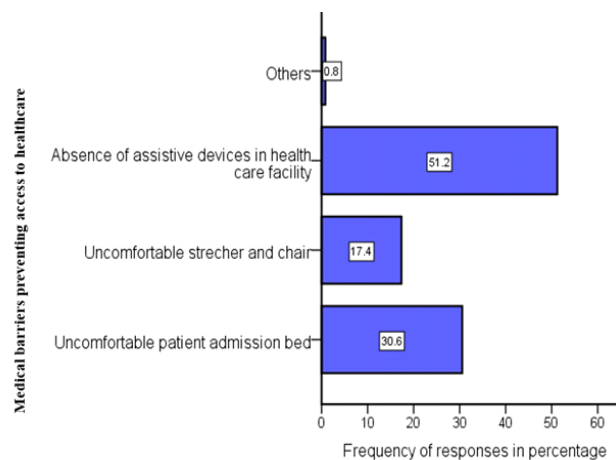


Figure 3: Medical equipment barriers preventing access to healthcare services

#### DISCUSSION

This study explored the barriers preventing access to health care services and QOL among PWDs. The respondents in this study were within the age range (21-40) years. Similar age ranges occurred in disability studies in a supporter/school of disability in Enugu, a PWDs study among urban dwellers in Ethiopia and an Indian study in a district in Bangalore, India.<sup>3,4,15</sup> This age range (21-40) comprises the working-age population. The high proportion of disability in this working age group has significant economic and societal consequences. Most were of male gender, married, staying with family members and had attained secondary education. This agrees with the study in India and Ethiopia but is at variance with the study in Enugu where the respondents were mostly female in a People with Disability school and were yet to complete secondary education.<sup>3,4,15</sup> The preponderance of males in this study could be due to more males than females showing interest and being active in PWD groups.

The study explored some barriers preventing access to health care services which include physical barriers, communication barriers and medical equipment barriers. The most frequently occurring physical barriers in this study were disability-friendly transport challenges like difficulty in getting wheelchairs and supportive rails followed closely by the absence of ramps in the health facility. The study in the North-West of Nigeria, Peru in South America and Ethiopia also

depicted similar findings as in this study.<sup>13,15,21</sup> The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) outlines the rights of people with disabilities, including the right to accessible healthcare. Specifically, it addresses accessibility and emphasizes the need for physical accessibility to and within health facilities.<sup>22</sup> For instance, the building should feature wheelchair access, broaden the sidewalk and adequate lighting for those with visual defects.

This study revealed that communicative barriers frequently encountered by PWDs include limitations in disability assistance (communication aids and healthcare workers with skills in interpreting comprehensively information relayed between healthcare workers and PWDs) and lack of comprehensive knowledge in communication with healthcare providers. A study in Nigeria and another in North America gave similar affirmation.<sup>13,14</sup> Another study in the United Kingdom further revealed that the problem of communication could be bidirectional.<sup>23</sup> Difficulties of passing information by healthcare givers to PWDs and PWDs expressing their expectations to healthcare givers hence, giving rise to a bidirectional conundrum. This calls for the need to train and retrain healthcare workers in the area of communication regarding PWDs to ensure quality health care services to this special group.

The absence of assistive devices and uncomfortable or non-customized bed for PWDs featured most as medical equipment barriers preventing access to healthcare services in this study. Another study in Nigeria and Sao Paulo Brazil revealed that lack of customized medical equipment and assistive devices deter to a great extent good quality health care for PWDs.<sup>13,14</sup> Health care professionals should endeavour to address this important need which is a perennial barrier in accessing healthcare services in the developing world.

The proportion of overall good QoL among PWDs in this study was below average at 47.1% portraying a prevailing low QoL among this special group. A survey of Nigeria and India which are developing countries described a low QoL across the four components which

include physical, psychological, social, and environmental.<sup>3,24,25</sup> Sweden a developed country also revealed that the psychological component of QoL was low among PWDs.<sup>7</sup> Disability limits functionality and diminishes self-image which could explain the below-average good QoL among PWDs in this study.

Being female and living a considerable distance from the town where this health facility was located was associated with poor QoL. There are studies at present from Nigeria, India, and Pakistan indicating that disabilities and female gender are significant factors contributing to further impairment and reduced QoL in PWDs.<sup>3,4,26</sup> The Nigerian study revealed that the high prevalence of chronic diseases like diabetes, obesity and osteoarthritis among the female gender were the reasons for the reduced QoL.<sup>4</sup> Also, the study in Nigeria, India and another study in South Asia revealed that QoL was low among PWDs whose residents were far from the health facility.<sup>3,4,27</sup> The inability to access health facilities due to the difficult terrain and lack of convenient transport modality could explain this problem.

PWDs that had chronic illnesses, were on medication and did not frequently visit health facilities for check-ups were reported to have low QoL in this study. Similar findings revealed that PWDs could live healthy lives however, when disability co-exists with chronic illness, the QoL is greatly compromised.<sup>3,19,24,28</sup>

## CONCLUSION

Many PWDs in Benue State face physical barriers like the lack of disability-friendly amenities, communication challenges due to insufficient aids and trained staff, and medical obstacles from inadequate customized beds. These issues, alongside factors like gender, chronic illness, and infrequent check-ups, contribute to a generally below-average quality of life.

In addition, challenges confronting PWDs in accessing services in this healthcare facility include physical barriers like disability-friendly amenities like wheelchairs and lack of ramps. Communication barriers included the absence of communication aids and skilled health assistance. Other significant medical barriers

included, lack of customized beds to accommodate the disabilities that present and lack of assistive medical devices for People With Disability. The QoL was generally below the total average and factors affecting QoL in this study were being female and residing outside the town where this facility was located, having a chronic illness and on long-term medication and those not availing themselves for frequent medical check-ups.

#### Recommendations:

- 1. Implement Universal Design Standards in health facilities:** Health facilities should be retrofitted and new ones constructed in compliance with the UN Convention on the Rights of Persons with Disabilities (UNCRPD), ensuring physical accessibility through installation of ramps, widened doorways, accessible toilets, and provision of disability-friendly transport options or partnerships with community transport schemes.
- 2. Integrate Disability-Inclusive Communication Training into health worker curricula and In-Service Programs:** Healthcare providers should receive mandatory training in disability-competent communication, including the use of sign language interpreters, visual aids, and plain-language techniques. Hospitals should also be equipped with basic communication aids to facilitate bidirectional understanding, thereby improving patient-provider interactions and care quality.
- 3. Establish community-based Quality of Life support and outreach programs:** Given that female PWDs, those with chronic illnesses, and those residing far from health facilities reported poorer QoL, targeted outreach programs are needed. These should include mobile clinics, chronic disease management support, telehealth options where feasible, and community health worker follow-ups to encourage regular check-ups and address social determinants of low QoL, particularly among high-risk subgroups.

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