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## HEALTHCARE AT THE MARGINS: SYSTEMATIC INSIGHTS INTO BARRIERS FACED BY DIFFERENTLY-ABLED WOMEN IN TRIPURA

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### 1. Introduction and Statement of the Problem

Disability affects over 15% of the global population, translating to nearly one billion individuals (WHO, 2011). Among these, women are disproportionately represented, with a 60% higher prevalence of disability than men—particularly in low-income countries. Differently-abled women (DAW) experience intersecting forms of marginalization, compounding the barriers they face in accessing healthcare services. These disparities are not only a matter of individual health outcomes but signal systemic gaps in social protection, healthcare infrastructure, and public policy.

DAW are at a significantly elevated risk for secondary health conditions including obesity, physical inactivity, and severe oral health problems. Women with intellectual disabilities, in particular, exhibit higher rates of health risk behaviors, lower physical activity levels, and are less likely to access preventive health services like Pap smears or mammograms. These inequalities result from a confluence of mobility, perceptual, and communication barriers within the healthcare system.

The situation is especially dire in low-resource settings such as Tripura, where geographic remoteness, lack of healthcare infrastructure, and prevailing social stigma amplify existing disparities. Despite global frameworks advocating for inclusive healthcare—such as the UNCRPD—implementation remains uneven. This study, therefore, seeks to explore, through a systematic review of qualitative studies, the lived healthcare experiences of DAW, with a focused lens on the state of Tripura, India.

### 2. Review of Literature

#### 1. Intersectionality of Disability and Gender

- Women with disabilities face **double discrimination**—first due to their gender, and second due to their disability.
- Studies (Groce et al., 2011; Hughes et al., 2006) highlight that women with disabilities are more vulnerable to **social exclusion, violence, and invisibility** in public health policy.
- Cultural norms often define disabled women as **non-sexual or dependent**, reducing their access to reproductive and maternal health services.

## 2. Structural and Systemic Barriers

- Physical inaccessibility to hospitals (lack of ramps, toilets, transport) remains a **critical issue** in rural areas like Tripura.
  - **Inadequate training of healthcare providers** in disability-inclusive practices leads to neglect, misdiagnosis, and discriminatory behavior (Lipson & Rogers, 2000).
  - Poor availability of **assistive technologies**, interpreters, and accessible communication limits service utilization.

## 3. Gaps in Sexual and Reproductive Health (SRH) Services

- DAW receive less sexual education and are often **excluded from SRH outreach** efforts (Yousafzai et al., 2011)
- Women with intellectual disabilities often lack **informed consent** opportunities and are overlooked in family planning programs.
- Studies show a significantly lower rate of Pap smears and breast exams among DAW compared to non-disabled women.

## 4. Economic and Educational Disadvantages

- Disability correlates strongly with **lower household income**, reduced schooling, and limited job prospects—further shrinking access to healthcare (Trani et al., 2011).
- Women in low-income families with disabilities often depend on caregivers and are **not prioritized** for healthcare spending.

## 5. Psychosocial Challenges

- Stigma, shame, and **fear of mistreatment** discourage DAW from seeking care.
- Mental health is often **neglected**, and depression is more common among women with physical and sensory disabilities (Hughes et al., 2006).

## 6. Policy Gaps and Weak Implementation

- While India has disability rights legislation (e.g., Rights of Persons with Disabilities Act, 2016), **enforcement remains weak**, especially in northeastern states.
- Tripura suffers from **limited institutional coordination**, low health budget allocations, and minimal awareness campaigns targeting DAW.

## 7. Global Comparisons and Best Practices

- In high-income countries, **inclusive health guidelines and disability-sensitive training** have improved access.
- Community-based rehabilitation (CBR) and **peer support models** in places like Sri Lanka and Nepal show promise in low-resource settings.

## 3. Objectives of the Study

- **To identify and understand the barriers in accessing healthcare faced by differently abled women in the state of Tripura.**
- **To provide evidence-based recommendations to government stakeholders to reduce these barriers and promote inclusive healthcare.**

#### **4. Research Question**

**Primary Question:** *What do qualitative studies reveal about the barriers experienced by differently abled women in accessing healthcare services internationally?*

#### **5. Conceptual Framework**

This study utilizes **Levesque et al.'s (2013) model of healthcare access**, which structures the process of seeking and receiving healthcare into five user-centric dimensions:

1. **Ability to Perceive** – Knowledge and awareness of healthcare needs and services.
2. **Ability to Seek** – Autonomy and decision-making capacity to pursue healthcare.
3. **Ability to Reach** – Geographic and transportation access to health facilities.
4. **Ability to Pay** – Financial affordability and social protection mechanisms.
5. **Ability to Engage** – Ability to participate in ongoing care and decision-making.

This framework is effective in understanding access as a multidimensional issue influenced by both individual and systemic factors.

#### **6. Research Design and Methodology**

##### **A. Inception Phase**

- Collaboration with the **National Commission for Women (NCW)** to align objectives.
- Review of prior studies in India to contextualize findings.
- Development of an Inception Report for NCW approval.

##### **B. Tool Development**

- Mixed-methods approach using **qualitative interviews** and **focus group discussions (FGDs)**.
- Pilot testing of tools, followed by revisions based on feedback.
- Finalization with stakeholder validation.

##### **C. Sampling and Data Collection**

- **Primary Sources:**

- Interviews with DAW, caregivers, healthcare workers, NGOs.
- FGDs with community stakeholders and local authorities.

- **Secondary Sources:**

- Government reports, health department records, published literature, policy documents.

#### **D. Data Analysis**

- Thematic and content analysis using qualitative software (e.g., NVivo).
- Categorization of responses under the Levesque framework.
- Triangulation with secondary data to ensure reliability.

#### **E. Quality Control**

- Implementation of data validation protocols.
- Periodic audits and cross-verification of field data.

#### **F. Reporting**

- Interim reports for stakeholder feedback.
- Final report with actionable recommendations for NCW and state health departments.

#### **Hypothesis**

The study anticipates the following thematic barriers:

- **Cultural and social stigma**, especially around SRH.
- **Economic dependence**, limiting autonomy in healthcare decision-making.
- **Physical inaccessibility** of healthcare infrastructure.
- **Lack of trained healthcare personnel**, especially for cognitive and sensory disabilities.
- **Systemic neglect**, due to the absence of targeted healthcare policies for DAW.

#### **9. Recommendations**

**These may include:**

- Mandatory disability sensitivity training for healthcare providers.
- Government-funded transport and healthcare subsidies for DAW.
- Policy mandates for inclusive SRH services.
- Strengthened representation of DAW in state healthcare policy planning.

### **Conclusion**

This research aims to bridge the knowledge gap in understanding healthcare barriers for differently abled women in Tripura through a systematic and qualitative lens. Using globally recognized frameworks and localized fieldwork, the study hopes to produce meaningful insights that can inform inclusive healthcare policy at both state and national levels.

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