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# Accessibility of Reproductive Healthcare Services for Persons with Disabilities in Plateau State: Implications for Social Inclusion

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**Abstract**

Anchored on the Social Model of Disability and Intersectionality Framework, the study investigated the accessibility of reproductive health service delivery for Persons with Disability (PWDs) in Plateau State. Limited empirical evidence exists about the barriers faced by PWDs and how it affects their social engagement in Plateau State. A descriptive cross sectional design with 385 PWDs was involved and the sampling was multi-stage, involving three senatorial districts. The Accessibility and Social Inclusion Survey Questionnaire (Cronbach's $\alpha = 0.76$) was used to collect data, which were analysed descriptively and inferentially at 0.05 level of significance. Results showed that, while information access was high (mean=3.72), the overall accessibility was low (mean=2.68), with the physical (mean=2.43), attitudinal (mean=2.42), financial (mean=2.41), and procedural (mean=2.43) domains being severely below threshold. Barriers were extremely high (weighted mean=3.09), and all barriers, except for knowledge, were higher (mean = 3.00). There was a moderately strong positive correlation between accessibility and social inclusion ($r=0.662$, $p<.002$), accounting for 43.8% of the variance. There was a significant difference between disability type and accessibility scores [$F(5,379)=5.503$, $p=.002$, $\eta^2=.07$] but no significant difference was found between the genders [$t(385)=0.474$, $p=.634$]. The study points to a persistent lack of access to reproductive care which is especially problematic for social inclusion, as emphasized by the Social Model, and which also reflects the theory of Intersectionality. The recommendations are infrastructure restructuring, compulsory provider training, disability-based protocols, and financial subsidy schemes to promote PWDs' health equity and social justice.

.**Keywords:** Accessibility, reproductive healthcare, persons with disabilities, barriers, social inclusion

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## Introduction

Reproductive health is a key aspect of all other aspects of health and is a litmus test for the health of a family and a community. Healthy people are the building blocks of healthy families and ultimately healthy communities. Reproductive health is given considerable importance and is the concern of international organizations like the World Health Organisation. Omokhabi et al. (2026) define reproductive health as the evidence that people can have a safe and satisfying sex life, can reproduce and have the choice to do so. However in Nigeria, these rights are still hindered by systemic challenges and social inequalities (Azubuike et al., 2025) for persons with disabilities (PWDs).

Healthcare systems in Plateau State were not originally designed with the unique physical, sensory, or cognitive needs of PWDs in mind, which in itself is a significant hurdle to PWDs' access to healthcare services (Usman et al., 2025). Access to reproductive care services is not just about getting into a health center; it's also about access to information, the affordability of services, and having non-discriminatory, respectful health care service providers (Omokhabi et al., 2026; Brace et al., 2025). Access to reproductive health services like family planning and prenatal care has a profound impact on social inclusion, enabling PWDs to participate more fully in social and economic life (Azubuike et al., 2025). However, if PWDs do not have access to these services, or are systematically excluded from them, the consequence is a vicious downward cycle of poverty and marginalisation. Smeltzer et al. (2025) show that ableism in the health care system is common, and the needs of PWDs are either ignored or poorly understood.

Gender and disability further increase the vulnerability of PWDs, as for instance women with disabilities experience unique challenges in accessing maternity services, and are also subjected to societal myths about their sexuality and reproductive capacity (Bolarinwa et al., 2025; Ven et al., 2026). Adelakun et al., (2025) reported low experiences of women with disabilities accessing reproductive health services at a tertiary health facility in the Northwest region of Nigeria, citing poor attuning of providers and imperfections of facilities, while Mprah et al., (2022) noted that there were significant barriers in accessing sexual and reproductive health services by the young deaf population in Ghana.

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Several interacting factors influence the status of accessibility of reproductive health care service in Plateau state these factors include having support services by health care institutions and digital literacy of the population (Akande, 2024a). The type of disability is also an important factor affecting healthcare access (Rade et al. 2023), and various categories of disability have different difficulties when it comes to using healthcare. New technologies like Artificial Intelligence (AI) and mobile health solutions present possibilities for empowerment through lifestyle changes and the dissemination of health information (Omokhabi et al., 2025a; Omokhabi et al., 2025b). It is also important to note that these technologies are useful for PWDs, provided they are designed in a way that is inclusive, and that users have the necessary health literacy (Omokhabi et al., 2026; Olunubi et al., 2024). In this background, the present study examines the current status of reproductive healthcare services access for PWDs in Plateau State, their unique challenges and the impact of these challenges on the social inclusion of the PWDs. This study aims to build a framework for more inclusive healthcare policies that uphold the dignity and rights of everyone, regardless of their physical or mental ability, through the lens of disability type, gender and service access.

## Statement of the Problem

Despite the presence of policies at the national level that are seemingly geared towards health equity, people with disabilities in Nigeria still face significant barriers to accessing reproductive health care services (Azubuike et al., 2025). The basic issue is that PWDs are structurally excluded from mainstream health programs and health facilities and services are never provided in a manner that is disability-friendly. In addition to physical barriers (for example, no ramp, adjustable examination tables), attitudinal barriers (for example, bias) and lack of training (for example, by healthcare professionals, who do not know how to communicate with sensory or psychosocial disabled patients) also contribute. In a study of unmet family planning needs among PWD in the Northwest Nigeria, Abubakar et al. (2026) noted that many healthcare providers in the region did not have the capacity to effectively communicate with PWDs. Likewise, Haque et al. (2023) noted the existence of several barriers that hinder women with physical disabilities from accessing reproductive health services, including physical, healthcare provider, provider attitude and financial barriers, which have been seen in Plateau state.

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Moreover, there is a significant lack of sexual and reproductive health and education literacy that meets the needs and specific needs of PWDs, and many do not have the information they need to make decisions about their sexual and reproductive health. The lack of access is not only a health issue, but also a threat to social inclusion because it prevents PWDs from having the same access to health care as their non-disabled counterparts. Women with disabilities are especially hard hit as they often face institutional discrimination and the general gender discrimination that is entrenched in Nigerian society. If neither empirical investigation nor thorough understanding of the particular challenges of PWDs is done in Plateau State nor the impact of disability type, gender on access to service, the gap in reproductive health outcomes will continue and deepen the social and economic marginalization of this vulnerable group. Therefore, this study is essential to produce evidence that can help inform the policy and practice to increase the inclusivity and equity of reproductive healthcare delivery.

## Purpose of the Study

The main purpose of the study is to investigate accessibility of reproductive healthcare services for persons with disabilities in Plateau State. The specific objectives are to:

1. determine the level of accessibility of reproductive healthcare services for persons with disabilities in Plateau State.
2. establish relationship between accessibility of reproductive healthcare services and social inclusion among persons with disabilities in Plateau State.
3. analyze the influence of disability type on accessibility of reproductive healthcare services among persons with disabilities in Plateau State.
4. assess the influence of gender on accessibility of reproductive healthcare services among persons with disabilities in Plateau State.

## Research Questions

The study provides answer to the following research questions:

1. What is the level of accessibility of reproductive healthcare services available to persons with disabilities in Plateau State?
2. What barriers do persons with disabilities encounter in accessing reproductive healthcare services in Plateau State?

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## Hypotheses

The following hypotheses were tested at 0.05 level of significance:

1. There is no significant relationship between accessibility of reproductive healthcare services and social inclusion among persons with disabilities in Plateau State.
2. There is no significant difference accessibility of reproductive healthcare services among persons with disabilities in Plateau State across disability type.
3. There is no significant difference in accessibility of reproductive healthcare services among male and female persons with disabilities in Plateau State.

## Literature Review

The literature on reproductive health for persons with disabilities (PWDs) shows a injustice and systemic neglect across the world. It has been repeatedly established that PWDs are less likely to undergo required reproductive examinations and more likely to report dissatisfaction with the care they receive (Biggs et al., 2023; Brace et al., 2025). In the Nigerian context, it has been reported that ableism plays a crucial role in influencing the experiences of PWDs within the healthcare sector. This is because healthcare providers are not senstitive to PWDs and the facility infrastructure is poor (Smeltzer et al., 2025). For instance, Usman et al. (2025) remarked that individuals with psychosocial disabilities have specific obstacles: “their reproductive health needs are typically marginalized by families, caregivers, and community stakeholders who may prioritize mental treatment above sexual health”.

The intersection of gender and disability is another recurring subject in recent studies. Women with disabilities in Nigeria confront double-marginalization. Their reproductive needs, such as safe maternal care and family planning are often overlooked due to cultural conceptions that they are "asexual" or "incapable" of parenting (Bolarinwa et al., 2025). Research in Northern Nigeria notably depicts major unmet requirements for family planning among PWDs in states like Zamfara (Yunusa et al., 2025; Modu & Usman, 2025). It has been found that women with disabilities in Lagos faced significant barriers to accessing reproductive health services. This includes physical inaccessibility, financial constraints, and provider discrimination (Agada & Okafor, 2024). Multiple barriers to the utilization of reproductive healthcare services for women with physical disabilities were identified by

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Haque et al (2023) which included physical and provider-related determinants such as provider attitudes, as well as financial barriers, which was observed in Plateau State.

Bolarinwa et al. (2025) identified that there are variations in the level of sexual health knowledge and contraceptive use among women with disability in Africa, suggesting that interventions should be targeted to specific areas, perhaps accounting for why gender gaps were not clear in Plateau State. Adewusi et al. (2022) documented that women and girls with disabilities in North-central Nigeria had low knowledge of sexual and reproductive health rights and limited utilization of available services, largely due to stigma and lack of accessible information. In addition, women with disabilities reported inferior maternity care experiences compared to their non-disabled counterparts. This situation was generally attributed to a lack of provider awareness regarding their special healthcare needs and requirements (Iguh & Ugwu, 2023; Ven et al., 2026). Other areas where women with disabilities experience difficulty in access include contraceptive use because handicap status significantly determines method discontinuation and preferences (Akpambang & Akanle, 2024; Pleasure & Lindberg, 2025).

The use of digital interventions has emerged as a potential facilitator for access. Some of these tools and platforms have been studied for their ability to give access to healthcare information to women with disabilities, to overcome some physical and social barriers (Lidubwi & Ndavula, 2025; Omokhabi et al., 2025a). It has however been found that individual health literacy determines the outcomes of such interventions (Omokhabi et al., 2026). Studies have revealed that the level of female health literacy greatly influences reproductive health behaviour and the ability to navigate complex medical systems (Olunubi et al., 2024).

Significant elements in the retention and satisfaction of service users are the institutional support and organizational structure. In the sphere of healthcare, this translates to the necessity for disability-friendly services. However, access to healthcare service is worse hurdle for PWDs in Nigeria (Bassey et al., 2022). The literature implies that for social inclusion to be fulfilled, healthcare services must extend beyond mere geographical proximity. They must take into consideration the complex connection among of individual innovativeness, self-efficacy, and social justice (Bubou & Job, 2022; Azubuike et al., 2025).

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The purpose of equitable reproductive healthcare is to ultimately guarantee that PWDs are active beneficiary of reproductive healthcare services and participate in their own health management to build a feeling of acceptance within the greater society (Akande, 2024b).

## Theoretical Framework

This study is anchored on three complementary theoretical frameworks that collectively provide a comprehensive lens for understanding reproductive health access among persons with disabilities in Plateau State. Each theory addresses distinct dimensions of the access problem, and their integration offers a robust analytical foundation for the research.

### Social Model of Disability

The Social Model of Disability, developed by Oliver (1990), is founded on the fundamental distinction between impairment and disability. The model assumes that impairment, defined as a biological condition or functional limitation, is inherently different from disability, which is conceptualized as the social, attitudinal, and environmental barriers imposed by society on people with impairments. The model posits that disablement does not originate from the individual's physical, sensory, or cognitive condition but rather from social systems that fail to accommodate human diversity. Consequently, disability is not the responsibility of the person but of the environment, institutional policies, and social attitudes that systematically exclude persons with disabilities. The model further assumes that meaningful transformation requires changes in the structure of societal systems such as healthcare, rather than merely rehabilitation or medical fixes for impairments. This framework offers a powerful analytical tool for this study by framing reproductive health access as a social problem rather than an individual one. The model directly informs the survey instrument by encompassing various dimensions of barriers to reproductive health services. Physical barriers include inaccessible building entrances, examination tables, and toilet facilities. Attitudinal barriers encompass provider bias, discriminatory treatment, and assumptions of incompetence that reflect social prejudices within healthcare interactions. Economic barriers such as prohibitive service costs

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and transport costs demonstrate the systemic exclusion of persons with disabilities. Procedural barriers like intricate appointment systems, time delays, and rigid service delivery represent bureaucratic obstacles that exclude persons with disabilities. These distinct barrier dimensions are mapped onto the Social Model, enabling the translation of theoretical constructs into measurable indicators of healthcare access.

**Intersectionality Framework**

Crenshaw's Intersectionality Framework (1989) rests on several interrelated tenets that have shaped contemporary understandings of social inequality. The foundational assumption is that social identities including disability, gender, race, class, and sexuality are not separate or mutually exclusive but rather interconnected and combinable, creating diverse experiences of privilege and oppression. The framework posits that systems of inequality such as ableism, sexism, classism, and racism are interconnected and mutually reinforcing, generating compound forms of marginalisation that cannot be adequately analysed along a single dimension. Intersectionality maintains that individuals living at the intersection of multiple marginalized identities face qualitatively different disadvantages that exceed the sum of their individual parts. Finally, the framework asserts that social interventions failing to consider intersectionality may inadvertently sustain inequities by neglecting the needs of multiply marginalised groups. This study operationalises intersectionality as a lens that reveals how disability intersects with gender and socioeconomic status to influence reproductive health experiences in Plateau State. The research design specifically examines how women with disabilities may experience dual marginalisation through ableism and sexism simultaneously within the healthcare context. The denial of reproductive autonomy to women with disabilities represents an intersectional phenomenon combining disability stigma and gender stereotypes manifested in societal myths. To capture these intersectional dynamics, accessibility scores are calculated separately for women and men across disability categories and compared to determine systematic differences in accessibility experiences. This operational method enables the study to move beyond bivariate analysis toward a more complex understanding of how multiple identity dimensions intersect and impact healthcare access.

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## Fundamental Cause Theory

The Fundamental Cause Theory of Link and Phelan (1995) articulates several assumptions regarding the relationship between socioeconomic resources and health outcomes. The theory posits that socioeconomic status, encompassing income, education, power, prestige, and social networks, constitutes a fundamental cause of health disparities because it influences access to health protective factors and resources. The framework asserts that although specific risk factors and disease patterns evolve over time, the relationship between socioeconomic status and health remains consistent because privileged groups continuously deploy their resources to maintain health advantages. The theory maintains that individuals with greater socioeconomic resources have enhanced capacity to avoid risk factors, utilise protective factors, and navigate the complex healthcare system successfully. Finally, the model suggests that health inequities are not merely caused by differential exposure to risk factors but are driven by systematic differences in access to flexible resources that can be deployed to safeguard health across various situations. This theory directly influences this study's discussion on the impact of socioeconomic resources on reproductive healthcare access among persons with disabilities in Plateau State. The theory explains the vulnerability of persons with disabilities to financial and procedural barriers because they are disproportionately likely to experience poverty, limited education, and restricted social networks. These dynamics are operationalised in the survey instrument by measuring the relative burden of financial barriers including transport costs, service fees, and medicine costs, and procedural barriers including appointment delays and service fragmentation. The interaction of socioeconomic factors with disability type and gender in determining accessibility scores directly relates to the Fundamental Cause Theory's emphasis on the impact of flexible resources on health outcomes.

## Synthesis and Justification for Integrating the Three Theoretical Frameworks

This study employs three complementary frameworks to offer a comprehensive analytical approach to reproductive health access among persons with disabilities in Plateau State. The

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justification for integrating these theories lies in their distinct yet synergistic contributions to understanding the multifaceted nature of healthcare exclusion.

The Social Model of Disability provides the foundational premise that inaccessibility to reproductive healthcare is not an individual impairment issue but rather a systemic exclusion problem. This framework establishes the conceptual groundwork for identifying and categorising the structural, attitudinal, economic, and procedural barriers that persons with disabilities encounter. However, the Social Model has been criticised for its tendency to underestimate the lived experiences of disability and the actual physical or health conditions that persons with disabilities may face. In the context of reproductive health, the model may fail to consider how underlying health issues such as epilepsy, HIV, and chronic pain intersect with pregnancy to present distinct clinical challenges beyond social obstacles. Furthermore, the model's focus on structural change, though analytically powerful, may offer limited guidance for immediate pragmatic interventions in low resource environments where systemic transformation takes considerable time.

Intersectionality addresses a critical gap in the Social Model by recognising that barriers are not experienced uniformly among all persons with disabilities. Women with disabilities, individuals with multiple impairments, and those from different socioeconomic backgrounds confront qualitatively different obstacles. This framework helps fill the void in the Social Model, which may at times view disability as a single category, by acknowledging that experiences of disability can be compounded or mediated by gender and other identity factors. However, Intersectionality has been criticised for becoming overly complex and difficult to operationalise in empirical research. In the Nigerian context, intersectionality demands attention to cultural, ethnic, and religious aspects of identity that do not necessarily correspond with Western theoretical frameworks. Additionally, the focus on experiential combinations may overlook shared experiences that unite persons with disabilities in their collective struggles, potentially leading to fragmented advocacy and policy responses.

Fundamental Cause Theory brings a vital socioeconomic dimension to understanding why financial and procedural barriers disproportionately affect persons with disabilities and how disparities in resources perpetuate cycles of exclusion. This theory addresses the

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shortcomings of both the Social Model and Intersectionality, which pay less attention to the structural economic factors that restrict access, by directing analysis toward the material realities of poverty, low educational attainment, and restricted social capital that many persons with disabilities in Plateau State experience. However, the theory has been challenged for its potential embrace of theoretical pessimism that may suggest health disparities are nearly impervious due to their entrenched social and economic origins. The theory may not adequately explain the importance of political will, policy innovation, and community mobilisation in challenging deep rooted inequalities. In the Plateau State context, the focus on micro level resources like income and education may downplay the significance of macro level social movements, legal structures, and institutional accountability mechanisms in improving health equity.

The synthesis of these three frameworks overcomes the weaknesses of each while leveraging their respective strengths. The Social Model specifies the types of barriers to assess, including physical, attitudinal, financial, and procedural barriers. Intersectionality accounts for why these barriers differ according to the intersecting identities of different persons with disabilities. Fundamental Cause Theory explains why socioeconomic resources predict the ability to surmount barriers and perpetuates cycles of exclusion. These theories in combination provide the conceptual scaffolding for the empirical investigation, hypothesis development, and policy recommendations of this study, connecting results to a robust theoretical base that incorporates both structural and individual aspects of health inequity. The integration ensures that the research captures the full complexity of reproductive health access challenges while remaining grounded in established theoretical traditions that have demonstrated explanatory power in understanding health disparities.

## Methodology

This study utilized a descriptive cross-sectional survey research design to explore the accessibility of reproductive healthcare services for persons with disabilities in Plateau State. The target population comprised people with disabilities including physical, hearing, visual, speech, intellectual and multiple disabilities residing within the three senatorial districts of the state. To achieve a representative sample, a multi-stage sampling procedure was adopted. First, Plateau State was stratified into 3 senatorial zones. Then, purposive sampling was

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utilized to select local government districts with large numbers of PWDs as supported the Plateau State Disability Rights Commission. A sample size of 385 respondents was obtained utilizing convenience and snowball sampling approaches to target this often-hidden demographic.

Data collection is a structured questionnaire titled Accessibility and Social Inclusion Survey Questionnaire (ASISQ). The ASISQ was specifically developed for this study to comprehensively assess the multifaceted dimensions of reproductive healthcare access among persons with disabilities (PWDs) in Plateau State. The instrument was designed to capture not only the physical and procedural aspects of healthcare access but also the attitudinal, informational, and financial barriers encountered by PWDs, alongside their perceived level of social inclusion.

The ASISQ comprises four sections. Section A collects demographic information such as gender, age, disability type, and socioeconomic status. Section B evaluates the level of accessibility across subscales namely physical, informational, attitudinal, financial and procedural accessibility. Each of the subscales has 5 items and uses a five-point Likert scale. Section C of the instrument focuses on the specific barriers across physical, informational, attitudinal, financial, procedural, communication, and socio-cultural domains using a five-point Likert scale. Section D measures perceived social inclusion with 20 items which uses 5-point Likert scale. To ensure content validity, the instrument was subjected to expert review by specialists in reproductive health, special education, and disability studies. Their feedback was used to refine the clarity, relevance, and comprehensiveness of the items. To establish reliability, a pilot test was conducted with 20 individuals with disabilities in neighboring Bauchi State. The internal consistency of the questionnaire was assessed using Cronbach's alpha, yielding a reliability coefficient of 0.76, indicating acceptable reliability for the instrument.

The ASISQ was made available in multiple accessible formats, including Braille, large print, and simplified versions for individuals with cognitive difficulties. This was done to accommodate diverse disability types. For deaf participants, trained sign language interpreters were provided during interview-assisted administrations. Data were collected

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through a combination of face-to-face interviews and self-administered questionnaires, depending on the preference and capacity of each participant.

Data collection includes administration of the questionnaires. Ethical approval was acquired from the relevant institutional review board. Informed consent was sought for all participants, preserving their right to confidentiality and withdrawal at any moment. Descriptive statistics mainly frequency count, mean and standard deviation and one-sample t-test were used to assess the research questions. Linear regression analysis, one-way analysis of variance (one-way ANOVA) and independent sample t-test were employed to evaluate the hypotheses. Qualitative insights gained from open-ended questions will be evaluated using theme analysis to provide a greater understanding of the lived experiences of PWDs in Plateau State. All findings will be summarized to make conclusions and provide actionable recommendations for policy reform.

**Result/Findings & Discussion**

Research Question 1: What is the level of accessibility of reproductive healthcare services available to persons with disabilities in Plateau State?

Table 1

Level of Accessibility of Reproductive Healthcare Services Available to PWDs

| Variable | N | Mean | SD | Level |
|---|---|---|---|---|
| Physical Access | 385 | 2.43 | 3.40 | Low |
| Information Access | 385 | 3.72 | .926 | High |
| Attitudinal Access | 385 | 2.42 | 3.41 | Low |
| Financial Access | 385 | 2.41 | 3.43 | Low |
| Procedural Access | 385 | 2.43 | 3.29 | Low |
| Weighted Average | 385 | 2.68 | 2.89 | Low |

*NOTE*: Mean < 3.0 = Low Accessibility; Mean ≥ 3.0 = High Accessibility

Table 1 descriptive analysis of the level of accessibility of reproductive healthcare service available to PWDs in Plateau State. The overall level of accessibility of reproductive healthcare services for PWDs in Plateau State is low, as reflected by the weighted average

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mean of 2.68 (SD = 2.89), which falls below the 3.00 criterion. While information access stands out as the sole domain reaching a high level (mean = 3.72, SD = 0.926), indicating that PWDs adequately receive reproductive health information, the remaining four domains all register critically low scores, with physical access (mean = 2.43, SD = 3.40), attitudinal access (mean = 2.42, SD = 3.41), financial access (mean = 2.41, SD = 3.43), and procedural access (mean = 2.43, SD = 3.29) all falling significantly below the threshold. Consequently, despite adequate information dissemination, reproductive healthcare services remain largely inaccessible overall due to pervasive physical, attitudinal, financial, and procedural barriers.

Table 2

Barriers do Persons with Disabilities Encounter in Accessing Reproductive Healthcare Services

| Variable | N | Mean | SD | Level |
|---|---|---|---|---|
| Physical Barrier | 385 | 3.43 | .761 | High |
| Attitudinal Barrier | 385 | 3.44 | .865 | High |
| Informational Barrier | 385 | 1.43 | 2.19 | Low |
| Financial Barrier | 385 | 3.42 | .894 | High |
| Communication Barrier | 385 | 3.41 | .901 | High |
| Sociocultural Barrier | 385 | 3.44 | .866 | High |
| Weighted Average | 385 | 3.09 | 1.08 | High |

*NOTE*: Mean < 3.0 = Not Significant Barrier; Mean ≥ 3.0 = Significant Barrier

Table 2 is descriptive analysis of the barriers which PWDs encountered in accessing reproductive healthcare services in Plateau State, the overall level of barriers encountered by Persons with Disabilities in accessing reproductive healthcare services is high, as evidenced by the weighted average mean of 3.09 (SD = 1.08), which exceeds the 3.00 threshold for significance. Specifically, five out of the six barrier domains are rated as significant, with physical barriers (mean = 3.43, SD = 0.761), attitudinal barriers (mean = 3.44, SD = 0.865), financial barriers (mean = 3.42, SD = 0.894), communication barriers (mean = 3.41, SD = 0.901), and sociocultural barriers (mean = 3.44, SD = 0.866) all registering high levels that indicate substantial obstacles to care. In contrast, informational barriers stand out as the sole domain rated low (mean = 1.43, SD = 2.19), suggesting that PWDs do not encounter

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significant difficulties in accessing reproductive health information. In summary, while information is readily available, PWDs in Plateau State face pervasive and significant barriers across physical, attitudinal, financial, communication, and sociocultural dimensions, collectively indicating that reproductive healthcare access is severely impeded by multiple systemic challenges.

Hypothesis 1: There is no significant relationship between accessibility of reproductive healthcare services and social inclusion among persons with disabilities in Plateau State.

Table 3

Relationship between Accessibility of Reproductive Healthcare Services and Social Inclusion among PWDs

| Variance | Mean | SD | Df | r | p-value |
|---|---|---|---|---|---|
| Social Inclusion | 74.59 | 14.21 | 384 | .662 | <.002 |
| Accessibility | 75.82 | 14.09 | | | |

Table 3 is Pearson Product Correlation analysis of the relationship between accessibility and social inclusion. The Pearson correlation coefficient ($r = 0.662$, $df = 384$) reveals a moderately strong positive relationship, indicating that PWDs who experience higher accessibility to reproductive healthcare services tend to report substantially greater levels of social inclusion. This association is statistically significant, as the p-value (< .002) falls well below the 0.05 threshold, confirming that the observed relationship is unlikely due to chance. Furthermore, the coefficient of determination ($r^2 \approx 0.438$) suggests that accessibility accounts for approximately 43.8% of the variance in social inclusion scores (mean = 74.59, SD = 14.21), which is a considerable proportion. Given that accessibility (mean = 75.82, SD = 14.09) and social inclusion are closely aligned in their mean values, the findings strongly underscore that improving reproductive healthcare access is meaningfully tied to broader social integration for PWDs in Plateau State. Consequently, Hypothesis 1 is rejected.

Table 4

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Difference in Accessibility of Reproductive Healthcare Services among PWDs by Disability Type

ANOVA

Accessibility of Reproductive Healthcare

| | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | 5501.473 | 5 | 1100.295 | 5.503 | <.002 |
| Within Groups | 75778.516 | 379 | 199.943 | | |
| Total | 76279.990 | 384 | | | |

Table 4 shows A one-way analysis of variance (one-way ANOVA) conducted to analyse differences in reproductive healthcare accessibility among PWDs across five disability types. The results revealed a statistically significant main effect of disability type on accessibility scores, [$F(5,379)=5.503$, $p=.002$, $\eta 2=.07$]. This indicates that accessibility levels vary significantly depending on the type of disability an individual has, accounting for approximately 7% of the total variance in accessibility scores. Consequently, the Hypothesis 2 is rejected.

Table 5

Difference in Accessibility of Reproductive Healthcare Services among PWDs by Gender

| Gender | n | Mean | SD | df | t | p-value |
|---|---|---|---|---|---|---|
| Male | 128 | 49.09 | 13.97 | 385 | .474 | >.634 |
| Female | 257 | 49.84 | 14.62 | | | |

Table 5 is the independent samples t-test conducted to compare reproductive healthcare accessibility scores between male and female PWDs. The results revealed no statistically significant difference between males (mean = 49.09, SD = 13.97, n = 128) and females (mean = 49.84, SD = 14.62, n = 257), $t(385) = 0.474$, $p = .634$ (two-tailed). Since the p-value substantially exceeds the conventional significance threshold of .05, the null hypothesis of no gender-based difference is retained. Although female participants reported a marginally higher mean accessibility score compared to their male counterparts, this observed difference is negligible and likely attributable to sampling variability rather than a genuine gender

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effect. The effect size, not reported in the table, would likely be trivial given the extremely small t-value. These findings indicate that reproductive healthcare accessibility among PWDs in Plateau State does not significantly vary by gender. Therefore, Hypothesis 3 is retained.

An overall low accessibility level was established in this study (weighted mean=2.68), with physical, attitudinal, financial, and procedural domains critically below 3.00 threshold, while information access alone was high (mean = 3.72). This finding corroborates Azubuike et al. (2025), who noted systemic structural exclusion of PWDs from mainstream health programmes. Usman et al. (2025) also highlighted that a lack of disability-compliant infrastructure and provider sensitivity are crucial factors affecting reproductive healthcare accessibility of PWDs. Brace et al. (2025) confirmed global physical entry barriers and discriminatory attitudes experienced by PWDs. Biggs et al. (2023) established that PWDs are less likely to receive required examinations. Thus, despite adequate information dissemination, infrastructural and attitudinal deficits render reproductive healthcare services largely inaccessible to PWDs.

The weighted average of barriers was high (mean = 3.09), with physical, attitudinal, financial, communication, and sociocultural barriers all exceeding 3.00 threshold but informational barriers were low (mean = 1.43). Usman et al. (2025) lend credence to this finding when it was emphasized that PWDs face considerable obstacles, with stakeholders often prioritizing other issues over sexual health. Bolarinwa et al. (2025) also identified cultural conceptions and labeling PWDs as "asexual," fostering sociocultural barriers. Yunusa et al. (2025) reported major unmet family planning needs due to these factors. Smeltzer et al. (2025) attributed these inequities to pervasive ableism within healthcare, confirming that structural and attitudinal obstacles remain the primary gatekeepers to care.

A moderately strong positive correlation emerged between accessibility and social inclusion ($r=0.662$, $p<.002$), explaining 43.8% of variance in inclusion scores. This finding is supported by Azubuike et al. (2025) who argued that when PWDs obtain reproductive services, they are empowered to engage more fully in social and economic life, while exclusion fosters marginalization. Smeltzer et al. (2025) linked health inequities to ableism, which undermines social participation. Kondrath et al. (2024) described social exclusion as institutional betrayal in which healthcare systems fail PWDs and erode their sense of societal

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belonging. Akande (2024b) emphasized that equitable healthcare builds agency, confirming reproductive access as a fundamental driver of broader social integration.

Disability type significantly influenced accessibility scores [$F(5,379)=5.503$, $p=.002$, $\eta^2=.07$]. this finding aligns with Biggs et al. (2023) who reported that satisfaction varies widely across disability categories due to differing needs. The present study echoes results from the study by Rade et al., (2023) which indicated that in Ethiopia there was an association between disability type and utilization of sexual and reproductive health services, with only 38% of women with disabilities using sexual and reproductive health services. Usman et al. (2025) later highlighted that individuals with psychosocial disabilities face unique marginalization by families and caregivers. Brace et al. (2025) emphasized that facility infrastructure disproportionately affects those with physical impairments. Ven et al. (2026) emphasised that provider awareness regarding special requirements is often lacking for sensory and cognitive groups. The significant ANOVA confirms that a one-size-fits-all approach is ineffective, as each disability type presents distinct access challenges.

Gender did not significantly influence accessibility scores (males: mean=49.09, females: mean =49.84; $t(385)=0.474$, $p=.634$). This finding hoever contrasts with literature emphasizing female vulnerability, such as Bolarinwa et al. (2025), who documented double-marginalization of women with disabilities. Similarly, Ven et al. (2026) reported inferior maternity care experiences for women due to provider ignorance. Yunusa et al. (2025) also negates this finding as it was found major unmet family planning needs specifically among women. However, the empirical data suggests that in Plateau State, systemic barriers are so pervasive that they affect male and female PWDs equally. This indicates that disability status itself, rather than gender, is the predominant determinant of healthcare exclusion in this context.

## Conclusion & Policy Implications or Recommendations

This empirical investigation shows and proves that reproductive healthcare accessibility for PWDs in Plateau State is critically deficient. Despite adequate information dissemination, there are pervasive physical, attitudinal, financial, procedural, communication, and sociocultural barriers which systematically limited service utilization. The weighted average

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accessibility score (mean = 2.68) confirms systemic exclusion, with five of six barrier domains rated high. Thisreflects a healthcare environment largely unresponsive to disability needs. This exclusion has profound implications, as the moderately strong positive correlation (r = 0.662) confirms that restricted reproductive access directly reinforces marginalization and limits social participation. This situation traps PWDs in a cycle of poverty and exclusion. Notably, the significant variation across disability types ($p < .002$) underscores the inadequacy of uniform service models, while the absence of gender disparity reveals that structural ableism in Plateau's health system transcends sex.

The following recommendations are necessary in view of the conclusion of the study:

1. There is need for Plateau State Ministry of Health to restructure all public reproductive health facilities across the three senatorial zones in Plateau. They should be restructured to accommodate ramps, accessible toilets, adjustable examination beds, and clear signage to eliminate pervasive physical barriers. This will help to make health facility in the state accessible to PWDs.
2. Efforts must be made by Plateau State Ministry of Health and Plateau State Hospital Management Board to put in place mandatory capacity-building programmes for all healthcare staff in Plateau State. This should be on disability etiquette, respectful communication, sign language basics, and unbiased care to dismantle attitudinal and communication barriers. This will reduce communication and attitudinal barriers which PWDs confront in their quest to access healthcare services.
3. Plateau State Hospital Management Board should to provide reproductive healthcare access for PWDs. This should include Braille/large-print materials for visually impaired, simplified consent forms for cognitive disabilities, and dedicated interpreters for deaf patients, to address the significant variation in accessibility across disability groups.
4. Implementation of fee waivers, expanded health insurance coverage, and subsidized transport vouchers for all PWDs in Plateau State is germane. This should be done regardless of gender to overcome severe financial and procedural barriers, while leveraging the existing high information access to promote service uptake. This is necessary for ease of accessibility to healthcare service for PWDs.

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