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Research Paper

Improving access to quality healthcare and promoting a patient-centric approach for "women with disabilities" in Bangladesh: insights from a qualitative study

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ABSTRACT

Healthcare services in Bangladesh remain non-inclusive despite policy initiatives, thereby compromising equity and the rights of Woman with disabilities (WWDs). This study explores the contextual barriers faced by WWDs in accessing quality healthcare in Bangladesh and advocates for a patient-centric approach to develop disability-friendly healthcare infrastructure. A qualitative research design was employed with a total of thirty in-depth interviews and a focus group discussion. Levesque's framework was used which provided a systematic lens to consolidate the findings under a single theme related to structural, socio-economic, attitudinal, and regional barriers. This framework guided to gather recommendations from WWDs for building disability-friendly infrastructure. It also helped obtain suggestions that reflect a grounded understanding from their perspectives and lived experiences. The findings revealed two major themes: (1) Layered barriers to access and inclusion; and (2) Recommendations for disability-friendly healthcare infrastructure. Participants emphasized the importance of a patient-centric approach, involving them in accessible healthcare planning and systemic design by addressing existing barriers and adopting universal design principles. WWDs highlighted the need for disability-inclusive training for healthcare professionals and the provision of assistive services, which could revitalize healthcare spaces and make them more inclusive and accessible for people of all abilities. Healthcare reform is critical to ensure that PWDs can access inclusive and equitable care.

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1. INTRODUCTION

Despite being the largest minority in the world, Persons with disabilities (PWDs) remain at the margins of society. The world report on disability estimates that around 15% of PWDs live in low-and middle-income countries (LMICs) [1], [2]. Public health programs must incorporate their needs and ensure access to quality healthcare [1]. This demography is rising because of aging, chronic diseases, dietary changes, substance use, natural disasters, armed conflicts, road accidents and other incidents [1]. Moreover, diagnosis and detection of disabilities have been improved due to technological advancement which is contributing to higher prevalence rate that once was unnoticed [3]. Hence, increasing survival from birth defects, road accidents, and premature births has also raised the number of people living with disabilities [3]. Enhanced life expectancy and advancements in medical field permit better strategies for coping age-related chronic illnesses and mobility-related disabilities [3].

Women with visual impairments face difficulties in navigating the hospital and those with hearing impairments struggle with notifications when called [1]. Infrastructural limitations include narrow doorways, non-adjustable exam tables, inadequate restroom and spacious lavatory facilities, elevators too small to accommodate wheelchairs [1]. Traveling to healthcare facilities are costly requiring accompany which is sometimes burdensome for rural PWDs [1].

Women with hearing impairment reported that absence of sign language in many hospitals obstructs their accessibility. Many perceived the quality of care in public hospitals is lower than in private facilities [1], [4]. PWDs often live in low-income households and unable to bear expensive medications [4], [5], [6]. Healthcare providers should recognize the socio-economic barriers faced by PWDs and acknowledge their unique needs [1], [7], [6]. Inaccessible medical equipment, transportation, buildings, lack of internet access, assistive tools, and the absence of disability-specific clinical guidelines negatively impact reproductive healthcare access for WWDs [7], [8], [9].

These aspects signify the growing needs of this demographic. In this qualitative study, the researcher aimed to explore the healthcare experiences of women with disabilities and understand the barriers they face in accessing quality healthcare in Bangladesh.

2. RELATED WORK

The Bangladesh Bureau of Statistics (BBS) reports the prevalence of PWDs at 9.7% that represents around 3.4 million people [3], [4]. Earlier reports highlighted a prevalence of 25.5 per 1000 people (2.55%), up from 24.1 per 1000 2021 [3], [4]. The survey in 2022 estimated 11.1% with severe disabilities, 18.8% with complex disabilities and 30.5% moderate disabilities, and 36.2% with partial disabilities [3], [4]. Most common causes were illness (33.5%), genetic/hereditary/natal factors (30.6%), aging (19.5%), road accidents (2.9%), disaster-related accidents and wrong medication treatment (1.6%) and other causes (10.4%) [3], [4]. Multiple disabilities affected 1.02% of the population, followed by physical mobility disabilities (0.64%) and vision-related disabilities (0.27%) [3], [4].

Age-specific prevalence increased rapidly among younger age groups: 7% per thousand in ages 0-4 years, 12.8% for ages 5-9 and 15.3% for ages 10-14, before declining in ages 15-24 and rising again from 25-29, continuing into older age groups (65+) [3], [4]. Limited life opportunities due to inadequate public health services, constricted education and unemployment makes their lives difficult, moreover, there are differences in prevalence rate regionally; Mymensingh reported the highest prevalence (30.3 per thousand), followed by Rajshahi (28.6), while Sylhet (21.3) and Dhaka (23.2) reported lower rates [3], [4]. Studies show that stigma and discrimination further restrict healthcare access of PWDs.

Higher accessibility was observed in Chittagong and Sylhet divisions, likely for the better resource allocation, infrastructure, cost-effective services, professional availability and attentive care [3]. A survey indicated that one in four PWDs could not access emergency healthcare within three months; because of healthcare costs (52.10%), lack of family support (27%), and absence of nearby facilities [3]. Among those who received care, 26.49% attended public hospitals, 20.52% consulted traditional village practitioners, and 19.87% accessed private healthcare centers [3]. Healthcare facilities in Bangladesh are not accessible

or disability-friendly. Often they are overcrowded involving long waiting periods, with limited doctor-patient consultation time for an unequal patient-to-provider ratio [3]. Moreover, the healthcare system largely follows a need-based model rather than a preventive care model, which places additional strain on PWDs, especially, women with disabilities (WWDs) who may require long-term medical support [1], [2], [3].

A study across 16 districts revealed that most healthcare facilities in Bangladesh are not inclusive, approximately 59.1% of PWDs reported unsatisfactory experiences concerning access to healthcare related information and communication with healthcare professionals [5]. Focal areas for establishing disability-friendly include accessible communication and information, access to healthcare facilities, inclusive infrastructure and ethical training of healthcare workers. For instance, national guidelines in Ireland and Malaysia implemented such measures to ensure equitable services for PWDs [5].

Due to the intersection of disability and gender, poverty and class struggles, WWDs face double marginalization. A systematic review on WWDs' reproductive healthcare indicated that women experienced discrimination, stigmatized behavior, advised against pregnancy and faced discomfort discussing reproductive health with providers [1], [2]. Challenges in public healthcare in LMICs include negative attitudes from health professionals and society, communication challenges, inaccessible facilities, inadequate knowledge and training of providers on disability, lack of accessible transportation, unnecessary referrals, poverty, high treatment costs and risks such as gender-based violence [1], [2]. Studies in Bangladesh documented institutional abuse and gender-based violence against women with disabilities [6].

Transportation is a critical barrier in developing countries and demoralizing for PWDs. Easy access to transport encourages them to attend healthcare facilities for consultations and follow-up sessions, whereas long travel distance often prevents them from seeking care [7], [8]. Interactions with healthcare staff are equally important, negligence, humiliation, and poor communication skills among nurses and support staff discourage WWDs from seeking care [7], [9]. Communication barriers includes lack of pictorial and braille information, sign languages and hearing aids, further constricts access [5]. A study in Kurigram district has reported high levels of dissatisfaction with existing disability care for insufficient healthcare services [10]. Similarly, a cross-sectional study on women with physical disabilities found that 78.3% experienced healthcare expenses as a barrier in accessing reproductive health services [11].

This study explored socio-economic, attitudinal, and infrastructural barriers faced by women with disabilities while accessing quality healthcare in Bangladesh. They face multilayered barriers in accessing healthcare services because of the infrastructural disadvantages, poor health system management, financial crisis and socio-cultural disadvantages. Through, this study the researcher attempted to understand the underlying causes for such conditions through emic views of WWDs; utilizing the acquired suggestions from the participants to build a patient-centric model.

3. METHODOLOGY

This is a qualitative study, conducted in Dhaka, Bangladesh; that included thirty in-depth interviews and a focus group discussion (FGD). Qualitative method with an interpretative lens best fitted to explore the lived experiences of women with disabilities (WWDs) while navigating the healthcare services in Bangladesh. The inclusion criteria were women with disabilities residing in Dhaka city for study purpose and medical issues, many of whom had migrated from rural areas for educational purposes, health issues and exclusionary causes because of mistreatment from family and later abandoned in the shelter homes. Purposive network sampling method was used to recruit the participants by contacting initially the student activists of the disability organizations active in the universities who provided a list of disabled students Women with visual and physical impairment were included as others with different impairments were not available in the selected institutions.

Open-ended interviews were conducted lasting approximately for two hours each in Bengali following informed verbal consent in their preferred locations. Later, those were transcribed verbatim into English professionally. The interview guide covered ethical concerns read aloud to them prior the study.

Other sections included participant's socio-demographic information, barriers to healthcare access, experiences of stigma and discrimination, and recommendations for the improvement of healthcare services and infrastructure. The FGD consisted of 6 participants lasting three hours. All sessions were audio-recorded with their permission. A pilot study was conducted before data collection to refine the research tools. Later the involved participants were excluded from the main sample.

Data collection phase sustained until thematic saturation and adhered to Denzin's critical qualitative inquiry [12], besides COREQ guidelines were followed foe qualitative reporting. Anonymity and confidentiality were maintained and all the participants were labeled with unique identification numbers. Pseudonyms were used in stating narratives. Data were secured in an encrypted file with only author access that will be erased after five years span from the study. Preliminary findings were discussed with the participants to ensure data accuracy.

Qualitative narrative analysis was used to identify patterns and recurring themes through an open coding system from which emergent themes thrived. All the interviews were digitally recorded with the informed consent, transcribed professionally and translated to English from Bengali. Data were ensured consistency and accuracy by reviewing, cross checking and triangulating to maintain reliability and credibility. Inductive method was implied for the derivation of the themes and interpretative lens was employed to analyze the varied lived experiences of women with disabilities. I repeatedly read and reread the transcripts, summarized key observations and recognized recurring patterns. Core themes, interconnected themes and subthemes were identified by connecting them to Levesque patient-centered accessibility framework [13].

Themes were further refined through iterative probing. The coding process is presented in Table 1 and Table 3 of the findings section.

Table 1. Core Theme, Interconnected Themes and Subthemes

Core Theme	Interconnected Themes	Subthemes
Layered Barriers to Access and Inclusion	Social Barriers	• Superstitious beliefs accentuating delay in neonatal and prenatal healthcare. • Vulnerability due to, stigmatization in accessing reproductive healthcare
	Financial Barriers	• Lack of resources and alienation • Promoting costly medications & healthcare provider's bias
	Attitudinal Barriers	• Discriminatory practices in healthcare • Lack of patient-centred communication

For the focus group discussions, independent open coding was initially carried out, later related quotations were clustered. These preliminary codes were then refined, organized and integrated into broader categories and overarching themes. To enhance data reliability and minimize bias, triangulation was employed by corroborating information across multiple sources.

4. RESULTS AND DISCUSSION

As shown in the Table 2, the total number of the participants were 30 (n=30), among which 3 participants were between age range 15-20, 10 participants were between age range 26-30. The highest proportion of the sample around 17(56.67%) participants fell under the age range 21-25; who happen to be undergraduate students studying and residing in various residential halls of Dhaka city. 10 participants (33.33%) were also studying in post-graduate levels at various institutions.5 participants living in the shelter house were illiterate aged between 26-30, and 3 participants reported to be aged between 15-20 studying at intermediate levels. 5 participants stated they were married, 2 of them had children, and

majority of them around 93.33% said they had no children, as 25(83.33%) of them were then single and the other married participants around 3(10%) reported not having a child.

Table 2. Demographic Characteristics

Variable	Number (n=30)	Percent
Age		
15-20	3	10 %
21-25	17	56.67 %
26-30	10	33.33 %
Gender		
Female	30	100%
Level of Education		
Illiterate	5	16.67%
Intermediate	3	10%
Undergraduate	14	46.67%
Post-Graduate	8	26.67%
Relationship Status		
Single	25	83.33%
Married	5	16.67%
Children		
No Children	28	93.33%
With a Child	02	6.67%

Several sub themes emerged under the first broad theme, capturing participants' experiences regarding the healthcare needs, challenges, and barriers to accessing healthcare services. The final broad theme showcases the suggestions provided by PWDs to improve access and inclusivity for quality healthcare experiences. These themes are described in detail in the following sections.

4.1. Layered Barriers to Access and Inclusion

Multiple barriers were found where women with disabilities (WWDs) had to face accessing quality healthcare in Bangladesh. As shown in the Table 3, the recurring themes were arranged in accordance with Levesque's Model of Healthcare Access [13]. The author categorized the findings through the five dimensions from the supply side (Approachability, Affordability, Acceptability, Availability, and Appropriateness) and their corresponding patient abilities from demand sides (Ability to perceive, seek, reach, and pay, engage). Here, WWD's ability to perceive is related to approachability, to seek is to acceptability, to reach is to availability, to pay is to affordability and to engage is to appropriateness.

Approachability means that PWDs can identify their health concerns and is aware of the whereabouts of the healthcare, Acceptability refers to respectful treatment and socio-culturally appropriate healthcare services provided, Availability is the existence of comfortable transport options, appointment system and client satisfaction, Affordability is the financial capacity to adopt a treatment plan, Appropriateness refers to the quality of care given to WWDs. Later, these findings have been consolidated into a singular theme. The social, attitudinal, and financial barriers are discussed within this theme.

Table 3, shows the conceptual framework used to identify the relationship with the findings with the theoretical model.

Table 3. Linking Inter-Related Themes with Levesque's Healthcare Model

⇩ → Approachability Ability to perceive	Social Barriers ⇩

	▪ Superstitious beliefs accentuating delay in neonatal and prenatal healthcare ▪ Vulnerability due to stigmatization in accessing reproductive healthcare
Affordability Ability to pay	Financial Barriers ▪ Lack of resources and alienation ▪ Promoting costly medications
Availability Ability to reach	Social and Financial Barriers ▪ Rural-Urban disparities and infrastructural gaps
Appropriateness Ability to engage	Attitudinal Barriers ▪ Discriminatory practices in healthcare ▪ Lack of patient-centred communication
Acceptability Ability to perceive	Social & Attitudinal Barriers ▪ Vulnerability due to stigmatization in accessing reproductive healthcare ▪ Discriminatory practices in healthcare ▪ Lack of patient-centred communication

Besides, Figure 1 represents the Barriers in accessing healthcare for women with disabilities and links ups the facts in a diagram.

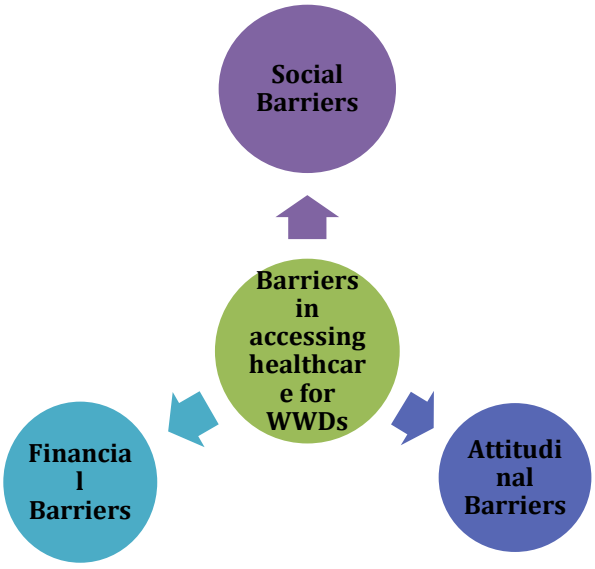

Figure 1.Barriers in Accessing Healthcare

4.2. Social Barriers in Accessing Healthcare

As shown in the Table 3, the first inter-related theme discusses about the social constructs, misbeliefs, norms and myths creating barriers in accessing healthcare for WWDs, especially, for those who are marginalized and belong to disadvantaged backgrounds living in remote rural areas of Bangladesh. These constructs obstruct their various healthcare needs and emergencies, also imposes financial constraints on them, further alienating them. WWDs are the most vulnerable ones suffering quietly for limited accessibility to quality healthcare options.

4.2.1. Superstitious Beliefs Accentuating Delay in Neonatal and Prenatal Healthcare

In Bangladesh, there are some superstitious beliefs prevalent in the rural areas that prevent many people from accessing quality healthcare, especially, neonatal and prenatal related reproductive healthcare. Women and children with disabilities are even doubly marginalized and vulnerable in seeking for healthcare, for the intersection of gender, socio-economic status and disability. One participant from the shelter home voiced her struggles during pregnancy.

"In urban areas, people speculate less about our disability, but in rural communities many myths persist," she explained. She described beliefs that chewing uncooked rice during pregnancy, engaging in intercourse during menstruation, or failing to maintain 'Parda/Cover' could result in a child with a disability, sometimes attributed to the influence of unseen spirits (Jinn). After the birth of her son with visual impairment, neighbors spread rumors rooted in these superstitions. Her husband and in-laws got influenced by such beliefs later refused her from seeking medical help, denied her access to providers and further screening.

Another participant with visual impairment from the shelter home recounted her painful memory of giving birth alone with no help from her husband's side family.

"I married my cousin, who had no disability—it was my biggest mistake," Mihrima (24, visually impaired) reflected. In her village, consanguineous marriage was stigmatized as a cause of inherited disease and "Bad Karma," and she was repeatedly told she would bear a disabled child. These accusations strained her marriage that eventually lead to abandonment by her husband during and after the pregnancy. Financially unstable and without any support, she couldn't afford any medical care though she gave birth to a healthy baby girl with the help of a neighbor.

These narrative indicates that superstitious myths and misbeliefs are widely spread in the remote regions of Bangladesh that mostly affect PWD's access to healthcare. They are most often excluded because of the societal constructs that inhibits them from seeking healthcare, very few people are conscious enough to take their financial responsibility for them to attend facility centers or accompany them to cost-free public medical centers.

4.2.2. Vulnerability due to stigmatization in accessing reproductive healthcare

During a one to one interview with a participant with physical impairment shared her experience. She was facing some reproductive health issue, but she couldn't discuss it immediately with anyone. When she tried confiding in friends they mocked her. So, she sought solutions online and wanted to see a doctor, but no one came forward to escort her to the facility center.

"Usually people do not talk about sexual and reproductive health. Women with disabilities cannot speak up because others disregard our feelings. If we share, we are mocked. This is a very sensitive and confidential matter, and there are some limits we cannot breach." - (Sabina, 21, physically impaired woman)

This aspect shows how vulnerability is reproduced in women with disabilities' lives by perpetuating stigma. Many of them suffer from reproductive health issues yet they remain unaware as they were silenced early for facing judgments of family members and people close to them, later from the broader society.

4.3. Financial Barriers in accessing healthcare

As shown in the Table 3, the second inter-related theme is connected to the first theme. Social barriers lead to economic hardships and financial blockages making PWDs more vulnerable and helpless.

Moreover, mismanagement in healthcare system and fragile infrastructure compounds their distress discouraging them from seeking healthcare. The following sub-themes discusses the drawbacks and anomalies in the healthcare system discussed by the participants.

4.3.1. Lack of resources and alienation

Some public sector physicians prioritize their private practices, making them unavailable to respond promptly to medical emergencies within government-operated facilities. Insights gleaned from participants have yielded significant findings that can provide valuable statements to improve awareness. One participant voiced her difficulty in accessing healthcare struggling with financial constraint, she was left all alone by herself as her father abandoned in childhood for her visual impairment, her mother remarried, and her maternal grandparents were incapable of taking care of her, so she did not have anyone to rely for medical treatments.

Whenever I face any health concerns I go to govt. hospitals which are cost free, but not often do I get to manage to complete treatment. Most often I stay silent if I am sick because I don't want to burden anyone with my ailments. (Akhira, a 21-year-old woman with visual impairment) This narrative reveals how WWDs from socio-economically disadvantaged background are suffering socio-economically.

4.3.2. Promoting costly medications

Sometimes, they cannot afford to buy proper medication because of the high cost, economic liabilities and poor socio-economic conditions. Medical practitioners have been known to promote their private practices and prescribe expensive medications despite knowing the financial strain it may place on patients. This behavior may be driven by financial incentives as pharmaceutical company representatives often monitor government doctors' prescription practices to ensure their products are recommended. Doctors may receive financial incentives from these companies, leading them to exploit the vulnerability of underprivileged patients. Consequently, patients may have no option but to purchase the high-priced medications without further questioning.

In this regard, a respondent with physical impairment commented, Sometimes doctors suggest that we visit their private clinics and they prescribe expensive medications, even though they know we cannot afford them. They do this for their own financial benefits as pharmaceutical company representatives wait outside government doctors' offices to check if the doctors are prescribing their products. (Lata, a 21-year-old physically impaired woman)

This narrative show how the discriminatory practices in the healthcare centers shapes the landscape of medical treatment in Bangladesh, especially in public healthcare spaces.

4.4. Attitudinal Barriers in Accessing Healthcare

Attitudinal barriers unlike structural barriers such as distance, cost, and accessibility are rooted internally- in mindsets, behavior, cultural norms and prejudices. In healthcare it refers to the stereotypical beliefs, negative perceptions or biased behaviors held by community and healthcare providers including the professionals and stuffs, impacting the access and inclusion overall.

This theme illustrates about the behavioral patterns and attitudinal barriers participants faced in Bangladesh that recessed inclusivity and quality in healthcare.

4.4.1. Biased practices in healthcare

One participant noted: Insights gleaned from the focus group discussions signify that healthcare professionals often embody biases against WWDs.

"A common scenario in government hospitals is healthcare providers; kind of prioritize referred patients than those waiting in the line. Lobbying is frequently used to secure an early spot, so the marginalized ones remains at the mercy."

Such preferential behavior emotionally strains women with disabilities, discouraging them from seeking treatment or using conventional healthcare facilities. In many public hospitals, health assistants, nurses, and physicians' aides favor patients offering financial incentives, reinforcing a system that privileges

the well-connected. The narrative reflects the effect of preferential treatment based on social capital and connection. We have observed throughout our study that, bribing and using referral connections to skip the que is a common practice in many public healthcare facility centers. This also reveals the loopholes in the system and showcases systematic corruption in the healthcare spaces.

4.4.2. Lack of patient-centered communication

Discussions with the participants reflected that attentiveness of healthcare providers is therapeutic, if consultations are rushed and quality time is not provided, then patients have negative feelings. One participant shared her frustration, if the doctors listen to the patients attentively with time, then the patient thinks that she is cured fifty percent already. And, if the doctor does not pay any attention, the patient feels hopeless. Doctors in our country barely gives us ample time or explains anything in details. (Raidah, a 21-year-old woman with visual impairment)

This narrative reflects PWDs are treated just as same as others, not taken extra care or given any extensive attention while they are most in dire need of attentive care requiring patience and empathic ability to understand their special needs. Unfortunately, we have observed that the public health infrastructure lacks these features in Bangladesh. Another participant in FGD stated, Doctor-patient relationship should be patient-centric but unfortunately in our country, it is commercial and based on profits. (Toma, a 22-year-old visually impaired woman)

4.5. Recommendations for Disability-Friendly Infrastructure in Healthcare

The participants have also advocated for the inclusion of disability-friendly features in healthcare facilities. They stressed the need for a healthcare infrastructure that is accessible to PWDs, complete with braille signage for persons with visual impairment, assistive tools and handrails along with the walls to aid people in finding their way to the doctor's chamber on their own or have a person assigned skilled in sign language for people with hearing impairment. They gave the opinion that the entrance and restrooms need to be free of steps or obstacles to allow individuals with disabilities to move around easily. Furthermore, clearly marked indented tiles or pathways can help guide people with disabilities throughout the hospital.

During emergency in Bangladesh, the ambulances lack accessible features. The untidy and unadjusted condition of restrooms impose serious health risks. Such narrow spatial arrangements pose considerable challenges for WWDs and those with physical limitations. Moreover, the shortage of necessary medical equipment is another problem both in rural and semi-urban healthcare spaces. Consequently, people with disabilities are devoid of high-quality healthcare facilities and services of specialized medical professionals.

This study signified the urgency for developing a disability-friendly healthcare infrastructure designed to accommodate the special needs of WWDs. The participants involved in the study, advocated for unique solutions to minimize the challenges they face because of non-inclusive spatial designs such as a dedicated medical aid helpline tailored to PWDs may help them overcome their hesitation to consult with the healthcare providers and get information as well as medical advice whenever they need. A ‘disability card’ may come as useful that would help others to acknowledge their condition and give them early access to the doctors, medical tests and reports. They have also suggested for braille packaging in medication packaging for visually impaired persons, that would encourage independent medication intake within them with no doubt or codependence.

FGD findings highlight that WWD hope for an inclusive healthcare system that would incorporate their voices and embody their lived experiences with informed policy design and practical implications [14]. The participants advocated for assertive attitude, patient-centric care and disability inclusive infrastructure development and overall healthcare alterations to enable inclusivity. As similar instances of infrastructural inadequacies are observed in South Asian contexts unable to accommodate diverse disability special care needs [2], [8], [15]. PWDs can be co-designer and co-creator of an assertive and inclusive healthcare system in Bangladesh. Hence, adopting a patient-centric approach is a must.

It emphasizes on the holistic participation of patients in decision-making process that is essential for improving the healthcare system for people of all abilities [16]. The commodification of healthcare directs

attention from patient welfare to profit generating mechanisms and strategies. The qualitative findings in this study points out that quality healthcare for WWDs is impossible without accommodating overall infrastructural changes, socio-cultural and informational modifications and behavior changing communication module can impact in changing the attitudinal issues of the healthcare providers and those related with PWDs. Simply, the availability of services does not ensure effective care. Here, Figure 2 shows the recommendations by the WWDs in a flowchart:

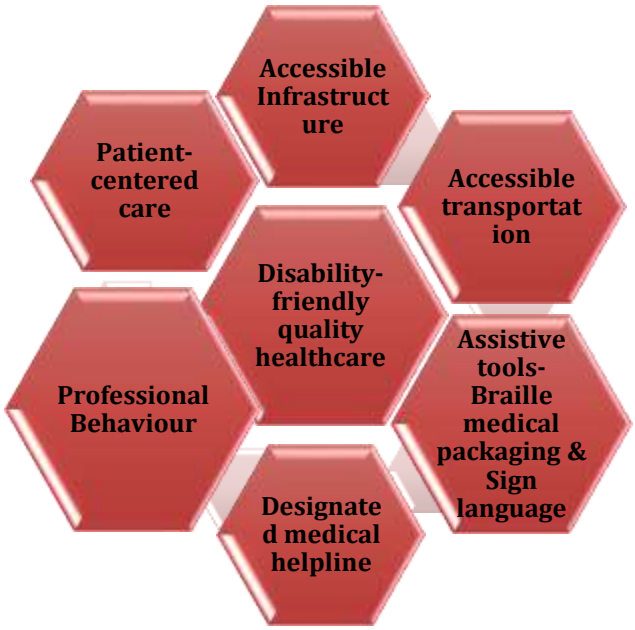

Figure 2. Disability-Inclusive Framework

Figure 2, outlines the disability inclusive framework related to the disability-friendly healthcare system suggested by the participants.

During the FGDs and IDIs, participants expressed their dissatisfaction on the systemic barriers and mentioned cases of referral connections affecting equal access in healthcare. They had to wait for longer period, accept the discriminatory behavior from the healthcare professionals. Bourdieu's framework of capital can be brought into this aspect to understand the situation from a sociological standpoint.

Physicians and healthcare institutions often holds economic and symbolic capital- the financial resources and social authority over the patients that permits them to affect patient experiences and healthcare deliverance which may not always align with the patient's best interests [17]. Patients from lower socio-economic backgrounds lack equal forms of capitals to negotiate their healthcare effectively accentuating structural inequalities in accessing quality treatment. Over time, such passive aggression practices in the healthcare sector discourages the patients and lessen their willingness to opt for medical advice. Global initiatives emphasized over the issue of training the healthcare professionals efficiently on humanitarian grounds. Bangladesh has signed these protocols yet failed to practically implement these all over the medical system [18], [19], [20].

So, participants in this study reinforced on the utility of communicative training on disability. Only a paradigm shift towards patient-centric care in Bangladesh could bring systemic reforms that would strengthen regulation in medical field and social spaces. The healthcare system can prioritize patient's need over profit generating mechanisms and strengthen doctor-patient relationship and improvise the overall public health sector.

5. CONCLUSION

Quality of health is inherently related to access and accessibility, especially for women with disabilities. Simply the availability of healthcare options and services can't ensure quality healthcare to this demography. Structural, cultural, financial and social transformation can bring the expected outcomes. If the social barriers remain unacknowledged, then the stigma perpetuates and the negative attitudinal determinants in the society increases substantially. It is important to recognize them and disseminate positive messages through disability education. To ensure disability friendly healthcare in Bangladesh- a patient centric model co-created by the people with disabilities, that emulsifies systemic, socio-cultural and structural reforms should be adopted in all over Bangladesh.

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Author Contribution Statement

Name of Author	C	M	So	Va	Fo	I	R	D	O	E	Vi	Su	P	Fu
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C : **C**onceptualization
M : **M**ethodology
So : **So**ftware
Va : **Va**lidation
Fo : **Fo**rmal analysis
I : **I**nvestigation
R : **R**esources
D : **D**ata Curation
O : Writing - **O**riginal Draft
E : Writing - Review & **E**diting
Vi : **Vi**sualization
Su : **Su**pervision
P : **P**roject administration
Fu : **Fu**nding acquisition

Conflict of Interest Statement

This is a single handedly written paper, so, the author declares no conflict of interests.

Informed Consent

Informed consent was obtained from all participants after explaining the study objectives, procedures, and their right to withdraw at any time.

Ethical Approval

The study was approved by the Academic committee of the Department of Sociology, Faculty of Social Sciences, University of Dhaka, Bangladesh (Approval no. Soc/AC 11.01.2023).

Data Availability

Data can be availed at reasonable request from the author.

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