

Barriers, Coping Strategies and Institutional Constraints Shaping Healthcare Access for People with Disabilities under Nigeria's Basic Health Care Provision Fund: A Qualitative Study from Bauchi State, Nigeria

Mahmud Abdullahi

mahmud.abdullahi@fuhsa.edu.ng

Nasarawa State University <https://orcid.org/0009-0005-9535-7137>

Akyala Ishaku Adamu

Nasarawa State University

Yakubu Boyi Ngwai

Nasarawa State University

Sakina Hamza Soye

Nasarawa State University

Research Article

Keywords: disability inclusion, health financing, primary health care, Nigeria, qualitative research, access barriers

Posted Date: September 11th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-10984517/v1>

License:   This work is licensed under a Creative Commons Attribution 4.0 International License.

[Read Full License](#)

Additional Declarations: The authors declare no competing interests.

Abstract

Background: Nigeria's Basic Health Care Provision Fund (BHCPF) is the country's flagship primary health care financing reform, framed around equity and prioritisation of vulnerable populations. Little empirical attention has been paid to whether people with disabilities experience this reform as inclusive, or to the institutional factors shaping their access.

Objective: To explore the lived experiences of people with disabilities accessing BHCPF-supported primary health care in Bauchi State, Nigeria, and to examine institutional and systemic factors shaping their inclusion or exclusion.

Methods: A qualitative, interpretive study using 25 in-depth interviews with people with disabilities in Bauchi State. Data were analysed using inductive-deductive thematic analysis, reported in line with COREQ.

Results: Awareness of BHCPF specifically was low and unevenly distributed. Participants reported persistent cost (56%), physical accessibility (36%) and communication (16%) barriers, and predominantly negative provider attitudes (80%); only 8% felt services consider disability-specific needs. Participants relied on self-medication, traditional remedies, private facilities, and family, community and civil-society support. Institutional analysis identified workforce and pre-service training gaps and an apparent absence of disability-specific monitoring, with informal actors substituting for missing institutional mechanisms.

Conclusion: Despite BHCPF's equity-oriented framing, people with disabilities in Bauchi State experience structurally disadvantaged access. Disability-responsive provider training, explicit accessibility standards, and disability-specific monitoring within BHCPF implementation are needed.

Highlights

- People with disabilities in Bauchi State report low, uneven awareness of BHCPF specifically.
- Cost, distance and communication barriers persist despite BHCPF's equity aims.
- 80% of participants reported negative provider attitudes toward disability.
- Family, community and NGOs informally substitute for missing institutional support.
- Disability-responsive training and monitoring are needed within BHCPF implementation.

1. Introduction

Health systems increasingly frame access to healthcare not merely as a technical or service delivery concern but as a reflection of social justice, human rights and state accountability [1]. Within this discourse, disability inclusion has become a key indicator of whether health systems genuinely respond

to population diversity or continue to reproduce entrenched inequalities. In low- and middle-income countries, people with disabilities remain among the most systematically excluded from healthcare access and utilisation [2, 3], facing financial hardship, physical inaccessibility, negative provider attitudes, communication barriers, and policy designs that fail to recognise disability as a determinant of health.

Nigeria's Basic Health Care Provision Fund (BHCPF), established under the National Health Act of 2014 and subsequently revised as BHCPF 2.0, is the country's principal financing mechanism for strengthening primary health care access, particularly for poor and vulnerable populations [4, 5]. While the Fund's policy discourse identifies vulnerable populations as priority beneficiaries, vulnerability within Nigerian health policy has tended to operate as a broad, loosely defined category, risking the subsumption of disability under general poverty or maternal and child health narratives rather than its explicit articulation as a distinct determinant of access [6, 7].

Existing Nigerian scholarship has documented barriers faced by people with disabilities in accessing healthcare, including physical inaccessibility, discriminatory provider attitudes, limited health information, and financial constraints [8–10]. However, relatively few studies examine these barriers specifically within the context of a large-scale, ongoing health financing reform such as BHCPF, or connect them explicitly to the institutional and governance conditions under which the reform is implemented at subnational level [11]. Evidence also indicates that many Nigerian primary health care facilities lack basic accessibility features and that health workers receive limited disability-inclusive care training [12, 13], yet, the lived experience of navigating BHCPF-funded services specifically, as distinct from the primary health care system in general, remains under-documented.

This study addresses this gap by exploring, first, how people with disabilities in Bauchi State, Nigeria, experience access to and utilisation of BHCPF-funded primary health care services, and second, what institutional, structural and socio-contextual factors shape their inclusion or exclusion within these services.

2. Methods

2.1 Study Design

This study employed a qualitative, interpretive descriptive design, appropriate for exploring meaning, perception and lived experience among a population whose voices remain underrepresented in health policy evaluation. Reporting follows the Consolidated Criteria for Reporting Qualitative Research (COREQ; completed checklist submitted separately).

2.2 Setting and Participants

The study was conducted in Bauchi State, north-eastern Nigeria. Participants were adults self-identifying as people with disabilities, resident in Bauchi State, with experience of interacting with public primary health care facilities. Purposive sampling was used to recruit participants across a range of impairment

types (physical/mobility, Deaf/hearing, and Blind/visual impairment), supported by community networks and a disabled persons' organisation. Sample size was guided by data saturation rather than a predetermined target. The original protocol also planned a key informant interview with a health system stakeholder to provide an institutional perspective; this could not be completed, as no health official or BHCPF implementer could be secured for interview within the study period, and the protocol was revised accordingly. Twenty-five in-depth interviews with people with disabilities were completed. Table 1 summarises participant characteristics.

Table 1: Demographic and Disability Profile of Study Participants (N = 25)

Characteristic	Category	n	%
Interview type	In-depth interview (IDI) with persons with disabilities	25	100.0%
Sex	Male	18	72.0%
	Female	6	24.0%
	Preferred Not to Respond	1	4.0%
Disability type	Physical / mobility impairment	18	72.0%
	Deaf / hearing impairment	3	12.0%
	Blind / visual impairment	3	12.0%
	Not Recorded	1	4.0%
Age	Range: 20-46 years (recorded for 20 of 25 participants)	-	-
	Mean age ≈ 31.8 years	-	-

2.3 Data Collection

Semi-structured interview guides, developed in Hausa and English, explored participants' background and disability, awareness of BHCPF and related programmes, experiences of accessing care, perceptions of disability inclusion in service delivery, coping strategies, and recommendations for improving access. Interviews conducted in Hausa were translated into English, with translations checked against original field notes.

2.4 Data Analysis

Interview data were analysed using inductive-deductive thematic analysis. Initial codes captured recurring ideas, experiences and concerns related to access to BHCPF-supported care, then grouped into broader themes reflecting shared experiences and structural dynamics. Theme frequencies reported

below describe the composition of this sample and are not intended as population-level prevalence estimates.

2.5 Ethical Considerations

Ethical approval was obtained. Participation was voluntary, informed consent was obtained from all participants, and confidentiality was assured; participants are identified in this paper only by anonymised codes (P01-P25). Reasonable accommodations were made to ensure the interview process was accessible.

3. Results

Table 2 summarises the frequency with which major themes were raised across the twenty-five interviews.

Table 2: Frequency of Major Themes Across Participants (N = 25)

Theme	Participants raising theme (n)	% of sample
Cost / affordability barriers	14	56.0%
Negative provider attitudes	20	80.0%
Positive provider attitudes (at least sometimes)	4	16.0%
Physical accessibility / distance barriers	9	36.0%
Communication barriers	4	16.0%
Awareness gained via radio/media/community	13	52.0%
Use of traditional or self-medication	6	24.0%
Reliance on private/paid facilities	9	36.0%
Family / community support	4	16.0%
Role of NGOs / civil society	3	12.0%
Facility, workforce or equipment shortages	4	16.0%
Perceived policy-practice gap	4	16.0%
Recommend staff training on disability	10	40.0%
Recommend free/subsidised care or concessions	4	16.0%
Recommend inclusion of PWDs in policy design	2	8.0%
Recommend dedicated/rehabilitation facilities	2	8.0%
Recommend employment opportunities for PWDs	5	20.0%

Derived from the study's thematic coding framework (Appendix). A participant may be counted under more than one theme.

3.1 Awareness of BHCPF and Primary Health Care-Supported Services

Awareness of BHCPF specifically, as distinct from health services in general, was inconsistent: 10 of 25 participants (40%) reported awareness of government-supported health programmes and 10 of 25 (40%) reported having heard of BHCPF or primary health care-supported services, while several participants who answered affirmatively appeared to be referring to related but distinct schemes.

"No, I am not aware of any." ... "No." (P20, male, hearing impairment, age 36)

"Have not heard of BHCPF, only BASHMA" (P23, male, Blind)

Where awareness was reported, it was most often attributed to radio broadcasts or affiliation with disability advocacy networks:

"Media" (P24, female, physically challenged, age 30)

"Yes, we are aware of the government's health insurance scheme for the poor and vulnerable." (P21).

3.2 Cost and Affordability Barrier

Cost was the most frequently cited barrier to healthcare access, raised by 14 of 25 participants (56%), despite BHCPF's explicit aim of reducing out-of-pocket healthcare costs.

"Medical bills unaffordable; stigmatisation from health personnel" (P25, physically challenged, age 34, Gamawa)

"I don't care" attitudes from medical personnel" ... "Medical bills unaffordable" (P05, male, physically challenged, age 32)

"I have faced difficulty paying for medical treatment." Lack of money, high cost of medicines, and other healthcare-related items. (P21, JONAPWD Secretary)

3.3 Physical Accessibility and Communication Barriers

Physical accessibility and distance to facilities were raised by 9 of 25 participants (36%), while communication barriers were raised by 4 of 25 (16%), concentrated among Deaf and hard-of-hearing participants.

"Distance from home" (P16, physically challenged (due to polio), age 40)

"Absence of a PHC nearby / near my house" (P04, Blind, male, age 37)

The most detailed account of communication exclusion came from a participant with a hearing impairment describing a recent hospital visit:

"My most recent experience at a public health facility was a visit to the Woman and Children Hospital, Railway Road, Bauchi, for a genotype test. There was a communication gap which forced me to communicate with the facility worker in writing." (P20, male, hearing impairment, age 36)

"Lack of a sign language interpreter, which causes a barrier in communication." ... "The communication gap makes facility workers reluctant to give satisfactory feedback, because they need to attend to the next patient without wasting much time." (P20, on the resulting quality of care)

This participant linked the communication gap directly to a sense of exclusion: "Yes, the lack of an interpreter leaves a person with hearing impairment like me at a disadvantage."

3.4 Provider Attitudes

Negative provider attitudes were the most frequently raised theme overall, cited by 20 of 25 participants (80%), though four participants (16%) also noted at least some positive interactions.

"Discrimination due to disability" (P24, female, physically challenged, age 30)

"Negative attitude from some medical personnel" Mostly negative, some tend to be nice (P23, Blind, male)

"Contempt/aversion (kyama)" (P10, physically challenged, age 33)

Only 2 of 25 participants (8%) felt that health services consider the needs of people with disabilities, and only 1 of 25 (4%) felt that facilities are equipped to support different types of disability.

3.5 Perceived Exclusion

Eleven of 25 participants (44%) reported having felt excluded or disadvantaged in a health facility because of their disability. Where exclusion was denied, this was sometimes qualified rather than a straightforward absence of disadvantage:

"I have never been excluded or shown contempt because of my disability." (P21, on whether he had felt excluded)

3.6 Coping Strategies

When formal BHCPF-supported services were difficult to access, participants described self-medication or traditional remedies, private or paid facilities, and support from family, community or civil society organisations.

"We go back home and endure it, or try using traditional remedies." (P21, on what happens when access is difficult)

"Through volunteer doctors." NGOs such as UNICEF, Red Cross, etc. (P22, on volunteer doctors and NGOs such as UNICEF and the Red Cross)

Reliance on private or paid facilities (36% of participants) and on self-medication or traditional medicine (24%) suggests that BHCPF's intended function, reducing out-of-pocket cost as a barrier, is, for a substantial share of participants, being met instead by informal, unregulated alternatives.

3.7 Institutional and Systemic Factors

Facility-level constraints such as shortages of trained personnel, absent primary health care centres within reasonable distance, and lack of appropriate equipment, were raised directly by 4 of 25 participants (16%) and echoed indirectly across many more accounts of long waiting times and poor service quality.

"Lack of trained healthcare personnel" (P04, Blind, male, age 37)

"[Answer given describes challenges rather than how he learned of services:] People with mobility disabilities face a lot of hardship accessing healthcare, including the high cost of care and the lack of specialists in this area, especially at primary healthcare facilities." (P21, JONAPWD Secretary)

"Recommendation: medical personnel should be trained in medical school on how to attend to PWDs in PHCs" (P23, recommending pre-service training reform)

This recommendation was echoed by 10 of 25 participants (40%), the most frequently recommended reform across the sample. Several participants, particularly those with formal advocacy roles, articulated a clear sense of disjuncture between the equity language of national health policy and its translation into practice:

"There are significant gaps in Nigeria's health policies, especially concerning people with mobility disabilities." (P21, JONAPWD Secretary)

"They do not fully meet the need, yet one is compelled to use them." (P21, on whether existing coping alternatives meet participants' needs)

The study's original protocol planned a key informant interview with a health system stakeholder to complement these accounts; this could not be completed, as no health official or BHCPF implementer could be secured for interview within the study period. As a result, the institutional-level findings reported in this section rest entirely on the perceptions and reported experiences of service users rather than on any account from within the health system itself. Participants' observations about staff shortages, facility conditions and apparent absence of accountability mechanisms are valuable evidence of how the system is experienced, but cannot substitute for a supply-side account of why these conditions exist or how they are perceived from within the system.

Where formal institutional support was perceived as absent, family, community networks and non-governmental organisations were repeatedly described as filling the resulting gap:

"Family, friends, organisations of people with disabilities, civil society groups, and other helpers can play an important role in helping a person get information, transportation, medicine costs, or access to support programmes." (P19, physically challenged (full narrative account))

3.8 Participants' Recommendations

Participants' recommendations clustered around five areas: training of healthcare personnel in disability-responsive care (40%); free or subsidised care and fee concessions (16%); dedicated units or rehabilitation centres within facilities (8%); employment opportunities for people with disabilities (20%); and inclusion of people with disabilities in health policy design (8%).

"Free medical care for PWDs; facilities should be accessible; sign language" (P23, male, Blind)

"Developing health policies for people with special needs that would provide free care, or care at a discounted/concessionary price." ... "As a person with a mobility disability, I would like the government to establish a health policy framework addressing mobility disability, and to provide specialised care centres (Rehabilitation Centres) for people with mobility disabilities and others with special needs." (P21, JONAPWD Secretary)

4. Discussion

This study found that people with disabilities in Bauchi State experience access to BHCPF-funded primary health care services as inconsistent, cost-burdened, and frequently marked by negative provider attitudes and unaddressed communication needs, shaped by workforce and training gaps, a perceived policy-practice disjuncture, and reliance on informal family, community and civil society support in place of institutional mechanisms.

These findings align with Aremu and Abiodun's identification of policy gaps and implementation challenges in disability inclusion within Nigerian health policy [10], and with Onalu and Nwafor's [9] and Oyewole's [8] documentation of persistent access barriers, including physical inaccessibility, discriminatory attitudes and financial constraints. This study extends that literature by situating these barriers specifically within the context of an ongoing, high-profile financing reform, showing that BHCPF's equity-oriented framing has not, to date, translated into a markedly different experience for people with disabilities than that documented in the pre-BHCPF literature.

The pattern of barriers identified here also mirrors the wider low- and middle-income country evidence base. The cost, physical accessibility and communication barriers reported by participants correspond closely to those identified in Bright and Kuper's systematic review [14] and in Kuper, Bright and Davey's analysis of access to healthcare for people with disabilities in comparable settings [3], and to the attitudinal and communication barriers identified as near-universal features of disability exclusion in the

World Report on Disability [15]. Several participants' reliance on private, fee-charging alternatives when BHCPF-supported services proved inaccessible resonates with the extra-costs-of-disability literature [16], and with the broader disability-poverty relationship documented elsewhere [2, 17]: formal financial protection intended to reduce cost as a barrier can, in practice, be circumvented by the barriers it fails to address, pushing people with disabilities toward more, rather than less, costly alternatives.

The institutional findings reported here are consistent with prior analysis of accountability mechanisms within the Nigerian health system [11], and with evidence that Nigerian primary health care facilities frequently lack basic accessibility features and that health workers receive limited disability-inclusive care training [12, 13]. Read through the social model of disability, the barriers most frequently reported by participants in this study are environmental and institutional in character which includes, inaccessible facilities, absent sign language provision, and inadequately trained health workers, rather than a function of participants' impairments as such, reinforcing the argument that disability exclusion in health systems is a matter of system design rather than individual limitation. The substitution of family, community and civil society support for missing institutional mechanisms, documented in Section 3.7, illustrates how the absence of formal, enforceable disability-inclusive rules within a financing reform allows responsibility for access to devolve informally rather than being embedded structurally within the health system itself.

The near-unanimous negative assessment of service responsiveness recorded in this study, only 8% of participants felt services consider disability-specific needs, and only 4% felt facilities are adequately equipped, is a striking finding given BHCPF's explicit equity orientation, and suggests that the gap between policy intent and lived experience identified qualitatively here may correspond to gaps at the level of policy design itself; this question is addressed directly in a companion documentary analysis of the BHCPF 2.0 policy document.

4.1 Strengths and Limitations

This study's principal strength is its direct engagement with people with disabilities as primary sources of knowledge about a health financing reform rarely evaluated from their perspective, achieving reasonable diversity across physical/mobility, Deaf/hearing and Blind/visual impairment and continuing data collection to thematic saturation. Limitations include the single-state, purposive sampling design, meaning proportions reported here describe this sample rather than population-level prevalence; the absence of any health-system-staff or policy-implementer interview, since the study's original protocol planned a key informant interview but none could be secured for interview within the study period, meaning institutional-level findings rest entirely on service-user perception rather than an institutional-insider account; and translation of Hausa-language interviews into English, which, despite verification against original field notes, carries some residual risk of nuance loss.

5. Conclusion

Despite BHCPF's explicit equity-oriented objectives, people with disabilities in Bauchi State experience access to BHCPF-funded primary health care services as inconsistent, cost-burdened, and frequently compromised by negative provider attitudes and unaddressed communication needs. In the near-total absence of confidence that services are responsive to disability-specific needs, people with disabilities rely substantially on self-medication, private care, and support from family, community and civil society actors. Addressing this gap requires disability-responsive pre-service training for health workers, explicit and enforced accessibility standards at BHCPF-supported facilities, disability-disaggregated monitoring within BHCPF's accountability architecture, and formal recognition of the role disabled persons' organisations already play informally in supporting access.

Declarations

Ethics approval and consent to participate

Ethical clearance for this study was obtained prior to data collection. All participants provided informed consent, were informed of their right to decline any question or withdraw at any time, and were assured of confidentiality. Reasonable accommodations were made to ensure the consent and interview process was accessible to participants with disabilities.

Consent for publication

Not applicable. No individually identifiable data are reported.

Availability of data and materials

The interview guides, coded thematic framework and de-identified data matrix supporting this study's findings are available from the corresponding author on reasonable request.

Declaration of competing interest

The author declares no competing interests.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

CRediT author statement

Mahmud Abdullahi: Conceptualization, Methodology, Investigation, Formal analysis, Data curation, Writing the original draft, Writing, review & editing, Visualization, Project administration.

Akyala Ishaku Adamu: Supervision, review & editing, Validation.

Yakubu Boyi Ngwai: Supervision, review & editing, Validation.

Acknowledgements

The author thanks all study participants for sharing their experiences, and the Joint National Association of Persons with Disabilities (JONAPWD), Bauchi State Chapter, for its support in participant recruitment.

References

1. World Health Organization (2022) Global Report on Health Equity. WHO, Geneva
2. Banks LM, Kuper H, Polack S (2017) Poverty and disability in low- and middle-income countries: a systematic review. *PLoS ONE* 12(12):e0189996
3. Kuper H, Bright T, Davey C (2018) Access to health care for people with disabilities in low- and middle-income countries. *BMJ Glob Health* 3:e000800
4. Federal Ministry of Health (2016) National Health Act Implementation Guidelines. FMOH, Abuja
5. National Health Insurance Authority (NHIA) (2023) Guidelines for the Implementation of the Basic Health Care Provision Fund. NHIA, Abuja
6. Mitra S, Posarac A, Vick B (2017) Disability and poverty in developing countries: a multidimensional study. *World Dev* 41:1–18
7. World Health Organization (2023) Disability and Health: Key Facts. WHO, Geneva
8. Oyewole O (2022) Disability, discrimination and access to health services in Nigeria. *J Soc Policy Health* 4(1):21–34
9. Onalu C, Nwafor E (2021) Barriers to healthcare access among persons with disabilities in Nigeria. *Afr J Health Econ* 10(2):67–78
10. Aremu S, Abiodun O (2023) Disability inclusion and health equity in Nigeria: policy gaps and implementation challenges. *Afr J Disabil* 12:1–10
11. Uzochukwu BSC, Onwujekwe OE, Mbachu C, Okeke C, Molyneux S (2018) Accountability mechanisms in the Nigerian health system. *Health Policy Plan* 33(1):1–12
12. Are E (2025) Accessibility of primary health care services for persons with disabilities in Nigeria. *J Public Health Afr* 16(1):45–56
13. London School of Hygiene and Tropical Medicine, Sightsavers CBM (2022) Disability Inclusive Health Systems: Evidence and Practice from Low- and Middle-Income Countries. LSHTM, London
14. Bright T, Kuper H (2018) A systematic review of access to general healthcare services for people with disabilities in low- and middle-income countries. *Int J Environ Res Public Health* 15(9):1–24
15. World Health Organization (2011) World Bank. World Report on Disability. WHO, Geneva
16. Mitra S, Palmer M, Kim H, Mont D, Groce N (2018) Extra costs of living with a disability: a review and agenda for research. *Disabil Health J* 10(4):475–484

17. Groce N, Kett M, Lang R, Trani JF (2019) Disability and poverty: the need for a more nuanced understanding of implications for development policy and practice. *Third World Q* 40(5):825–842