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Using the Disability Awareness Checklist to assess the readiness of healthcare facilities for people with disabilities across 35 primary healthcare facilities in Luuka District, Uganda

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Research Article

Keywords: Disability, Accessibility, Readiness, Primary, Healthcare facility, Inclusive and Disability Awareness Checklist

Posted Date: November 19th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-11358819/v1

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Additional Declarations: No competing interests reported.

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Abstract

Background

People with disabilities experience barriers to healthcare, including inaccessible facilities and inadequate reasonable accommodations, particularly in low-resource settings. Disability readiness audits of healthcare facilities can systematically identify barriers and guide improvements.

Methods

We conducted a cross-sectional facility readiness audit of 35 primary healthcare facilities in Luuka District, Uganda, between February and June 2024. Four trained auditors (each pair included one researcher with a disability and one without) used a locally adapted and pilot-tested Disability Awareness Checklist (DAC) to assess four domains: universal design and accessibility, reasonable accommodation, capacity of facility staff, and linkage to disability and rehabilitation services. 73 indicators across 13 subdomains were scored as met or not met. Audit teams and facility staff developed recommendations and classified anticipated costs together.

Results

Overall facility readiness was low, for both the median facility score of 19% (interquartile range 16-23%), and domain-specific scores (universal design and accessibility: 26%; reasonable accommodations 20%; links to disability and rehabilitation services: 8%; capacity of healthcare workers 7%). Only one facility (3%) had a toilet that met minimum requirements, and no facility had disability training, updated referral pathways, or formal rehabilitation linkages. Facilities scored higher if they were Level III or IV versus Level II facilities, or had six or more permanent health workers. The audits generated 775 recommendations, including infrastructure modifications, accessible equipment and information, and staff training, a third of which were estimated to be no or low cost.

Conclusion

Scaling up routine accessibility audits may strengthen disability-inclusive primary healthcare in Uganda and similar low-resource settings.

Key words

Disability, Accessibility, Readiness, Primary, Healthcare facility, Inclusive and Disability Awareness Checklist

Background

Ensuring access to healthcare for the 1.3 billion people living with disabilities remains a vital global health and human rights challenge [1]. Studies have consistently highlighted that people with disabilities experience higher unmet health needs and poorer health outcomes compared to their peers without disabilities [2, 3]. These disparities reflect both the underlying health conditions and systemic and facility-level barriers that limit the availability, accessibility, acceptability and quality of care [4]. Barriers include inaccessible facilities, lack of appropriate assistive products and equipment, negative attitudes and limited knowledge of disability among healthcare workers, and difficulties reaching facilities [5, 6].

Facility readiness is therefore central to the provision of quality, disability-inclusive healthcare. It reflects whether health facilities have the infrastructure, equipment, information and communication, staff capacity and organisational processes needed to effectively meet the needs of people with disabilities [7-10]. Accessibility is an important component of this readiness, encompassing the physical environment, communication and information that enables people with disabilities to reach and use healthcare services with autonomy, dignity and agency [9-13]. Readiness also depends on whether healthcare workers have the knowledge, skills and attitudes required to provide respectful and responsive care, and whether facilities have the systems in place to support disability-inclusive service delivery [7, 14].

In Uganda, like other low- and middle-income countries (LMICs), primary healthcare facilities are the first point of contact within the healthcare system. However, they often lack the infrastructure and resources required to provide disability-inclusive services [13, 15, 16]. There is limited evidence on facility readiness to provide disability inclusive in Uganda. Evidence from a pilot study of 5 primary healthcare facilities conducted in Uganda documented gaps in physical accessibility, limited availability of assistive technologies and alternative communication, and insufficient training of healthcare workers in disability-inclusive care [16]. Consequently, people with disabilities may delay or forego accessing care or receive inadequate or inappropriate care, which may worsen health outcomes [5]. In turn, poorer health outcomes contribute to higher mortality rates observed globally among people with disabilities

compared to those without [17]. Addressing these systemic barriers requires practical, context-appropriate approaches that can be implemented within existing health system constraints.

Assessing facility readiness can help identify whether facilities are equipped and prepared to provide quality services to people with disabilities. Readiness audits provide a structured method for assessing multiple dimensions of facility readiness including accessibility, healthcare-worker capacity, communication and information, equipment and organisational practices. These also help generate actionable evidence to inform facility- and health-system-level improvements. We built on our previous adaptation and pilot of the Disability Awareness Checklist in Luuka District [16], and applied the finalised checklist across all eligible non-pilot primary healthcare facilities in the district. We aimed to quantify facility- and domain-level gaps in disability inclusion, examine variation across facility characteristics, and categorise locally generated actions for facility, district, and health-system improvement.

Methods

Study design

The study employed a quantitative cross-sectional design to assess the readiness of 35 primary healthcare facilities to provide quality and responsive care to people with disabilities in Luuka district. This study was part of the Missing Billion study, a randomised controlled trial that evaluated participatory approaches to improve access to healthcare for people with disabilities in the district [18, 19]. This sub-study was part of the healthcare systems strengthening component of the trial, implemented in both trial arms alongside disability inclusive healthcare worker training. We adapted and pilot-tested the DAC [16], before using it to quantitatively assess multiple accessibility and reasonable accommodations domains at the facility level to determine overall disability readiness of health facilities.

Study setting

The study was conducted in primary healthcare facilities in Luuka district, Eastern Uganda. At the time of data collection, Luuka district had 40 primary healthcare facilities (32 government and 8 private not-for-profit (PNFP)) across seven sub-counties and five town councils. These include 25 health centre IIs [HCII], 14 health centre IIIs [HCIII], and one health centre IV [HCIV]. This represented a reduction from the 43 facilities included during the pilot phase, as three PNFP facilities had closed before the main study commenced. These facilities collectively

provide essential services, including outpatient care, maternal and child health services, HIV care and treatment, basic emergency care, and minor surgeries, among others, and serve as the first point of contact for most community members. The study was conducted in 35 primary healthcare facilities, excluding the five facilities that participated in the pilot phase [16].

Adapted Disability Awareness Checklist (DAC)

The DAC is a structured facility audit tool designed to assess the readiness of healthcare facilities to provide quality care for people with disabilities [20]. The DAC was adapted for the Ugandan primary healthcare context through participatory co-development with youth researchers with disabilities and alignment with national accessibility and building standards[16, 19]. Adaptations are described in full elsewhere, but included minor contextualisation to local health system structures, service delivery levels, and available infrastructure [16]. The revised tool was piloted in five selected health facilities in Luuka district in October 2023 to assess clarity, relevance, and feasibility of administration [16]. Findings from the pilot informed further minor revisions to improve consistency.

The adapted DAC has four key domains that reflect critical dimensions of facility readiness, operationalised through 13 sub-domains and 73 indicators. These include: universal design and accessibility (4 sub-domains and 31 indicators), reasonable accommodation of people with disabilities (2 sub-domains and 15 indicators), capacity of facility staff to identify and support people with disabilities (4 sub-domains and 15 indicators) and linkage to disability and rehabilitation services (3 sub-domains and 12 indicators) (Table 1). The DAC included a standardised feedback form used by the audit facilitators to systematically document the identified gaps in accessibility and reasonable accommodation, along with corresponding recommendations, that were shared with the facilities.

Table 1: List of domains, sub-domains and number of indicators within each section of the adapted DAC

Domain	Sub-Domain	No. Indicators within Sub-Domain
Universal Design and Accessibility	Entrance to services	7
	Reception, corridors and waiting rooms	9
	Examination rooms and emergency routes	10

	Toilets	5
	Total	**31**
Reasonable accommodation of people with disabilities	Information and communication	7
	Assistance and support	8
	Total	**15**
Capacity of facility staff to identify and support people with disabilities	Awareness and accessibility training (all)	4
	Specialist training for at least one staff member on duty	3
	Healthcare worker training (at least some staff)	3
	Other training and support capacity	5
	Total	**15**
Linkage to disability and rehabilitation services	Disability process data	4
	Annually updated referral processes	5
	Direct service linkages	3
	Total	**12**
Total		73

Data collection procedures

Data were collected between February and June 2024 from 35 primary healthcare facilities in Luuka District. Four trained DAC audit facilitators, who were experienced researchers, two of whom lived with disabilities (one with a hearing impairment and the other with albinism), conducted the facilities' audits. Facilitators were paired (one with a disability and one without) to enhance reflexivity, and they supported each other during the audits.

Before data collection, a 2-day training on the DAC was conducted to standardise data collection procedures. The training covered the purpose of the audit, interpretation of each indicator, scoring procedures, and ethical considerations and included classroom sessions, practical demonstrations, and pilot assessments to standardise scoring and improve inter-rater consistency. Audits were conducted following a healthcare worker training on disability at each facility, which was conducted as part of the Missing Billion Study. This sequence helped create awareness of disability and accessibility concepts pre-audit [21]. At each facility, auditors were supported by a healthcare worker, who was mostly the facility's "in-charge", or someone nominated by the in-charge, based on their familiarity with facility operations.

The tool was built on REDCap and administered using encrypted and password-protected tablets. Indicators were assessed through direct observation by the team or consultation with healthcare workers and recorded as "Yes", "No" or "Not Sure". Facilitators discussed and agreed on each response, resolving any discrepancies through consensus and, where necessary, consultation with facility staff. Infrastructure measurements (e.g., doors, corridors, ramps, and toilets) were taken in a straight line using a tape measure at the narrowest usable point. In contrast, heights (e.g., examination beds, dispensing windows) were measured at the highest usable point. Ramp gradients were measured in degrees using a mobile application (Angle Meter Pro) downloaded on the tablets, and the steepest point was recorded. GPS coordinates of the facility, the nearest public transport drop-off/pick-up point (boda-boda stage), and the nearest public taxi route were also taken. For indicators not directly observable, healthcare workers were asked to provide supporting evidence when available; otherwise, responses were recorded as "Not sure." Written consent was obtained from all participating facilities before conducting the audits.

Feedback sharing and recommendations identification

The final component of the facility audits was completion of the standardised feedback forms summarising identified gaps and proposing context-specific recommendations. The audit team described key gaps and developed feasible recommendations that the facilities could implement, within their existing capacity, to improve facility readiness and promote more disability-inclusive service delivery. Open discussion with facility staff followed to review and revise the identified gaps and suggested recommendations. The healthcare workers were also asked to indicate the presumed cost of implementing each recommendation, categorising them in their opinion as "high cost," "moderate cost", "low cost" or "no cost."

Study variables

The primary outcome of this study was healthcare facility readiness as assessed using the DAC. The overall health facility readiness score was derived by aggregating indicator-level responses (n=73) across all domains of the DAC and transforming them to a 0 – 100 scale. We treated each indicator as an equally weighted, independently actionable requirement of readiness and did not weight by domain. Each indicator in the DAC was scored as "Yes" (1) or "No"/"Not sure" (0), with several indicators (e.g. accessible ramp) comprising several sub-items (e.g. ramp has handrails, ramp gradient within standards). Domain (n=4) and sub-domain (n=13) -specific

readiness scores were calculated as proportions of indicators meeting readiness criteria within each domain. Cost classification of recommendations was categorised as "high cost," "moderate cost," or "no cost," as rated by healthcare workers.

Data analysis

Data were collected and managed using REDCap, cleaned for missing values and exported to R version 4.6.0 (2026-04-24) for analysis [22]. Descriptive statistics (frequencies, percentages, medians and inter-quartile ranges) were used to summarise facility characteristics, readiness scores and recommendations across the sub-domains in all 35 primary healthcare facilities in Luuka District. A heatmap was constructed using *ggplot2* to visualise performance across readiness indicators. Facility identifiers were anonymised, and indicator scores were expressed as the percentage of criteria not met. Indicators were ordered by the mean percentage of criteria not met, with facilities ordered by overall performance. Associations between facility characteristics (health centre level and type, number of health workers and patients) and the facility's likelihood of being above the median readiness score were assessed using Firth-penalised logistic regression on account of small cell sizes [23]. Feedback form data on recommendations and indicative costings were summarised using the *tidyverse* package.

Ethical considerations

Ethical approval was granted by the London School of Hygiene & Tropical Medicine Observational Research Ethics Committee (LSHTM Ref 28327-1), the Uganda Virus Research Institute Research and Ethics Committee (UVRI REC Ref: GC/127/904) and Uganda National Council for Science and Technology (UNCST Ref: SS1348ES). Written informed consent was obtained from all the facilities through the facility in-charges or a staff member assigned by the in-charges. The study was conducted in accordance with the Declaration of Helsinki

Results

In total, 35 facilities across Luuka District participated in the audit. Of these, the majority (63%) were Level II, 34% were Level III, and 3% (one facility) was Level IV (Table 2). Most facilities (83%) were government-operated, with a median of 5 permanent healthcare workers per facility and an estimated median population served of 7,200 (interquartile range 4,200 – 12,012). The median distance from the health facility to the nearest boda-boda (motorcycle taxi) stage was 0.3 kilometres, while the median distance to the nearest taxi minibus route was

3.1 kilometres. One facility (3%) had no healthcare workers available to support the audit. In the remaining 34 facilities, a nurse (66%) or midwife (11%) most frequently supported the audit team, and 56% of these had received disability training directly as part of the Missing Billion trial. The mean audit duration was 69 minutes.

The median overall facility readiness score was 19 out of a maximum of 100 (interquartile range 16 – 23), Table 3. The median readiness score was higher in the domains of *Universal Design and Accessibility* (26, 23 –31) and *Reasonable accommodation of people with disabilities* (20, 13 – 27) and lower in the domains of *Capacity of facility staff to identify and support people with disabilities* (7, 7 – 7) and *Linkage to disability and rehabilitation services* (8, 8 – 17). Individually, higher-scoring sub-domains included *Reception, corridors and waiting rooms* (33, 33 – 44), *Entrance to services* (29, 29 – 43), *Information and communication* (29, 14 – 29) and *Disability process data* (25, 25– 50). Median scores of zero were identified for the sub-domains of *toilets*, *awareness and accessibility training*, *specialist training*, *health worker training*, *annually updated referral processes* and *direct service linkages*.

Supplementary Tables 1-4 present indicator-level findings for each of the sub-domains. Pertinent findings include that 63% of facilities had a ramp, but that none of these met accessibility standards (95% gradient too steep, 95% no handrails, 40% lack of non-slip flooring). 20% of facility doors and 26% of corridors met access standards (width>800mm), and only 6% of facilities had accessible reception or triage areas (defined as being named, attended, clearly marked and near the main entrance, Table S-1). 11% of facilities had emergency evacuation routes, but only 3% had wheelchair accessible ones, and none marked the route with pictures, Braille or warning lights for Deaf or hearing-impaired patients. 20% of facilities had a designated disability accessible toilet or latrine, but only 9% had washpoints accessible for wheelchair users and only 3% met access minimums (width >900mm). 43% provided written health information for patients (e.g. vaccination leaflets) and 86% provided information on medicines and where to access them; however, only 3% had information available in alternative formats. 74% provided assistance to fill out forms or documents as needed, and 31% had functional assistive devices available for temporary use. No facilities had a disability focal person, specialist disability training or facility-wide training on disability sensitisation and accessibility, but 89% captured data on disability status of participants. One

facility provided direct service linkages to organisations of people with disabilities (OPDs), rehabilitation outreach and home-based or community-based rehabilitation only.

Figure 1 presents a heatmap of readiness sub-domains (as defined in Table 1) by anonymised facility. Readiness sub-domains are ordered by mean percentage of indicators within the sub-domain not met, with poorest-performing sub-domains toward the bottom. Facilities are ordered from left to right by overall performance, with total facility score displayed as a separate row along the top. Sub-domains linked to capacity-building such as *awareness and accessibility training for all staff* and *specialist training for at least one staff member on duty*, and linkages either through *annually updated referral processes* or *direct service linkages* performed poorly overall, even in otherwise relatively well-performing facilities. Sub-domains related to physical infrastructure showed greater heterogeneity, with some facilities scoring well across multiple physical sub-domains such as *entrance to services*, *examination rooms and emergency routes* and *toilets*, whereas others performed well in terms of *toilets* or *reception, corridors and waiting rooms* but not elsewhere.

In univariable analysis, facility level was associated with readiness: only 18% of Level II facilities scored above the readiness median, compared with 85% of those at Level III or higher (OR 0.05, 95% CI 0.01–0.26) (Table 4). We found no evidence that facility type (government versus private or private not-for-profit) or annual patient volume were associated with scoring above the median. A larger number of permanent health workers was associated with above-median readiness (90% of facilities with six or more health workers were above the median, versus 24% of those with five or fewer), although the effect size (OR 19.0, 95% CI 3.4–203.8) should be interpreted cautiously given the data sparsity.

Table 2: Facility basic Information

		N facilities	% Facilities
Facility level	Level 2	22	63%
	Level 3	12	34%
	Level 4	1	3%
Facility Type	Government	29	83%
	Private (not for profit)	6	17%
Health worker supporting audit	None available	1	3%

	Nurse	23	66%
	Midwife	4	11%
	Medical or clinical officer	3	9%
	Health assistant	1	3%
	Nursing assistant or officer	3	9%
Supporting HW had received training on disability as part of research project	Yes	19	56%
	No	15	44%
		Median	IQR
Transportation links[1]	Nearest boda stage (KM)	0.3	0.1 – 1.3
	Travel time on foot (mins)	3.6	1.7 – 17.4
	Nearest taxi bus route (KM)	3.1	0.2 – 6.4
	Travel time on foot (mins)	40.2	3.0 – 85.7
Number of permanent healthcare workers at facility		5	2 – 7
Population served (annual est.)		7,200	4200 – 12,012
[1]GPS Data missing for one facility			

262 Table 3: Median facility readiness scores overall, by domain and by sub-domain across
263 facilities

		Median (Max 100)	Range
Domain	Sub-Domain		
Universal Design and Accessibility	Entrance to services	29	29 – 43
	Reception, corridors and waiting rooms	33	33 – 44
	Examination rooms and emergency routes	20	20 – 30
	Toilets	0	0 – 0
	Domain total	26	23 – 31
Reasonable accommodation of people with disabilities	Information and communication	29	14 – 29
	Assistance and support	13	13 – 31
	Domain total	20	13 – 27

Capacity of facility staff to identify and support people with disabilities	Awareness and accessibility training (all)	0	0 – 0
	Specialist training for at least one staff member on duty	0	0 – 0
	Healthcare worker training (at least some staff)	0	0 – 0
	Other training and support capacity	20	20 – 20
	Domain total	7	7 – 7
Linkage to disability and rehabilitation services	Disability process data	25	25 – 50
	Annually updated referral processes	0	0 – 0
	Direct service linkages	0	0 – 0
	Domain total	8	8 – 17
Total Score		**19**	**16 – 23**

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Figure 1: Anonymised facility-level sub-domain scores

Table 4: Association between facility basic information and overall readiness score

		Facilities at or below the median readiness score (n=20)		Facilities above the median readiness score (n=15)		Odds Ratio (95% CI)
Health Facility Basic Information		N	%	N	%	
Health Facility Level	Level II	18	82%	4	18%	0.05 (0.01-0.26)
	Level III or IV	2	15%	11	85%	Ref.

Health Facility Type	Government	18	62%	11	38%	Ref.
	Private or Private NFP	2	33%	4	67%	2.90 (0.54-18.97)
Annual number of patients served	Less than 5000	6	60%	4	40%	Ref.
	5001 – 10000	3	27%	8	73%	0.44 (0.07-2.38)
	Over 10000	11	79%	3	21%	3.51 (0.65-22.05)
Number of permanent HWCs	1-5	19	76%	6	24%	Ref.
	6+	1	10%	9	90%	19.00 (3.40-203.82)

Recommendations to the identified gaps

A total of 775 suggestions were made to improve disability inclusion (Table 5). Most commonly, recommendations were categorised related to lobbying and engaging with policymakers (11%). Creating new signage (11%) and making minor structural amendments (11%). Health workers estimated costs for 610 of the suggestions, of these 29% were considered to be no or low cost, while 35% were considered to be moderate and high cost respectively.

Table 5: Proposed recommendations to the identified facility accessibility gaps

	Total	
Suggestion	N=775	%
Developing new protocols and tools	36	5%
Lobbying and engaging with policymakers	86	11%
Establishing a new role/ creating a focal person among existing personnel	61	8%
Provision of alternative accessible formats for existing info	67	9%
Purchasing of new equipment	78	10%
Creation of new signage	89	11%
Structural (major)	57	7%
Structural (minor)	88	11%
Tidying	71	9%
Training	61	7%
Linkage, referral, rehabilitation programme and policies	46	5%
Others	35	5%
Estimated Cost	**N=610**	**%**
No cost	44	7%
Low cost	135	22%
Moderate cost	215	35%

High cost	216	35%

Discussion

This study provides an assessment of facility readiness to provide disability inclusive healthcare across primary healthcare facilities in rural Luuka district in Eastern Uganda using the adapted DAC. Overall readiness was poor, with facilities achieving a median score of only 19% across the four domains of the DAC. This shows substantial gaps in the readiness and ability of primary healthcare facilities in Luuka district, to provide equitable and disability-inclusive healthcare. These findings are comparable with findings from other LMIC settings. A recent study in Ethiopia, which adapted the DAC, reported an overall readiness score of 35% among primary healthcare facilities [24]. The study emphasises that readiness gaps observed are systemic rather than isolated to individual facilities. The low scores observed reinforce growing evidence that healthcare systems remain inadequately prepared to meet the needs of patients with disabilities [3, 27-29]. Our findings align closely with other studies, which emphasise that inaccessible facilities, limited reasonable accommodations, poorly trained health workers and fragmented health systems remain major barriers to equitable healthcare access [2]. Readiness of primary healthcare facilities remains a global challenge in low-resource settings, despite increasing global recognition of the importance of disability-inclusive health [3, 6]. For example, studies in Brazil and India reported low median accessibility scores of 22% and 30.8% respectively [25, 26].

Although aspects of universal design and accessibility performed relatively better than other domains, major deficiencies were observed in reasonable accommodation, healthcare worker capacity and linkages to disability and rehabilitation services. Few facilities had trained staff, disability focal persons, disability-specific protocols or established referral pathways for rehabilitation and assistive technologies, a finding consistent with other studies [25-27, 30]. The findings show that an infrastructure-only approach to auditing the readiness of facilities would miss substantial deficits in communication, workforce capacity, organisational processes, and referral linkages. Disability-inclusive healthcare requires simultaneous investment in physical accessibility, communication, workforce competencies and information systems as highlighted by the CRPD [10, 28]. Accessible infrastructure alone does not guarantee disability-inclusive healthcare for all. Healthcare workers also need skills, accessible equipment and information, and referral systems to effectively engage and meet the needs of

patients with disabilities [2, 29]. Our findings therefore support a broader understanding of accessibility that extends beyond compliance with building standards to encompass the organisational capacity required to deliver person-centred, disability-inclusive and equitable healthcare [14, 31].

Higher-level facilities and those with more permanent staff demonstrated better readiness than lower-level facilities, suggesting inequities in the readiness of primary healthcare facilities to provide disability-inclusive services. Given that lower-level facilities are the first point of contact for most rural communities, persistent accessibility gaps are likely to undermine timely healthcare access and continuity of care for people with disabilities [3, 14].

Importantly, the DAC audits also generated context-specific recommendations to improve facility accessibility. Many recommendations involved low-cost or no-cost interventions, including improved signage, accessible information materials, queue management, staff sensitisation and routine maintenance of accessibility features. Therefore, accessibility audits have the potential to function as practical quality-improvement tools rather than solely assessment instruments [16, 32].

Uganda has established national disability legislation and accessibility standards, yet our results demonstrate a substantial implementation gap at the facility level. Closing this gap will require moving beyond infrastructure-focused approaches towards health system strengthening strategies that integrate disability inclusion into routine governance, financing, supervision, training and performance monitoring at all levels [2, 32].

Strengths and Limitations

A major strength of this paper was the rigorous process undertaken to adapt the DAC tool to ensure its contextual relevance in a rural, low-resource setting in Uganda. The tool was reviewed and modified to align with national accessibility standards and then pilot-tested. Another key strength was the involvement of people with disabilities throughout the study, from tool adaptation to data collection. Their participation enhanced reflexivity and contributed to a comprehensive assessment of accessibility by integrating lived experience and technical expertise. In addition, the audits were conducted after the healthcare worker disability training, which improved the healthcare workers' base understanding of accessibility and enabled more informed and productive discussions around the identified gaps and recommendations suggested. The study also benefited from its focus on primary healthcare facilities in resource-

limited settings and the inclusion of all eligible facilities in the district. This provided a comprehensive overview of accessibility challenges and opportunities for improvement across low-level healthcare facilities. However, the study also had some limitations. The involvement of people with disabilities as audit facilitators may have introduced subjective biases during assessments, potentially resulting in either over- or under-emphasis of certain indicators in alignment with their own impairments or experiences. To minimise this risk, facilitators received training and were paired with facilitators without disabilities to support balanced assessment and reflexivity during the audit process. The cost categorisation of implementing recommendations as high, moderate, low or no cost was based on subjective perceptions of healthcare workers and was not defined using standardised cost thresholds. Consequently, cost estimates may have varied across facilities and should therefore be interpreted as perceived rather than standardised estimates of implementation cost.

Conclusion

Primary healthcare facilities in Luuka District demonstrated substantial deficiencies in readiness to provide high-quality care for people with disabilities, despite existing national policies and international commitments. It is a cliché, but what isn't counted doesn't count. Use of the adapted DAC, or other tools, can help governments identify gaps across care delivery by health facilities to help prioritise investments and track progress towards disability-inclusive universal health coverage.

Author contributions

HK conceptualised the study. AM, IM, ASS, FBM and HK developed the methodology for the study design. AM, IM, ASS and RB developed and led the training for the data collection. AM, ASS and RB oversaw data collection activities, while AN, ANT, WS and BA collected the data. AM, IM and RB developed the data analysis plan. IZM and RB completed the analyses. AM and IZM drafted the manuscript. ASS, RB, TS, SM, AN, ANT, WS, BA, FBM and HK reviewed and revised the manuscript. All authors read and approved the final manuscript.

Data availability

All data supporting the findings of this study are available within the paper and its Supplementary Information. Supplementary Tables 1 to 4 present indicator-level findings for each of the sub-domains.

Declarations

Ethics approval and consent to participate Ethical approval was granted by the London School of Hygiene & Tropical Medicine Observational Research Ethics Committee (LSHTM Ref 28327-1) and Uganda Virus Research Institute Research and Ethics Committee (UVRI REC Ref: GC/127/904) and Uganda National Council for Science and Technology (UNCST Ref: SS1348ES). Written informed consent was obtained from all participating healthcare facilities. The study was conducted in accordance with the Declaration of Helsinki.

Funding Declaration

This work was supported by the National Institute for Health and Care Research (NIHR), Award ID: NIHR301621. The funder had no role in the study implementation, including the study design, data collection, analysis and interpretation of the findings or the decision to submit the manuscript for publication.

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

Acknowledgement

We thank the Luuka District Health Office, led by Dr Christopher Wandira, the District Health Officer (DHO) and Sister Josephine Babirye Kyobe, the Assistant DHO maternal and child health, for the unwavering support during the study. We also acknowledge the healthcare workers and facility staff in Luuka District who participated in the facility assessments and shared their perspectives on improving disability-inclusive healthcare. We also acknowledge the youth advisory board who contributed to the adaptation and development of the Disability Awareness Checklist for the Ugandan context.

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