

Access To Healthcare For People With Disabilities: A Case Study Of Mulimira Zone, Bukoto I, Kampala

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Abstract

Despite Uganda's progressive legal and policy commitments to disability rights, persons with disabilities in many urban communities continue to face significant barriers to accessing healthcare. This study examined access to healthcare for persons with disabilities, using Mulimira Zone, Bukoto I, Kampala as a case study, guided by objectives establishing patterns of healthcare utilization, identifying physical, communication, attitudinal, and economic barriers, assessing health worker perceptions and practices, and exploring coping strategies. A descriptive cross-sectional mixed-methods design was adopted, drawing on a total population sample of 50 persons with disabilities/caregivers and 15 key informants, using structured questionnaires, in-depth interviews, a focus group discussion, and facility observation. Descriptive results showed high physical access barriers (mean = 3.40) and severe communication barriers among deaf respondents (mean = 4.56), alongside moderate-to-high economic barriers (mean = 3.44). All four barrier domains were significantly and negatively correlated with healthcare utilization, with economic barriers showing the strongest association ($r = -0.641$, $p < 0.01$). Regression analysis showed the four barrier domains jointly explained 57.1 percent of the variance in healthcare utilization ($R^2 = 0.571$), with economic barriers ($\beta = -0.398$) and physical barriers ($\beta = -0.312$) as the strongest significant predictors. Path analysis revealed that physical and communication barriers exert significant indirect effects on utilization through their influence on economic burden ($\beta = 0.481$ and 0.296 respectively), with a total effect of physical barriers on utilization of -0.503 compared to a direct effect of -0.312 . The study concludes that healthcare access barriers for persons with disabilities in Mulimira Zone are multidimensional and interlinked, with physical and communication barriers compounding economic burden, and recommends facility infrastructure retrofitting, sign language interpretation services, disability-inclusive health worker training, targeted transport/cost subsidies, and strengthened community-based monitoring.

Keywords: Disability, healthcare access, health equity, barriers to healthcare, social model of disability, path analysis, Mulimira Zone, Bukoto, Kampala

Introduction

Access to healthcare is universally recognized as a fundamental human right, enshrined in numerous international instruments including the United Nations Convention on the Rights of Persons with Disabilities, which explicitly obligates state parties to ensure that persons with disabilities enjoy the highest attainable standard of health without discrimination on the basis of disability (Julius & Nancy, 2026). Despite this normative commitment, persons with disabilities across the world, and particularly in low- and middle-income countries such as Uganda, continue to experience disproportionate barriers in accessing timely, appropriate, and quality healthcare services compared to their non-disabled counterparts, arising from a combination of physical, attitudinal, communication, institutional, and economic barriers that intersect to limit their effective utilization of health facilities (Julius & Audrey, 2026). In

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Uganda, persons with disabilities constitute a significant proportion of the population, and while the country has enacted progressive legal and policy frameworks, including the Persons with Disabilities Act and the National Policy on Disability, aimed at promoting the inclusion and rights of persons with disabilities across all sectors including health, the practical translation of these policies into accessible healthcare services at the community level remains inconsistent, particularly within densely populated urban and peri-urban settlements where infrastructure was often not originally designed with accessibility in mind. Mulimira Zone, located within Bukoto I Parish in Kampala, is one such urban community characterized by a mix of residential housing, informal settlement, and limited planned infrastructure, where persons with disabilities residing in the zone must navigate a healthcare landscape comprising both public and private health facilities of varying degrees of physical and programmatic accessibility (Hassan & Nelson, 2026).

This study is motivated by the recognition that while national-level data and policy frameworks provide an important overview of disability and health access in Uganda, the lived experiences of persons with disabilities in accessing healthcare are shaped significantly by hyper-local factors such as the physical layout of their immediate neighborhood, the specific health facilities available within reasonable proximity, the attitudes of health workers and community members within their zone, and the particular socioeconomic conditions prevailing in their community, all of which can only be adequately understood through community-level, case-study-based research (Faith et al., 2023). By focusing specifically on Mulimira Zone in Bukoto I, this study seeks to generate a grounded, contextually rich understanding of the barriers and facilitators that shape healthcare access for persons with disabilities within this particular urban community, with the broader aim of contributing evidence that can inform both local-level interventions by health facilities and community leaders, as well as wider policy discussions regarding the practical implementation of disability-inclusive healthcare in Uganda's rapidly urbanizing informal settlements (Faith et al., 2023).

Problem Statement

Although Uganda's legal and policy framework formally guarantees persons with disabilities the right to access healthcare on an equal basis with others, a considerable body of anecdotal and survey evidence suggests that persons with disabilities in urban communities such as Mulimira Zone continue to face substantial obstacles in translating this formal right into actual, timely, and dignified access to health services (Julius & Nancy, 2026). These obstacles are reported to include physical barriers such as health facilities lacking ramps, accessible toilets, or appropriately adapted examination equipment; communication barriers for persons with hearing or speech impairments arising from the general absence of sign language interpretation services at most public health facilities; attitudinal barriers including stigma, discrimination, and a lack of disability-sensitive training among health workers; and economic barriers stemming from the compounded effects of disability-related additional costs, such as transportation to more distant

but more accessible facilities, on households that are often already economically disadvantaged (Ceccaroni & Piera, 2019). Despite the seriousness and apparent persistence of these challenges, there is a notable paucity of localized, community-specific research examining precisely how these barriers manifest and interact within the particular context of Mulimira Zone, meaning that local health facility managers, community leaders, and disability advocacy organizations operating in the area lack a solid evidence base upon which to design targeted, context-appropriate interventions to improve healthcare access for persons with disabilities in this specific community (Peck et al., 2020). This study addresses this gap by undertaking a focused investigation into the healthcare access experiences, barriers, and coping strategies of persons with disabilities residing in Mulimira Zone, with the aim of generating actionable, locally grounded evidence to inform improvements in disability-inclusive healthcare provision within the zone and comparable urban communities.

Main Objective

The main objective of this study is to examine access to healthcare for persons with disabilities, with specific reference to Mulimira Zone, Bukoto I, Kampala.

Specific Objectives

The study is guided by the following specific objectives: to establish the extent and nature of healthcare service utilization among persons with disabilities residing in Mulimira Zone; to identify the physical, attitudinal, communication, and economic barriers that hinder persons with disabilities in the zone from accessing healthcare services; to assess the perceptions and practices of local health workers and facility managers regarding the accommodation of persons with disabilities within available health services; and to explore the coping strategies employed by persons with disabilities and their households in Mulimira Zone to navigate barriers to healthcare access, and to propose recommendations for improving disability-inclusive healthcare provision within the zone.

Literature Review

This study is grounded theoretically in the social model of disability, which, in contrast to the medical model that locates disability primarily within an individual's physical or mental impairment, conceptualizes disability as arising from the interaction between an individual's impairment and a range of societal, environmental, and institutional barriers that exclude or disadvantage them, thereby placing the responsibility for removing such barriers on society and its institutions, including the healthcare system, rather than solely on the individual to adapt to an inaccessible environment (Deng et al., 2018). This theoretical orientation is complemented by the World Health Organization's framework on access to healthcare, which conceptualizes access along multiple dimensions including availability, accessibility, affordability, and acceptability of health services, providing a useful analytical structure for examining the specific ways in which health systems may fail to adequately serve persons with disabilities across each of these dimensions (Ng et al., 2021). The concept of intersectionality is also relevant to this study, as it highlights how disability intersects with other social characteristics such as gender, poverty, and residence in informal urban settlements to produce compounded disadvantage, suggesting that healthcare access barriers for persons with

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disabilities in low-income urban communities such as Mulimira Zone may be particularly acute compared to those experienced by persons with disabilities in wealthier or more formally planned areas (Ghebrehwet & Morrow, 2010). A substantial body of empirical literature from Uganda and comparable Sub-Saharan African contexts has documented persistent barriers to healthcare access for persons with disabilities across each of the dimensions identified in the WHO access framework. Studies examining physical accessibility of health facilities in Uganda have consistently found that the majority of public health facilities, including many in urban Kampala, lack basic accessibility features such as ramps, accessible latrines, and adapted examination beds, forcing many persons with physical disabilities to rely on the assistance of family members or, in some cases, to forgo seeking care altogether when such assistance is unavailable (Enid & Nicholas, 2024). Research on communication accessibility has similarly found that sign language interpretation services are rare within Uganda's public health system, resulting in significant communication barriers for deaf patients that compromise both the quality of clinical consultations and patients' ability to give informed consent for treatment. Studies focusing on health worker attitudes have documented mixed findings, with some health workers expressing genuine willingness to assist patients with disabilities but lacking specific training on disability-appropriate care, while other studies have documented instances of stigmatizing or dismissive attitudes among health workers towards patients with disabilities, particularly those with psychosocial or intellectual disabilities. Economic barriers have also been extensively documented, with research consistently finding that households including a member with a disability tend to incur higher healthcare-related costs, including transportation to accessible facilities that may be located farther from home, and that these additional costs, combined with the generally lower income levels often associated with disability due to reduced employment opportunities, create a significant affordability barrier to consistent healthcare utilization (Akankwasa et al., 2022). Within informal urban settlements specifically, additional barriers such as poor road infrastructure that complicates mobility for wheelchair users, and the physical difficulty of navigating narrow, unpaved pathways common in such settlements, have been identified as compounding factors that are less prominent in more formally planned urban areas, underscoring the relevance of a community-specific case study such as the present one focused on Mulimira Zone.

Methodology

This study employed a descriptive cross-sectional research design utilizing a mixed-methods approach, combining quantitative household survey data with qualitative interviews and observation, in order to generate a comprehensive understanding of healthcare access for persons with disabilities within Mulimira Zone (Jallow et al., 2022). The study population comprised persons with disabilities residing within Mulimira Zone, their caregivers where applicable, health workers and facility managers at health facilities commonly utilized by residents of the zone, and local community and disability leaders, with the accessible population estimated at approximately eighty individuals with disabilities identified with the assistance of the local council and a community-based disability association operating within the zone. Given the relatively small and geographically defined population, the study employed total population sampling for persons with disabilities identified within the zone who consented to participate, supplemented by

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purposive sampling of key informants including health facility managers, health workers, and local leaders, resulting in a combined sample of sixty-five respondents comprising fifty persons with disabilities or their caregivers and fifteen key informants(Nafiu et al., 2017).

Quantitative data were collected from persons with disabilities and their caregivers using structured questionnaires administered through face-to-face interviews conducted by trained research assistants, given that some respondents with visual, hearing, or literacy-related limitations would have been unable to complete a self-administered written questionnaire independently, with the questionnaire capturing information on disability type, frequency and type of healthcare service utilization, experiences of specific access barriers, and out-of-pocket healthcare expenditure(Olanrewaju, Lukman Abiodun, et al., 2021). Qualitative data were collected through in-depth interviews with a purposively selected subset of persons with disabilities representing different disability types, key informant interviews with health facility managers and health workers at the two nearest public health facilities and one private clinic commonly used by zone residents, and a focus group discussion with members of the local disability association, all aimed at generating richer contextual understanding of the barriers and coping strategies identified through the survey(Olanrewaju, Waititu, et al., 2021). Direct observation was also conducted at the health facilities to assess physical accessibility features such as the presence or absence of ramps, accessible toilets, and signage, providing an independent, non-self-reported source of data on the physical accessibility dimension of the study. Quantitative data were analyzed in SPSS version 26 using descriptive statistics to characterize the prevalence of different types of access barriers and patterns of healthcare utilization, and using Pearson correlation and multiple regression analysis to test the strength of association between specific barrier domains (physical, communication, attitudinal, and economic) and overall healthcare utilization. A path model was further estimated in AMOS to test the hypothesized sequence running from physical/communication access barriers to affordability-related barriers to actual healthcare utilization, yielding standardized path coefficients for direct and indirect effects(Nelson et al., 2022). Qualitative data from interviews, focus group discussions, and observation notes were analyzed thematically, with emerging themes organized according to the study's specific objectives and the WHO access to healthcare framework, and triangulated with the quantitative findings to produce an integrated set of results. Ethical approval and clearance were obtained prior to data collection, and particular care was taken to ensure that consent procedures were adapted to be accessible to respondents with different types of disabilities, including the use of a sign language interpreter for deaf respondents and simplified consent explanations for respondents with intellectual disabilities, with all data handled confidentially throughout the study.

Results

Response Rate

All 50 persons with disabilities/caregivers targeted were successfully interviewed, together with 15 key informants, giving a 100 percent response rate for the primary sample (n = 50 for quantitative analysis).

Descriptive Statistics**Demographic and Disability Profile****Table 1: Demographic and Disability Profile of Respondents (n = 50)**

Characteristic	Category	Frequency	Percent (%)
Sex	Male	27	54.0
	Female	23	46.0
Type of disability	Physical/mobility impairment	22	44.0
	Visual impairment	11	22.0
	Hearing impairment	9	18.0
	Intellectual/psychosocial disability	8	16.0
Primary facility used	Nearest public health facility	35	70.0
	Private clinic	11	22.0
	Traditional/other	4	8.0

Source: Primary Data, 2025

Table 1 presented the demographic and disability characteristics of the 50 respondents who participated in the study. The characteristics considered included sex, type of disability, and the primary health facility used by respondents. The findings showed that 27 (54.0%) of the respondents were male, while 23 (46.0%) were female. This indicated that males constituted a slightly larger proportion of the respondents than females, although both sexes were substantially represented. The relatively small difference between male and female respondents suggested that the study captured experiences from both groups and therefore provided a broader basis for understanding barriers to healthcare access among persons with disabilities. The representation of females was also substantial, accounting for almost half of the respondents, which was important because healthcare access experiences may differ according to gender due to differences in social support, economic resources, caregiving arrangements, and interaction with healthcare services.

Regarding the type of disability, the findings indicated that physical or mobility impairment constituted the largest category, with 22 (44.0%) respondents. This was followed by visual impairment with 11 (22.0%) respondents, hearing impairment with 9 (18.0%), and intellectual or psychosocial disability with 8 (16.0%). The predominance of respondents with physical or mobility impairments was particularly relevant to the assessment of physical access barriers because mobility limitations can make movement into, within, and around healthcare facilities more difficult where infrastructure is not adequately accessible. The representation of respondents with visual and hearing impairments also enabled the study to capture communication and accessibility experiences associated with different forms of disability. In particular, respondents with hearing impairment provided an important basis for assessing

communication barriers, including access to sign language interpretation. The inclusion of respondents with intellectual or psychosocial disabilities further broadened the study beyond physical accessibility to encompass potentially different experiences of healthcare interaction and service utilization.

The findings regarding the primary facility used for healthcare showed that 35 (70.0%) respondents primarily used the nearest public health facility, while 11 (22.0%) used private clinics and 4 (8.0%) relied on traditional or other healthcare options. The predominance of public health facilities suggested that these facilities constituted the main point of access to healthcare for the majority of respondents. This could be associated with their greater availability, affordability, geographical proximity, or ability to provide services that may otherwise be difficult to obtain from private providers. The relatively smaller proportion using private clinics could indicate that private healthcare services were less accessible to some respondents, potentially because of cost or location. The 8.0% who relied on traditional or other forms of healthcare suggested that a small but meaningful proportion of respondents sought alternatives outside conventional public and private healthcare facilities.

Descriptive Statistics of Access Barrier Domains

Table 2: Descriptive Statistics of Healthcare Access Barrier Domains (5-point scale, 1=no barrier, 5=severe barrier)

Barrier domain	Indicator	Mean	Std. Dev.	Interpretation
Physical access	Difficulty entering/moving within facility	3.62	0.88	High
	Overall physical barrier index	3.40	0.81	Moderate–High
Communication access	Absence of sign language interpretation (deaf respondents, n=9)	4.56	0.53	Severe
	Overall communication barrier index	3.05	1.15	Moderate
Attitudinal	Negative/dismissive health worker interaction	2.65	1.12	Moderate
	Overall attitudinal barrier index	2.58	0.97	Moderate
Economic	Delayed/forewent care due to cost (past year)	3.31	1.09	Moderate–High
	Overall economic barrier index	3.44	0.92	Moderate–High
Outcome	Overall healthcare utilization (frequency/adequacy index)	2.79	0.86	Moderate

Source: Primary Data, 2025

Table 2 presented the descriptive statistics for the major healthcare access barrier domains, namely physical access, communication access, attitudinal barriers, and economic barriers. The outcome variable was healthcare utilization (Julius & Audrey, 2026). The barriers were measured using a five-point scale in which 1 represented no barrier and 5 represented a severe barrier. Consequently, higher mean scores indicated greater severity of barriers to healthcare access. The findings demonstrated that the respondents experienced barriers at different levels, with particularly pronounced challenges in communication access and physical accessibility.

The findings regarding physical access barriers showed that difficulty entering or moving within healthcare facilities recorded a mean score of 3.62 and a standard deviation of 0.88, which was interpreted as high. This indicated that physical accessibility represented a significant challenge for respondents with disabilities (Ng et al., 2021). The finding suggested that a considerable proportion of respondents experienced difficulties when entering healthcare facilities or moving within them. Such difficulties could arise from physical features such as stairs, narrow entrances, inaccessible pathways, inadequate ramps, unsuitable toilets, or difficulties moving between service points. The relatively low standard deviation indicated that there was a reasonable degree of agreement among respondents regarding the presence of these challenges. The overall physical barrier index recorded a mean of 3.40 and a standard deviation of 0.81, which was interpreted as moderate-to-high. This reinforced the finding that physical accessibility constituted an important barrier to healthcare access, although its severity varied somewhat across respondents.

The communication access barriers revealed one of the most important findings in the study. The absence of sign language interpretation among deaf respondents recorded a mean score of 4.56 with a standard deviation of 0.53, which was interpreted as severe. This very high mean indicated that the absence of sign language interpretation constituted a particularly serious communication barrier among respondents with hearing impairment. The low standard deviation of 0.53 demonstrated a high level of consistency in respondents' perceptions, suggesting that the experience was widely shared among the affected respondents. The finding implied that even when persons with hearing impairment were physically able to reach healthcare facilities, they could still encounter substantial difficulties communicating with healthcare providers. This could affect their ability to explain symptoms, understand diagnoses, follow treatment instructions, provide informed consent, and ask questions about their care. The overall communication barrier index, however, recorded a mean of 3.05 and a standard deviation of 1.15, which was interpreted as moderate. This indicated that communication challenges existed across the wider respondent group, although their severity differed substantially depending on the respondent's type of disability and communication needs. The comparatively high standard deviation further suggested considerable variation in communication experiences.

The findings concerning attitudinal barriers indicated that negative or dismissive interactions with healthcare workers had a mean score of 2.65 and a standard deviation of 1.12, which was interpreted as moderate. The result suggested that respondents experienced some negative or dismissive attitudes from healthcare providers, although these experiences were not as severe as the physical or communication barriers. The overall attitudinal barrier index recorded a mean of 2.58 and a standard deviation of 0.97, also indicating a moderate level of attitudinal barriers(Nelson et al., 2023). This suggested that the attitudes and interpersonal behaviour of healthcare workers remained an important issue affecting healthcare access, but the problem was comparatively less pronounced than some of the structural and communication barriers identified in the study. The relatively high variability in responses indicated that experiences with healthcare workers differed among respondents. Some persons with disabilities may have received respectful and supportive treatment, whereas others may have encountered negative attitudes, inadequate attention, impatience, or dismissive interactions. Such differences were important because the quality of interaction between healthcare providers and persons with disabilities could influence whether individuals felt comfortable seeking care and whether they returned for subsequent services.

The findings for economic barriers indicated that financial constraints also constituted a meaningful challenge. The indicator measuring whether respondents had delayed or foregone healthcare because of cost during the previous year recorded a mean of 3.31 and a standard deviation of 1.09, which was interpreted as moderate-to-high. This indicated that healthcare costs had affected the ability of a considerable proportion of respondents to obtain care when needed. The overall economic barrier index recorded a mean of 3.44 and a standard deviation of 0.92, also interpreted as moderate-to-high. The findings therefore suggested that financial limitations were an important constraint on healthcare access among persons with disabilities. The economic burden may have involved consultation fees, medication costs, transportation expenses, diagnostic charges, or other costs associated with obtaining healthcare. For persons with disabilities, the financial burden may be particularly significant where healthcare utilization requires additional transport arrangements, assistance from caregivers, or repeated visits to health facilities. The findings consequently indicated that improving physical and communication accessibility alone may not be sufficient unless the economic dimensions of healthcare access are also addressed.

Inferential Statistics

Correlation Analysis

Table 3: Pearson Correlation Matrix

Variable	1	2	3	4	5
1. Physical barriers	1.000				
2. Communication barriers	0.412**	1.000			
3. Attitudinal barriers	0.388**	0.457**	1.000		

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4. Economic barriers	0.596**	0.371*	0.298*	1.000	
5. Healthcare utilization	-0.588**	-0.402**	-0.335*	-0.641**	1.000

Note: *Correlation significant at 0.05 level; **significant at 0.01 level (2-tailed), n = 50.

Source: Primary Data, 2025

All four barrier domains are significantly and negatively correlated with healthcare utilization, with economic barriers showing the strongest association ($r = -0.641$, $p < 0.01$), followed by physical barriers ($r = -0.588$, $p < 0.01$), communication barriers ($r = -0.402$, $p < 0.01$), and attitudinal barriers ($r = -0.335$, $p < 0.05$).

Regression Analysis

Table 4: Multiple Regression Results — Dependent Variable: Healthcare Utilization

Predictor	B	Std. Error	Beta (β)	t	Sig. (p)
(Constant)	5.117	0.384	—	13.326	0.000
Physical barriers	-0.241	0.089	-0.312	-2.708	0.010
Communication barriers	-0.128	0.071	-0.176	-1.803	0.078
Attitudinal barriers	-0.079	0.068	-0.104	-1.162	0.251
Economic barriers	-0.312	0.084	-0.398	-3.714	0.001

Model summary: $R = 0.756$, $R^2 = 0.571$, Adjusted $R^2 = 0.533$, $F(4, 45) = 14.98$, $p = 0.000$

Source: Primary Data, 2025

The overall model was significant ($p < 0.001$) and explained 57.1 percent of the variance in healthcare utilization ($R^2 = 0.571$), with economic barriers ($\beta = -0.398$, $p < 0.01$) and physical barriers ($\beta = -0.312$, $p < 0.05$) emerging as the strongest significant predictors, while communication and attitudinal barriers, although negatively correlated, did not retain statistical significance once the other barrier domains were controlled for.

6.4 Path Analysis (Structural Model)

A path model was estimated to test the hypothesized sequence in which physical and communication access barriers increase economic burden (through the need to seek more distant, accessible facilities), which in turn reduces overall healthcare utilization.

Table 5: Standardized Path Coefficients

Path	Standardized β	C.R. (t-value)	p-value	Decision
Physical barriers → Economic barriers	0.481	3.98	0.000	Significant
Communication barriers → Economic barriers	0.296	2.44	0.015	Significant
Economic barriers → Healthcare utilization	-0.398	-3.71	0.001	Significant
Physical barriers → Healthcare utilization (direct)	-0.312	-2.71	0.010	Significant

Physical barriers → Economic barriers → Utilization (indirect)	-0.191	—	0.006 (bootstrap)	Significant
Total effect (Physical barriers → Utilization)	-0.503	—	0.000	Significant

Model fit indices: $\chi^2/df = 1.62$, GFI = 0.938, CFI = 0.957, RMSEA = 0.061 — acceptable model fit.

Source: Primary Data, 2025

The path analysis shows that physical access barriers reduce healthcare utilization both directly ($\beta = -0.312$) and indirectly by increasing economic burden ($\beta = -0.191$ via economic barriers), with economic barriers functioning as a partial mediator; the total effect of physical barriers on utilization ($\beta = -0.503$) is thus considerably larger than its direct effect alone. Communication barriers, while not directly significant predictors of utilization in the regression (Table 4), exert a significant indirect effect through economic barriers ($\beta = 0.296$ on economic barriers), indicating that their influence on healthcare access operates primarily through the added cost of seeking more accessible alternative facilities.

6.5 Qualitative Findings

Qualitative data corroborated the quantitative patterns: all interviewed deaf respondents reported a complete absence of sign language interpretation at public facilities and reliance on family members to interpret, while respondents with intellectual or psychosocial disabilities disproportionately reported dismissive treatment by health workers. Coping strategies included reliance on family/neighbors for transport and physical assistance, informal cost-sharing through the local disability association, and — among several respondents with mobility impairments — a general pattern of minimizing healthcare-seeking behavior except in cases of acute necessity, consistent with the negative economic-barrier-to-utilization path identified in Table 5.

Discussion Of Results

The findings of this study provide strong empirical grounding for the social model of disability's central proposition that disability-related exclusion from healthcare arises not primarily from individual impairment itself, but from the failure of the surrounding built and social environment to accommodate diverse bodies and communication needs, as clearly illustrated by the widespread absence of basic physical accessibility features such as ramps and accessible toilets at the health facilities serving Mulimira Zone, features whose absence transforms a routine health facility visit into a significant, sometimes insurmountable, barrier for persons with mobility impairments. The path coefficients in Table 5 add an important mechanistic layer to this picture: physical and communication barriers do not only suppress utilization directly, they also operate indirectly by inflating the economic burden of seeking care ($\beta = 0.481$ and 0.296 respectively on economic barriers), so that the total effect of physical barriers on utilization ($\beta = -0.503$) is markedly larger than its direct effect ($\beta = -0.312$) alone, confirming that affordability is not an independent barrier domain but is itself partly produced by inaccessible physical and communication infrastructure. When examined through the WHO access to healthcare framework, the findings reveal deficits across nearly all dimensions of access: availability is compromised by the near-total absence of sign language interpretation services; physical accessibility is

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compromised by inadequate facility infrastructure; affordability is compromised by the disproportionately higher transportation costs incurred by households seeking out more accessible, though often more distant, facilities; and acceptability is compromised, at least for a meaningful minority of respondents, by dismissive or impatient health worker attitudes, particularly towards those with intellectual, psychosocial, or communication-related disabilities. This multidimensional pattern of exclusion aligns closely with prior research conducted in other Ugandan and Sub-Saharan African urban contexts, suggesting that the barriers documented in Mulimira Zone are not idiosyncratic to this particular community but rather reflect broader systemic gaps in disability-inclusive healthcare provision that are simply made especially visible within the constrained infrastructural context of an informal urban settlement.

The finding that a significant proportion of respondents had delayed or foregone needed healthcare due to cost, combined with the qualitative finding that some respondents with mobility impairments had adopted a general strategy of minimizing healthcare-seeking behavior altogether, is particularly concerning from a public health perspective, as it suggests that the cumulative effect of physical, communication, attitudinal, and economic barriers may be producing a pattern of chronic healthcare avoidance among persons with disabilities in the zone, with likely negative consequences for the management of chronic conditions and the early detection of emerging health problems within this population, consistent with the intersectionality framework's prediction that the combination of disability and urban poverty produces compounded disadvantage greater than either factor alone. At the same time, the finding that a majority of respondents did report respectful and helpful interactions with health workers, and the existence of informal community-based coping mechanisms such as mutual assistance within the local disability association, point to important existing strengths and social capital within the Mulimira Zone community that could be deliberately leveraged and formalized as part of any intervention aimed at improving healthcare access, rather than requiring entirely new systems to be built from scratch. Overall, the discussion suggests that while the specific manifestations of healthcare access barriers documented in this study are shaped by the particular infrastructural and socioeconomic conditions of Mulimira Zone, the underlying dynamics reflect a broader, systemic failure to operationalize Uganda's progressive disability rights framework at the point of actual service delivery, reinforcing the conclusion found throughout the disability studies literature that legal and policy commitments to disability inclusion, however well-intentioned, remain insufficient without deliberate, resourced, and locally tailored implementation efforts.

Conclusion

This study concludes that persons with disabilities residing in Mulimira Zone, Bukoto I, continue to face substantial and multidimensional barriers to accessing healthcare, spanning physical infrastructure, communication support, health worker attitudes, and affordability, despite the existence of a supportive national legal and policy framework for disability rights in Uganda. The near-universal absence of basic physical accessibility features at health facilities serving the zone, combined with the complete absence of sign language interpretation services and the disproportionately higher costs borne by households with a disabled member, collectively constrain the ability of persons with disabilities in this community to access healthcare in a manner that is timely, affordable, and dignified,

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with some individuals adopting a pattern of healthcare avoidance that carries significant risks for their long-term health outcomes. The study further concludes that while negative health worker attitudes are not universal and existing community-based support mechanisms provide an important, if informal, buffer against some access barriers, these existing strengths are insufficient on their own to overcome the structural and infrastructural deficits identified, underscoring the need for deliberate, targeted intervention at both the health facility and community levels to close the gap between Uganda's disability rights commitments and the lived healthcare access experiences of persons with disabilities in urban communities such as Mulimira Zone.

Recommendations

Based on the findings and conclusions of this study, it is recommended that the health facilities serving Mulimira Zone, in collaboration with the Kampala Capital City Authority health directorate and the Ministry of Health, prioritize retrofitting existing facility infrastructure with basic accessibility features, including properly constructed ramps with appropriate gradients, accessible toilets, and adapted examination furniture, recognizing that such improvements, while requiring initial investment, are generally far less costly than constructing new facilities and would yield immediate benefits for a significant number of patients with mobility impairments. It is further recommended that the Ministry of Health, in partnership with organizations of persons with disabilities, develop and roll out basic sign language training for health workers at facilities serving communities with significant deaf populations, or alternatively establish a system for on-call or remote sign language interpretation services that can be accessed by public health facilities as needed. The study also recommends that disability-inclusive customer care training be incorporated into continuing professional development programs for health workers, with specific modules addressing the needs and appropriate communication approaches for patients with intellectual, psychosocial, and communication-related disabilities, in order to address the attitudinal barriers identified among a meaningful minority of health workers. To address economic barriers, it is recommended that local leaders and health facility managers explore the feasibility of targeted transport support or subsidized healthcare access schemes for households with a member with a disability, potentially in partnership with the existing local disability association, whose informal cost-sharing practices could be formalized and expanded with external support. Finally, the study recommends that the local disability association and community leaders in Mulimira Zone be actively engaged as partners in monitoring and advocating for continued improvements in disability-inclusive healthcare provision, and that further research be conducted across a wider sample of Kampala's informal settlements to assess the extent to which the barriers identified in this case study are replicated elsewhere, in order to inform citywide and national-level policy responses to disability-inclusive healthcare access.

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