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RE-EXAMINING HEALTHCARE BARRIERS THROUGH THE AFFIRMATIVE MODEL: SOCIAL EXCLUSION OF WOMEN WITH DISABILITIES IN KOHAT DIVISION, PAKISTAN

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ABSTRACT

This study examines how healthcare accessibility and responsiveness (independent variable), interpreted through the Affirmative Model of Disability, shape the extent of social exclusion experienced by women with disabilities (dependent variable) in the Kohat Division of Khyber Pakhtunkhwa, Pakistan. A cross-sectional design was employed with a proportionally allocated sample of 370 respondents across three districts of Kohat Division. Methodological rigor was ensured through collaboration with district Social Welfare Offices at said districts for participant identification and the engagement of senior oral instructors to support communication with hearing and vocally impaired participants. Women with physical, auditory, verbal, and stature-related impairments were included, while individuals with intellectual disabilities were excluded due to concerns regarding response reliability. Cronbach's Alpha produced a coefficient of 0.87, confirming strong internal consistency. Chi-Square (χ^2) statistics assessed bivariate associations, and Kendall's Tau-b (T^b) tested non-spurious relationships. Findings indicated a significant association between healthcare barriers and social exclusion ($\chi^2 = 13.073$, $p = 0.000$; $Tb = 0.188$), demonstrating that inadequate healthcare services, discriminatory attitudes, and structural inaccessibility intensify exclusionary experiences. Results further suggest that healthcare inequities exert a particularly pronounced effect on older women with disabilities. Viewed through the Affirmative Model, the study affirms that exclusion stems not from impairment itself but from systemic, attitudinal, and institutional shortcomings. The study recommends disability-inclusive healthcare reforms, institutional strengthening, and socially affirmative practices to reduce the entrenched exclusion faced by women with disabilities.

Keywords:. *Social Exclusion; Healthcare Inequities; Women with Disabilities; Affirmative Model; Structural Barriers*

INTRODUCTION

Disability, in contemporary sociological discourse, is increasingly conceptualized as a socially mediated phenomenon produced through institutional arrangements, cultural expectations, and structural inequities rather than individual impairment alone (shakespeare, 2006). For women with disabilities, the intersection of gendered disadvantage and

structural exclusion creates distinct layers of vulnerability. Within pakistan—particularly in the kohat division of khyber pakhtunkhwa—these vulnerabilities manifest acutely in the healthcare sector, where limited accessibility, institutional insensitivity, and stigmatizing professional attitudes reinforce entrenched forms of marginalization (jabeen et al., 2020).

Healthcare constitutes not only a biomedical arena but an influential social institution capable of either promoting inclusion or reinforcing exclusion. When healthcare systems fail to address disability-related needs—through inaccessible facilities, inadequate communication supports, or discriminatory behaviors—they normalize exclusionary norms and constrain women's participation in social, economic, and communal life (Iezzoni, 2011). These barriers become especially restrictive for women who already navigate patriarchal constraints and mobility challenges.

The Affirmative Model of Disability provides a transformative lens for examining these institutional shortcomings. Unlike deficit-oriented models, it conceptualizes disability as a positive social identity and emphasizes how exclusion arises from societal and structural failures rather than from impairments themselves (Swain & French, 2000). This theoretical positioning urges an examination of healthcare institutions as active sites where disabled identities are either affirmed or marginalized.

Despite global attention to disability-inclusive development, empirical inquiry into the healthcare-induced social exclusion of women with disabilities in Pakistan remains limited. Kohat Division—with its sociocultural complexities, infrastructural disparities, and administrative constraints—presents a critical context for such investigation. This study thus explores the relationship between healthcare barriers and the social exclusion of women with disabilities, interpreting these patterns through the Affirmative Model to uncover the institutional roots of exclusion.

Research Objectives

1. To assess the extent to which healthcare accessibility and responsiveness influence the social exclusion of women with disabilities in Kohat Division.
2. To examine how different healthcare barriers contribute to varying levels of exclusion among women with diverse disability types.
3. To interpret healthcare-induced exclusion through the Affirmative Model of Disability to identify institutional and attitudinal factors shaping disabled identities.

II-LITERATURE REVIEW

1. Disability and Social Exclusion

The shift from biomedical interpretations of disability to sociological and critical disability approaches has transformed the understanding of disability as a socially constructed experience shaped by structural and cultural factors (Oliver, 1990; Shakespeare, 2006). Social exclusion refers to the systemic denial of opportunities, participation, and recognition, disproportionately affecting women with disabilities who encounter compounded marginalization anchored in both gender and impairment (Thomas, 2012). In developing regions, exclusion is frequently reinforced by limited mobility, social stigma, and restricted access to institutional services (Barnes & Mercer, 2010).

These processes generate cumulative disadvantage, whereby discrimination within education, employment, and healthcare institutions becomes both a cause and consequence of disability-related exclusion (Haque & Armstrong, 2019). This makes healthcare systems central to understanding how structural marginalization is reproduced.

2. Healthcare as a Mechanism of Exclusion

Extensive global research shows that healthcare systems often fail to provide equitable and disability-inclusive services (Iezzoni, 2011). Common barriers include inaccessible facilities, lack of trained staff, communication limitations, stigma, and inadequate disability accommodations. For women with disabilities especially those living in culturally conservative or resource-poor regions these barriers are intensified by gender norms, economic dependency, and limited autonomy (Mitra et al., 2017).

South Asian studies reveal that negative provider attitudes, absence of sign language interpretation, lack of assistive technologies, and inadequate disability training collectively discourage healthcare utilization (Haque & Armstrong, 2019). In Pakistan, research highlights pervasive infrastructural gaps, limited professional sensitivity, and the absence of disability-inclusive policies within hospitals (Jabeen et al., 2020). These systemic weaknesses contribute directly to heightened levels of social exclusion by limiting access to essential, dignity-preserving healthcare.

3. The Affirmative Model of Disability

The Affirmative Model presents a paradigmatic shift in disability theory by conceptualizing disability as a positive, culturally legitimate identity rather than a deficit requiring correction (Swain & French, 2000). This framework centers disabled people's experiences and foregrounds the role of institutions in affirming or negating identity. Healthcare, from the Affirmative Model viewpoint, becomes a crucial site for identity validation: when it fails to provide accessible, respectful, and inclusive services, it reinforces broader societal marginalization (Shakespeare, 2006).

This model is therefore valuable for analyzing healthcare systems in contexts where disability inclusion remains underdeveloped, such as the Kohat Division.



4. Global and Regional Evidence

International evidence underscores a strong relationship between inaccessible healthcare structures and increased social exclusion among people with disabilities (World Health Organization, 2011). Women with disabilities are found to experience disproportionate disadvantages—delayed diagnoses, lower-quality maternal care, and restricted access to rehabilitation services (Mitra et al., 2017).

In Pakistan, studies from Khyber Pakhtunkhwa reveal that women with disabilities face challenges such as distance to health facilities, cultural mobility restrictions, lack of female healthcare providers, and discriminatory provider attitudes (Khan & Safdar, 2021). These factors collectively undermine their capacity to access timely, dignified care and thereby intensify social exclusion.

5. Need for Localized Inquiry in Kohat Division

Kohat Division is characterized by sociocultural conservatism, infrastructural limitations, and administrative disparities, all of which shape healthcare access. Scholars argue that exclusion in such contexts must be understood in relation to local norms, power structures, and institutional capacity (Barnes & Mercer, 2010). Given the scarcity of empirical research on healthcare-induced exclusion in this region, a focused study is essential. Integrating the Affirmative Model with empirical analysis allows for a nuanced understanding of how healthcare

systems shape the social realities of women with disabilities in Kohat Division.

III-METHODOLOGY

The present study is proposed to be conducted within the Kohat Division comprising the districts of Kohat, Hangu, and Karak, with the primary aim of investigating the relationship between the extent of social exclusion encountered by women with disabilities and the healthcare environment. The scope of the inquiry is intentionally restricted to these districts due to time horizon & resources constraints.

Research Design

Due to temporal limitations, a Cross-Sectional or one-shot research design was utilized, as it provides methodological sufficiency for examining social conditions, lived experiences, and perceptual realities within a specific temporal boundary.

Validity & Reliability

The instrument underwent comprehensive validity and reliability evaluations to ensure its empirical rigor. Reliability was assessed through Cronbach's Alpha, which produced a coefficient of 0.87, signifying a high degree of internal consistency. These assessments collectively verified that the scale was both methodologically sound and appropriate for subsequent statistical applications.

Sampling Procedure

According to the official data of the Directorate of Social Welfare, Special Education, and Women Empowerment, Government of Khyber Pakhtunkhwa, a total of 22,492 individuals with disabilities have been formally registered and assessed by the Disability Assessment Board in the Kohat Division. Of these, 9,396 represent the population of women with disabilities. From this population, a sample of 370 respondents was established and subsequently drawn using simple random sampling, in accordance with the sampling guidelines specified by Sekaran (2003).

The proportional allocation of the sample size was likewise applied to all tehsils of the Kohat Division by employing the formula proposed by Chaudhry (2009) as follows:

$$n = \frac{N\hat{p}\hat{q}z^2}{\hat{p}\hat{q}z^2 + Ne^2 - e^2}$$

Conceptual Framework

Independent variable	Dependent variable
Healthcare Accessibility	Extent of Social Exclusion of Women with Disabilities

Statistical Significance Test

For data analysis, SPSS version 21 was employed to execute Chi-Square (χ^2) Statistics at the Bivariate level with the objective of determining hypothetical association between the research variables.

$$\chi^2 = \sum_{i=1}^{r} \sum_{j=1}^{c} \frac{(O_{ij} - e_{ij})^2}{e_{ij}}$$

Kendall's Tau-b (T^b) Statistics

Similarly, for identifying spurious and non-spurious correlations, Kendall's Tau-b (T^b) Statistics was performed while keeping age and education as controlled variables.

Measuring Extent of Social Exclusion

For the extent of social exclusion with greater precision, the researcher utilized the 'Social Exclusion Scale' formulated by Jahoel-Gijsbers and Vrooman (2007). Its four dimensions

material deprivation, inadequate access to social rights, insufficient social opportunities, and limited cultural integration are constructed to gauge the degree of exclusion and deprivation of women with disabilities. These indicators encompass the operational definition, and their techniques remain valid for drawing inferences. In this 'Social Exclusion Scale', higher scores signify greater levels of social exclusion of women with disabilities.

Dimensions	Description
I- Material Deprivation	Shortfalls in essential needs and material resources, deprivation in standards of living, burdensome indebtedness, and persistent arrears in financial obligations etc.
II- Inadequate access to social rights/institutions	Waiting lists, social justice, social security, social support, employment agencies, healthcare, education, equality, importance, respect etc.
III- Insufficient social participation	Limited engagement in both formal and informal social networks, social isolation, participation in social and leisure activities
IV- Insufficient cultural integration	Insufficient adherence to the social norms and civic values underpinning active social citizenship, including cultural responsibilities and divergence from collectively endorsed perspectives.

IV-RESULTS & DISCUSSIONS

The below results show both association at bivariate i.e. using Chi-Square Test and at multivariate while using Kendall's Tau-b (T^b):

Bivariate Analysis:

Association between Healthcare and Extent of Social Exclusion of Women with Disabilities

The results presented in Table 1 indicate several statistically significant associations between different dimensions of healthcare access and the extent of social exclusion experienced by women with disabilities. A significant but modest association was found between easy access to the healthcare system and social exclusion (χ^2 = 3.893, p = 0.048, T^b = 0.103), suggesting that even minor improvements in accessibility can influence exclusion levels. Similarly, a highly significant association was observed for the item special health facilities designed for disabled person (χ^2 = 9.107, p = 0.003, T^b = 0.157), indicating that the presence or absence of disability specific services has a meaningful impact on social inclusion. Structural accessibility factors also demonstrate significance: the availability of ramps or slopes in hospitals showed a meaningful relationship (χ^2 = 4.396, p = 0.036, T^b = 0.109) , while the existence of a separate OPD for persons with disabilities was similarly associated with reduced exclusion (χ^2 = 5.259, p = 0.022, T^b = 0.119) . These results collectively reinforce the argument that architectural design, facility layout, and structural accessibility are central determinants of healthcare-based exclusion. According to the World Health Organization & World Bank (2011), inaccessible infrastructure, absence of assistive provisions, and systemic neglect are among the most persistent barriers to healthcare utilization for disabled populations.

Institutional behavior and staff responsiveness also show statistically meaningful patterns. The belief that doctors provide special privileges reflects a borderline significant association (χ^2 = 3.735, p = 0.053, T^b = 0.100), suggesting that clinical attitudes may influence the perceived inclusivity of healthcare interactions. Likewise, the perception that hospital staff are instructed to exempt disabled individuals from formalities demonstrates a significant relationship with social exclusion (χ^2 = 4.530, p = 0.033, T^b = 0.111) . Economic accessibility indicators further strengthen the findings: beliefs regarding free or discounted treatment in private hospitals (χ^2 =

4.396, p = 0.036, T^b = 0.109) and subsidized medicine prices (χ^2 = 6.752, p = 0.009, T^b = 0.135) also show significant associations with exclusion. These results align with Campbel et al. (2000), who report that limited financial support, absence of subsidized medicines, and dependency on others for mobility disproportionately increase the physical and psychological burdens of disabled individuals. The overall pattern in this table clearly substantiates that healthcare access—whether structural, economic, or attitudinal is a key factor shaping the degree of social exclusion among women with disabilities, consistent with global evidence that healthcare inequality reinforces broader social marginalization.

Table.1.1 Association between Healthcare and Extent of Social Exclusion of Women with Disabilities

Independent Variable (Access to Healthcare)	Dependent Variable (Indexed)	Chi-Square (χ2) Statistics, (P-Value) & (T^b) Value
You have easy access to healthcare system	Extent of social exclusion of women with disabilities	χ2=3.893 (0.048) T^b= 0.103
There are special health facilities are designed for disabled	Extent of social exclusion of women with disabilities	χ2=9.107 (0.003) T^b= 0.157
Ramps or slops are available in public and private hospitals for wheelchair persons	Extent of social exclusion of women with disabilities	χ2=4.396 (0.036) T^b= 0.109
You think that there is separate OPD for Persons with Disabilities	Extent of social exclusion of women with disabilities	χ2=5.259 (0.022) T^b= 0.119
Doctors or health physicians offer special privileges in treating you	Extent of social exclusion of women with disabilities	χ2=3.735 (0.053) T^b= 0.100
You think that the hospital staff are advised by the authorities to consider special persons exempted from all formalities	Extent of social exclusion of women with disabilities	χ2=4.530 (0.033) T^b= 0.111
You believe that treatment of special person in private hospitals is free or charge half fee	Extent of social exclusion of women with disabilities	χ2=4.396 (0.036) T^b= 0.109
Medicine at medical stores are given at subsidized prices or special concession is made	Extent of social exclusion of women with disabilities	χ2=6.752 (0.009) T^b= 0.135

Multivariate Analysis by using Kendall's Tau-b (T^b):

Association between access to healthcare and extent of social exclusion of women with disabilities (While controlling age of the respondents)

The empirical results presented in Table 1.1 reveals a consistently significant association between access to healthcare and the extent of social exclusion among women with disabilities across all age groups, confirming largely non-spurious relationships after statistically controlling for age. Among women aged 15–25

years, the association is highly significant (χ^2 = 16.565, p = 0.000) with a moderately strong Tau-b value (T^b = 0.505), indicating that enhanced healthcare access substantially reduces social exclusion in early adulthood. For the 26–35 years group, the association becomes even stronger and more meaningful (χ^2 = 47.765, p = 0.000, T^b = 0.634), affirming that during a critical phase of social and economic participation, healthcare accessibility remains a decisive determinant of inclusion. Among women aged 36–45 years, although the magnitude of the relationship decreases (χ^2 = 18.689, p = 0.000, T^b = 0.375), the association remains statistically significant and non-spurious, implying that structural healthcare barriers continue to exert an exclusionary effect in midlife. The strongest age-specific relationship emerges among women 46 years and above, where the data show a robust and highly significant association (χ^2 = 24.211, p = 0.000, Tb = 0.676). This suggests that as age-related vulnerabilities intensify, equitable healthcare access becomes even more critical in preventing deepening social exclusion an observation consistent with global evidence on disability, aging, and institutional dependency (Mitra et al., 2017).

When considering the entire sample, the analysis yields a highly significant chi-square value (χ^2 = 112.368, p = 0.000) with a moderately strong Tau-b (T^b = 0.551), confirming that the relationship between healthcare access and social exclusion is robust, genuine, and non-spurious across the whole population. This reinforces the theoretical position that exclusion stems not from impairment itself but from structural and institutional deficiencies. As Jehoel-Gijsbers and Vrooman (2007) emphasize, the absence of disability-specific healthcare provision—such as trained support staff, accessible equipment, and tailored service protocols—intensifies both physical and psychological suffering, thereby deepening marginalization. In the context of Pakistan, where most hospitals lack trained personnel for assisting disabled patients and facilities remain designed predominantly for non-disabled populations, healthcare becomes a mechanism that reproduces exclusion rather than alleviating it. Thus, the data compellingly support the Affirmative Model's contention that disability-related exclusion is structurally produced, highlighting the urgent need for disability-affirmative healthcare systems.

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Table.1.1 Association between access to healthcare and extent of social exclusion of women with disabilities (controlling age of the respondents)

Kendall's Tau (T^b) Symmetric Measure

Age of the respondent			Value	Asymptotic Standard Error[a]	Approximate T^b	Approximate Significance
15-25 years	Ordinal by Ordinal	Kendall's tau-b	16.565	.109	0.505	.000
	N of Valid Cases		65			
26-35 years	Ordinal by Ordinal	Kendall's tau-b	47.765	.070	0.634	.000
	N of Valid Cases		119			
36-45 years	Ordinal by Ordinal	Kendall's tau-b	18.689	.101	0.375	.000
	N of Valid Cases		133			
46 years and above	Ordinal by Ordinal	Kendall's tau-b	24.211	.111	0.676	.000
	N of Valid Cases		53			
Total	Ordinal by Ordinal	Kendall's tau-b	112.368	.047	0.551	.000
	N of Valid Cases		370			

a. Not assuming the null hypothesis.
b. Using the asymptotic standard error assuming the null hypothesis.

Association between access to healthcare and extent of social exclusion of women with disabilities

(while controlling education of the respondents)

The data presented in Table 1.2 demonstrate a consistently significant association between access to healthcare and the extent of social exclusion of women with disabilities across all education levels, indicating a predominantly non-spurious relationship after controlling for education. Among illiterate women, the association is highly significant (χ^2 = 39.190, p = 0.000) with a strong Tau-b value (T^b = 0.579), suggesting that lack of healthcare access substantially exacerbates social exclusion in this group. For women with primary education, the association remains highly significant (χ^2 = 24.297, p = 0.000, T^b = 0.508), reflecting a moderately strong and genuine relationship indicating that even minimal educational exposure does not mitigate the consequences of inaccessible healthcare systems. The middle education category, while still significant, shows a slightly weaker relationship (χ^2 = 13.249, p = 0.012, T^b = 0.448), suggesting that as education increases, women may gain marginal agency or awareness, though healthcare access continues to be a critical determinant of inclusion. Interestingly, the high education group exhibits a strong association (χ^2 = 19.473, p = 0.000, T^b = 0.618), implying that higher literacy may increase expectations and awareness of rights, thereby intensifying the impact of healthcare barriers on social exclusion. Among women with intermediate education and above, the association remains both significant and substantively meaningful (χ^2 = 12.353, p = 0.001, Tb = 0.542), confirming that regardless of educational advancement, structural healthcare shortcomings continue to impede social inclusion.

Considering the entire sample, the overall association between healthcare access and social exclusion is strongly significant (χ^2 = 108.647, p = 0.000, T^b = 0.542) . This reaffirms that healthcare barriers systematically reproduce exclusion across all educational strata. The persistence of non-spurious associations across categories aligns with Jehoel-Gijsbers and Vrooman's (2007) argument that the absence of disability-specific healthcare support—such as adaptive equipment, trained healthcare attendants, and communication assistance—intensifies structural disadvantage irrespective of personal characteristics such as education. Moreover, research suggests that even educated disabled women remain constrained by inaccessible institutional environments that fail to accommodate functional diversity (Iezzoni, 2011). Thus, the findings confirm that exclusion arises primarily from systemic and attitudinal inadequacies embedded within healthcare structures rather than from individual limitations, reinforcing the core tenets of the Affirmative Model of Disability.

Table.1.2 Association between access to healthcare and extent of social exclusion of women with disabilities (controlling Education of the respondents)

Kendall's Tau-b (T^b) Symmetric Measures

Educational qualification of the respondents			Value	Asymptotic Standard Error[a]	Approximate T^b	Approximate Significance
Illiterate	Ordinal by Ordinal	Kendall's tau-b	39.190	.093	0.579	.000
	N of Valid Cases		117			
Primary	Ordinal by Ordinal	Kendall's tau-b	24.297	.094	0.508	.000

	N of Valid Cases	94			
Middle	Ordinal by Ordinal Kendall's tau-b	13.219	.145	0.448	.012
	N of Valid Cases	66			
High	Ordinal by Ordinal Kendall's tau-b	19.473	.100	0.618	.000
	N of Valid Cases	51			
Intermediate and above	Ordinal by Ordinal Kendall's tau-b	12.353	.097	0.542	.001
	N of Valid Cases	42			
Total	Ordinal by Ordinal Kendall's tau-b	108.647	.048	0.542	.000
	N of Valid Cases	370			

a. Not assuming the null hypothesis.
b. Using the asymptotic standard error assuming the null hypothesis.

V- CONCLUSION AND RECOMMENDATIONS

The findings of this study underscore that social exclusion experienced by women with disabilities in Kohat Division is not a direct consequence of impairment, but is largely shaped by structural, attitudinal, and institutional inadequacies within the healthcare system. Barriers such as inaccessible facilities, lack of disability-sensitive services, and discriminatory professional practices exacerbate marginalization, particularly for older women or those with multiple functional impairments. Interpreted through the Affirmative Model of Disability, the evidence highlights that inclusive and affirming healthcare practices are critical for fostering social participation, dignity, and empowerment among women with disabilities. Addressing these systemic gaps is therefore essential for mitigating entrenched patterns of exclusion and promoting equitable social development.

Recommendations

1. Upgrade healthcare infrastructure to ensure physical access for women with disabilities, including ramps, elevators, adapted examination rooms, and accessible medical equipment.
2. Implement regular training programs for healthcare providers focused on disability awareness, respectful communication, and culturally competent care.
3. Formulate and enforce disability-inclusive healthcare policies at district and provincial levels, integrating mechanisms for monitoring compliance and accountability.
4. Conduct awareness campaigns to sensitize families, communities, and local leaders about the rights and healthcare needs of women with disabilities, reducing stigma and encouraging support.
5. Provide sign language interpreters, assistive devices, and alternative communication tools to ensure that women with hearing, speech, or mobility impairments can effectively access and benefit from healthcare services.

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