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Inclusive Healthcare in Emerging Economies: Regional Insights from Bihar's Women with Disabilities

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ABSTRACT

Health is a basic human right and fundamental to the Indian constitution; good health and well-being are central to our very existence. Women in rural India face barriers in accessing healthcare services because of the infrastructural issues, geographical disadvantages, lack of transport services, etc., and this intensifies already existing problems for the disabled women. In spite of so many government policies and initiatives, including the National Health Mission (NHM), disabled women still face significant barriers in accessing healthcare services. This Paper examines the relationship between the realization of the right to healthcare for disabled women and geographical accessibility in rural Bihar. This study is a review paper conducted for the years 2015-2026. A systematic literature search was conducted using Google Scholar, and relevant literature, policy documents, and government reports were selected using the PRISMA framework. The selected literature was categorized under different themes for analysis, and it emphasized how gender, disability, lack of legal knowledge or awareness, long distance to healthcare centers, and uneven distribution of healthcare resources intensify healthcare exclusion of disabled women. The findings suggest that, while the NHM has played a significant role in rural healthcare, its expansion still lacks in providing disability inclusive healthcare services. This paper highlights the need for inclusive health policies under NHM for realizing the right to healthcare for disabled women in rural Bihar. The paper contributes to the ongoing discussion on disability-friendly healthcare services, accessibility, and inclusive public health policy in India. While the study is regionally focused on Bihar, its findings resonate with broader challenges faced by women with disabilities in emerging economies, where infrastructural deficits, uneven healthcare distribution, and policy gaps remain common.



Keywords: Women with Disabilities, Healthcare Accessibility, Geographical Barriers, National Health Mission, Right to Healthcare.



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INTRODUCTION

The World Health Organization defines disability as a broad term covering impairments, activity limitations, and participation restrictions. While the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) defines disability as “any long-term physical, mental, intellectual or sensory impairment which, in interaction with various barriers, may hinder the full and effective participation of disabled people in society on an equal basis with others.”

Right to healthcare is not a sort of privilege rather it is a legal right where an individual by all means has the right to access healthcare services in order to be healthy and work efficiently (Aneraye & Shirpurkar, 2023). It is the fundamental human right of every individual to access healthcare, and so the same right is also applicable to the disabled person. Article 25 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) recognizes the right of persons with disabilities to attain quality healthcare without any biases.

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India officially ratified this in October 2007, and to fulfill the ratification agreement, it implemented this as the [Rights of Persons with Disabilities \(RPwD\) Act, 2016](#). India is bound to provide all the means by which a person with disability can access or attain a standard health facility without any discrimination on the grounds of disability. This act has increased the number of disabilities from the 7 categories of the previous Persons with disability act of 1995 to 21 categories in RPwD 2016 ([Balakrishnan et al., 2019](#)).

In a study conducted to review and analyze the legislation of the RPwD Act 2016, it was found that inclusion of persons with disabilities in society is still a challenge ([Gupta & Arora, 2020](#)). People with disabilities face significant barriers in accessing healthcare services ([Senjam & Singh, 2020](#)). Women with disabilities have complex healthcare issues as compared to men with disabilities, so they need special healthcare as compared to the rest of the population, particularly in reproductive health ([Matin et al., 2021](#)). Not only this, despite having provisions under the [RPwD Act 2016](#), women with disabilities are still subjected to non-consensual sterilizations and abortions, which violate their right to health ([Raha & Sengupta, 2018](#)).

In one of the studies conducted, the author reported how the lack of healthcare at the early stages of development in the girl child led to permanent disability ([Mishra, 2019](#)). Another study highlighted that there are instances of physical abuses against women with disabilities as per media sources, despite having specific provisions for their protection in Section 4 of the RPwD Act, which is solely meant for Women and children with disabilities ([Gupta & Arora, 2020](#)).

Although legal provisions exist, there are implementation gaps, especially in rural areas, disabled women remain invisible in policy application ([Dhar & Roy, 2021](#)).

As per the National Health Systems Resource Center (2021), there were awareness gaps regarding National Health Mission entitlements among disabled women. The Government of India subsumed the National Rural Health Mission (NRHM, 2005) and the National Urban Health Mission (NUHM) into the National Health Mission and launched it in 2013. Its aim is to attain universal access to equitable, affordable, and quality health care services. Some of the flagship initiatives of NHM include Janani Suraksha Yojana, Pradhan Mantri Surakshit Matritva Abhiyan, and ASHA program have evidently shown improvement in the subsequent years and significantly reduced maternal mortality ratio.

National Health Mission's RMNCAH+N (Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition) or guidelines for maternal health do not have dedicated provisions for women with disabilities, and there are no separate guidelines to address accessibility issues of pregnant disabled women. In this way, NHM misses out on providing inclusive healthcare to all, and especially to the marginalized section, i.e., women with disabilities. Even though the government of India and other stakeholders are putting an enormous effort to ensure welfare and health coverage of the disabled population, particularly the women counterparts, yet for women with disabilities, the right to healthcare is legally recognized but hardly enforced into practice, so implementation of these rights must become a reality ([Senjam & Singh, 2020](#); [Prakash, 2018](#)).

Bihar has a population of around 124 million inhabitants as per the census 2011, its ranking in the Human Development Index is below a satisfactory level among all the states of India. Some of the pressing issues of the state include flood-prone rural regions of the state, poverty, high maternal and infant mortality rate, early marriage, hunger, migration of labor in search of better economic activities (National Disaster Management Authority, NITI Aayog, Sample Registration System, Economic Survey of Bihar).

In order to reach its maximum potential to contribute in nation's development, it is very important to look after its human capital. A fit and healthy population contributes much more efficiently than those who are not healthy or suffering from any form of disability. In a study conducted, it was found that there is a high disability prevalence in Bihar due to poverty and poor health infrastructure ([Roy, 2019](#)).

In a study conducted, it was observed that women who were poor as well as disabled were much more vulnerable than the general population, and it was argued in the triple disadvantage framework (Diwakar, 2023). Women with disabilities have to face challenges in accessing healthcare services, be it geographical, social, economic, etc. Of all the barriers, the geographical factor is a deterministic one; it covers the spatial dimension of health issues (Mishra, 2019). It does not encompass only physical distance that is required for accessing health services, but also includes availability of transportation system, road network, flood-resilient infrastructure, and equally distanced healthcare centers. Women with visual, locomotor, intellectual, or hearing challenges find it extremely difficult to access even a routine check-up as these spatial barriers act as constraints in seeking health services (WHO 2011, 2022; UNCRPD articles 9 and 25).

The barriers identified in Bihar reflect wider patterns across emerging economies, where rapid population growth, poverty, and weak health infrastructure intersect with disability to restrict healthcare access.

Objective:

1. To understand the geographical barriers faced by women with disabilities while accessing healthcare services in Bihar.
2. To examine policy interventions that should be taken into consideration to realize the right to healthcare for women with disabilities in Bihar?

METHODOLOGY

Search Strategy

This study adopts a systematic review design, and for this, the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 framework has been used. A review paper is based on the findings of other papers, and the purpose of this review paper is to organize suitable literature in a structured way to present new findings related to the core issue. It is important to write a review paper so as to highlight the pros and cons of various approaches adopted for a study and to spot research gaps.

Systematic review is the gold standard for conducting a review paper, which includes locating and evaluating relevant research articles in order to establish procedures and methods, reducing biases, and producing scientific findings that help to formulate policy guidelines or changes.

Inclusion and exclusion criteria

The inclusion criteria consisted of the studies published between 2015 and 2026 in the English language, specifically peer-reviewed articles and research papers. Precisely those articles and research papers were searched that addressed the geographical barrier faced by women with disabilities in accessing healthcare services. Publications related to women with disabilities, geographical barriers faced by WwD, and the National Health Mission in association with disability were taken into consideration. The final selection procedure consisted of reviewing abstracts, whereby 25 papers were found to be apt as per the objective of the study. This included studies based on primary data, secondary data, government reports, and review papers. Those papers were excluded from the study that did not belong to the said time frame, nor were they in the English language. Research papers or articles that were done on non- NHM private health systems, opinion pieces without any credible data source, duplicate studies, and conference abstracts or proceedings without full data were excluded.

Data Extraction and Analysis

Strict inclusion and exclusion criteria were taken into consideration for the selection of relevant research papers and articles using Google Scholar as the database. Post-selection, the respective papers were moved to an Excel spreadsheet for an additional analysis. The given table 1 summarises the studies, which include the authors, Location, study design, purpose, and findings of the study. Further papers citing geographical barriers as one or the only issue were closely reviewed.

Table 1. Summary of selected papers

Authors	Study design	Location	Purpose	Findings
Dhar & Roy, 2021	Secondary data	India	RPwD act	The progress of making an enabling environment for PwDs is rather slow. Weak enforcement of disability rights in healthcare systems, strengthen the implementation mechanism and monitoring of the RPwD Act. Ensure an inclusive healthcare infrastructure that covers the needs of disabled women.
Kushwah & Maurya, 2025	Review paper	India	Geographical & structural barrier. Rights of WwD	Structural issue faced by PwD: lack of ramps, elevators, tactile paving, audio signals, and accessible last-mile services. Adopt universal design principles for upgrading the infrastructure used by PwD.
Alam et al. 2022	Review paper	Global	Structural barrier & Rights of WwD	limited research to understand the mobility needs, patterns, and constraints of PwD in rural areas of developing countries. Infrastructural inequities like a lack of sidewalks, lighting, and safe public transit. Invest in inclusive infrastructure for disabled women.
Kumari, 2025	Secondary data	Bihar	Geographical & structural barrier.	Uneven distribution of facilities, shortage of medical staff, weak referral systems, and overcrowding at district hospitals. Poor disaster preparedness in flood-prone areas. Invest in flood-resilient healthcare infrastructure. Ensure community participation, empower panchayats, ASHA workers, NGOs, and upgrade PHCs into H&WCs.
Kumar & Birendri, 2024	Secondary data	Bihar	Geographical & structural barrier. Rights of WwD	Infrastructural deficits, workforce shortages: Doctor-to-patient ratio: 1:17,685 (vs. WHO's 1:1000), a considerable percentage of rural patients still buy medicines privately despite NHM provisions. Rural-urban disparities in healthcare accessibility. Alternatives like Telemedicine, mobile health apps, and opening HWCs should be adopted.
Dassah et al., 2018	Review paper	Global	Geographical & structural barrier.	High costs of care and transport deter PWDs. Geographical barriers like long distances to facilities, poor roads, lack of transport, and difficult terrain (mud, floods, rivers) affect PwD. Physical inaccessibility of facilities leads to a financial burden on PwD. Disability grants provision and an inclusive health insurance scheme should be made in the existing policies.
Udas et al., 2021	Primary data	Bihar	Geographical barrier	Disability intersects with gender and poverty, amplifying vulnerabilities for them. Recurrent floods make it difficult for disabled women to access healthcare services. Improve healthcare accessibility and healthcare infrastructure.

Madhuri et al., 2016	Mixed-method	Bihar	Geographical barrier	Structural flood control measures like dams and levees have failed to address waterlogging and drainage congestion in the region, which consequently affects the service accessibilities of the population. Establish local camp centers or offices for rehabilitation.
Baart & Taaka, 2017	Secondary data	Developing countries	Rights of PwD	For many PwD getting into the facility is so challenging that it immediately discourages them from even attempting to seek healthcare. Reproductive health services were particularly inaccessible due to the stigma that PwD are "asexual". construct physically accessible buildings, Improve physical accessibility of health facilities, subsidize healthcare and transport costs for disabled persons.
Dean et al., 2017	Primary data	Gujarat	Geographical barrier & Rights of PwD	Physical barriers to Sexual and reproductive health services for disabled women. Improve accessibility and physical infrastructure. Ensure disabled women's experiences are included in the women's rights movement.
Yadav et al., 2025	Primary +Secondary data	Bihar	Geographical & structural barrier	Shortage of doctors, Infrastructural gaps, limited transport facilities, geographical inaccessibility, and weak implementation of government health schemes were some of the findings. PHC should be strengthened, and adequate staffing should also be done at healthcare centers.
Pattnaik et al., 2023	Secondary data	India	Rights of PwD	PwDs often prefer NGO/Trust facilities over public/private hospitals; gaps were found in policy implementation. Strengthen disability inclusive policies under the RPwD Act 2016.
Patel et al., 2018	Primary data	India	Geographical & structural barrier. Rights of PwD	Women with disabilities experience limited access to reproductive and maternal care. Physical barriers and infrastructural gaps restrict service use. Improve infrastructure and integrate disability rights into mainstream gender and health rights.
Garg et al., 2025	Mixed-method	India	Geographical & structural barrier, NHM.	Distance Barrier, Specialist Shortage, policy gaps, no dedicated disability budget under MoHFW, weak integration of disability provisions in NHM. A dedicated disability budget should be made, along with it, NHM should integrate more disability specific provisions.
Venkatesulu, 2017	Secondary data	India	Geographical barrier & Rights of PwD	Inaccessible hospitals, scarcity of disability data related to reproductive and sexual health violence. Disability related laws should be properly implemented.
Casebolt et al., 2023	Secondary data	Rajasthan	Rights of PwD	Limited ANC use, data gaps, and systematic barriers. Ensure maternal health services are accessible to WWD under the Rights of Persons with Disabilities Act (2016).

Kumar et al., 2025	Mixed-method	Bihar	Geographical & structural barrier. Rights of PwD	Participants reported low trust in public healthcare. Inadequate services, shortages of doctors, Poor management, long waiting times, longer distances, and difficulties accessing facilities worsened distrust. Improvement is needed in all these aspects so as to make healthcare accessible, especially to WwD.
Roy, 2019	Secondary data	Bihar	Geographical & structural barrier. Rights of PwD	Bihar shows a higher incidence of disability as compared to the national average; it is strongly linked to poverty, illiteracy, and rural residence. Improve data collection on disability and monitoring to guide targeted interventions.
Raj et al., 2020	Secondary data	Bihar	Geographical & structural barrier. Rights of PwD	Accessibility barriers in transport and public buildings. Low coverage of disability certificates and pensions. Increase coverage of disability certificate issuance.
Das et al., 2023	Secondary data	India	Rights of WwD	Gender norms restrict autonomy and mobility. Make Policies focused on marginalized women to reduce inequalities.
Kumar, 2024	Mixed-method	Bihar	Geographical & structural barrier. Rights of WwD	Low awareness of the RPWD Act among PwDs. Poor infrastructure and limited accessibility in rural areas. Underrepresentation of PwDs in policy implementation. Improve accessibility in remote areas, and initiate awareness campaigns to educate PwDs. Conduct longitudinal studies to monitor the implementation of the act.
Kewaliya et al., 2025	Secondary data	India	Rights of WwD	Legal frameworks such as the RPwD Act, 2016, exist, but they fail to address the reproductive rights of WwD. Integrate disabled women's reproductive rights into reproductive health policies.
Rahman & Kumar, 2023	Secondary data	Bihar	Geographical barrier	The district has overall good connectivity, but accessibility is uneven. Accessibility decreases as the distance from the district HQ increases. New roads should be built in remote settlements.

Source: Prepared by the author

Although the review is regionally grounded, the analytical framework is designed to highlight issues that are transferable to other emerging economies facing comparable geographical and infrastructural barriers.

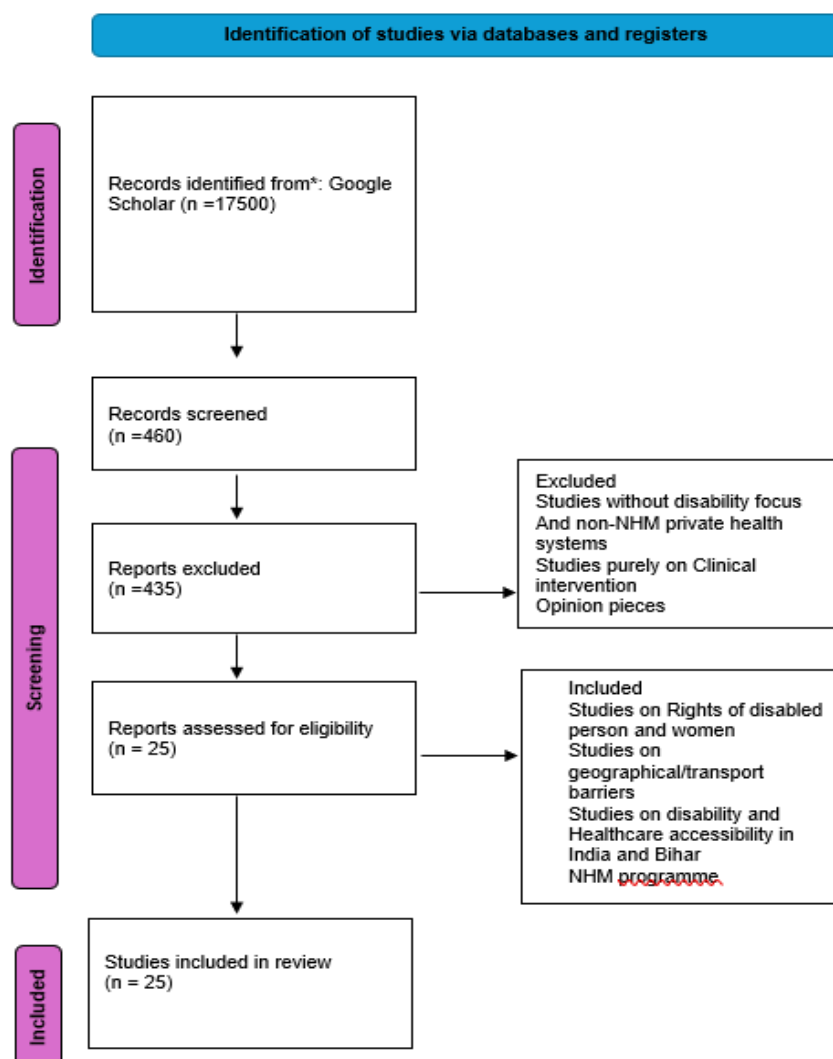
RESULTS

The barriers faced by women with disabilities in Bihar are not isolated; they reflect wider challenges across emerging economies where poverty, weak infrastructure, and geographical disadvantages converge to restrict healthcare access. Positioning Bihar within this global context allows the study to serve as a representative case for understanding how geography and disability intersect to limit healthcare rights in societies undergoing rapid development.

Figure 1 represents the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 flowchart, clearly showing the study selection for this review paper, for this certain keyword were used which generated a total of 17,500 hits in the Google scholar. About 460 studies were screened after removing duplicates. After carefully going through the titles/abstracts of studies, 435 studies could not be included as they were not found relevant according to the inclusion criteria. Ultimately, 25 studies made it to the final selection list, comprising relevant papers, research articles, government reports, secondary data from health surveys, NFHS – 5 report, Census of India (2011), ranging between 2015 and 2026. This method is used for identification, screening,

inclusion, and exclusion of relevant book chapters, peer-reviewed research papers, grey literature, government reports, and review papers.

Figure 1: PRISMA flowchart, 2020



Source: Prepared by the Author

The final selection of 25 studies provided the empirical foundation for thematic analysis, particularly highlighting geographical barriers and disability-specific challenges in healthcare access. Figure 1 illustrates the systematic screening process that ensured methodological rigor.

Discussions on Geographical Barriers to Healthcare Access

Geographical barriers remain one of the most persistent challenges in ensuring equitable healthcare access for rural women in Bihar, and these challenges intensify for women with disabilities who face compounded disadvantages. The discussion is organized around three major themes of geographical barriers, distance and proximity, transport connectivity, and spatial isolation, each of which intensifies healthcare exclusion for women with disabilities in Bihar.

Distance and Proximity - Numerous studies have confirmed that physical distance to healthcare facilities is one of the significant geographical barriers for rural women of Bihar, and this is intensified for those women who are differently abled. According to a study, 33% of women in India have reported distance to health facility as a primary barrier in accessing health services (Kumar, G., & Reshmi, R. S). Further long distances required for

accessing healthcare services have created a negative sentiment and resulted in low trust in public healthcare ([Kumar et al., 2025](#)).

Proximity remains a significant barrier in accessing healthcare services by the rural women of Bihar, and especially disabled women. Despite the implementation of national health policies and programs, proximity and physical distance continue to affect the healthcare accessibility of the disabled women of the state. Although over the year it has improved, a lot more needs to be done. The annual report of the Ministry of Health and Family Welfare highlighted that the lack of sufficient healthcare facilities makes proximity a more significant constraint than affordability ([Balla et al, 2026](#)).

Transport connectivity - In a study conducted, it was found that there is a regional imbalance in the road infrastructure of the study area (Bihar). Also, the peripheral and the rural areas remain underserved, which severely impacts the social development of the region ([Rahman & Kumar, 2023](#)). Poor road connectivity directly affects the accessibility of healthcare services to rural women in the state, and limited road accessibility impacts women who have mobility impairments and women with disabilities.

As per a Report from the Office of the State Commissioner for Persons with Disabilities (Bihar), most people with disabilities did not access public transport, and the share was found to be around 54%. It emphasized how important it is to have disabled friendly infrastructure for their holistic welfare ([Raj et al., 2020](#)). The transportation system is an important nodal point in serving healthcare services to rural women and especially disabled women, and it needs to be strengthened as per the National Health Systems Resource Center.

Spatial Isolation – The spacing of healthcare infrastructures is one of the core issues that needs to be addressed to ensure access to healthcare services for disabled women. In a study conducted, it was found that villages were far from health facilities, which significantly affects the needs of the residents that need to be provided. ([Yadav et al., 2025](#)). In another study, it was suggested to improve

Healthcare accessibility in remote areas through resource centers. (S Kumar, NFHS – 5). Further, low trust in public healthcare has been reported due to inadequacy of services like infrastructure, facilities, and lack of health workers' visits. This ultimately affects a section of those individuals who are marginalized and already vulnerable, that is, disabled women ([Kumar et al., 2025](#)).

Altogether, distance, transport connectivity, and spatial isolation illustrate how geography interacts with disability and gender to restrict healthcare access, underscoring the urgent need for inclusive, disability-sensitive infrastructure and policy interventions in Bihar. These geographical barriers are not unique to Bihar; they mirror conditions in other emerging economies where rural isolation, poor transport, and uneven facility distribution similarly disadvantage women with disabilities.

Thus, while this paper is regionally grounded in Bihar, its findings resonate with broader patterns across emerging economies. The analysis highlights how inclusive healthcare policies must move beyond expansion to address accessibility and rights, making Bihar a microcosm of the wider struggle for equity and disability-sensitive health systems in emerging contexts.

Policy Implications for Inclusive Healthcare in Bihar

The findings of this review have important policy implications for strengthening inclusive healthcare services for women with disabilities in rural Bihar. The existing barriers indicate that healthcare policies under the National Health Mission need to move beyond general service expansion and give greater attention to accessibility, mobility, infrastructure, and the specific needs of women with disabilities.

Realization of the right to healthcare for women with disabilities in Bihar is difficult, even after the RPwD Act and NHM implementation. The review shows how the geography of an area is responsible for excluding disabled women from accessing healthcare services — whether it is physical distance, infrastructural issues like poor road network, insufficient transport system, or lack of climate-resilient infrastructure during floods. Further, other factors like shortage of healthcare centers, lack of skilled medical professionals, absent disaggregated data, slow

process of issuing disability certificates, and structural issues such as inaccessible buildings, pavements, reproductive care facilities, stretchers, and sidewalks exacerbate the problem. These concerns should have been considered under mainstream health programs to provide equitable access to women with disabilities.

The literature and evidence clearly show that geographical distances, poor road connectivity, and transportation issues are major barriers faced by women with disabilities in accessing healthcare services. However, these issues cannot be interpreted solely as physical distance problems; they are connected with poverty, transport accessibility, gendered mobility restrictions, and financial dependence on caregivers. As a result, many studies noted that a health facility may be geographically available but functionally inaccessible due to these intersecting factors. This suggests that the lack of physical expansion of healthcare facilities and conventional measures of healthcare coverage under NHM may affect usage by women with disabilities.

These points highlight a critical gap in evidence, which is not only about NHM implementation. From the 24 included studies, it was clear that disability-specific data are sparse. Most studies focused on rural or marginalized women, while women with disabilities were either absent, reported without validation, or treated as secondary variables. This indicates that “geographical barrier” and “disability and healthcare access” literature have developed in parallel rather than in dialogue. Such fragmentation limits the degree to which NHM-specific recommendations can be made confidently for women with disabilities and is a methodological limitation that should be stated clearly.

The continuation of these obstacles also amounts to an implicit criticism of NHM’s design principles. A program largely centered on facility-based service delivery and outreach presumes a minimum standard of physical accessibility that flood-affected and geographically remote regions of Bihar do not consistently offer, a situation further aggravated by disability. The findings indicate that NHM’s transport and outreach mechanisms, such as referral transport schemes, have not been thoroughly examined with disability access as an exclusive criterion during drafting, raising the question of whether current interventions systematically exclude this demographic instead of merely underserving it.

This is not only an implementation failure but a rights failure. The motive of NHM is equity and welfare for all, yet healthcare accessibility should reach everyone — especially those marginalized by the intersection of gender, disability, and geography. This is a classic example of triple disadvantage with no single policy addressing all these issues simultaneously, and women with disabilities in Bihar are prime examples.

The recommendations include ASHA training, improving road networks, addressing waterlogging, strengthening health infrastructure with climate-resilient design, better spacing and distribution of healthcare services, and structural improvements such as pavements, sidewalks, and street lighting. The process of issuing disability certificates should be expedited, with legal support provided in case of mishaps. Ultimately, realizing the right to healthcare for women with disabilities in Bihar is not a peripheral concern but a test of India’s commitment to the UNCRPD promise of full and equal enjoyment of human rights.

Key policy priorities should therefore include strengthening ASHA workers through disability-sensitive training, improving road and transport connectivity, addressing flood-related disruptions, and developing climate-resilient and physically accessible healthcare infrastructure. Greater attention is required to the spatial distribution of healthcare facilities, including accessible pavements, sidewalks, and adequate street lighting. The process of issuing disability certificates should be made more accessible and timely so that eligible women can effectively access entitlements and services.

Bihar serves as a microcosm of the wider struggle in emerging economies to reconcile healthcare expansion with equity, accessibility, and rights-based inclusion. These measures can help bridge the gap between formal recognition of healthcare rights and their practical realization for women with disabilities in emerging economies. A disability-inclusive approach within NHM is essential for ensuring equitable, accessible, and rights-based healthcare delivery.

Limitations and scope for future research

This review has some limitations, including less Bihar-specific disability data of women related to health studies, and that certainly means much of the analysis draws on national-level data or comparable state contexts. Also, only Google Scholar has been used as a database for searching the relevant papers. This is a review paper, and it is based on secondary sources; no original data collection was done to match the results.

Future research should move beyond documenting barriers, and Policy attention should shift from general rural outreach expansion toward accessibility-focused, transport, and facility design that gives more importance to disability needs rather than treating it as a secondary concern.

CONCLUSION

The review demonstrates that women with disabilities in rural Bihar continue to face significant barriers to healthcare despite the implementation of the National Health Mission and the Rights of Persons with Disabilities Act, 2016. Geographical distance, poor transport connectivity, inadequate infrastructure, shortage of healthcare personnel, and flood-related disruptions collectively limit accessibility. These barriers are further intensified by gender, poverty, limited awareness, and social restrictions. The findings highlight the need to integrate disability-inclusive measures into NHM through accessible infrastructure, improved transport, trained healthcare workers, better outreach, and reliable disability-disaggregated data. Realizing the right to healthcare for women with disabilities in Bihar is not only a regional imperative but also a test case for emerging economies worldwide, where inclusive health systems remain central to achieving equity and global commitments under the UNCRPD.

AUTHOR DECLARATIONS

CRedit author statement / Author contributions

Jahanvi: Conceptualization; Validation; Formal Analysis; Investigation; Writing – Original Draft; Writing – Review & Editing.

Awadhesh Kumar: Supervision; Project Administration; Visualization; Review.

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