



Exploring the healthcare access challenges faced by visually impaired young women in Nepal: Navigating sexual harassment and stigma within healthcare settings

Amit Timilsina^{a,b}, Pabitra Neupane^a, Janaki Pandey^c, Aastha Subedi^d, Subash Thapa^{e,*}

^a Department of Gender Studies, Tribhuvan University, Kathmandu, Nepal

^b Department of Public Health, University of Southern Denmark, Esbjerg, Denmark

^c Nepal Health Research Council, Kathmandu, Nepal

^d Central Department of Public Health, Tribhuvan University, Kathmandu, Nepal

^e Rural Health Research Institute, Charles Sturt University, Orange, New South Wales 2800, Australia

ARTICLE INFO

Keywords:

Disability-related prejudice
Intersectionality
Sexual harassment
Structural factors
Visually impaired women
Women's health

ABSTRACT

Introduction: Despite global progress in gender equality, still not every woman has access to safe and the highest quality health care. Visually impaired young adult women represent one of the most vulnerable groups with a poorer ability to access necessary healthcare services. This study aims to explore and comprehend the experiences of visually impaired young adult women in accessing healthcare services in Nepal.

Methods: A descriptive phenomenological study was conducted among 16 visually impaired women aged 20 to 35 years who had utilized healthcare services within the past 12 months. Face-to-face, in-depth interviews were conducted for data collection, and thematic analysis was conducted for data analysis.

Results: Our study revealed a range of challenges faced by visually impaired young women that impeded their healthcare-seeking. These challenges included sexual harassment by male healthcare providers, disability-related stigma, financial difficulties, limited autonomy in decision-making, and a lack of disability-friendly healthcare facilities and services. Particularly, experiencing sexual harassment from male healthcare providers, coupled with underlying disability-related stigma, profoundly influenced the avoidance of healthcare. To navigate these challenges, some women sought support by having family members or friends accompany them or by requesting to be seen by a female healthcare provider. Nevertheless, financial dependence on families and women lacking employment and income led to a feeling of burden on the family, contributing to a reluctance among women to seek expensive healthcare. Social organization-based, collaborative efforts and peer support networks played a significant role in breaking down barriers and improving overall healthcare experiences.

Conclusions: While integrating disability-friendly healthcare services and infrastructure is essential, fostering attitudinal and behavioral change—particularly among male healthcare providers—is more important to ensure safety for young women in healthcare settings. The implementation of anti-sexual harassment policies is imperative to ensure a safe and respectful environment. Community mobilizing and peer group-based programs can be tested for increasing visually impaired women's utilization of relevant healthcare services.

1. Introduction

Disability is a multifaceted construct that encompasses impairments, activity limitations, and participation restrictions arising from the interaction between individual, contextual and environmental factors. The World Health Organization (WHO) estimates that over one billion individuals, comprising approximately 15% of the global population,

live with some form of disability—a number projected to double by 2030 [1]. Due to its profound impact on daily functioning and personal circumstances, visual impairment — partial or total loss of vision or visual function — is considered a substantial disability. In low- and middle-income countries (LMICs), including Nepal, visual impairment is highly prevalent. Although exact figures are challenging to document, approximately one in five persons with disabilities in Nepal report some

* Corresponding author.

E-mail address: suthapa@csu.edu.au (S. Thapa).

<https://doi.org/10.1016/j.dialog.2024.100171>

Received 4 August 2023; Received in revised form 25 January 2024; Accepted 25 January 2024

Available online 26 January 2024

2772-6533/© 2023 The Authors. Published by Elsevier Inc. CC BY-NC-ND 4.0 This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

form of visual impairment or blindness (approximately 130,000 persons) [2,3].

Previous studies have explained vulnerabilities of people with disabilities due to the interplay of individual level factors and higher social and structural factors, including prejudices (among policy makers, healthcare providers, and society at large), denial of services, or a general lack of tailored disability-friendly services in healthcare institutions and travel systems [4,5,6,7,8,9]. One commonly reported mechanism among the studies is that experiences of discrimination, stigma and harassment within the healthcare systems and associated feeling of shame or fears of mistreatment lead to avoidance of seeking health care [10]. Healthcare access can differ according to personal characteristics as well as the severity and nature of disability. Compared to various other groups, young adult women with visual disabilities are more vulnerable to facing barriers to a greater extent and may experience significantly lower rates of healthcare service utilization.

Among the other important barriers to healthcare access for women with visual impairment is a financial barrier, which is a result of low socio-economic situation compounded by disabilities and adverse health conditions [11,12]. Coupled with gender, young women with disabilities, including those with visual impairment, further experience heightened levels of abuse, stereotyping, and gendering related to their disability condition, along with limited access to information and services [13,14,15]. In high-income country settings, health systems have made significant progress in achieving inclusivity and tailoring services to be disability friendly. Still, it is undeniable that stigma and harassment remain prevalent. While in LMICs, including Nepal, the challenges faced by young women with visual impairment in accessing healthcare services are not clearly known due to a lack of studies focusing on this pertinent issue [14,16].

A few available studies in Nepal have focused on investigating persons with disabilities, reporting on physical, architectural, socioeconomic, and attitudinal barriers to healthcare access [17,16,8]. In the last decade, Nepal has made some progress in the developing and implementing policies and programs to integrate individuals with disabilities into mainstream healthcare systems. Examples include the Act Relating to Rights of Persons with Disabilities-2017, Gender Equality and Social Inclusion Strategy of the Health Sector-2018, Right to Safe Motherhood and Reproductive Health Act-2018, National Guidelines of Disability Health Services-2019 [18–21]. The aim of these policies is to reduce social and health inequalities, promote empowerment and social inclusion of persons with disability and enhance their access to healthcare services through community rehabilitation and education programs. However, it is unclear whether and to what extent these interventions have been effective for young women with visual impairment [22].

It is important to gain a better understanding of the challenges faced by visually impaired young women while accessing healthcare services. Only by exploring these experiences through intersectionality we can comprehend the comprehensive need of visually impaired women, and the attitudes and behaviors that exist within the healthcare system are whether supportive towards increasing access to healthcare [23,14]. Therefore, this study explored the lived experiences of healthcare access among visually impaired young women, aiming to comprehend the challenges they face through an intersectionality approach. The intersectionality approach analyzes the experiences of women with visual impairments from the perspective of the women themselves, taking into account associated power dynamics, positionalities, and access to opportunities and resources [24]. We believe that the findings of this study will provide insights to inform the development of healthcare policies and practices, emphasizing patient-centered care, and ultimately lead to improved healthcare outcomes for visually impaired young women.

2. Methods

This was a descriptive phenomenological study aimed at exploring lived experiences of visually impaired women about their healthcare

access, which is an understudied phenomenon, especially in the context of Nepal. Phenomenology is a philosophical framework that focuses on understanding the subjective experiences and meanings attributed to phenomena from the perspective of those experiencing them [25]. It seeks to explore the essence and structure of lived experiences, aiming to capture the first-person perspective and provide rich descriptions about unique challenges, perceptions, and adaptations (coping mechanisms) that arise from living with visual impairment. Further, the intersectionality approach allows us to delve into the lived world of women who navigate their surroundings, and explores how they engage with their environment, interact with others amidst varying power dynamics, and make meaning of their experiences [25].

2.1. Participants and sampling

Women aged 20-35 years, who had low vision or total blindness and had used multiple healthcare services for health reasons or had interactions with healthcare providers in the past 12 months were included. Women with total blindness were described as those who do not see the fingers of their hand at 10 feet or read the first line of the Snellen chart (3/60), while women with low vision were defined as those who do not differentiate fingers of a hand from a distance of 20 feet or read the letters on the fourth line of the Snellen chart. Participants with other disabilities such as deafness or mental illness were excluded. A total of 16 women were approached and all provided the consent to participate in the study.

Participants were purposively sampled using a list of women with visual impairment provided by the Blind Women Association Nepal (BWAN) and Nepal Association of the Blind (NAB). Then, each participant was contacted either in person or over the phone, assessed for meeting the inclusion criteria, and then invited for an interview. We assumed that women who had been in contact with the organizations could articulate their own experiences and might not encounter difficulty in doing so, even if they had undergone traumatic life experiences.

2.2. Data collection

The research team developed an interview guide, initially created by the first author and commented on and agreed upon by other team members. The guide consisted of 13 topic questions followed by probing questions. The guide was initially developed in English and later translated into Nepali. After translation, it was pretested with two participants, and questions regarding ethical discrimination and the role of organizations working for visually impaired individuals were added.

The study employed face-to-face, in-depth, semi-structured interviews conducted at the locations referred to by the participants. The interviews were conducted by three female interviewers who were well-trained in qualitative research and were familiar with the research subject and background of the participants. The interviews were audio-recorded, and participants' socio-demographic data were collected (Table 1). The interviews lasted an average of 39 minutes. Verbal consent was obtained prior to the interview and all participants were informed about pseudonymization of their identity for anonymity. The study followed the Helsinki declaration of research ethics.

The study involved 16 participants (Table 1), with a mean age of 24 years. A total of 13 women (81.25%) were fully blind, while three women (18.75%) had low vision. Women were from diverse ethnic backgrounds, with the majority from indigenous groups (56%) and most women followed Hinduism (56%). In total 50% of the participants were married while remaining 50% of the participants were unmarried. Ten women (62.5%) of them were unemployed. The participant's identification numbers were pseudonymized to keep the real identify of the participants anonymous.

Table 1
Socio-demographic characteristics of the study sample.

Participants	Age	Employment	Marital status	Type of blindness	Religion
1	25	Unemployed	Unmarried	Full Blind	Christian
2	23	Unemployed	Unmarried	Full Blind	Hindu
3	25	Employed	Married	Full Blind	Hindu
4	22	Unemployed	Unmarried	Low blind	Hindu
5	24	Unemployed	Unmarried	Full Blind	Hindu
6	24	Unemployed	Unmarried	Low Vision	Hindu
7	21	Unemployed	Unmarried	Full Blind	Hindu
8	19	Unemployed	Unmarried	Low Vision	Buddhist
9	25	Employed	Unmarried	Full Blind	Hindu
10	32	Employed	Married	Full Blind	Buddhist
11	35	Self-employed	Married	Full Blind	Christian
12	27	Self-employed	Married	Full Blind	Christian
13	24	Unemployed	Married	Full Blind	Christian
14	26	Unemployed	Married	Full Blind	Hindu
15	21	Unemployed	Married	Full Blind	Buddhist
16	35	Employed	Married	Full blind	Hindu

2.3. Data analysis

The data for analysis consisted of transcripts of audio recordings obtained from the in-depth interviews. To ensure quality, the third author transcribed all the recordings in English, and the primary researcher checked the quality of the transcripts. Necessary reconciliations were made after discussion.

Thematic analysis was conducted for data analysis, which followed a systematic process, beginning with familiarization with the interview transcripts and understanding of the participants’ narratives by reading and re-reading of the transcripts. Next, an initial coding process was conducted, where meaningful units of data were identified and assigned codes. The coding process involved capturing the participants’ descriptions, emotions, and perspectives related to their experiences of utilizing healthcare services. The coded data were then organized and clustered into broader themes. Themes emerged through a careful examination of the coded data, considering patterns, similarities, and shared meanings across participants’ accounts. The themes were refined and reviewed in relation to the research question and the specific context of healthcare use among visually impaired women. Nvivo-10 software was used for the analysis.

3. Results

From the analysis, 52 codes were developed and were grouped together into two broader themes: ‘health care seeking behaviors’ and ‘reluctance to seek healthcare’. Furthermore, the theme ‘reluctance to seek healthcare’ had five sub-themes, including sexual harassment by male healthcare providers, disability-related prejudice and discrimination, dependence on the family and lack of autonomy in decision-making, financial hardship and lack of support, and lack of disability friendly infrastructures and services. The codebook including themes, subthemes and codes is summarized in [Table 2](#).

3.1. Health care seeking behaviors

This theme analyzes the health care services the participants sought, ways to access health information and services and knowledge regarding critical health issues. Ocular or vision-related problems were identified as the main reason for seeking healthcare among the participants. Other health problems that required healthcare services included common cold, headache, fever, injuries, pain in body parts, menstruation-related problems, need for family planning services, hospitalization due to accidents, and chronic/long-term health problems such as arthritis. A few had been hospitalized for vision-related treatments, ocular surgeries,

Table 2
Description of codes, sub-themes, and themes.

Theme	Subtheme	Codes
Health care seeking behavior		Health related problems, Preference for health service sites, Satisfaction for health services, Health related behavior, Health care practices, Source of information, Health Care accessibility, Availability of information, Peer influence, Trust towards institutions, Trust towards health care providers, Disability friendly environment, Seriousness of disease and sickness, Free health services, Preference for female doctors,
	Reluctant to seek healthcare	Out of pocket expenditure, Cost of medicine, Expensive tests, Lack of financial support, Limited-service incentives, Loans taken for health care services, Lack of information regarding health insurance, Limited financial support from social organizations
	Sexual harassment by male healthcare providers	Unpleasant touching, Sexual comments, Unnecessary touching of private parts, Sexual abuse, No realization of sexual harassment
	Dependence on family and lack of autonomy in decision making	Family support required to seek services, Peer-support to seek service, Need of care taker, Decision making ability, Economic dependency on family, Access to resources, Gender roles, Distrust among family members,
	Lack of disability friendly infrastructure and services	Lack of digital health platforms, Lack of disability friendly infrastructure at service sites, Lack of disability friendly roads, Difficulty to commute, Limited organizational support, Limited health information provided by social organizations, Limited disability friendly training and consultations among service providers, Lack of braille and sign language, Provision of Audio-visual system, Lack of client centric approach in disability care
	Disability related prejudice and discrimination	Gender based barriers, Humiliation, Negative perception of people, Psychological harassment by service providers, Perception of health provider regarding women with disability, behavior of support staff, Self-stigma, discrimination based on cast and class,

and other surgeries such as treatment of hemorrhoids and childbirth. Unmarried women visited health institutions much less frequently than married women with most of their problems being eye check-ups and seasonal infections. While, married women had a wider range of healthcare needs, including also menstrual irregularity and pregnancy, family planning services, delivery and postpartum care, and minor operations.

Educated women explained how they access health information on topics, including the Covid19 disease and vaccines. Participants explained that the tendency to acquire new health information from media sources, including radio, TV, toll free numbers, and direct health provider consultations, had shifted to newer digital media using mobile apps (e.g., YouTube, website). They also mentioned learning from school textbooks particularly regarding diet, sexual and reproductive

health, and communicable and non-communicable diseases.

Radio programs, such as khulduli.com has been a very popular program and is the main source of information for many participants regarding sexual and reproductive health. The questions asked are interesting and the program, in a very easy way, provides information related to adolescent sexual and reproductive health and bodily changes.

(Participant 7)

While some participants with low levels of education had no knowledge of important healthcare issues including breast cancer screening, while others sought information from sources including the radio and YouTube.

3.2. Reluctance to seek health care

This theme analyzes the barriers or challenges faced while accessing and utilizing health information and services. Most participants explained a tendency to avoid visiting health institutions until their health problems became serious, and they did not visit their healthcare providers for routine eye checkups or other medical follow ups. They opted to go to private clinics for convenience, as public hospitals were often far, inconvenient, and difficult to reach. There was also a general perception that health care quality was better in private clinics, despite higher costs of care.

Sexual Harassment by male healthcare providers: A few participants shared incidents of being sexually harassed by male healthcare providers and feeling uncomfortable and unsafe. Women explained instances of unpleasant touching with sexual undertones, moments of being undressed with sexual undertones, and unnecessary physical touch against their will.

I remember that, particularly one male doctor, when he used thermometer, he had to put that inside my t-shirt, under my arms and I could literally feel his hands touching my breast. Which I thought was unnecessary. And I was not explained at all about the procedure.

(Participant 2)

One participant recalled an incident where a male healthcare provider questioned their right to free healthcare, including education, menstrual products, and pregnancy tests. Participant 14 recounted an experience during pregnancy check-up where a male doctor asked invasive and uncomfortable questions about her sexual life.

The majority of participants expressed a preference for female healthcare providers over male healthcare providers. They felt safer and more comfortable with female providers and trusted them to provide appropriate treatment and information when needed. Married women, in particular, stated that they would choose a female provider if given the option.

During my ultrasound appointment, I was initially assigned a male doctor, but I felt nervous and uncomfortable. However, a female doctor came forward and offered to perform the ultrasound instead, which made me feel safer and more at ease. A female doctor is who I need to feel more comfortable. I feel nervous when there is a male doctor, and it would be better if there were more female doctors in the hospitals.

(Participant 15)

One of the participants felt safer when being accompanied by their family or friends. Most participants had doubts about what the intention of a male healthcare provider would be. Here is what Participant 5 stated:

I am not sure if I will have the same experience if I go alone to health centers. Since, I go with my family or friends, doctor also respond appropriately so I did not feel anything inappropriate as such.

(Participant 5)

Disability-related prejudice and discrimination: The participants

engaged in discussions regarding their experiences of relying too much on others, which led to a sense of devaluation in terms of their worth as living with disabilities. They shared how they faced discrimination within their families, including labelling, gossiping, and being criticized, and how this led to feelings of helplessness and low confidence in their ability to do things independently. Negative attitudes, insensitivity towards visually impaired women and fear of bullying at healthcare facilities were described as significant barriers to healthcare use. Participant 4 received advice from a healthcare provider to bring a sighted person as a visitor instead of someone who was also visually impaired. Participants reported instances of being charged higher fees and prescribed unnecessary tests, often for the financial benefit of physicians and hospitals. Participant 8 stated,

To a woman like me with low vision, they say I cannot do anything in my life, who will marry to a woman like me. Despite this low vision problem, I have come to this far, after struggling, and they do not see that. Even my own parents do not treat me equally as my brothers who can see perfectly.

(Participant 8)

In addition to facing discrimination herself, Participant 6 also shared how healthcare providers did not believe her when she mentioned about her problems due to visual impairment, and even her family members were mistreated by the providers. She had to repeatedly explain her situation and use a stick as a visual aid to prove the impairment. She explained that visually impaired women face skepticism and insensitivity from healthcare providers, causing discomfort and discouraging them from seeking medical help.

One participant from an ethnic and religious minority community reported experiencing discrimination from healthcare providers who appeared to favor members of higher ethnic communities. In contrast, other participants did not report similar experiences. They did, however, speculate that discrimination based on lower ethnicity could be more pronounced among women with disabilities.

The representative of blind organization prioritized individuals from higher caste (ethnic groups) to provide the services and ignored us knowing that as we belonged to Indigenous communities and not from higher caste.

(Participant 1)

Dependence on the family and lack of autonomy in decision-making: While the family could provide the safety against inappropriate behaviors of male healthcare providers, most participants also described being a burden to the family. All the participants found to be dependent on their family for financial support, as well as for assistance to go to the hospital due to poor road conditions and difficulty in navigation. Economic dependence on family members was explained by the participants as one of the reasons for lacking autonomy in making self-decisions was financial hardships.

Especially when there was the need, the women were taken to hospital by their family members and the costs for expensive services was paid by the family members. Particularly, married participants often consulted their spouse or family members for suggestions on when to use health care. Participant 16 mentioned:

Due to my inability to travel alone, and the unavailability of immediate support from others who are occupied with their own work, it becomes challenging for me to access healthcare services. Consequently, I often need to rely on my husband to assist me and, he has to agree on what is the best for me.

(Participant 16)

One of the participants worried about not having a good relationship with the family, which could result into neglect and lack of support from the husband and family. Participants also mentioned of being withheld about their health information, not included in the medical and familial decision making and being ignored or excluded while making decisions.

Women who perceived themselves as potential burdens to their families believed they lacked the authority to make decisions often refrained from telling their health needs to family members and delayed seeking care unless their issues became too serious or apparent.

Financial hardship and lack of support: Participants without income found it harder to use health services because of the higher costs. One of the participants mentioned a situation when she did not buy essential medicines during pregnancy as she did not have enough money. All the participants expressed an urgent need for financial support, incentives, and free health checkups, while only the educated participants were aware of free healthcare services available to them. Only two participants mentioned benefitting from the government insurance scheme and free health services that were provided to people with disability. However, free health services covered only general health needs, and participants had to depend on their family members for financial support for expensive specialized health services.

We, people living with disabilities, belong to a lower-middle-class family, and most of the people living with disabilities have become disabled due to poverty. Many of our disabled friends might not have enough money for expensive specialized treatment. The government should provide financial support to people with visual impairment for checkups, medicines, and specialized treatments.

(Participant 1)

Participants acknowledged the value of seeking healthcare or services from social organizations either in pairs or as a group, where services are free and mutual support and assistance could be obtained. However, they also believed that these organizations working for the group of visually impaired people had not done enough to provide substantial support, particularly in increasing access to healthcare.

Lack of disability friendly infrastructures and services: Visually impaired women face barriers for commuting and navigating within the premises of health facilities. Regular changes on the way to healthcare institutions, including construction of roads or buildings, old building not having elevators, and lack of staff to aid disabled patients made it difficult to access services. One of the participants stated:

As visually impaired individuals, it is challenging to navigate to the 3rd or 4th floors as we are unaware of the staircase's location. Similarly, we face difficulty in locating the elevator. Even when the hospital is on the ground floor, we face difficulties as we cannot see anything. This makes it challenging for us to navigate through the hospital.

(Participant 7)

Participants discussed their concerns about the risks of accidents due to unsafe road conditions, which could result in hospitalization. One participant shared a traumatic experience of being hit by a motorbike when she was pregnant, which she rated as the most challenging time of her life. In addition, the participants identified several factors that influenced their preference for healthcare service sites. These included disability-friendly infrastructure, the seriousness of illness or disease, and incentives offered.

Mostly I go to government (public) eye hospital in Kathmandu for my problem with low vision. I go to private hospitals as well, but they are not disability friendly. Even though this public hospital is also not fully disability friendly but in comparison with others it is still better.

(Participant 8)

The participants highlighted the need for a disability friendly environment, which includes making ramps, installing railings, provision of voice information system, provision of braille, and providing guides for people living with disability including visually impaired. Further, the participants believed that digital health platform including mobile applications, reliable internet sources, and information databases as well

as toll-free number could help increase their knowledge about health concerns and access to health-related services. The participants believed that comprehensive information regarding health issues and services would be helpful to increase accessibility of health care services and mentioned about sharing and discussing health information among their peers.

4. Discussion

To the best of our knowledge, this is the first study to explore the challenges faced by visually impaired young women while accessing healthcare within Nepalese healthcare settings. The challenges included sexual harassment by male healthcare providers, disability-related stigma, financial difficulties, limited autonomy in decision-making, and lack of disability-friendly healthcare facilities and services. To navigate these challenges, some women sought support by having family members or friends accompany them or by requesting to be seen by a female healthcare provider. Nevertheless, this coping mechanism sometimes led to a feeling of burden on the family, contributing to a reluctance among women to seek healthcare.

Themes including financial hardship, lack of autonomy in healthcare access decision-making, prejudice and discrimination, and lack of disability-friendly health institutions and services are consistent with previous studies conducted in Nepal among women with disabilities [17,26,16]. The existing inequity in health care access due to disability has been established in general health services as well as in specific preventative health services including pap smear testing for cervical cancer as well as physical exercise, healthy diet, and safe sex programs [27,28,29].

The fact that sexual harassment appeared to be a commonly encountered issue among young women requires careful attention. Intersectionality should be considered when addressing the needs of visually impaired women and designing policies and programs, as they experienced violence, discrimination and marginalization based on their younger age, being female, disability status and overall vulnerabilities (due to lower caste, poverty and not accompanied by friends/families/spouse). Visiting healthcare institutions with family and friends can provide a protective environment. However, our study highlights that this is not always possible for everyone. To address this sensitive issue, integrating disability-friendly healthcare services and healthcare infrastructure into the mainstream health system is necessary. But there is more to do than this. Education and behavioral change targeting male health care providers is also important. Moreover, it is imperative to implement and enforce anti-sexual harassment policies in public as well as private hospitals to ensure a safe and respectful environment for both patients and healthcare providers.

In their study conducted in Pakistan, Ahmed and Naveed [30] identified a lack of accessible physical environments and accommodations for communication and information access as additional barriers to healthcare access [30]. Similarly, in our study, we found that women generally expressed willingness to visit private clinics but preferred to avoid public hospitals due to the hassles involved. This preference reflects a health-seeking behavior and cultural aspects. To address the neglect at healthcare for individuals with disability, it is crucial for health workers to receive training in disability-friendly services, and for their behavior to be more inclusive. Transforming hospitals and healthcare institutions to be disability-friendly could have a transformative impact. Our findings strongly support government investment in creating disability-friendly structures.

The presence of female healthcare providers is widely welcomed, as it helps foster a sense of safety and comfort. However, it is important to note that having female providers or family members accompanying them may not guarantee disability-friendly healthcare services of high quality without prejudice. In general, establishing trust between women and healthcare providers is of utmost importance. Simultaneously, community and familial sensitization play a crucial role in addressing

this issue. Family support, open dialogues, and raising awareness are essential components [31]. Research from Ghana has demonstrated the positive impact of social media and digital platforms in providing health-related information to visually impaired women [32].

The visually impaired women in our study exhibited a remarkable sense of solidarity, actively supporting one another during visits to healthcare facilities. They engaged in knowledge sharing, disseminating information, and providing assistance to overcome barriers they faced. This exemplifies the effectiveness of social organization-based capacity building or empowerment sessions, peer education, and women's engaging in facilitating healthcare access (peer group mobilization). The community mobilizing efforts and peer support network play a significant role in breaking down barriers and improving their overall healthcare experiences.

There are a few limitations of the study. Due to a highly selective sample of young women aimed at obtaining data richness, it could miss out the interests and experiences of comparatively wider women's population. However, we did recruit participants of various education levels and ethnic backgrounds, which contributes to the richness of the data. Due to a small sample size, our study may not have adequately reflected on all the contextual insights. Since the scope of this study was purely phenomenological and descriptive, the applied qualitative method can be believed to generate enough information to understand the phenomenon under study and provide a relevant basis for the future studies in this area, thus ensuring trustworthiness of the study results.

5. Conclusions

Visually impaired young women face various social and psychological barriers that hinder their healthcare-seeking. Among all, experiencing sexual harassment by male health workers and underlying disability-related stigma have a profound impact on avoiding healthcare. Being accompanied by family members provides the safety against inappropriate behaviors of male healthcare providers, however this is not possible for everyone. It is important to address structural issues related to sexual harassment, stigma, and lack of tailored services. Sensitivity training as well as education and behavioral change, especially among male healthcare providers is important. Community mobilizing and peer group-based programs can be tested for increasing visually impaired women's utilization of relevant healthcare services.

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

CRedit authorship contribution statement

Amit Timilsina: Writing – review & editing, Writing – original draft, Formal analysis, Conceptualization. **Pabitra Neupane:** Writing – review & editing, Conceptualization. **Janaki Pandey:** Writing – review & editing. **Aastha Subedi:** Writing – review & editing. **Subash Thapa:** Writing – review & editing, Supervision, Methodology, Formal analysis.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

All the data of this study has been presented in this study.

Acknowledgements

We gratefully acknowledge all the study participants who generously spent their time sharing their experiences and information for the purpose of this study. Additionally, we would like to thank the Blind Women Association Nepal (BWAN) and Nepal Association of the Blind (NAB) for the help and support provided to conduct this study.

References

- [1] World Health Organization. World report on disability 2011. World Health Organization; 2011.
- [2] Nepal Government. Definition and Classification of Disability in Nepal. Nepal, https://rcrdnepa.files.wordpress.com/2010/09/definition-and-classification-of-disability-in-nepal_english.pdf; 2006.
- [3] Ministry of Health and Population. Population and Housing Census. C. B. O. Statistics; 2011. <https://unstats.un.org/unsd/demographic-social/census/documents/Nepal/Nepal-Census-2011-Vol1.pdf>.
- [4] Demmin DL, Silverstein SM. Visual impairment and mental health: unmet needs and treatment options. *Clin Ophthalmol* (Auckland, NZ) 2020;14:4229.
- [5] Gibson BE, Mykitiuk R. Health care access and support for disabled women in Canada: falling short of the UN Convention on the Rights of Persons with Disabilities: a qualitative study. *Womens Health Issues* 2012;22(1):e111–8.
- [6] Morton C, Le JT, Shahbandar L, Hammond C, Murphy EA, Kirschner KL. Pregnancy outcomes of women with physical disabilities: a matched cohort study. *Pm&R* 2013;5(2):90–8.
- [7] Reichard A, Stolzle H, Fox MH. Health disparities among adults with physical disabilities or cognitive limitations compared to individuals with no disabilities in the United States. *Disabil Health J* 2011;4(2):59–67.
- [8] Shiwakoti R, Gurung YB, Poudel RC, Neupane S, Thapa RK, Deuja S, et al. Factors affecting utilization of sexual and reproductive health services among women with disabilities—a mixed-method cross-sectional study from Ilam district, Nepal. *BMC Health Serv Res* 2021;21(1):1–19.
- [9] van Munster EP, van der Aa H, Verstraten P, van Nispen R. Barriers and facilitators to recognize and discuss depression and anxiety experienced by adults with vision impairment or blindness: a qualitative study. *BMC Health Serv Res* 2021;21(1):1–10.
- [10] Ingal N. Mainstreaming disability in the new development paradigm: Evaluation of Norwegian support to promote the rights of persons with disabilities. Norwegian Agency for Development Cooperation; 2012.
- [11] Rahi JS, Cumberland PM, Peckham CS. Visual impairment and vision-related quality of life in working-age adults: findings in the 1958 British birth cohort. *Ophthalmology* 2009;116(2):270–4.
- [12] Schakel W, van der Aa HP, Bode C, Hulshof CT, van Rens GH, van Nispen RM. The economic burden of visual impairment and comorbid fatigue: a cost-of-illness study (from a societal perspective). *Invest Ophthalmol Vis Sci* 2018;59(5):1916–23.
- [13] Hanass-Hancock J. Interweaving conceptualizations of gender and disability in the context of vulnerability to HIV/AIDS in KwaZulu-Natal, South Africa. *Sex Disabil* 2009;27:35–47.
- [14] Mahmood S, Hameed W, Siddiqi S. Are women with disabilities less likely to utilize essential maternal and reproductive health services?—A secondary analysis of Pakistan Demographic Health Survey. *PloS One* 2022;17(8):e0273869.
- [15] Rohleder P, Eide AH, Swartz L, Ranchod C, Schneider M, Schür C. Gender differences in HIV knowledge and unsafe sexual behaviours among disabled people in South Africa. *Disabil Rehabil* 2012;34(7):605–10.
- [16] Pita Y, Bigler C, Sony K, Amacker M. The right to health: An examination of health care access for women with disability in Nepal. *SSM-Qualitat Re Health* 2023;4:100315.
- [17] Devkota HR, Murray E, Kett M, Groce N. Are maternal healthcare services accessible to vulnerable group? A study among women with disabilities in rural Nepal. *PloS One* 2018;13(7):e0200370.
- [18] Ministry of Health and Population. The Act Relating to Rights of Persons with Disabilities. 2017. p. 2074. <https://www.lawcommission.gov.np/en/wp-content/uploads/2019/07/The-Act-Relating-to-Rights-of-Persons-with-Disabilities-2074-2017.pdf>.
- [19] Ministry of Health and Population. The Right to Safe Motherhood and Reproductive Health Act. 2018. p. 2075. <https://www.lawcommission.gov.np/en/wp-content/uploads/2019/07/The-Right-to-Safe-Motherhood-and-Reproductive-Health-Act-2075-2018.pdf>.
- [20] Ministry of Health and Population. National Guidelines for Disability Inclusive Health Services. https://www.nhssp.org.np/Resources/GESI/National_Guidelines_Disability_Inclusive_Health_Services2019.pdf; 2019.
- [21] Ministry of Health and Population. National Medical Standard for Maternal and Newborn Care. <https://nhssp.org.np/Resources/SD/NMS%20for%20Maternal%20&%20New%20Born%20Care%20-%20PD%20R6%20-%20July%202020.pdf>; 2020.
- [22] Ministry of Health and Population. Nepal Health Sector Strategy 2015-2020. Ministry of Health and Populations; 2014. Retrieved from, http://www.nhssp.org.np/NHSSP_Archives/health_policy/NHSS_english_book_2015.pdf.
- [23] Goethals T, De Schauwer E, Van Hove G. Weaving intersectionality into disability studies research: Inclusion, reflexivity and anti-essentialism. *DiGeSt J Diversit Gender Stud* 2015;2(1-2):75–94.

- [24] Davis K. Intersectionality as buzzword: A sociology of science perspective on what makes a feminist theory successful. *Fem Theory* 2008;9(1):67–85.
- [25] Munhall PL. A phenomenological method. In: Munhall P, editor. *Nursing Research: A qualitative perspective*; 2012. p. 113–76.
- [26] Eide AH. Living conditions among people with disability in Nepal. *Sintef Rapport*. 2016. p. 10–6. Version date 2016-04-28.
- [27] Abdul Karimu A. Exploring the sexual and reproductive health issues of visually impaired women in Ghana. *Reprod Health Matters* 2017;25(50):128–33.
- [28] Fang W-H, Yen C-F, Hu J, Lin J-D, Loh C-H. The utilization and barriers of Pap smear among women with visual impairment. *Int J Equity Health* 2016;15:1–9.
- [29] Panigrahi A, Nageswar Rao G, Kumari Konar A. Vision-related quality of life and its sociodemographic correlates among individuals with visual impairments. *J Visual Impairm & Blindness* 2021;115(4):319–28.
- [30] Ahmed MR, Naveed MA. Information Accessibility for Visually Impaired Students. *Pakistan J Informat Manag Librar* 2021;22:16–36.
- [31] Beverley CA, Bath P, Booth A. Health information needs of visually impaired people: a systematic review of the literature. *Health Soc Care Community* 2004;12(1):1–24.
- [32] Badu E, Gyamfi N, Opoku MP, Mprah WK, Edusei AK. Enablers and barriers in accessing sexual and reproductive health services among visually impaired women in the Ashanti and Brong Ahafo regions of Ghana. *Reprod Health Matters* 2018;26(54):51–60.