

**ACCESS TO REPRODUCTIVE HEALTH SERVICES: THE CASE OF
WOMEN WITH PHYSICAL DISABILITIES IN NAIROBI**

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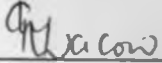


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DECLARATION

This research project is my original work and has not been presented for a degree award in any other university.

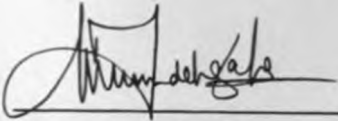


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Date

This research has been submitted for examination with my approval as University supervisor.



Dr. Charles Owuor Olungah



Date

DEDICATION

I wish to dedicate this research project to my daughters, Jemima and Kezia.

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Abbreviations and Acronyms

| | |
|-----------------|---|
| ANC | Antenatal Care |
| APDK | Association for the Physically Disabled of Kenya |
| HIV/AIDS | Human Immune Virus/Acquired Immune Deficiency Syndrome |
| ICPD | International Conference on Population and Development Programme of Action |
| KEDAN | Kenya Disability Action Network |
| KNBS | Kenya National Bureau of Statistics |
| PID | Pelvic Inflammatory Disease |
| PWD | People with Disabilities |
| NCAPD | National Coordinating Agency for Population and Development |
| NCPWD | National Council for Persons with Disabilities |
| SAGA | Semi-Autonomous Government Agency |
| STD | Sexually Transmitted Disease |
| STI | Sexually Transmitted Infection |
| UDPK | United Disabled Persons of Kenya |
| USAID | United States Agency for International Development |

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Abstract

This study was on 'Access to Reproductive Health Services for Women with Physical Disabilities in Nairobi'. Its objectives were; to explore factors that prevent disabled women from visiting reproductive health service providers; to establish the difficulties disabled women face when they visit reproductive health service providers; to explore the challenges reproductive health care providers face when serving disabled women; and to find out measures that can be put in place to increase access to reproductive health care for disabled women.

The study found that among the difficulties that women with disabilities face when they visit reproductive health service providers are mainly accessing the various physical facilities as they are disability unfriendly. Some have steps/stairs and no ramps for those on wheel chairs and who use crutches. Getting on to high exam beds with not steps or assistance was also a problem that the women experienced at the service provider. Accessing public transport, which is the most convenient means of travel to the health facility, was also a challenge. This is because of the way the buses and *matatus* are built does not allow for easy boarding. The doors and the aisles are narrow and wheel chairs cannot fit. The steps are also steep such that even those using crutches and wearing calipers have difficulties. In addition most public service providers/personnel are always in a hurry and are in competition with others and therefore, do not have the patience to wait or assist women with disabilities board the vehicles. The challenges experienced just trying to get to a health provider discourages the women from going when they are unwell.

The study observed that most of these women had not progressed beyond primary school level and were thus engaged in small petty businesses. As such, they were struggling to make a living and the financial resources available were strained and this affected their ability to afford health care. The study noted that a significant proportion of those who did not seek the information on reproductive health did not think they needed to. This was either because they had stopped having children, did not have any or were not sexually active, indicating a lack awareness as to the scope of reproductive health issues and limiting them to child-bearing and contraceptives, yet there are other concerns like breast and cervical cancer and management of infertility.

The survey also revealed that medical personnel have a bad attitude towards women with disabilities. Some were said to use abusive language, ignore them, harass them when they cannot move at the same speed or do things as other able bodied women. The women interviewed also said that they received negative reactions when they sought information on sexuality and family planning as the personnel wondered why they would want to engage in sex in their condition. Thus, personal and shared unfavourable experiences at the hands of service providers and with the facility may be factors that prevent disabled women from visiting reproductive health providers.

On the service provider side, the challenges they face when serving women with physical disabilities included positioning them for procedures and lack of appropriate equipment in the facility suited to those with disabilities. Lack of awareness and information on reproductive health among women with disabilities was also found to be a challenge by the service providers. They also admitted as to there being no training that prepares them on how to deal with patients with disabilities.

In light of the findings, the study recommends that since awareness seminars for those with disabilities are an important source of reproductive health information these should be enhanced to include topics covering more than STDs, contraceptives and HIV/AIDS. There is also need for creating awareness among the medical personnel to change their attitude towards sexuality and disability as was indicated by the reactions the women with disabilities received on seeking information on sexuality and family planning. Given the challenges women with disabilities face in accessing buildings and public transport the government should establish a responsible authority to oversee the accessibility of the build-up environment by leveling of pavements, building of ramps, installing lifts and ensuring access to other public places and utilities and the building of accessible public vehicles. Formulation and implementation of the relevant policies as per the Persons with Disabilities Act, 2004 to enhance the built environment to make it disability friendly will ease access not only to health providers but also to other facilities and amenities.

CHAPTER 1: BACKGROUND

This research project presents results of a study on 'Access to Reproductive Health Services for Women with Physical Disabilities in Nairobi'. The paper is divided into five major chapters. Chapter 1 gives a background to the local and international state of reproductive health both in general and for people and specifically women with disabilities. Chapter 2 is a summary of the relevant literature review, while chapter 3 covers the methodology used in the research. The findings, analysis and discussion are presented in Chapter 4. Chapter 5 presents a summary of the main findings while Chapter 6 gives conclusions and recommendations of the study. The paper also has appendices, which contain the research instruments used to collect data for the study.

1.1 Introduction

As a follow up to the recommendations of the International Conference on Population and Development Programme of Action (ICPD-PA 1994) Kenya developed the *National Reproductive Health Strategy* in 1996. This was the first activity to operationalise the reproductive health agenda as recommended by the ICPD. According to the strategy, reproductive health includes the following main components; family planning and unmet needs, safe motherhood and child survival initiatives, promotion of adolescent and youth health, gender and reproductive rights, management of STIs/HIV/AIDS, management of infertility, and other reproductive health issues (Ministry of Health, 1996).

Although accessibility to health care in Kenya is high with 42 percent of the population living within four kilometres of a health facility, and 75 percent within eight kilometres, the utilisation of the health facilities is low probably due to high cost of health care coupled with poverty (Ministry of Health, 1996). According to the Kenya Integrated Household Budget Survey (2005/6), 53 percent of births are delivered at home and 39.1 percent in a health facility (Republic of Kenya, 2007).

In addition, maternal mortality in Kenya is unacceptably high. Four hundred and fourteen (414) women per 100,000 live births die due to pregnancy and child-birth related causes for the 10-year period before the '2003 Kenya Demographic Health Survey' (Central Bureau of Statistics; Ministry of Health; and ORC Macro, 2004).

Cancer of the cervix and breast is a common reproductive health issue in Kenya. If detected early, cancer can be treated. However, often women report when it is too late because they have no information to help them make informed decision regarding seeking care (Ministry of Health, 1996). In addition, it is also estimated that about 30 percent of babies born to HIV positive mothers in Kenya will themselves be infected. HIV transmission can occur during pregnancy, at birth or during breast-feeding. Apart from HIV, other STDs such as syphilis and gonorrhoea can be transmitted from mother to child. Mother to child transmission is also prevented through a complete package of care including strengthened family planning and maternity services, ante-natal care, counselling and testing for HIV, and use of anti-retrovirals. However, anti-retrovirals are beyond the reach of the many poor Kenyan mothers because they are expensive (Ministry of Health, 1996).

Approximately 300 million women around the world have mental and physical disabilities. Women with disabilities comprise 10 percent of all women worldwide, and yet, their reproductive health and rights are all too often neglected (Center for Reproductive Rights, 2002).

Women with disabilities, like all people, enjoy the full range of human rights that are secured by international law and custom. Reproductive rights are among these fundamental freedoms, including: the right to equality and non-discrimination, the right to marry and found a family; the right to comprehensive reproductive health care including family planning and maternal health services, education, and information; the right to give informed consent to all medical procedures including sterilization and abortion; and the right to be free from sexual abuse and exploitation (Center for Reproductive Rights, 2002).

Health care providers, assuming that women with visible or disfiguring disabilities are not interested in sex or not sexually active, are less likely to offer information on birth control, safe sex practices, sexually transmitted disease, and possible effects of their disabilities on sexual response than they are to women without disabilities (Nosek, 1996).

In Kenya, though a lot of attention has been given to women and men's reproductive health issues in form of programmes and research, little has been done about those of physically

challenged women in a bid to cater for their special needs. Indeed, the country's *National Reproductive Health Strategy 1997-2010* developed by the Ministry of Health in response to the ICPD, 1994 noted that among the challenges the strategy faced was that vulnerable groups such as post-menopausal women, the elderly and the disabled have special needs that have not been adequately addressed (Ministry of Health, 1996).

A review of literature on disabled women's access to reproductive health services also reveals that little has been done in Kenya. Most research in the country has been done on employment, education and rehabilitation of people with disabilities but none on their reproductive health. Nevertheless, visits and discussion with various disability organisations like Association for the Physically Disabled of Kenya (APDK), National Council for Persons with Disabilities (NCPWD) and United Disabled Persons of Kenya (UDPK) and reproductive health NGOs like Population Council, Family Health International and the Ministries of Health and that of Gender, Sports and Social Services yielded only one unpublished baseline survey by the NCPWD. The survey titled 'Challenges Facing Women with Disabilities: A Baseline Survey' had a small portion touching on their health, which did not yield much since the survey was on challenges in general and not specifically about their reproductive health challenges (NCPWD, 2007).

The study found that at the national level, policy makers are not responsive to the reproductive and sexual needs of women with disabilities due to lack of institutionalised mechanisms on the use of Braille in hospitals and on contraceptives and safer sex methods (NCPWD, 2007). Comparing this study with those done in other countries like Zambia (Smith et al., 2004) and Canada (Odette et al., 2003) we find that there are a lot of other aspects that need to be studied to adequately address the reproductive health needs of physically disabled women in Kenya, who have evidently been overlooked.

In addition to the above, it is acknowledged that the health status of women in pregnancy and motherhood is of particular relevance to the health status of future generations (Republic of Kenya, 2006) and that many disabled women are able to have children like able-bodied women (Best, 1999). Also, various studies have dispelled the myth that most women with disabilities are asexual. They show that they are sexually active making them susceptible as women without disabilities to getting STDs (Nosek, 1996). It is with the above in mind and to

fill the dearth in literature that this study on 'Access to Reproductive Health Services: The Case of Physically Disabled Women in Nairobi' is being undertaken. The data collected will help inform policy makers and reproductive health service providers on how to best serve this vulnerable but key population in Kenya.

1.2 Statement of the Problem

Women with disabilities have reported negative experiences with pregnancy and childbirth because they have difficulty finding health care providers and hospitals with experience in managing pregnancy and childbirth in women with disabilities. This lack of knowledge and experience has led some doctors to communicate unwarranted negative expectations about pregnancy outcomes to women with disabilities who become pregnant or who express the desire to have children. In some cases, pregnant women with disabilities have been advised to end the pregnancy and to have a tubal ligation or a hysterectomy to prevent future pregnancies (Best, 1999).

The prevalence of sexually transmitted infections, (STIs), is the same for women with disabilities and non-disabled women. For several reasons, STIs often go undetected or diagnosis is delayed in women with disabilities, leading to preventable pelvic inflammatory disease (PID) and infertility. Doctors who assume women with disabilities are not sexually active may fail to screen for STIs or educate them about safe sex practices (Best, 1999).

Women with disabilities are discouraged from getting screened for STIs by inaccessible doctors' offices, difficulty getting onto the examination table, or previous experience with doctors not knowing how to handle disability-related symptoms during the exam, such as imbalance. In addition, women with disabilities may not take medication prescribed for their STIs because they cannot swallow pills or open the bottle, and no alternatives were offered (Best, 1999).

In addition to the barriers that poor and other disadvantaged people face in accessing health services generally, such as distance from services, lack of transport, cost of services and discriminatory treatment of users, reproductive health presents special difficulties. These derive from social and cultural factors such as taboos surrounding reproduction and sexuality, women's lack of decision-making power related to sex and reproduction, low values placed

on women's health, and negative or judgmental attitudes of family members and health-care providers (World Health Organisation, 2004).

Kenyans are beginning to appreciate that disabled people are part of the society and their needs have to be catered for as well. The purpose of this study is to find out factors that prevent disabled women in Kenya from accessing reproductive health care and services, the difficulties faced, the effect of lack of visits and what can be done to ease access.

1.3 Research Questions

The research questions that guided the study are:

- i) What factors prevent disabled women from visiting reproductive health service providers?
- ii) What difficulties do disabled women face when they visit reproductive health service providers?
- iii) What challenges do reproductive health service providers face when serving disabled women?
- iv) What measures can be put in place to enhance access to reproductive health care for disabled women?

1.4 Objectives of the Study

The objectives of this study were:

- i) To explore factors that prevent disabled women from visiting reproductive health service providers;
- ii) To establish the difficulties disabled women face when they visit reproductive health service providers;
- iii) To explore the challenges reproductive health care providers face when serving disabled women; and
- iv) To find out measures that can be put in place to increase access to reproductive health care for disabled women.

1.5 Justification/Rationale of the Study

Disabled women have health problems associated with their disability, which are greatly compounded by reproductive health related illnesses. Given their situations and

circumstances they are normally ignored when it comes to reproductive health services as they are assumed not to be sexually active and, therefore, not to need these services.

The findings of this study will help service providers and policy makers improve access to reproductive health services to this underserved population. It will aid in the formulation of appropriate policies and strategies to increase the level of access by women with disabilities. This will consequently improve the reproductive health of disabled women in Nairobi and Kenya as a whole.

Numerous studies have been done on employment, education and rehabilitation of PWD (e.g. International Labour Organisation, 2004; and Mbindyo and Mutere, 1987). Few if any have been done on disabled women's access to reproductive health. Yet the health status of women especially in pregnancy and motherhood is of particular relevance to the health status of future generations (Republic of Kenya, 2006). Many disabled people are able to have children just, like able-bodied people (Best, 1999). As such, a study focusing on disabled women's access to reproductive health services will no doubt highlight their experiences and provide information to direct the formulation of responsive policies geared towards meeting their health needs.

Given the dearth of information on reproductive health issues of women with disabilities in Kenya, the findings of this study will lay the foundation for further research in this area and also empower advocates to press for change in service systems so that they can effectively assist women with disabilities achieve healthy lives and participate fully in all spheres of life.

CHAPTER 2: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Scope of Reproductive Health

According to a report titled 'Women: The Current Status of Reproductive Health and HIV/AIDS in Kenya' by the Women's Bureau (1997), reproductive health for women is only attainable in an atmosphere that provides comprehensive and factual information on sexuality and a full range of affordable, accessible and acceptable health services including family planning. The same report defines reproductive health care as the constellation of methods and techniques and services that contribute to reproductive health and solving reproductive health problems.

Reproductive health has several components (Ministry of Health, 2004), namely:

- Safe motherhood, including antenatal care, safe delivery and post-natal care and child survival initiatives;
- Family planning unmet needs including male involvement;
- Management of HIV/AIDS and STIs;
- Promotion of adolescent and youth health;
- Screening and management of cancers of reproductive organs and other reproductive health issues; and
- Prevention and appropriate management of infertility.

2.2 Attitude and Treatment towards People With Disabilities

The *Persons with Disabilities Act, 2003* defines disability as 'a physical, sensory, mental or other impairment, including any visual, hearing, learning or physical incapability, which impacts on social, economic or environmental participation' (Republic of Kenya, 2004).

The history of the treatment of persons with disabilities has been one of ignorance and isolation. In developing nations, people with handicapping conditions are still victimized by neglect, superstition, inaccurate stereotyping and exploitation. Cultural beliefs about disabilities and attitudes towards PWD include shame, prejudice and exclusion from the community. Disabilities are often feared by people and may be associated with supernatural forces, such as the god's anger at a parent for wrong doing or breaking a taboo (Anderson, 2004).

Anderson (2004) continues to say that 'hospital physicians have been known to ignore patients who are disabled, giving preferences to able-bodied patients. Whether rejected as less worthy because of disability or because they may be less able to pay for services clearly communicates disrespect and devaluation of the disabled person, he writes.

Despite scientific evidence into the causes of disabilities, majority of the Kenyan people believe, as in the past, that disability is retribution of past wrong deeds. The disabled children are seen as a bad omen or a curse. Consequently, many parents conceal their disabled children from the public to save themselves from the stigma associated with disability, denying them their rights to education, play, protection and participation (Ndinda, 2005).

Prior to the colonial period in Kenya there were certain communities where a child with a handicap was considered to be suffering this way due to an offence against an ancestor; and recourse to witchdoctors to establish the cause was not uncommon (Anderson, 2004).

According to Ogechi and Ruto (2002) in their study titled 'Portrayal of Disability through Personal Names and Proverbs in Kenya: Evidence from Ekegusii and the Nandi' different perceptions and attitudes to and the treatment of the disabled people seem to be determined by the indigenous belief system.

They go into detail and say that there is an 'indigenous view' of the disabled that views the disabled person as normal, but different. This person is therefore, *in principle*, integrated into the community. Although the disabled person is considered normal, the belief system tries to find an explanation for the causes of disabilities and efforts are made to avoid their occurrence. As a way of avoiding disabilities, the indigenous view stresses being in harmony with the other. Two broad levels can thus be discerned. *The vertical relationship* – comprising the hierarchy from God, to the ancestors and to the present and the future descendants, and *the horizontal relationship* – constituting parents, uncles, aunts, grandparents, children, siblings, neighbours and so on. Any alteration of a harmonious functioning of these relationships is deemed to lead to or cause disability (Ogechi and Ruto, 2002).

Among the Akamba community, disability is considered to be a tragedy for the individual and a burden for the family (Ndinda, 2005).

2.3 The Prevalence of Disability in Kenya

In Kenya, there is no data on the situation of persons with disabilities. Some statistics are available, although it is generally agreed that these do not give an accurate picture of the actual prevalence of disability. The Kenya Population Census of 1989 estimated that 0.7 per cent of the total population (estimated at 21.4 million in 1989) was disabled (International Labour Organisation, 2004). According to the NCPWD, the information collected from this Census was inadequate for policy formulation and national planning (NCPWD, 2006).

The Kenya Integrated Household Budget Survey (2005/6) reporting on its findings on disability patterns in the country says the most widespread types of handicap are lameness (25.7 percent and 18.4 percent for mental disabilities (Republic of Kenya, 2007). Chesoni (2006) says that 10 percent of Kenya's population are people with disabilities and that such persons suffer exclusion and inequalities in different ways. She continues to say that while the general characteristic of gender inequality is invisibility, women with disabilities suffer this even more. Chesoni (2006) suggests that PWDs comprise 6-10 percent of respective country populations.

A 'National Survey on Persons With Disabilities in Kenya' that is aimed at establishing the number of disabled people and their needs is currently on-going in the country. The survey, which is being coordinated by the National Coordinating Agency for Population and Development (NCAPD), involves the Kenya National Bureau for Statistics (KNBS), National Council of Persons with Disabilities (NCPWD), and the United States Agency for International Development (USAID) among others (National Coordinating Agency for Population and Development, 2008).

2.4 Reproductive Health Services for Women with Disabilities

Worldwide, the reproductive health of men and women with physical disabilities is usually given low priority or dismissed. This often arises from the myth that disabled people are not sexually active and have no need to control their fertility. Many disabled people are able to have children and, like able-bodied people, may wish to use contraception temporarily.

Others may seek a permanent or long-acting contraceptive method, since childbearing and child rearing may be difficult for them. Some may prefer a permanent method if they suffer from a genetic condition that could be passed to their children (Best, 1999).

Hughes (2006) in his study titled 'Achieving Effective Health Promotion for Women with Disabilities' says that the field of health promotion has yet to acknowledge the unique needs of women with disabilities. He argues that women with disabilities face a lack of access to multitudinous opportunities for maintaining and improving their overall health.

Women with disabilities require comprehensive health care services to manage their physical disabilities and to prevent secondary conditions. In their study on 'Health Needs of Women with Disabilities Across the Lifespan' Piotrowski and Snell (2007) discovered that many women with disabilities encounter attitudinal, informational, environmental and geographic barriers as they seek access to health care. In another study, Schopp et al., (2002) concur with Piotrowski and Snell (2007) as regards the obstacles disabled women encounter as they access health services. In addition, they say, standard screening and preventive services can be especially difficult to obtain, potentially placing women with disabilities at greater risk for diseases such as breast cancer and cervical cancer.

In a similar study done in Zambia, it was found that the barriers disabled women face in accessing reproductive health services are no different from those faced by similar women in the west. Smith et al., (2004) say that women with disabilities encounter various social, attitudinal and physical barriers to accessing safe motherhood and reproductive health services. They concur that there is a generalised assumption among reproductive health service providers that women with disabilities will not be sexually active and not require reproductive health services which leads to increased vulnerability to sexually transmitted infections including HIV. Once pregnant, traditional beliefs about transmission of disabilities can create barriers to integration in ante-natal clinics. Their qualitative study, which used in-depth interviews with purposively selected women with disabilities and reproductive health service providers concludes that there is need for greater understanding of the influences underpinning societal attitudes towards sexuality and disability. In addition, there is need for more extensive communication between health care staff and women with disabilities, which

would facilitate positive action towards improving safe motherhood and reproductive health services for women with disabilities (Smith et al., 2004).

In a study done in Northern Ireland by Anderson and Kitchin (2000) on access to family planning clinics, it was discovered that physical access to these clinics was partial and access to information and services were extremely limited. The results of this study indicate that disabled people are not expected to be using the services (consultation, treatment and information) that family planning clinics provide. As such, the authors say, family planning clinics in Northern Ireland represent a landscape of exclusion, denying disabled people access to services and reproducing cultural ideologies concerning disability and sexuality.

Odette et al., (2003) in their study on 'Barriers to Wellness Activities for Women with Disabilities in Canada' found that individual and structural barriers exist for the women, with structural barriers (physical, informational and systemic access) being predominant. The women studied also made recommendations to create greater access such as increasing health professionals training in disability issues, a recommendation which concurs with Mele et al., (2005) who say that health service providers require education about working with women with disabilities.

In their study, Mele et al., (2005) used a semi-structured interview guide to explore the experiences of women with disabilities seeking breast cancer screening services. To recruit women for the study, they used purposive sampling and also used community collaborators working with people with disabilities to identify eligible participants. Although this study focused on breast cancer screening services, the women also described barriers that affect all their health care services. Similar to the other studies reviewed above, these barriers include financial, architectural, environmental and attitudinal barriers such as poor transportation, heavy doors, inaccessible exam tables and bathrooms. In addition they also felt devalued by their providers and believed their symptoms were overlooked.

According to a report of the proceedings of a conference on 'African Decade of Persons with Disabilities (1999-2009: Kenya Reflection and Action) held in 2004, HIV/AIDS spread and prevalence among people with disabilities is fuelled by the fact that they have no access to

information due to their disability and illiteracy (Ministry of Gender, Sports, Culture and Social Services, 2004).

A 'Report on Literature Review on Kenya National Policy on Disability' (Echotech Consultants, 2004) says that most disabled persons are marginalised and disadvantaged as majority of them have no access to many basic social and economic facilities. These include lack of access to education, employment, health and rehabilitation. Most social amenities do not take into account the need for their access to the disabled. It continues to say that disabled women are often disadvantaged partly because of their gender and partly due to their disability or both.

As far as the health needs of disabled people are concerned, a survey of disabled persons in Murang'a district of central province shows that majority require medical care. Nearly all disabled persons obtain medical treatment in government hospitals and majority are not satisfied with the services they get (Mbindyo and Mutere, 1987).

2.5 Policies on Disability in Kenya

People with disabilities in Kenya not only represent a crucial sector of the marginalized population but also face special problems as a result of their disabilities. Many have no adequate access to basic services such as education, information, medical health care, employment, transport and rehabilitation. The majority of the disabled people experience hardships as a result of the in-built environment, cultural and economic prejudices, stigmatisation and more often ostracism, abuse and violence. The laws and policies intended as instruments of social engineering and avenues of awareness and intervention have not been explicit enough in addressing their human rights. It is only until recently in 2004, when the government established the *Persons with Disabilities Act 2004*. Previously, Kenya did not have a Disability Act. The government was using *Sessional Paper No.5 of 1968* as the policy framework for disability issues. This *Sessional Paper* is old and outdated and did not take into consideration the special needs of the disabled and their human rights (Ndinda, 2005).

With the growing realisation of the need to cater for the needs of women and consequently gender concerns and for people with disabilities (PWDs) in Kenya, the government in 2003 established the Ministry of Gender, Sports, Culture and Social Services. To realign the

Ministry to achieve its mandate of catering for PWDs a semi-autonomous government agency (SAGA) – National Council of Persons with Disabilities (NCPWD) was also created (Ministry of Gender, Sports, Culture and Social Services, 2006).

The NCPWD is responsible for providing policy guidance, coordination of programmes and mainstreaming concerns for PWD as well as implementing and operationalisation of the *Persons with Disabilities Act, 2003*. Among its functions is to enhance the capacity of disabled person's organisations, institutions and individual PWD (Ministry of Gender, Sports, Culture and Social Services, 2006).

According to the Act, the NCPWD shall be represented in the implementation of the national health programme under the Ministry responsible for health for the purpose of; prevention of disability; early identification of disability; early rehabilitation of persons with disabilities; enabling PWD to receive free rehabilitation and medical services in public and privately owned health institutions; availing essential health services to PWDs at an affordable cost; availing field medical personnel to local health institutions for the benefit of PWDs; and prompt attendance by medical personnel to PWDs (Republic of Kenya, 2004).

In 2007, the NCPWD commissioned a baseline survey to obtain data on challenges facing women with disabilities; develop a strategy of engagement with Government and other stakeholders; and make recommendations on the way forward for women with disabilities. The study, which was undertaken in the informal settlements of Nairobi, Kiambu, Thika and Machakos sampled and interviewed women with all forms of disabilities. Forty-eight (48) of these were women with physical disability; two with cerebral palsy; two albinos, two with mental handicaps; four with hearing impairment and two with autism. The study respondents were selected using non-probability sampling methods, namely, convenience and snowball (NCPWD, 2007).

This study found that at the national level, policy makers are not responsive to the reproductive and sexual needs of women with disabilities due to lack of institutionalised mechanisms on the use of brail in hospitals, and on contraceptives and safer sex methods (NCPWD, 2007). The study recommends that the NCPWD lobby government to institutionalise and provide disability support such as braille, mobility and hearing aids to

institutions dealing with disabled women; conduct massive training for sign language instructors, lobby policy makers to ensure that medicines and contraceptives manufactured in Kenya and imported into the country are also inscribed in braille (NCPWD, 2007).

The above study also interrogated the *Persons with Disabilities Act, 2003* and found that it has no specific reference to women with disabilities. This, the report says weakens support/legitimacy of persons and institutions advocating for women and girls with disability. It recommends that the NCPWD spearheads the review of the Act to make it gender sensitive towards all categories of disability and with specific focus on women with disabilities (NCPWD, 2007).

Although the disabled continue to lobby the government to meet their special needs and rights, they continue to face great challenges in accessing public places which are not accessible to them. There is no responsible authority to co-ordinate disability issues and to observe accessibility of the build-up environment by levelling of pavements, installing lifts and accessible toilets and ensuring access to other public places and utilities. In addition, there are no special transport arrangements for the disabled. Many difficulties continue to be met when planning to build accessible environments. The difficulties include negative traditional beliefs towards the disabled, lack of knowledge and adequate data in the field of disability and lack of political will and commitment to provide the necessary disability awareness and integrate these into the training of planners, architects and construction engineers (Ndinda, 2005).

2.6 Theoretical Framework

This study will determine whether access to reproductive health services for physically disabled women in Nairobi is determined and affected by prejudice and discrimination as posited by the Critical Theory.

2.6.1 What is Critical Theory?

Writing on 'Theories in Health Care and Research: Theories of Disability in Health Practice and Research' Michael Oliver, a Professor of Disability Studies at University of Greenwich, London says that "*Critical Theory* sees disabled people's problems explicitly as the product of an unequal society. It ties the solutions to social action and change. Notions of disability as

social oppression mean that prejudice and discrimination disable and restrict people's lives much more than impairments do. It is argued for example that the problem with public transport is not the inability of some people to walk but that buses are not designed to take wheelchairs. Such a problem can be "cured" by spending money, not by surgical intervention, assistive computer technology, or rehabilitation" (Oliver, 1998).

The basis of this theory is that ordinary things which most people can take for granted like education, employment, buildings, public transport, and other things, remain largely closed to disabled people, or at least they present obstacles which each person has to tackle individually (Oliver, 1998).

2.6.2 Relevance of Critical Theory

Based on the findings of the literature review done in the main part of this section (see part 2.3) that women with physical disabilities encounter various social, attitudinal and physical barriers when accessing reproductive health services (eg Smith et al., 2004; Anderson and Kitchin, 2000; and Piotrowski and Snell, 2007) this study will find out whether 'access to reproductive health services for physically disabled women' can be enhanced by working at removing physical barriers to ease access and at changing service providers perceptions and attitudes that women with physical disabilities are not sexually active and thus do not need reproductive health services.

2.6.3 Strengths of Critical Theory

According to Oliver (1998) the impact of this critical theorising on health care and research though said to be indirect, has raised political awareness, helped with the collective empowerment of disabled people, and publicised disabled people's critical views on health care. It has criticised the medical control exerted over many disabled people's lives, such as repeated and unnecessary visits to clinics for impairments that do not change and are not illnesses in need of treatment. It calls for a more appropriate societal framework for providing health services for disabled people.

Using the tenets of Critical theory, this study will endeavour to raise awareness on the challenges that face physically disabled women's access to reproductive health services that require policy intervention and implementation.

2.7 Hypotheses/Assumptions

- i) Disabled women do not access reproductive health services because they are physically inaccessible.
- ii) Disabled women do not access reproductive health services because of the stigma/attitude attached to disability.
- iii) Disabled women do not access reproductive health services because health professionals do not know how to deal with them.

2.8 Operationalisation of Variables

Access – the actual use of reproductive health services as defined by Gutiérrez and Wallace (2005) and everything that facilitates or impedes the use of the services.

Women with physical disabilities – these are women who are incapacitated in one way or another physically, that is either their lower or upper limbs constrict their mobility.

Reproductive health care – services/treatments that deal with illnesses and needs that affect women's reproductive system.

CHAPTER 3: METHODOLOGY

3.1 Study Design

The study used the survey method to explore factors that prevent disabled women from visiting reproductive health service providers; to establish the difficulties disabled women face when they visit reproductive health service providers; to explore the challenges reproductive health care providers face when serving disabled women; and to find out measures that can be put in place to increase access to reproductive health care for disabled women.

The tools used to collect data were researcher administered questionnaires and a key informant guide. The questionnaires had both closed and open ended questions. The data collected was analysed using SPSS.

3.1.1 Study Site

The study was conducted in Nairobi. Nairobi was chosen as a result of its convenient location given, the limitations in financial resources and time available to conduct the research. The fact that it is the capital city of Kenya also made it an ideal location because disabled women from all parts of the country can be found here.

Nairobi doubles up as both a province and has three districts. As per the '1999 Population and Housing Census' Nairobi had a population of 2,143,254 people (Central Bureau of Statistics, 2001). Nairobi's health service infrastructure includes both private and public health facilities. The city is serviced by 29 public facilities, namely, 18 dispensaries, eight health centres, one district hospital and two national and specialist hospitals. These serve a population of about 2.7 million people as per the Ministry of Health's/World Health Organisation 'Personnel Mapping Survey' published in 2004 (Nyanjom, 2006).

The national referral hospitals are at the apex of the health care system and provide sophisticated diagnosis, therapeutic and rehabilitation services. The country's two national referral hospitals are Kenyatta National Hospital (KNH) in Nairobi and Moi Referral and Teaching Hospital in Eldoret (NCAPD et al., 2005). Guided by the need to optimise available resources and to also collect credible data from the field the study purposively selected three

study sites; Kenyatta National Hospital, which is also the largest hospital in Eastern and Southern Africa and Pumwani Maternity Hospital, which is largest maternal health centre in East and Central Africa. The hospital helps some 27,000 women give birth each year (Kimani, 2008). The third site was the greater Nairobi area, which was to be used to reach physically disabled women who had not accessed reproductive health services at KNH and Pumwani Maternity Hospital.

However, it was not possible to get access to Kenyatta National Hospital and Pumwani Maternity Hospital to collect data. Getting the necessary permissions from the Ministry of Health which oversees the operations of KNH was not forthcoming. Several visits to Pumwani Hospital prior to the research indicated that women with physical disabilities rarely go there. Personal communication with the nursing matron at the hospital confirmed that the hospital had not attended to such women in the last two months. Therefore, the study purposively picked women with physical disabilities within Nairobi to respond to the questionnaires.

3.2 Sampling

3.2.1 Sampling Frame

Kenya has no accurate data on disability that scholars can rely on. The 1989 National Population Census included a module on disability but the information collected was inadequate for policy formulation and national planning. As a result it is not, therefore, possible to indicate with certainty the level of prevalence of disability in Kenya (NCPWD, undated). Thus, the study had no sampling frame with which to draw its sample population from.

3.2.2 Sample Population

The study was on access to reproductive health services for physically disabled women. Thus the target population under study was women with physical disabilities in Nairobi. The sample population for this study was 31 women with physical disabilities six key informants- three programme officers from disability organisations and three reproductive health service providers. The unit of analysis was the individual disabled woman.

3.2.3 Sampling Method

Given that there are no official statistics to determine the number of disabled women in Nairobi and in the country as a whole and the limitation in resources, the study used non-probability sampling method to pick the respondents who are women with physical disabilities in Nairobi. Non-probability sampling is used when a researcher is not interested in selecting a sample that is representative of the population (Mugenda and Mugenda, 1999).

Thus the study used convenient sampling technique, which is one of methods of non-probability sampling to pick 31 respondents as they become available in different parts of Nairobi, namely Pumwani, Kibera, and South B (Mukuru kwa Njenga, kwa Ruben and Kaiyaba) during the month of July and August, 2008. The researcher purposively picked women who manifest physical disabilities.

According to Mugenda and Mugenda (1999) this technique involves selecting cases or units of observation as they become available to the researcher. The main feature of this method is that subjects are easily and conveniently available and are also accessible.

The study also talked to six key informants who are the service providers of reproductive health services and Programme Officers of disability organisations (three in each category) to share their experiences in dealing with the health aspects of physically disabled women.

3.3 Methods of Data Collection

Various methods were used to collect data for the study.

3.3.1 Questionnaire

Data was collected using structured and unstructured researcher administered questionnaires with 31 purposively selected women with physical disabilities. This method aimed at collecting data that would help the study explore factors that prevent women with disabilities from visiting reproductive health service providers and to establish the difficulties they faced when they visit the providers. It also enabled the study to get an idea of the measures the women would want put in place by government and the providers to enable them have greater access.

3.3.2 Key Informant Interviews

Key informant interviews were held with three reproductive public health service providers and three programme officers of disability organisations. This form of data collection was used to explore the challenges the service providers face when serving women with disabilities.

Both methods used structured questions to obtain factual information and open-ended questions to obtain opinions, explanations or descriptions of access to reproductive health care services. This approach was supplemented with follow-up questions in order to enable clarification of the responses. The questions were determined in advance and derived from issues that the interviewer wanted to discuss (see Appendices section containing the research instruments). The questions were asked in a clear and non-directive manner in order not to predetermine or 'lead' the answers.

Prior to going to the field to collect data, the questionnaire and the interview guide were pre-tested with select physically disabled women to ensure that the questions are appropriate for the study.

3.3.3 Secondary Data

To supplement primary data, documentary sources were used to yield secondary data to better inform the problem under study. These included sources such as books, government publications and journals.

3.4 Data Analysis

The study collected both qualitative and quantitative data. The quantitative data was cleaned, coded and analysed using Statistical Package for the Social Sciences (SPSS) software to get statistical data, which was then presented using frequencies and descriptive statistics.

Qualitative data and information from key informants was analysed thematically and used to enrich quantitative derived results and draw conclusions as guided by the objectives and assumptions of the study.

3.5 Ethical Considerations of the Study

The researcher ensured that all the necessary ethical considerations were taken care of in this research project.

As regards the respondents, all the interviews were prefaced with an introduction in which the respondents were assured of anonymity, and confidentiality. They were informed of the objective of the research for them to give informed consent. There was no coercion or promise for payment for answering the questionnaire. The respondents were also given the right to withdraw from the study if at any point during the interview they did not wish to continue answering questions.

3.6 Problems Encountered During the Study

Among the difficulties encountered in the study are; reluctance to answering the questionnaires from both physically disabled women and service providers. This was because issues of health and sexuality are sensitive to most people and some service providers thought they were under scrutiny as to how they do their job. In both cases, the respondents were assured of confidentiality of the information they gave and that their identity would be protected through out the study. Another major challenge was transport within Nairobi's residential areas where most of the study respondents reside. It involved walking, which made it difficult to interview many people in a day. Some of the respondents felt the interviews were a waste of time and they could not afford to stop fending for themselves to respond. To solve this problem, they were interviewed as they went about their businesses, which involved tailoring and selling of vegetables and fruits. They were also assured that the results would be shared with disability organisations and government to help inform policy formulation that would be of benefit to them. However, despite all these challenges, the respondents were cooperative.

CHAPTER 4: FINDINGS AND ANALYSIS

The study talked to 31 women with physical disabilities and six key informants. The study used convenience and probability sampling to get the respondents of the study within Nairobi. Both quantitative and qualitative data was gathered. This was analysed statistically to generate frequencies, percentages and cumulative percentages. These data has been presented using tables.

4.1 Characteristics of Respondents

i) Age

Out of the women with physical disabilities interviewed 52 percent were aged 35 years and above, 19 percent belonged to the 31-35 age category, 10 percent were between 26 and 30 years of age; and 13 percent and 6 percent were aged 22-25 years and 18-21 years respectively. Table 1 shows a breakdown of the above.

Table 1: Age Categories of Women with Physical Disabilities

| Age in Years | No. of Women | Percentage (%) |
|--------------|--------------|----------------|
| 18-21 | 2 | 6 |
| 22-25 | 4 | 13 |
| 26-30 | 3 | 10 |
| 31-35 | 6 | 19 |
| >35 | 16 | 52 |
| Total | 31 | 100 |

Source: Primary data

It is evident that women of all ages suffer disability, though majority of those interviewed were found to belong to the more than 35 years of age category.

ii) Marital Status and Number of Children

The study found that out of the respondents, most were single (52 percent). Seven of them (23 percent) were married, two (6 percent) were divorced, while 16 percent of them (five) were separated and 3 percent were widowed (see Table 2 below). In addition, 24 of them (77 percent) had children and seven (23 percent) did not. The number of children per woman

ranged from one to 10. Two women had 10 and nine children each. Majority 26 percent (8 women) had one child each. Table 3 shows the breakdown of the number of children the respondents had.

The above findings confirm that women with disabilities are sexually active and are able to have children just like able-bodied women. Thus, they require the whole range of reproductive health services provided for the rest of the population. Similar studies conducted have also confirmed this (e.g. Nosek, 1996; Best, 1999).

Table 2: Marital Status of Respondents

| Marital status | Frequency | Percentage |
|----------------|-----------|------------|
| Single | 16 | 52 |
| Married | 7 | 23 |
| Separated | 5 | 16 |
| Divorced | 2 | 6 |
| Widowed | 1 | 3 |
| Total | 31 | 100 |

Source: Primary data

Table 3: Number of Children

| No. of children | Frequency | Percentage |
|-----------------|-----------|------------|
| None | 7 | 23 |
| 1-3 | 15 | 48 |
| 4-6 | 5 | 16 |
| 7-10 | 4 | 13 |
| Total | 32 | 100 |

Source: Primary data

iii) Education Level Attained and Employment Status

As Table 4 indicates, most of the women with physical disabilities interviewed had not gone past primary school. Only 19 percent had done the primary school completion exam (Kenya Certificate of Primary Education or Certificate of Primary Education). Four (13 percent) of them had made it to secondary, completed and gone on to college. The low education level could limit access to reproductive health services as it limits understanding of the scope of the services, the importance of reproductive health and what services are available.

Table 4: Education Levels of the Women

| Education level | Frequency | Percentage |
|----------------------|-----------|------------|
| Primary complete | 6 | 19 |
| Primary incomplete | 11 | 35 |
| Secondary complete | 5 | 16 |
| Secondary incomplete | 3 | 10 |
| College | 4 | 13 |
| No education | 2 | 6 |
| Total | 31 | 100 |

Source: Primary data

In light of the education level of the respondents, majority of them were not engaged in formal employment. Only 10 percent were formally employed. The rest 90 percent were in informal employment ranging from hawking to tailoring and others were dependent on relatives and well-wishers for their upkeep. However, both those engaged in formal and informal employment earned less than Ksh 10,000 per month. Table 5 shows the respondents source of livelihood.

Education level determines the kind of employment one can get. The study observed that most of these women were struggling to make a living and their financial resources were constrained, consequently affecting their ability to afford health care.

Table 5: Respondents Source of Livelihood

| Employment type/livelihood source | Frequency | Percentage |
|--|-----------|------------|
| Formally employed | 3 | 10 |
| Hairdressing | 1 | 3 |
| Hawking | 4 | 13 |
| Land lady | 1 | 3 |
| Selling vegetables & fruits | 1 | 3 |
| Tailoring/weaving | 6 | 19 |
| Washing clothes | 1 | 3 |
| Unemployed (dependent on well wishers, spouse, siblings, children) | 14 | 45 |
| Total | 31 | 100 |

Source: Primary data

All the women were engaged in only one type of livelihood source as indicated in Table 5 above. This could mean that disability limits the number of activities a woman with a disability can be engaged at a go.

iv) Respondents' Nature of Disability

Most of the women with physical disabilities interviewed were disabled on one leg (35.48 percent), 10 of them (32 percent) had paralysis of the lower limbs and one (3 percent) had kyphosis. Most of the disability had been caused by polio (81 percent) and 10 percent each had resulted from accidents and birth defects. Table 6 and 7 show the nature of disability of the women and the causes respectively.

Table 6: Nature of Disability

| Disability | Frequency | Percentage |
|--------------|-----------|------------|
| Athritis | 3 | 10 |
| Both legs | 5 | 16 |
| Humpback | 1 | 3 |
| Kyphosis | 1 | 3 |
| One leg | 11 | 35 |
| Paraplegic | 10 | 32 |
| Total | 31 | 100 |

Source: Primary data

Table 7: Cause of Disability

| Cause of disability | Frequency | Percentage |
|---------------------|-----------|------------|
| Accident | 3 | 10 |
| Birth | 3 | 10 |
| Illness (Polio) | 25 | 80 |
| Total | 31 | 100 |

Source: Primary data

As seen above, polio is the greatest cause of disability among the women. Polio is a preventable disease through childhood immunization, which is one of the components of reproductive health (Ministry of Health, 2004). Given that the women with disabilities are able to have children and some do, it is important that the whole range of reproductive health

care be made accessible to prevent disability among the children of both able bodied and women with disabilities.

4.2 Access to Reproductive Health Care Services

i) Common Reproductive Health Illnesses Suffered

The most common reproductive health illness among the respondents was fibroids at 10 percent; 3 percent had HIV/AIDs; 6 percent had problems with menstruation (over bleeding), severe pain causing dizziness and missed periods. One (3 percent) had swelling in the breast and lower abdomen and 74.19 percent indicated they had not suffered a reproductive health illness. Table 8 shows this breakdown.

Table 8: Common Reproductive Health Illnesses

| Common reproductive health illnesses | Frequency | Percentage |
|---|-----------|------------|
| None | 23 | 74 |
| Fibroids | 3 | 10 |
| Problems with menstruation (painful and missed periods, excessive bleeding) | 2 | 6 |
| STI (HIV and VD) | 2 | 6 |
| Swelling in breast and lower abdomen | 1 | 3 |
| Total | 31 | 100 |

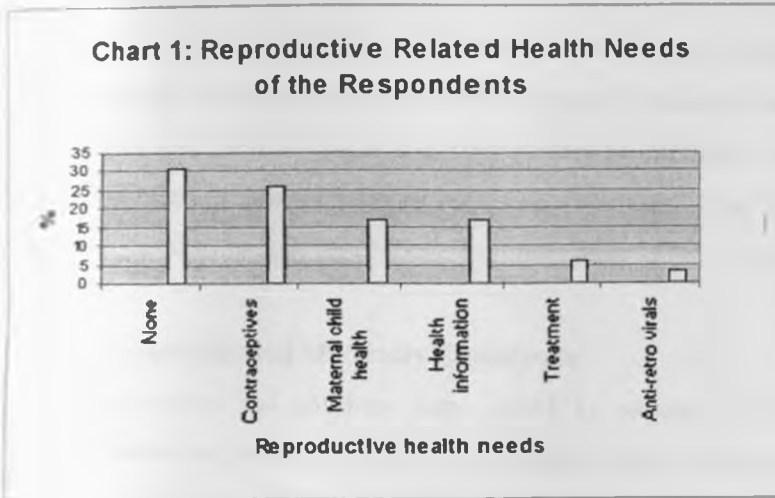
Source: Primary data

Although most of the women interviewed said that they had not suffered a reproductive health illness, the results of those who indicated show that they are susceptible as other able bodied women. It also shows that disability does not necessarily make one prone to these illnesses than the rest of the population.

ii) Reproductive Health Related Needs and How they have been Met

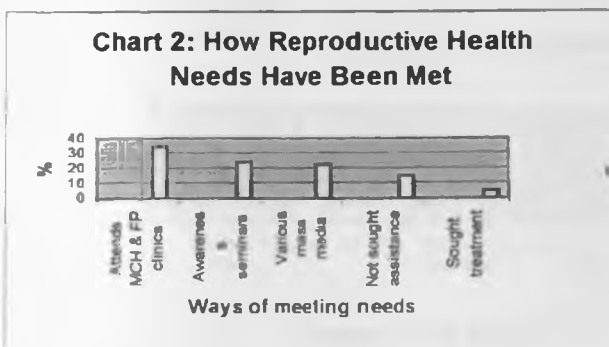
Chart 1 shows the most common reproductive health needs among the women with physical disabilities interviewed was contraceptives. This was indicated by 9 women (26 percent). Those with children had need for maternal child health services (17 percent). Health information was indicated by six of them. Eleven of them (31 percent) indicated no need. For those who had reproductive health illnesses, namely, fibroids and swelling in the breasts had a need for information on their conditions and treatment for the same. Some women indicated more than one need. Some of the women who indicated in Table 8 as not having suffered a

reproductive health illness indicated having reproductive health related needs such as health information and contraceptives



Source: Primary data

The women use various avenues to meet the reproductive health needs they have. These range from visiting maternal child health clinics and major hospitals for contraceptives and child wellness and attending awareness seminars for the disabled organised by various organisations in addition to reading various literature they come across and listening to radio and watching television (see Chart 2).



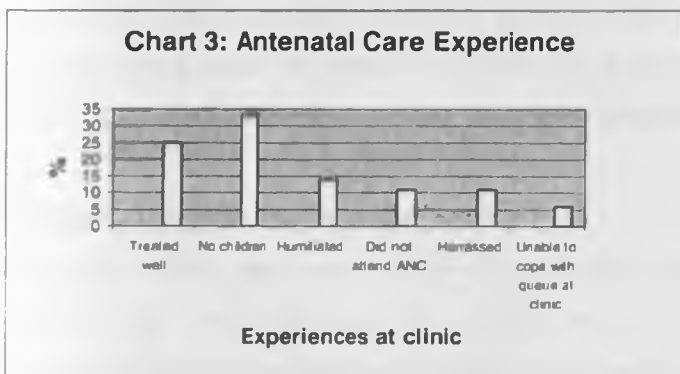
Source: Primary data

The above findings indicate that getting information about reproductive health issues like sexuality and contraceptives among the women with disabilities are important and that they use the avenues and channels available to get this information. However, it was noted that those who did not seek the information on reproductive health did not think they needed to.

This was either because they had stopped having children, did not have any or were not sexually active. This shows that these women lack awareness as to what reproductive health issues are and limit them to child-bearing and contraceptives, yet there are other concerns like breast and cervical cancer and management of infertility. From the findings, it is evident that awareness seminars organised for those with disability are an important avenue that should be enhanced to include topics covering more than STDs, contraceptives and HIV.

iii) Antenatal and Maternity Experience

Those who had children were asked to narrate their experiences when they visited reproductive health providers for antenatal (ANC) check-up and when they eventually went to deliver. Nine (25 percent) say they had a normal experience and were treated well. There are those who did not go for ANC (11 percent). Those who said they had difficulties were 11 (31 percent). These difficulties ranged from being harassed for arriving late for the clinic, which resulted in them being sent away till the next day (11 percent), five (14 percent) were humiliated by the personnel who asked them how they got pregnant in their state and two could not cope with the queuing due to discomfort, going to the clinic and getting on to the exam bed. These experiences are summarised in Chart 3 (some respondents gave multiple experiences).



Source: Primary data

The delivery experiences of the women with physical disabilities interviewed were also varied. Those who had home deliveries were seven (23 percent). Five (16 percent) had no problem as they were treated well and assisted by the staff. Seven (23 percent) said they had bad experiences ranging from inability to push during labour and being harassed to do so like other able bodied women, doctor wanting to perform a caesarean without consulting them

and one was ignored and ended up delivering on her own. Table 9 presents a breakdown of these experiences.

Table 9: Maternity Experience

| Maternity experience | Frequency | Percentage |
|---|------------------|-------------------|
| Had no children yet/had them before disability | 12 | 39 |
| Home delivery (preference and no money) | 7 | 23 |
| No problem was treated well and assisted | 5 | 16 |
| Expected to push like other women during labour was harassed when unable | 3 | 10 |
| Doctor wanted to do caesarean section without discussing | 1 | 3 |
| Ignored and delivered on her own | 1 | 3 |
| No help to get on delivery bed | 1 | 3 |
| Was kept waiting for long before admission (nobody wanted to attend to her for fear of complications) | 1 | 3 |
| Total | 31 | 100 |

Source: Primary data

The above findings on antenatal and maternity experience show that the women with disabilities encounter various social, attitudinal and physical barriers accessing safe motherhood. These include difficulties going to the clinic, getting onto the exam bed, decisions being made for them like undergoing a caesarean section without consultation assuming they have no capacity to discuss with the medical personnel among others.

iv) Visit to Hospital, Distance and Facility Type

Most of the women interviewed (48 percent) indicated that they always visit a hospital when they are sick. Twelve of them (39 percent) have not visited a facility for treatment of a reproductive health illness because they had had no need. Three (10 percent) said they do not go to hospital and one (3 percent) said they do go sometimes. This is shown on Table 10.

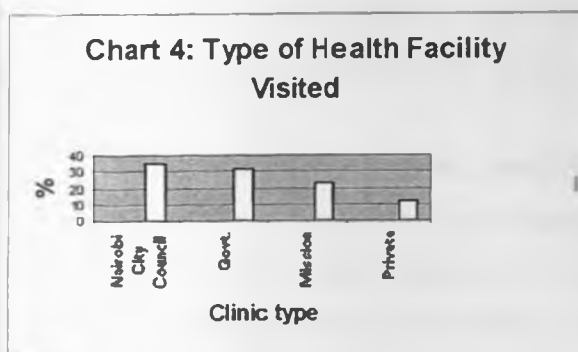
As seen in Table 10 above there are those who do not go to hospital when sick (10 percent). Among these are those who said they could not afford to go to hospital and some said they preferred to buy drugs from a chemist.

Table 10: Visit to Hospital

| Visit hospital when sick | Frequency | Percentage |
|--------------------------|-----------|------------|
| Yes | 15 | 48 |
| Has had no need yet | 12 | 39 |
| No | 3 | 10 |
| Sometimes | 1 | 3 |
| Total | 31 | 100 |

Source: Primary data

For those who visit a health facility when sick, most go to government and city council of Nairobi clinics. They are represented by 35 percent and 31 percent respectively. Three (12percent go to private facilities and 23 percent go to mission based clinics. Some go to more than one type on different occasions depending on distance, need and availability of finances. This breakdown can be seen on Chart 4.



Source: Primary data

Most of the respondents (see Table 11) access the health facility by walking. The distances range from a 15 minutes to one hour walk. It was evident from the research that most of these women experienced problems going to the health facility. Most have to walk because getting onto public transport is difficult or there is none that services their residential areas.

Table 11: Distance to Facility

| Distance to facility | Frequency | Percentage |
|---|-----------|------------|
| 15 - 20 minutes walking | 17 | 55 |
| 1 hour walking | 6 | 19 |
| 15 - 20 minutes by bicycle taxi/vehicle | 4 | 13 |
| 30 minutes walking | 4 | 13 |

Source: Primary data

Affordability and proximity to home was the most common reason cited by respondents for visiting the above facilities. Twenty-two women (71 percent) indicated this. Most of the women (39 percent) cannot afford to pay for the services themselves and said that family members ranging from spouses, children and siblings assisted them meet medical expenses. Nine (29 percent) pay for themselves. From the above results, most of the women cannot afford to pay for their healthcare. This definitely limits access as it causes them to overlook some illnesses as not serious given that it is costly to treat them.

v) Quality of Services Received at the Facilities

Of those who visit health service providers 55 percent rate the services as good, while 18 percent rate it as average. Very poor and poor service was rated by 9 percent of the women each and very good by a similar number (see Table 12).

Table 12: Rate of Service at Health Facility

| Quality of service received at facility | Frequency | Percentage |
|---|-----------|------------|
| Average | 4 | 18 |
| Good | 12 | 55 |
| Poor | 2 | 9 |
| Very good | 2 | 9 |
| Very poor | 2 | 9 |
| Total | 22 | 100 |

vi) Difficulties Experienced with Facility and Personnel

On the question of the difficulties the women face when they visit health facilities, most of them (50 percent) say lack of ramps to ease access, high exam beds with no steps and difficulties moving within the facility for various services like x-rays and laboratory as the

most common. On the other hand, 45 percent, say they had no difficulties accessing the facilities. Table 13 shows this.

Table 13: Difficulties Experienced in Accessing Facilities

| Difficulties accessing facility | Frequency | Percentage |
|--|-----------|------------|
| Difficult (no ramps, stairs, services far apart, high exam beds, movement within facility difficult) | 11 | 50 |
| Long distance to facility | 1 | 5 |
| No difficulty | 10 | 45 |
| Total | 22 | 100 |

As regards their experience with medical personnel, most women (50 percent) described them as having a bad attitude towards those with disabilities as they were found to be what they described as cruel, rude, and humiliating among others. Despite this, an almost similar number (45 percent) found them good and helpful as indicated on Table 14.

Table 14: Difficulties with Personnel

| Difficulties with medical personnel | Frequency | Percentage |
|---|-----------|------------|
| At public facility staff rude, cruel, humiliated, harassed when late, ignored, treated with pity, expected to operate like able bodied women. | 11 | 50 |
| Experienced no difficult | 10 | 45 |
| Turned away if unable to pay for services | 1 | 5 |
| Total | 22 | 100 |

Source: Primary data

The difficulties experienced by the women in terms of access to facility and with personnel show a generalised assumption that women with disabilities are not sexually active and may thus not require reproductive health services. These women encounter physical and attitudinal barriers as they seek care. For example results show that women with disabilities are not expected to be using exam beds or go to clinics with stairs and no ramps. Long queues resulting in long waiting time was a problem experienced by 13 (42 percent) of the women interviewed, while 29 percent of them found it normal.

vii) Thoughts on the Services Provided at Health Facility

On their thoughts about the services they receive at health facilities as women with disabilities they said that it was bad, it lacked privacy, staff used abusive language and gossiped about them in their presence. They also felt discriminated and disrespected. However, there are some who thought the service was normal.

When asked whether they think health professionals treat them differently as result of their disability 65 percent said yes and 23 percent said no, while those who said sometimes were represented by 6 percent.

On whether they had been denied a medical service as a result of their disability, 81 percent (18 women) said no and 19 percent said yes. The women, however, said that much as they had not been denied a service they were often ignored until the last minute and felt that their disability hindered faster access. All those who said they had been denied a service because of disability said they felt very bad and helpless and some never went back to that particular facility again.

viii) Effect of Difficulties Experienced

The difficulties experienced with access to facilities, with personnel and the waiting time have affected the women with disabilities in various ways. These include getting discouraged from seeking care and treatment (36 percent) resulting to buying non-prescribed drugs over the counter or enduring the difficulties for lack of choice (9 percent). These challenges are experienced in public facilities i.e. government and city council facilities and so those who can afford or have access prefer to visit private or mission facilities which is a minority – 5 percent (see Table 15).

The effect of not seeking appropriate care or delay as a result of the difficulties experienced with facilities and personnel can have far reaching repercussions on the health of the women with disabilities. They may miss out on opportunities for maintaining and improving their overall health in addition to some serious reproductive health conditions being diagnosed when it is too late.

Table 15: Effect of Difficulties on Access to Health Care

| Effect of difficulties | Frequency | Percentage |
|---|------------------|-------------------|
| Discouraged from seeking services from public facilities and buys drugs instead | 8 | 36 |
| No effect | 8 | 36 |
| Sometimes doesn't get treatment if queue too long | 2 | 9 |
| Feels bad when staff are rude but endures for lack of alternative | 2 | 9 |
| Have to wake up early to avoid long queues | 1 | 5 |
| Prefer to go to missionary rather than public facility | 1 | 5 |
| Total | 22 | 100 |

Source: Primary data

From the above, it can be said that among the difficulties that women with disabilities face when they visit reproductive health service providers are mainly accessing the various facilities due to the physical facilities being disability unfriendly and personnel having a bad attitude towards them. Personal and shared unfavourable experiences may be factors that prevent disabled women from visiting reproductive health providers.

4.3 Disability and Reproductive Health

i) Feelings of Women with Disabilities

The study also wanted to find out the feelings of women with disabilities to see whether it affected their reproductive health. Six (19 percent) of them have accepted their disability while 25 (80 percent) feel disadvantaged, helpless and a burden to their families (see Table 16).

A large proportion of the women as seen below have negative feelings regarding their disability. This can be interpreted to mean that they have a low self-esteem and a negative image, which can be attributed to lack of economic independence and their restricted mobility, which prevents them from doing daily basic chores for themselves including personal care without help.

Table 16: Feelings about their Disability

| How do you feel about your disability | Frequency | Percentage |
|--|------------------|-------------------|
| Disadvantaged as have to struggle more than other able bodied people | 11 | 35 |
| Accepted her condition | 6 | 19 |
| Helpless, ignored, prefers to die, unable to cope | 9 | 29 |
| Pity on self, a burden to family | 3 | 10 |
| Expensive- special shoes and calipers | 1 | 3 |
| Hope of recovery | 1 | 3 |
| Total | 31 | 100 |

Source: Primary data

On whether their disability contributes to any reproductive health illness they have suffered, 58 percent said no, while 19 percent said yes. The reasons given by those who said that disability had contributed to reproductive illnesses/problem that they had suffered ranged from loosing babies after delivery, rape, uterine over bleeding, and inability to have more children. These reasons, however, would need to be medically proven to have been caused by disability as they are the same problems able-bodied women face.

iii) Experience on Seeking Information on Sexuality and Family Planning

When seeking information on sexuality and family planning, the women who had asked (32 percent) said they received negative reactions. These are summarised in Table 17. There are those who said they had not sought such information and service and were represented by 55 percent. Those who described the reaction they received as normal (13 percent) said they were assisted and counselled appropriately.

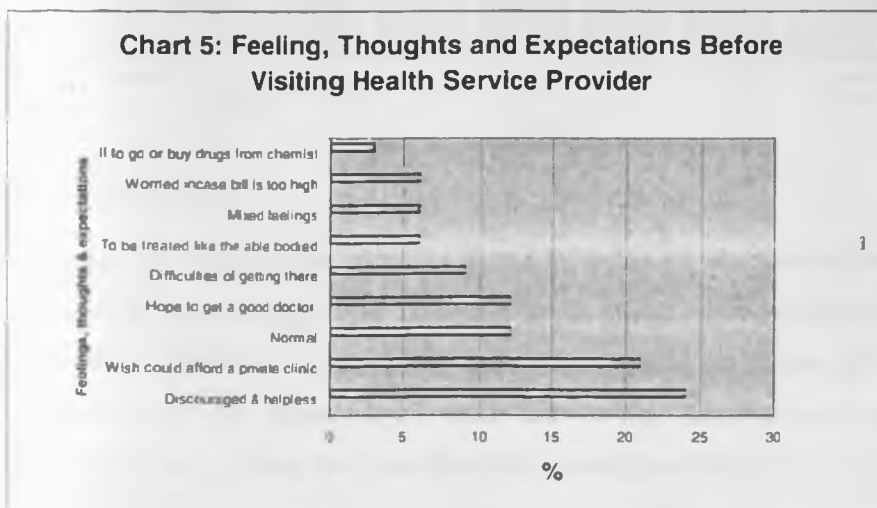
The findings below tally with those of similar studies like Smith et al., (2004) and Best (1999) who found that the reproductive health of women and men with physical disabilities is usually given low priority or dismissed. This arises from the myth that disabled people are not sexually active and have no need to control their fertility. Thus, when they seek such services they are met with negative reactions. This could also be a deterrent to those who are yet to seek such information and services given that as many as 55 percent had not as yet.

Table 17: Reactions on Seeking Information on Sexuality and Family Planning

| Reactions received when seeking information on sexuality and family planning | Frequency | Percentage |
|--|-----------|------------|
| Never asked | 17 | 55 |
| Normal – was assisted and counselled | 4 | 13 |
| Negative - pitied for engaging in sex in their condition, asked to stop prostitution, was asked why a disabled would be interested in sex, staff wondered who would want to have sex with a disabled, advised not to engage in sex | 10 | 32 |
| Total | 31 | 100 |

iv) Thoughts and Expectations Before Seeking Health Services

The study also wanted to find out what the women's feelings, thoughts and expectations were before going to seek health services. The responses received were as varied as were the women. These ranged from feeling discouraged and helpless when they think of how to get to the facility either by walking or taking a public vehicle. Some wondered whether they will afford to pay for the services including buying drugs, as others wished they could afford to visit a private health facility where there are better services. Some are often torn between whether they should go to a health facility or buy drugs over the counter. See Chart 5 below for a summary of these responses.



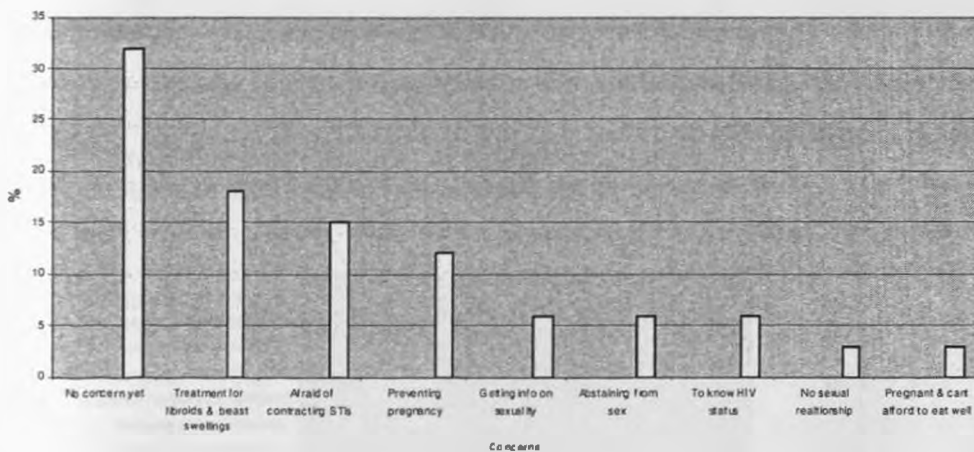
Source: Primary data

The above thoughts and expectations of the women before going to seek health services indicate the multitude of challenges the women face before making the decision to either go or not. This shows that women with disabilities face a lot of barriers as they seek health services most of them caused by society including service providers. These can be changed to ease access.

v) Reproductive Health Concerns

On what concerns them most about their reproductive health there were a wide range of issues as summarised in Chart 6. These included being careful not to get pregnant again, some were afraid of contracting STDs and HIV as they do not know how they could cope with that plus a disability, those who had fibroids and swelling on their breasts want treatment, others have felt they do not have a choice but to abstain from sex.

Chart 6: Reproductive Health Concerns

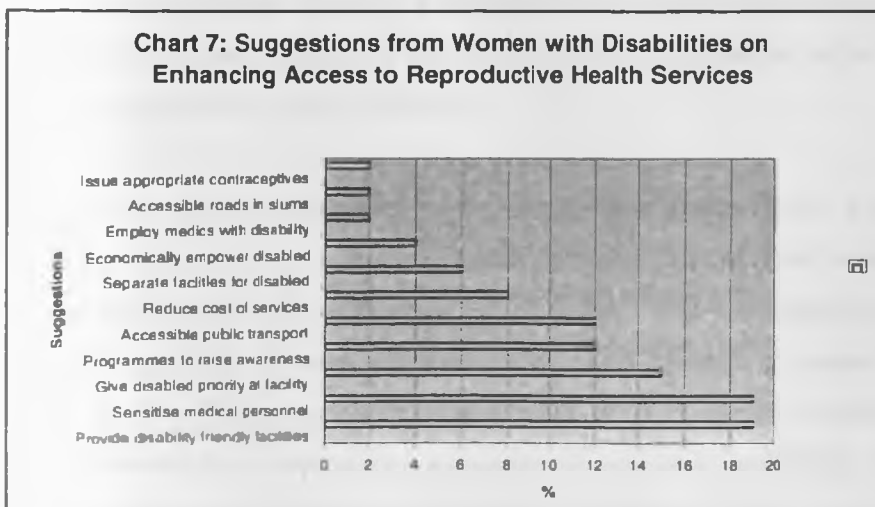


Source: Primary data

The range of reproductive health concerns indicated by the women show that they lack information, awareness and the means to attain proper reproductive health. This includes information on safe sex to ensure they do not contract STI's including HIV and so most want to abstain from sex. These include those who are not concerned about their reproductive health as yet because they feel their disability is enough to deal with.

4.4 Improving Access to Reproductive Health Services

Multiple suggestions were given by the women with physical disabilities on how access to reproductive health services can be improved. This was by both those who had indicated as to visiting facilities for a reproductive health illness and those who were yet to seek for the same. Majority of them (19 percent) recommended that disability friendly facilities be constructed. A similar number would like personnel sensitised on how to deal with people with disability, 6 percent would want separate facilities for disabled and 15 percent would want those with disabilities given priority to avoid the long waiting time which excessively tires most of them because of mobility. Public transport was also mentioned as an area that needs improvement, as most women do not find them user friendly. They find the steps into the public vehicles too high and the doors too narrow such that those with wheel chairs cannot fit. They also called for the public transport staff to be accommodating as most of them harass them to get in quickly, something they are not able to do. Since they cannot keep up with the speed, most are always left at the bus stops as the vehicles avoid carrying them because of the inconvenience they cause. These suggestions are summarised in Chart 7.



Source: Primary data

The challenges experienced by women with disabilities as they seek care can be addressed and eliminated to increase access to reproductive health care for this category of women with disabilities. Formulation and implementation of the relevant policies as per the Persons with Disabilities Act, 2004 to enhance the built environment to make it disability friendly will ease

access not only to health providers but also other facilities and amenities. Medical personnel also need to change their attitude towards sexuality and disability and treat women with disabilities with respect and consideration as they would able bodied women.

4.5 Challenges Reproductive Health Providers Face

A survey of reproductive health service providers revealed that the services they provide are not specific to those with disabilities only but are for all including able bodied. All the three providers surveyed said that the common reproductive illnesses and needs among women with disabilities are mainly, sexually transmitted diseases, unwanted pregnancies, complications arising from pregnancy and family planning services.

Financial constraint was pointed out as one of the main factors that hinder women with disabilities from accessing reproductive health services. Service providers said that they also lacked appropriate equipment to serve women with disabilities. The providers also cited transport to the health facilities as a problem that greatly constrained women with disabilities from accessing health services. Lack of information on reproductive health among women with disability was also given as a hindrance to accessing to reproductive health services. They said that most thought that the fact that they were disabled meant that they may not suffer any reproductive health illnesses.

On the challenges they experience in providing health services to the women they said that the women are unable to express themselves about their illnesses and sometimes the medical professionals are not able to communicate with them. They also said that they are not well equipped especially in maternity and antenatal to attend to women with disabilities effectively. The positioning for procedures was also pointed out as a challenge that faces the medical professionals in providing services to women with disabilities. This was especially when it came to pelvic exams for those women with paralysis of the lower limbs.

They also noted that health service providers are not always trained and equipped to deal with women with physical disabilities. Some also said that they had never heard of any personnel trained specifically on how to provide reproductive health services to women with physical disabilities.

On the potential measures to enhance access to reproductive health services, the providers suggest that door-to-door services be offered to women with disabilities as most of them have mobility problems as a result of their disability and with the public transport system. They also suggested that the women with disabilities be provided with information and be educated on their reproductive health so that they know that they are as vulnerable as able-bodied women and need to seek care. On their part, the providers suggested that the health facilities should be equipped with disability friendly equipment like accessible exam tables.

Key informant interviews with programme officers of disability organisations were of the opinion that in the area of reproductive health and disability, a lot of sensitisation still needs to be done, as many are not well informed. Intensive awareness campaigns are needed so that even the disabled themselves know that they have a right to seek and access reproductive health care. This sensitisation should also target government and policymakers because the reproductive health policy does not articulate disability issues.

In the area of reproductive health services offered, they said that whatever service is offered for able-bodied people, the same should be availed for those with disabilities and should be made disability friendly. This is because most of these services are inaccessible where one finds facilities located in high-rise buildings with no lifts or ramps. This is as a result of poor planning, which does not take care of the needs of all in society like those with disabilities.

They also said that most people with disabilities have low-self esteem, a finding that is also consistent with the survey on women with disabilities where most of them were found to be discouraged with their status. As a result of this, one key informant said that most people with disability want everything done for them. Thus, they should be empowered to believe in themselves and take care of their health and thus seek reproductive health services and information.

A programme officer also said that most disabled people are not aware that they can suffer reproductive health illnesses like able bodied people and so, do not bother to seek information and health care. Thus, he said that there is need to create awareness among them so that they can know that they are as vulnerable and what they should do to safeguard their health.

CHAPTER 5: SUMMARY OF MAIN FINDINGS

A summary of the main findings of this study are presented in this section.

5.1 Factors that Prevent Women with Disabilities from Visiting Reproductive Health Providers

Various factors were found to prevent women with disabilities from visiting reproductive health providers. The main ones were that;

- i) Most women with disabilities are engaged in small petty businesses and their financial resources were constrained, a factor that affected their ability to afford health care;
- ii) The women lacked awareness and information on the importance of reproductive health and thus do not consider visiting providers a priority;
- iii) The main means of transport to the health service providers is by public means, which are unfriendly. Most vehicles have narrow doors with no ramps and aisles that cannot accommodate wheel chairs; and
- iv) Women with disabilities encounter various social, attitudinal and physical barriers when accessing reproductive health services and this is a factor that discourages them from accessing the services.

5.2 Difficulties Women with Disabilities Face when they Visit Reproductive Health Service Providers

Women with disabilities experience various difficulties when they visit reproductive health service providers. The main ones being that;

- i) Physical facilities within the premises of the providers are disability unfriendly. Most have staircases and no ramps to ease accessibility by those on wheel chairs and crutches. In addition, most exam beds are too high with no steps to enable the women get on;
- ii) Personnel were found to be unfriendly and there was a generalised assumption that women with disabilities are not sexually active and thus received negative reactions when seeking reproductive health services like contraceptives and maternity; and

- iii) Long queues resulting in long waiting time at the service provider was also found to be a difficulty experienced by the women. This discourages the women as some go back home without treatment.

5.3 Challenges Reproductive Health Care Providers Face when Serving Women with Disabilities

Reproductive health care providers face a number of challenges. These include;

- i) Most women have financial constraints and cannot afford to pay for health services offered by the providers. This means that the providers are not able to serve them adequately as some are turned away if they cannot pay; and
- ii) Lack of appropriate equipment for offering antenatal and maternity services to women with disabilities.

5.4 Measures to Enhance Access to Reproductive Health Care for Women with Disabilities

Various measures were suggested by the women with disabilities and reproductive health service providers on how access could be enhanced. These include;

- i) Offering door-to-door services as most of the women have problems with mobility and the public transport system;
- ii) Creation of awareness and provision of information and education on reproductive health to empower the women to safeguard their health;
- iii) Sensitising policymakers to incorporate disability issues in the reproductive health policy;
- iv) Incorporate disability friendly facilities in the physical planning of all buildings and in the public transport system; and
- v) Sensitising medical personnel to treat women with disabilities with respect;
- vi) Giving those with disabilities priority at the health facility to reduce the long waiting time that tires them easily.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

This study's objectives were; to explore factors that prevent disabled women from visiting reproductive health service providers; to establish the difficulties disabled women face when they visit reproductive health service providers; to explore the challenges reproductive health care providers face when serving disabled women; and to find out measures that can be put in place to increase access to reproductive health care for disabled women.

From the findings, it can be concluded that women with disabilities are sexually active and are able to have children just like able bodied women. Thus they require the whole range of reproductive health services provided for the rest of the population.

Education level determines the kind of employment one can get. The study observed that most of these women had not gone beyond primary school level and were thus engaged in small petty businesses. As such, they were struggling to make a living and the financial resources available were strained and this affected their ability to afford health care.

It was also found that polio is the greatest cause of disability among the women. Polio is a preventable disease through childhood immunization, which is one of the components of reproductive health. Given that the women with disabilities are able to have children and some do, it is important that the whole range of reproductive health care be made accessible to prevent disability among the children of both able bodied and women with disabilities.

Although most of the women interviewed indicated that they had not suffered a reproductive health illness, the results of those who indicated show that women with disabilities are susceptible as other able bodied women. The study also found that living with disability is very challenging such that the women do not give their reproductive health priority as they feel that they have enough to deal with as a result of disability.

The above findings indicate that getting information about reproductive health issues like sexuality and contraceptives are important and that the women use the avenues and channels available to get this information. However, it was noted that those who did not seek the

information on reproductive health did not think they needed to. This was either because they had stopped having children, did not have any or were not sexually active. This shows that these women lack awareness as to what reproductive health issues are and limit them to child-bearing and contraceptives, yet there are other concerns like breast and cervical cancer and management of infertility. Since from the findings it is seen that awareness seminars held for those with disability are an important source of reproductive health information these should be enhanced to include topics covering more than STDs, contraceptives and HIV/AIDS.

The above findings on antenatal and maternity experience show that the women with disabilities encounter various social, attitudinal and physical barriers accessing safe motherhood. These include difficulties going to the clinic, getting onto the exam table, decisions being made for them like undergoing a caesarean section without consultation and lack of assistance during delivery.

It was evident from the research that most of these women had problems going to the health facility. Most have to walk because getting onto public transport is difficult or there is none near where they reside.

From the study results, most of the women cannot afford to pay for their healthcare. This definitely limits access as it causes them to overlook some illnesses as not serious given that it is costly.

The difficulties experienced by the women in terms of access to facility and with personnel show a generalised assumption that women with disabilities are not sexually active and may thus not require reproductive health services. These women encounter physical and attitudinal barriers as they seek care.

Long queues resulting in long waiting time at the service provider was a problem experienced by most of the women interviewed. The difficulties experienced with access to facilities, with personnel and the waiting time have affected the women with disabilities in various ways. These include getting discouraged from seeking care and treatment resulting to buying non-prescribed

drugs over the counter or enduring the difficulties for lack of choice. These challenges are experienced in public facilities ie government and city council facilities and so those who can afford or have access prefer to visit private or mission facilities which is a minority.

The effect of not seeking appropriate care or delay as a result of the difficulties experienced with facilities and personnel can have far reaching repercussions on the health of the women with disabilities. They may miss out on opportunities for maintaining and improving their overall health. in addition to some serious reproductive health conditions being diagnosed when it is too late.

From the above it can be said that among the difficulties that women with disabilities face when they visit reproductive health service providers are mainly accessing the various facilities due to the physical facilities being disability unfriendly and personnel having a bad attitude towards them. Personal and shared unfavourable experiences may be factors that prevent disabled women from visiting reproductive health providers.

6.2 Recommendations

There is need for understanding of what influences negative societal attitudes towards sexuality and disability as was indicated by the reactions the women with disabilities received on seeking information on sexuality and family planning. Government and non-governmental organisations working in the area of reproductive health should do research and use the results to put in place policies and regulations that can be used to advocate for non-discriminatory treatment at health facilities.

Given the challenges women with disabilities face in accessing reproductive health facilities government should establish a responsible authority to oversee the accessibility of the build-up environment. In addition, laws and regulations should be passed that guide the building of public service vehicles to ensure that doors and aisles are wide enough to accommodate people with disabilities especially those who use wheel chairs and crutches. Public transport providers and their staff should be sensitised to treat people with disabilities with consideration as they are not able to board and alight with the same speed as the able bodied passengers. There is need for

political will and commitment to provide the necessary disability awareness and integrate these into the training of planners, architects and construction engineers.

The above difficulties experienced by women with disabilities as they seek care can be said to be man-made. Therefore, these difficulties can be addressed and eliminated to increase access to reproductive health care for this category of women with disabilities. Formulation and implementation of the relevant policies as per the Persons with Disabilities Act, 2004 to enhance the built environment to make it disability friendly will ease access not only to health providers but also other facilities and amenities.

A large proportion of the women as seen above have negative feelings regarding their disability. This can be interpreted to mean that they have a low self-esteem and a negative image which can be attributed to lack of economic independence and stigma associated with disability. There is need for further research and analysis on this aspect. In general there is need for esteem building activities to be incorporated in medical and vocational rehabilitation services in the community.

From the study, it was evident that most women with physical disabilities would prefer to visit private and mission facilities where they say they get better services rather than at public facilities. To enhance access to reproductive health services for women with disabilities, the study recommends that the government enters into a private-public partnership with mission and private facilities to enhance access.

It was evident from the data collected from both the women with disabilities and the key informants that most women with disabilities lack awareness and information on reproductive health issues. As policymakers prepare and implement awareness programmes, those with disabilities should be included to destroy the myth that they cannot suffer the whole range of reproductive health illnesses because they are disabled and may not be sexually active.

In addition to the above, other studies focusing on the awareness of reproductive health issues among the disabled should be done and appropriate measures taken to fill this gap.

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APPENDICES – RESEARCH INSTRUMENTS

Questionnaire no. ____

Questionnaire 1: Questionnaire for Women with Physical Disabilities

My name is Grace and I am a student from the University of Nairobi undertaking a research on women with disabilities' access to reproductive health services. The research aims at generating information to help service providers improve their services and women with disabilities to make maximum use and benefit from these services. You are requested to participate in this survey that is aimed at improving your access to reproductive health services. All the information that you will provide shall be used for this study and will be treated with STRICT CONFIDENTIALITY. However, if there is any question you are not comfortable with you are free not to answer. You can also terminate this interview at any point. There will be no consequences for turning down the interview.

A. Personal Information

Please tick and fill where appropriate

- A1. Name (optional)
- A2. How old are you?
- A3. What is your marital status 1. Married..... 2. Single..... 3. Separated..... 4. Divorced....
5. Widowed.....
- A4. Do you have any children 1. Yes..... 2. No.....
- A5. If yes how many?.....
- A6. What is your level of education?
- A7. Are you employed? 1. Yes..... 2. No.....
- A8. If yes what form of employment are you engaged in?.....
- A8. If yes how much do you earn per month? 1. Below Ksh 10,000..... 2. Between Ksh 11,000-
20,000..... 3. Between Ksh 21,000 – 30,000..... 4. Above Ksh 30,000
- A9. If no, what is your source of livelihood?.....
- A10. What is the nature of your disability.....
- A11. How did it come about? 1. Birth..... 2. Accident..... 3. Illness.... 4. Other.....

B. Access to reproductive health services

- B1. Please indicate the most common reproductive health illnesses that you have ever suffered from?
.....
- B2. Please indicate the various reproductive health needs that you have (probe for contraceptives,
health information, maternal child health, pregnancy and child birth)
.....
.....
- B3. How have you met these needs?.....
- B4. If your answer to A4 is yes, what was your experience when seeking the following services
Antenatal care
- Maternity (child birth)

- B4. Do you always go to a hospital whenever you have a reproductive related illness? 1. Yes.....
2.No.....
- B5. If no why?
- B6. Where do you go for reproductive health services? 1. Government health institution.....
2. Private health institution..... 3. Missionary health institution..... (**probe for others**).....
- B7. How far is the nearest reproductive health facility?.....
- B7. Why do you go to the particular service provider you indicated above? (**can tick more than one**)
1. It is near where I live..... 2. I can afford the charges..... 3.The staff are able to help me.....
4. I am able to use the physical facilities easily..... 5. Other (specify).....
- B8. Who pays for the health services that you receive (including buying drugs)? 1. Self..... 2.
Family member (specify relationship)..... 3. Other (specify).....
- B9. How would you rate the kind of service you receive whenever you go there?
1.Very good..... 2.Good..... 3.Average..... 4. Poor..... 5.Very poor.....
- B10. What difficulties do you face when you go to the reproductive health service provider in terms of
Facilities?.....
Medical personnel.....
Waiting time.....
- B11. How have the above difficulties affected you?.....
- B12. Where do you get information on reproductive health issues?
.....

C. Improving access to reproductive health services

- C1. What do you think can be done to make the reproductive health services more accessible to women with disabilities?
.....
.....
- C2. What other comments and suggestions can you make regarding access to reproductive health services by women with disabilities?.....

THANK YOU FOR FINDING TIME TO RESPOND TO THIS QUESTIONNAIRE

Questionnaire 1b: Questionnaire for Evaluating Feelings of Women with Disabilities

- A. How do you feel about your disability?.....
.....
.....
- B. Do you think it contributes to any reproductive health illness that affects you?.....
- C. If so how?.....
.....
- D. What do you think about the services you receive as a disabled woman in a health facility?
.....
.....
- E. Do you think health professionals treat you differently as a result of your disability?.....
.....
- F. Have you been denied a medical service because you have a disability?.....
.....
- G. If yes how did that make you feel?.....
- H. What kind of reactions do you get from health service providers when seeking information on
sexuality?.....
.....
- I. What about for family planning services?.....
- J. What are your feelings, thoughts and expectations before going to seek health services?.....
.....
.....
- K. What are you most concerned about as regards your reproductive health?.....
.....
.....

THANK YOU FOR FINDING TIME TO RESPOND TO THIS QUESTIONNAIRE

Key Informant Guide

My name is Grace, I am a student from the University of Nairobi undertaking a research on the barriers that prevent women with physical disabilities from accessing and benefiting from reproductive health services. The research aims at generating information to help service providers improve their services and women with disabilities make maximum use of these services.. All the information that you will provide shall only be used for this study and will be treated with STRICT CONFIDENTIALITY. However, if there is any question you are not comfortable with you, are free not to answer. You can also terminate this interview at any point. There will be no consequences for turning down the interview.

A. Background information

- A1. Name of organization.....
- A2. Your designation.....
- A3. State nature of reproductive health services that your organisation provides to women with disabilities.....

B. Reproductive health services provision

- B1. From your experience, what would you say are the common reproductive health related illnesses and needs among women with disabilities? (probe also according to age).....
- B2. What in your opinion hinders women with disabilities from accessing reproductive health services?.....
- B3. What challenges do you experience in providing health services to women with disabilities as?
An institution?.....
A medical professional?.....
- B4. What difficulties do you face when providing services to women with disabilities that are patient specific?.....
- B5. In your opinion, are health service providers trained and equipped to deal with women with disabilities?.....

C. Potential measures to enhance access to reproductive health services

- C1. From your experience, what can reproductive health service providers do to enhance access to reproductive health services for women with disabilities?.....

THANK YOU FOR FINDING TIME TO RESPOND TO THIS QUESTIONNAIRE