CHALLENGES FACED BY WOMEN WITH PHYSICAL DISABILITIES IN ACCESSING REPRODUCTIVE HEALTH SERVICES IN NAIROBI COUNTY

BY

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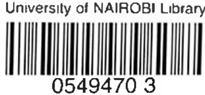

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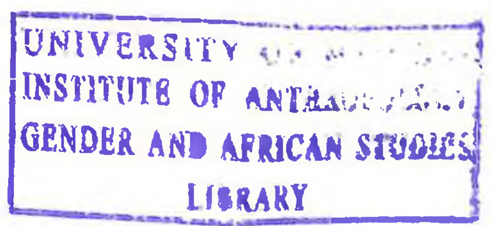

DECLARATION

I declare that this project is my original work and has not been presented for a degree in any other University or Institution.

Signature.. Date...14/11/2011...............

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This project has been forwarded for examination with my approval as the University supervisor.

Signature .... Date...17/11/11...................

Dr. Stevie M. Nangendo

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ABSTRACT

This study was on challenges faced by women with physical disabilities in accessing reproductive health services in Nairobi County. Its objectives were to find out the factors that hinder women with physical disabilities from visiting reproductive health service providers and to describe their experiences when they visit reproductive health service providers.

The study mainly used a cross-sectional descriptive research design utilizing qualitative methods of data collection. The study used convenient sampling and purposive sampling to select 34 informants. The individual disabled woman was the unit of analysis. The qualitative data were obtained from in-depth interviews and key informants interviews and were transcribed and analysed thematically to generate frequencies and percentages presented using tables and charts.

This study was guided by the critical theory by Michael Oliver (1998). This theory covers the health care given to disabled people, but it sees the problems of disabled people explicitly as products of an unequal society. The relevance of this theory is shown by the factors that hinder women with physical disabilities from accessing reproductive health services. Prejudice and discrimination as expounded in the theory are significant in explaining the factors that hinder women with physical disabilities in accessing reproductive health services. The discrimination aspect of the theory helps to explain the experiences of women with physical disabilities in accessing reproductive health care services.

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. These difficulties include lack of stairs, ramps and steps and getting onto high examination beds. Accessing public transport, which is the most convenient means of travel to the health facilities, was also a challenge.

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

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 HIVIAIDS. There is also a need for creating awareness among the medical personnel to change their attitudes towards sexuality and disability. 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 buildup 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.

ABBREVIATIONS AND ACRONYMS

APDK	Association for the Physically Disabled of Kenya
DPOs	Disabled People's Organizations
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ICPD	International Conference on Population and Development
IUD	Intra-Uterine Device
KNBS	Kenya National Bureau of Statistics
KNSPWD	Kenya National Survey for Persons with Disabilities
MoH	Ministry of Health
NCPWD	National Council for Persons with Disabilities
NRHS	National Reproductive Health Strategy
PID	Pelvic Inflammatory Disease
PWD	People with Disabilities
STIs	Sexually Transmitted Infections
UDPK	United Disabled Persons of Kenya
WHO	World Health Organization

CHAPTER ONE
BACKGROUND TO THE STUDY

1.1 Introduction

This study was on the challenges faced by women with physical disabilities in accessing reproductive health services in Nairobi County. Physical disabilities are long-term impairments which limit the normal functioning of the affected parts and are caused by bodily defects or injuries (Nosek, 1996). According to the International Conference on Population and Development (ICPD), 1994, reproductive health is defined as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and its functions and processes (www.iisd.ca/Cairo/program). The World Health Organization (WHO) has estimated that disability affects hundreds of millions of families in developing countries. Currently around 10 per cent of the total world's population, or roughly 650 million people, live with a disability. In most of these countries, females have higher rates of disability than males, (www.disabled-world.com).

In Kenya, the Preliminary Report of the Kenya National Survey for Persons with Disabilities (KNSPWD 2008) indicates that 4.6% of Kenyans experience some form of disability. The survey also shows that the most common forms of disability are physical (3.5%), visual (30%), hearing (11%), mental (7%) and speech (4%). According to the Persons with Disability Act of 2003, the lack of access for persons with disabilities to health facilities is due to discrimination on the basis of disability and also denial of access (Ministry of Public Health and Sanitation, 2009). Persons with disabilities are confronted with multiple discriminatory practices, including stigma within the society as well as in the health facilities, which constitute a denial of their human rights. In order to promote the rights of persons with disabilities and mainstream disability in all aspects of national development in Kenya, a National Council for People with Disabilities (NCPWD) was established in 2004 under the Ministry of Gender, Children and

Social Development. Its 21 members represent various disability organisations and government ministries. The council has established the National Development Fund for Persons with Disabilities, which is provided for in the People with Disabilities Act of 2003. The fund supports organizations of, and for, persons with disabilities and may also be used in support of poor persons with disabilities. The council is leading on implementing the Action Plan of the African Decade of PWDs, 1999-2009, which was recently extended to 2019 (Kenya National Survey for Persons with Disabilities, 2008). Approximately, 300 million women around the world have mental and physical disabilities. Such women comprise 10 percent of all women worldwide, and yet, their reproductive health and rights are all too often neglected (Center for Reproductive Rights, 2002). 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).

Kenya developed the National Reproductive Health Strategy (NRHS) 1997-2010 as the first activity to operationalise the reproductive health agenda. According to the National Reproductive Health Survey 1997-2010, 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 HIV/AIDS, management of infertility, and other reproductive health issues (Ministry of Health, 2007). Although a lot of attention has been given to women and men on reproductive health issues in the forms of programmes and research, little has been done on the physically challenged women in a bid to cater for their special needs about reproductive health. The 1997-2010 National

Reproductive Health Strategy noted the challenges faced by vulnerable groups such as post-menopausal women, the elderly and the disabled who have special needs that have not been adequately addressed (Ministry of Health, 2007). The government launched the National Reproductive Health Strategy (NRHS) 2009-2015 to facilitate operationalization of the National Reproductive Health Policy as a revision of the 1997 one. In addition, the strategy aims to improve financing for reproductive and maternal health care and to facilitate implementation of the reproductive and maternal health aspects of the Community strategy. Some of its objectives are to markedly reduce maternal mortality rates, to ensure the presence of skilled attendants at 90 percent of deliveries, and to have all health facilities providing basic emergency obstetric care, all by the year 2015 (MOPHS and MMS, 2009).

Reproductive health issues have often been ignored among women with physical disabilities because the society tends to view PWDs as asexual, therefore, not in need of reproductive health services (Haight-Liotta, 1996). It is acknowledged that the health status of women in pregnancy and motherhood is of particular relevance to the health status of future generations (Government of Kenya, 2006) and that many disabled women are able to have children just like non-disabled ones (Best, 1999). Very little information is available on the risks and benefits of various forms of contraception for women with disabilities. A mistaken belief that only a few women with disabilities are sexually active and, therefore, do not need birth control has caused lack of research about safe and effective birth control methods for this group. 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 diseases (PIDs) and infertility (www.crowdbcm.net). Women with disabilities have negative experiences with pregnancies and childbirths because they have difficulties finding health care providers and

hospitals with experiences in managing pregnancies and childbirths (Nosek, 1996). This lack of knowledge and experience has led some doctors to communicate unwarranted negative expectations about pregnancy outcomes to women with disabilities who get pregnant or express the desire to have children. In some cases, pregnant women with disabilities have been advised to end the pregnancies and have tubal ligations or hysterectomies to prevent future pregnancies (Best, 1999). The purpose of this study was to explore the reproductive health challenges of women with physical disabilities and to determine how their reproductive health services can be improved.

1.2 Problem statement

Women with disabilities experience numerous challenges to quality reproductive health services that include inaccessible equipment and facilities, limited contraceptive options, insensitivity of health care providers and lack of knowledge about disabilities as well as limited information about their needs. 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, accessing reproductive health services is so difficult that some of these women avoid regular gynaecologic visits. There is a gap in needed information, transportation problems, inaccessible offices, provider attitudes and inadequate knowledge among health care providers, particularly in the areas of pregnancy, menopause, contraception, and sexually transmitted diseases in women with physical disabilities. In order to fill the gap the study sought answers to the following questions.

I) What factors hinder women with physical disabilities from visiting reproductive health service providers?

II) What experiences do women with physical disabilities face when they visit reproductive health service providers?

1.3.0 Objectives of the study

1.3.1 Overall objective

To explore the challenges faced by women with physical disabilities in accessing reproductive health services in Nairobi County.

1.3.2 Specific objectives

I) To find out the factors that hinder women with physical disabilities from visiting reproductive health service providers.

II) To describe the experiences faced by women with physical disabilities when they visit reproductive health service providers.

1.4 Justification of the study

Disabled women have health problems associated with their disabilities, which are greatly compounded by reproductive health-related illnesses. Given their situations and circumstances they are sometimes ignored when it comes to reproductive health services. Therefore, the findings of this study should help, theoretically, by adding literature to the existing academic knowledge on the challenges faced by women with physical disabilities. At the policy level, the findings will provide information necessary for the training needs of reproductive health care providers with respect to women with physical disabilities.

1.5 Scope and limitations of the study

The study focused on the challenges faced by women with physical disabilities in accessing reproductive health services in Nairobi. The study used only qualitative data collection methods, thus, it did not determine the nature and intensity of the relationship between the study variables. Another limitation to the study was that the informants were reluctant to answer questions truthfully because issues of health and sexuality are sensitive to most people.

1.6 Definition of key terms

I) **Access** – In this study, this refers to a means to reach or a way to obtain services.

II) **Challenges** – In this study, these are difficulties experienced by women with physical disabilities.

III) **Physical disabilities** – The study defines these as, any long term impairments that limit the normal functioning of one caused by bodily defects or injuries.

IV) **Reproductive health** – In this study, this is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and its functions and processes.

V) **Women** – The study defines these as adult human beings who are biologically female.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This section reviews literature across three sub-headings under challenges faced by women with physical disabilities. First, is the prevalence of disability in Kenya, second, factors that hinder disabled women from visiting reproductive health providers and third, experiences and treatment of women with disabilities. The section also contains the theoretical framework and the assumptions of the study.

2.2 The prevalence of disability in Kenya

Over the years, there have been unsuccessful attempts in Kenya to determine the disability status through national censuses and studies by civil societies, non-government organizations and the government (Kenya National Survey for Persons with Disabilities, 2008). Lack of evidence-based data on the nature and extent of disabilities as well as other factors that affect persons with disabilities (PWDs) in Kenya have, therefore, posed challenges in terms of planning. The Kenya National Survey for Persons with Disabilities (KNSPWD) was designed to provide up-to-date information for planning, monitoring and evaluating the various activities, programmes and projects geared towards improving the wellbeing of PWDs (Kenya National Survey for Persons with Disabilities, 2008). In 1989, the National umbrella organisation namely the United Disabled Persons of Kenya (UDPK), was formed by the national and community-based Disabled People's Organisations (DPOs). The UDPK is made up of 194 disabled persons organizations and its aim is to address disability equality concerns through legislation, advocacy and awareness-raising. Over the past years, United Disabled Persons of Kenya has worked closely with the government in policy review, planning and evaluation. However, the strength of the organisation and many of the individual Disabled People's Organisations are heavily

challenged by internal conflicts and power struggles, making the total disability movement appear rather fragile and fragmented (www.udpk.org).

In order to promote the rights of persons with disabilities and mainstream disability in all aspects of national development, a National Council for People with Disabilities (NCPWD) was established in 2004 under the Ministry of Gender, Children and Social Development. Its 21 members represent various disability organisations and government ministries. The council has established the National Development Fund for Persons with Disabilities, which is provided for in the 2003 People with Disabilities Act, by allocation of 200 million Kenya shilling. The fund supports organizations of, and for, persons with disabilities and may also be used in the support of poor persons with disabilities. The council is leading on implementing the action plan of the African Decade of PWDs 1999-2009, which was recently extended until 2019 (www.ncpwd.go.ke). Kenya National Survey for Persons with Disabilities (2008), found that 4.6% of Kenyans experience some form of disability and more disabled persons reside in rural than in urban areas. Fifteen percent of PWDs are likely to be affected by environmental factors on a daily basis, 3% on a weekly basis and 65% regard the environment as a major problem in their daily lives. A quarter of PWDs work in family businesses but a third do not work at all. Sixteen percent of women with disabilities aged 12–49 years use some form of family planning. Overall, nine in ten PWDs are aware of the health care services available but more PWDs in urban areas (95%) were likely to be aware of health services than their rural counterparts (86%) (Kenya National Survey for Persons with Disabilities, 2008).

In October 2007, Kenya's Ministry of Health (MOH) formally approved and adopted the country's first National Reproductive Health Policy (NRHP). With the theme "Enhancing the Reproductive Health Status for All Kenyans," the policy provides a framework for equitable, efficient and effective delivery of high-quality reproductive health services throughout the

country and emphasizes reaching those in greatest need and most vulnerable. It aims at guiding, planning, standardization, implementation, monitoring and evaluation of reproductive healthcare provided by various stakeholders (Ministry of Health, 2007). The new policy allowed the government to incorporate and address key emerging issues such as reproductive health commodities security, the prevention of mother-to-child transmission of HIV, emergency obstetric care, adolescent reproductive health issues, gender-based violence and reproductive health needs of persons with disabilities. The focus of the new policy is strengthening community midwifery practices and helping traditional birth attendants become advocates of safe motherhood so as to contribute to enhanced maternal health. Its integration of reproductive healthcare and HIV services will conserve vital resources while continuing to provide patients with comprehensive care (Ministry of Health, 2007). The National Reproductive Health Strategy covering the period 2009 to 2015 is a revision of the National Reproductive Health Strategy 1997-2010. The need for revision was to address several issues and challenges most of which were not factored in during the time of its development. This was necessary to provide clear guidance and alignment with implementation of the National Reproductive Health Policy which was launched in 2007. This policy states Kenya's commitment to the achievement of the International Conference on Population and Development (ICPD) and Millennium Development Goals (MDGs), as well as other international development goals and targets, and identifies priority actions through which the adverse reproductive health outcomes, including those related to the impacts of the HIV and AIDS pandemic, will be reversed. The Vision 2030 acknowledges the growing concern of reversals in reproductive health gains made in the 1980s and the early part of 1990s. This is reflected in many other national policies and strategies that have been developed to guide response and focus programme efforts to the myriad of current and emerging issues in health and development (Ministry of Public Health and Sanitation and Ministry of Medical Services, 2009).

In addition, the revision of this strategy is made necessary by the significant change in recent years in government approaches to conducting business, which recognises the need for strategic planning across all sectors and ministries, the need for evidence-based management, as well as the need for enhanced citizens' participation in planning and implementing development programmes in a devolved manner. Thus, the revised strategy seeks to ensure that the inter-linkages between reproductive health and all other sectors of development are properly identified and effectively addressed through a multisectoral approach. This strategy is a product of extensive consultations and collaboration with stakeholders including the provincial and district level reproductive health coordinators. Other key stakeholders who were involved in this process include development partners, non-governmental and faith-based organizations, and the private health sector. The overall goal of this strategy is to facilitate the operationalization of the National Reproductive Health Policy through a national multisectoral approach. The goal echoes the overall goal of the National Reproductive Health Policy that is to enhance the reproductive health status of all Kenyans by increasing equitable access to reproductive health services; improving quality, efficiency and effectiveness of service delivery at all levels; and improving responsiveness to the client needs. It will also aid the Division of Reproductive Health in advocating for increased resources and partnership involvement in its implementation. Reproductive health is a development issue as it contributes to death and disability that affect many families. Access to reproductive health is crucial to achieving the eight Millennium Development Goals, population, development and health goals as well as realizing vision 2030. The strategy calls for enhanced multisectoral participation at all levels and we are confident that it will provide the necessary framework for the requisite multisectoral approach towards enhanced reproductive health status of all Kenyans (Ministry of Public Health and Sanitation and Ministry of Medical Services, 2009).

The new constitution adopted in August 2010, explicitly prohibits discrimination on the grounds of health status and disability (Article 27) and obliges the state to fulfil the social and economic rights of citizens (Article 43) (www.kenyalaw.org). Actions are still guided by the People with Disabilities Act of 2003. So far, only minor parts of the Act have been implemented, however, the government has recently gazetted several remaining sections such as steps towards accessible public buildings, transport and income tax exemptions for PWD, but progress is slow (www.ncpwd.go.ke). According to the Kenya Demographic and Health Survey 2008-09, the number of persons with disabilities was recorded to be 647,689 (3.4%) for males while that of the females being 682,623 (3.5%) (Kenya National Bureau of Statistics and ICF Macro 2010). The most common forms of disabilities are associated with chronic respiratory diseases, cancer, diabetes, malnutrition, HIV/AIDS, other infectious diseases and injuries such as those due to road accidents, falls, land mines and violence (Kenya National Survey for Persons with Disabilities, 2008).

2.3 Factors that hinder disabled women from visiting reproductive health providers

The main components of reproductive health services in Kenya consist of safe motherhood, including antenatal and post-natal care, safe delivery as well as child survival initiatives. The others are family planning unmet needs including male involvement, management of HIV/AIDS and STIs, promotion of adolescent and youth health, management of infertility and gender issues as well as reproductive rights (Ministry of Health, 1996). Women with disabilities often encounter physical, attitudinal, and policy barriers in seeking to meet their health service needs. Physical barriers include the unavailability of transportation, stairs and narrow doorways into clinics, doctors' offices, written information such as intake forms and patient education materials not available in alternative formats for example, the Braille, tape and large print. High examining tables prevent transfer of women using wheelchairs and mammogram machines, which require patients to

stand. Lack of personal assistance for women who need it during clinic visits are other barriers (www.crowdbcm). Most disabled persons are marginalized and disadvantaged as a majority of them have no access to many basic social and economic facilities. These include lack of access to education, employment, health and rehabilitation. In addition, most social amenities do not put into account the need for their access by the disabled (Ecotech Consultants, 2004).

Gans *et.al*, (1993) identified five commonly recognized reasons for inadequate reproductive health services for disabled women. These consisted of transportation problems, inaccessible offices, inadequate knowledge among health service providers, provider attitudes and inadequate insurance coverage. On the other hand, physically inaccessible tables, stirrups and examining instruments not designed for women with disability. Women with disabilities require comprehensive health care services to manage their physical disabilities and to prevent secondary conditions such as illnesses that come due to disabilities. However, a majority encounter attitudinal, informational, environmental and geographic barriers as they seek access to health care (Piotrowski and Snell, 2007). In addition, such women state that, standard screening and preventive services can be especially difficult to obtain, potentially placing them at greater risks of diseases such as breast cancer and cervical cancers (Schopp *et al*., 2002).

A survey was done focusing on the use of contraceptives by PWDs as well as information on children ever born and child survival (Kenya National Survey for Persons with Disabilities, 2008). Overall, the use of family planning among women with disabilities between ages 12-49 years was found to be 16% and out of this proportion, 14% used pills, 28% injections and 19% surgical methods. The use of Norplant and condoms was highest among PWDs in urban areas while female sterilization and periodic abstinence were more common among the rural PWDs. In the urban areas, all the women practicing family planning used modern methods while in rural areas the proportion was 79%. Overall, the proportion of women using modern family planning

methods was 83%. Slightly more than a quarter of disabled women aged 35–54 years had 12% of those aged 15 to 24 years have undergone female sterilization. About two out of every five married women with disability and a third of those who were divorced or separated were likely to use injections as a method of family planning. Two out of three of these divorced or separated women also used condoms while among single women the proportion was three out of ten (Kenya National Survey for Persons with Disabilities, 2008).

Policy barriers may be imposed by hospitals or clinic regulations, insurance companies and other third party such as medicare. For example, some insurance providers discriminate against individuals with disabilities by barring coverage for preexisting conditions or by other services, which may be essential for managing a disability (Shapiro, 1993). Another major barrier is that some necessary services such as in-home personal assistance services, prescription medications, durable medical equipment, holistic health services, assistive technology and preventive care as well as physiotherapies services may not be covered by private or government-funded insurance plans (Shapiro, 1993).

2.4 Experiences and treatment of women with disabilities

The history of the treatment of persons with disabilities has been one of ignorance and isolation (Anderson, 2004). In developing nations, people with handicapping conditions are yet victimized by neglect, superstition, stereotyping, and exploitation. Cultural beliefs toward persons with disabilities often include shame, prejudice and exclusion from the community. This is because disabilities are often feared by people and may be associated with supernatural forces such as the anger of the gods for wrongdoing or breaking taboos (McConkey and O'Toole, 1995). Women with disabilities may lack knowledge about their bodies and sexual functions. Conversely, parents of children with disabilities are often overprotective and set up the expectations that their children will never marry, reproduce or have intimate relationships

(Mayers, 1978). Other parents conceal their disabled children from the public to save themselves from the stigma associated with disabilities, denying their rights to education and play (Ndinda, 2005).

Women with physical disabilities may also have low self-esteems and diminished perceptions of social acceptance relative to no-disabled women (King *et al.*, 1993). With limited knowledge and low self-esteem, women with physical disabilities may not have the self-efficacies to advocate for themselves in relation to their reproductive health. Reproductive health issues have often been ignored in part because societies tend to view persons with disabilities as asexual beings and, therefore, not in need of reproductive health care services (Haight-Liotta, 1996). Women with physical disabilities such as paralysis, cerebral palsy or multiple sclerosis have limited contraceptive options and they may experience complications if they become pregnant (Lanig *et al.*, 1996). The oral contraceptive may not be a choice for women with decreased mobility, diminished muscle tone in a lower extremity, or pre-existing circulatory problems, because of increased risks of thrombosis (Rieve, 1989). Conversely, barrier methods such as the diaphragm and cervical cap are problematic for women with limited use of their hands. Although an intrauterine device (IUD) may be an option for some women, decreased pelvic sensation may reduce the ability of a woman to perceive discomfort or pain, which signal infection or displacement of the device. Women with limited manual dexterity may be unable to check for the presence of the string that assures that the IUD is in place. Progestin-only methods such as Depo-Provera and Norplant have been associated with periods of irregular bleeding and other side effects that may not be acceptable for women with impaired mobility (Rieve, 1989).

Information about how women with physical disabilities experience menopause is limited because many of such women enter menopause with decreased weight-bearing and aerobic activity histories. They may also be at greater risks of cardiovascular problems and osteoporosis (Welner, 1996). Similarly, women with disabilities frequently encounter negative experiences

and these can have lifelong traumatic impacts. In fact, such women report emotional, physical, and sexual abuses from the health care provider as well as the society at large. Some reported that they lacked basic knowledge about their reproductive health, in part because they had restricted access to such information as adolescents. Many of these women also have difficulties obtaining reliable contraceptive information (Nosek *et al.*, 1995). Disabled women experience attitudinal barriers that arise from negative societal beliefs about the worth of women with disabilities in society. These barriers may include the disrespect and discomfort of medical professionals, unwillingness to communicate with women whose speech or hearing is impaired, professionals' lack of knowledge about particular disabling conditions, and focus upon a disability to the exclusion of other health needs. Some practitioners wrongly believe that disability inevitably diminishes a disabled woman's value or quality of life. They may, therefore, fail to explore or offer all treatment options, assuming instead that death is preferable to living with a significant disability.

2.5 Theoretical framework

This study was guided by the critical theory by Michael Oliver (1998). This theory covers the health care given to disabled people, but it sees the problems of disabled people explicitly as products of an unequal society. It similarly ties the solutions to such problems as social action and change. The notions of disability as social oppression mean that prejudice and discrimination disable and restrict the lives of people much more than impairments do. For example, 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 solved by spending money, on assistive computer technology and rehabilitation and not by surgical interventions (Sutherland, 1981).

Ideologies perpetuate practical barriers and exclusions (Abberley, 1987). As long as a disability is assumed to be an individual matter of personal tragedy or heroic triumph over a

difficulty, disabled people are excluded from society. Ordinary education, employment, buildings, public transport and other things, which most people can take for granted remain largely closed to disabled people, or at least, they present obstacles which each person has to tackle individually. In fact, by emphasizing deficiency and dependency, doctors tend to reinforce these ideologies (Oliver, 1990). The impact of this critical theorizing on health care and research has tended to be indirect. However, it has raised political awareness, helped with the collective empowerment of disabled people, (Campbell and Oliver, 1996) and publicized disabled people's critical views on health care. It has moreover criticized the medical control exerted over many lives of disabled people, such as repeated and unnecessary visits to clinics for impairments that do not change and are not illnesses in need of treatment. Finally, it suggests a more appropriate societal framework for providing health services for disabled people (Barnes, 1991).

2.5.1 Relevance of the theoretical framework

The relevance of this theory is shown by the factors that hinder women with physical disabilities from accessing reproductive health services. Prejudice and discrimination as expounded in the theory are significant in explaining the factors that hinder women with physical disabilities in accessing reproductive health services. The discrimination aspect of the theory helps to explain the experiences of women with physical disabilities in accessing reproductive health care services.

2.6 Assumptions of the study

I) There are factors that hinder women with physical disabilities from visiting health care providers.

II) Experiences from the health service providers discourage women with physical disabilities from seeking reproductive health services.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This section presents the study site, study design, study population, sample population, sampling procedure, methods of data collection and analysis and, finally, ethical considerations.

3.2 Study site

This study was carried out in Nairobi County. This is because as the capital city of Kenya it is an ideal location to access women with physical disabilities from all parts of the country. The county is served by 29 health facilities which include both government and private institutions that provide reproductive health services to both disabled and non-disabled women. The study concentrated mostly on Kenyatta National Hospital and Pumwani Hospital.

3.2.1 Map

Source: (Google Maps, 2011)

3.3 Study design

The study mainly used a cross-sectional descriptive research design utilizing qualitative methods of data collection. Individual lived experiences were examined through in-depth interviews while key informant interviews were used to generate opinions of the health service providers. Relevant documents such as books, journals, theses, dissertations, reports and the internet were utilized.

3.4 Study population

The study population consisted of women living with disabilities in Nairobi County. Currently, there are no statistics giving the actual number of women with physical disabilities in the county.

3.5 Sample population and sampling procedure

The sample population consisted of 30 women with physical disabilities and 4 health service providers. The study used convenient sampling to select 30 women with physical disabilities. Purposive sampling was used to select 4 health service providers from the hospitals and the Association for the Physically Disabled of Kenya (APDK) for key informant interviews. The individual disabled woman was the unit of analysis.

3.6.0 Methods of data collection

3.6.1 In-depth interviews

In-depth interviews were used to collect data from 30 women with physical disabilities on the nature of the disabilities and challenges faced when seeking reproductive health services. An in-depth interview guide was used (Appendix 1).

3.6.2 Key informant interviews

These were conducted with 4 health service providers to obtain data on the challenges and experiences they faced when serving women with physical disabilities and the level of training they require on how to treat the physically disabled women. A key informant interview guide was used (Appendix 2).

3.6.3 Secondary sources

Documents such as books, journals, theses, government reports and internet information touching on persons with disabilities and access to reproductive health services were utilized to enrich this study.

3.7 Data analysis and processing

Qualitative data were obtained from in-depth interviews and key informants interviews and were transcribed and analysed thematically to generate frequencies and percentages. These data have been presented using tables and charts.

3.8 Ethical considerations

Permits were obtained from the Ethical Board of Kenyatta National Hospital and from the National Council for Science and Technology under the Ministry of Higher Education, Science and Technology for authority to conduct research in Kenya. All information pertaining to this study was explained to the informants in terms of objectives, scope as well as the intended use of the information in order to receive informed consent. Anonymity and confidentiality were maintained through the use of pseudonyms instead of the real identities of the individuals. This was maintained throughout the study process and at the reporting and publication levels. Informants in this study were duly informed of their rights to withdraw at any stage of the study.

CHAPTER FOUR

CHALLENGES FACED BY WOMEN WITH DISABILITIES

4.1 Introduction

This section presents socio-demographic characteristics of respondents, access to reproductive health care services, disability and reproductive health, improving access to reproductive health services and challenges faced by reproductive health providers when dealing with women with disabilities.

4.2 Socio-demographic characteristics of respondents

4.2.1 Age

The study interviewed 30 women with physical disabilities. Fifty percent were aged 35 years and above, 20% between 31-35 years, 10% between 26 - 30 years, 13% aged between 22-25 years and 7% were between 18-21 years. It is evident that women of all ages suffer disabilities, though a majority of those interviewed were more than 35 years of age (Table 4.1).

Table 4.1: Age categories of respondents

Age in Years	Frequency	Percentage (%)
18-21	2	7
22-25	4	13
26-30	3	10
31-35	6	20
Above 35	15	50
Total	**30**	**100**

4.2.2 Marital status and number of children

The study found that most respondents were single 50%, 23% were married, 7% divorced, 17% separated and 3% widowed. In addition, 77% had children and 23% did not. The number of children per woman ranged from one to ten and Table 4.2 and 4.3 show this respectively.

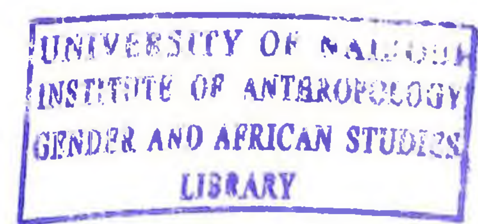


Table 4.2: Marital status of respondents

Marital status	Frequency	Percentage
Single	15	50
Married	7	23
Separated	5	17
Divorced	2	7
Widowed	1	3
Total	**30**	**100**

Table 4.3: Number of children

No. of children	Frequency	Percentage
None	7	23
1-3	14	47
4-6	5	17
7-10	4	13
Total	**30**	**100**

4.2.3 Education levels attained

As Table 4.4 indicates, most of the women with physical disabilities interviewed had not gone past primary school. In fact, only 20% had completed the primary school education level 13% while at least had gone to college.

Table 4.4: Education levels of the respondents

Education level	Frequency	Percentage
Primary complete	6	20
Primary incomplete	10	33
Secondary complete	5	17
Secondary incomplete	3	10
College	4	13
No education	2	7
Total	**30**	**100**

A majority of the respondents were not engaged in formal employment because only 10% were formally employed, while the rest 90% were in informal employment ranging from hawking, hairdressing, washing clothes to tailoring and weaving. Others were dependent on relatives and well-wishers for their upkeep (Table 4.5). However, both of those engaged in formal and informal employment stated that they earned less than Ksh.10, 000/= per month.

Table 4.5: Sources of livelihoods of the respondents

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	5	18
Washing clothes	1	3
Unemployed (dependent on well wishers, spouses, siblings and children)	14	47
Total	**30**	**100**

4.2.4 The nature of disabilities

Most of the women interviewed were disabled on one leg 37%, 9 of them 30% had paralysis of the lower limbs and one 3% had kyphosis. Further more, the findings indicate that many of the disabilities had been caused by polio 80% and 10% each had resulted from accidents and birth defects. Table 4.6 and 4.7 show the nature and causes of the disabilities of the women, respectively.

Table 4.6: The nature of disabilities

Disability	Frequency	Percentage
Arthritis	3	10
Both legs	5	17
Humpback	1	3
Kyphosis	1	3
One leg	11	37
Paraplegic	9	30
Total	**30**	**100**

Table 4.7: Causes of disabilities

Cause of disability	Frequency	Percentage
Accident	3	10
Birth defects	3	10
Illness (polio)	24	80
Total	**30**	**100**

4.3 Access to reproductive health care services

4.3.1 Common reproductive health illness suffered

The most common reproductive health illness among the informants was fibroids at 10%, 7% had HIV/AIDS and another 7% had problems with menstruation including over bleeding, painful and missed periods as well as severe pain causing dizziness. Three percent had swelling in the breast and lower abdomen and 73 percent indicated they had not suffered a reproductive health illness. 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 as susceptible as non-disabled women and it also portray that disability does not necessarily make one prone to these illnesses (Table 4.8).

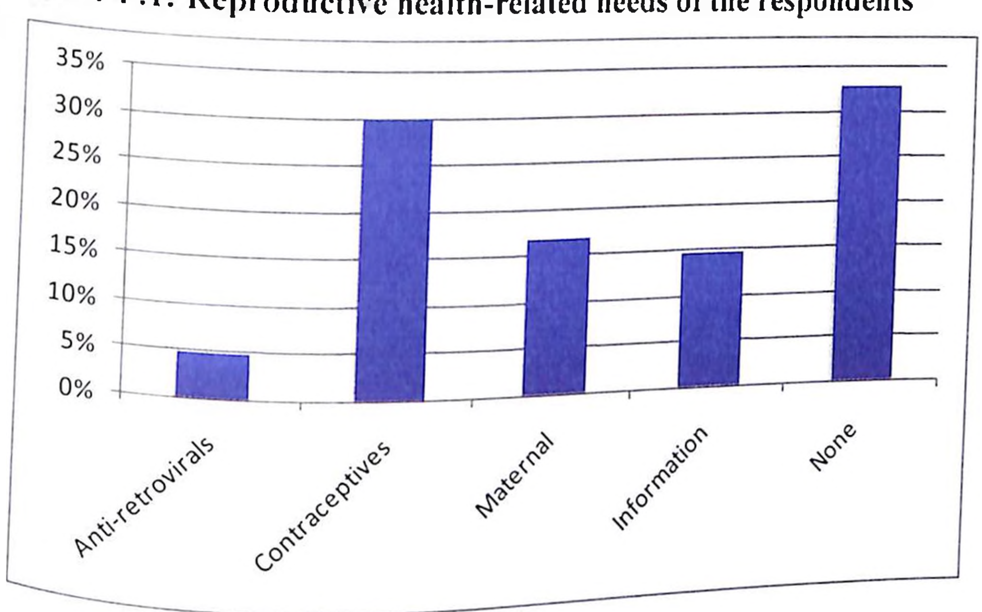
Table 4.8: Common reproductive health illnesses

Common reproductive health illnesses	Frequency	Percentage
None	22	73
Fibroids	3	10
Problems with menstruation (painful and missed periods, excessive bleedings)	2	7
STI	2	7
Swelling in breast and lower abdomen	1	3
Total	**30**	**100**

4.3.2 Reproductive health-related needs and how they have been met

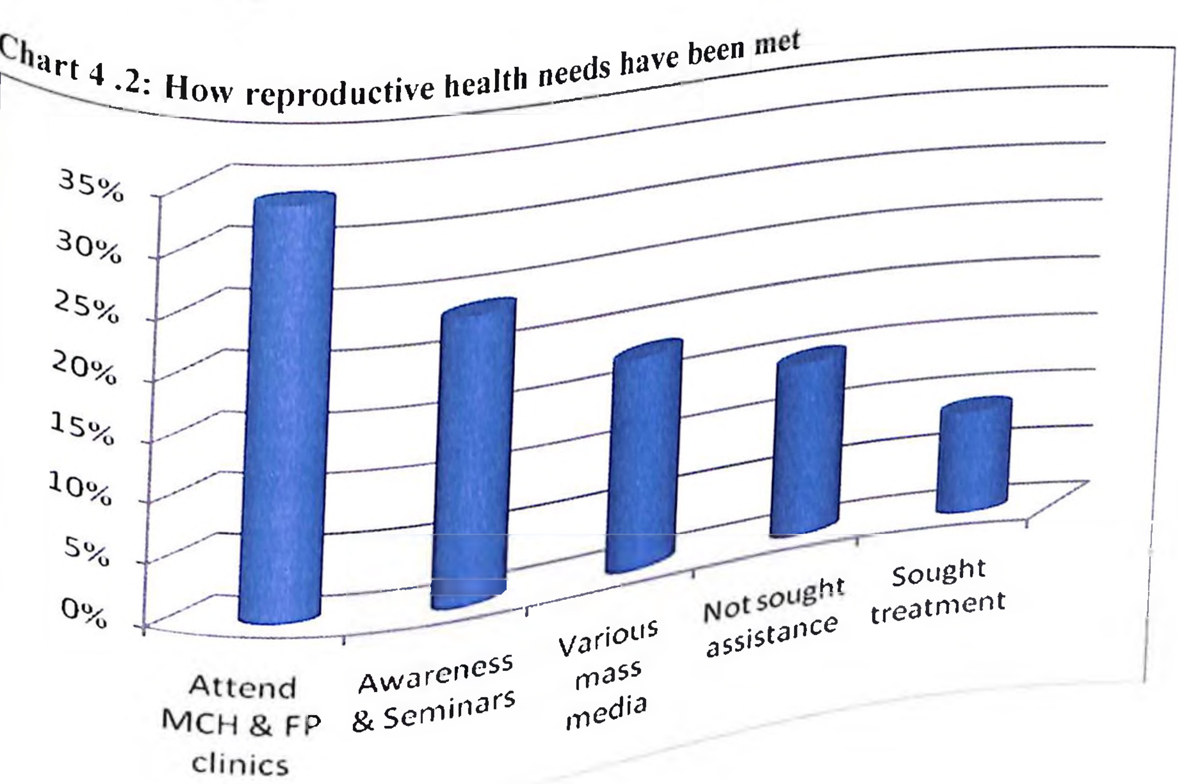
The most common reproductive health need among the women interviewed was contraceptives 30%. However, those women with children had a need for maternal child health services 17% while health information was indicated by six women on the other hand, 33% these women indicated that they did not have large reproductive health needs. For those who had reproductive health illnesses, namely, fibroids and swellings in the breasts, their need was information on their conditions and treatment for the same. Some women indicated more than one need, for example, those who had not suffered from a reproductive health illness had health-related needs such as information and contraceptives (Chart 4.1).

Chart 4 .1: Reproductive health-related needs of the respondents



The women use various avenues to meet the reproductive health needs. These ranged from visiting MCH and FP clinics and major hospitals for contraceptives and child wellness, attending seminars and reading various literature they came across as well as listening to the radio and watching television (Chart 4 .2)

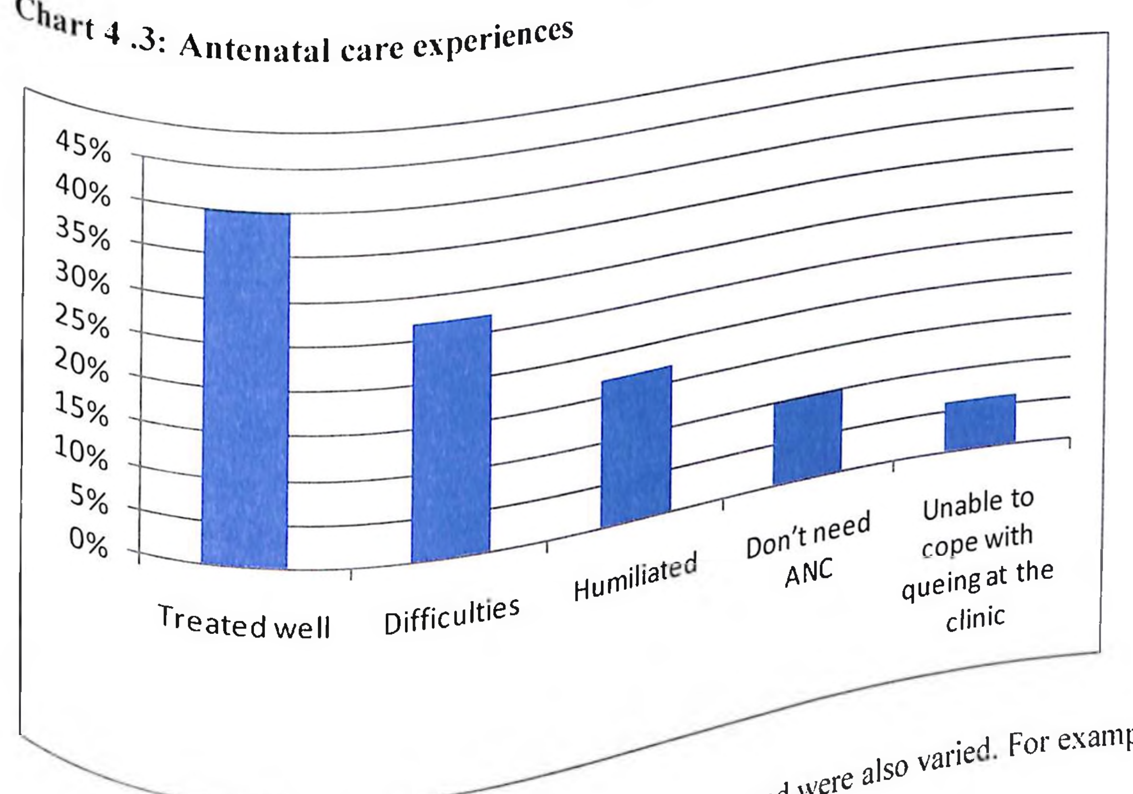
Chart 4 .2: How reproductive health needs have been met



4.3.3 Antenatal and maternity experiences

Those who had children were asked to narrate their experiences when they visited reproductive health providers for antenatal check-ups and when they eventually went to deliver. Twelve of them 40% said they had normal experiences and were treated well in terms of, were given adequate maternal care regardless of their disabilities. However, 10% did not go for antenatal clinics (ANC). On the other hand, those who stated that they had difficulties were eight 27%. These difficulties ranged from being harassed for arriving late for the clinic, which resulted in them being sent away until the next day. Five of the informants 17% were humiliated by the personnel who asked them how they got pregnant in their state and two 6% could not cope with the queuing due to discomfort, going to the clinic and getting on to the examination bed. These experiences are summarized in Chart 4 .3.

Chart 4 .3: Antenatal care experiences



The delivery experiences of the women interviewed were also varied. For example, seven 23% and five 18% had no problems as they were treated well, three 10% were expected to push like non-disabled women during labour, one 3% got no help to get on delivery table, one 3%

were kept waiting for long before admission, while others had difficulties during birth. Similarly, some of them mentioned that doctors wanted to perform caesarean without consulting them while others were ignored and they ended up delivering on their own (Table 4.9).

Table 4.9: Maternity services

Maternity experiences	Frequency	Percentage
Had no children yet/had them before disability	11	37
Home delivery (preference and no money)	7	23
No problem was treated well and assisted	5	18
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	**30**	**100**

4.3.4 Visit to hospital, distance and facility type

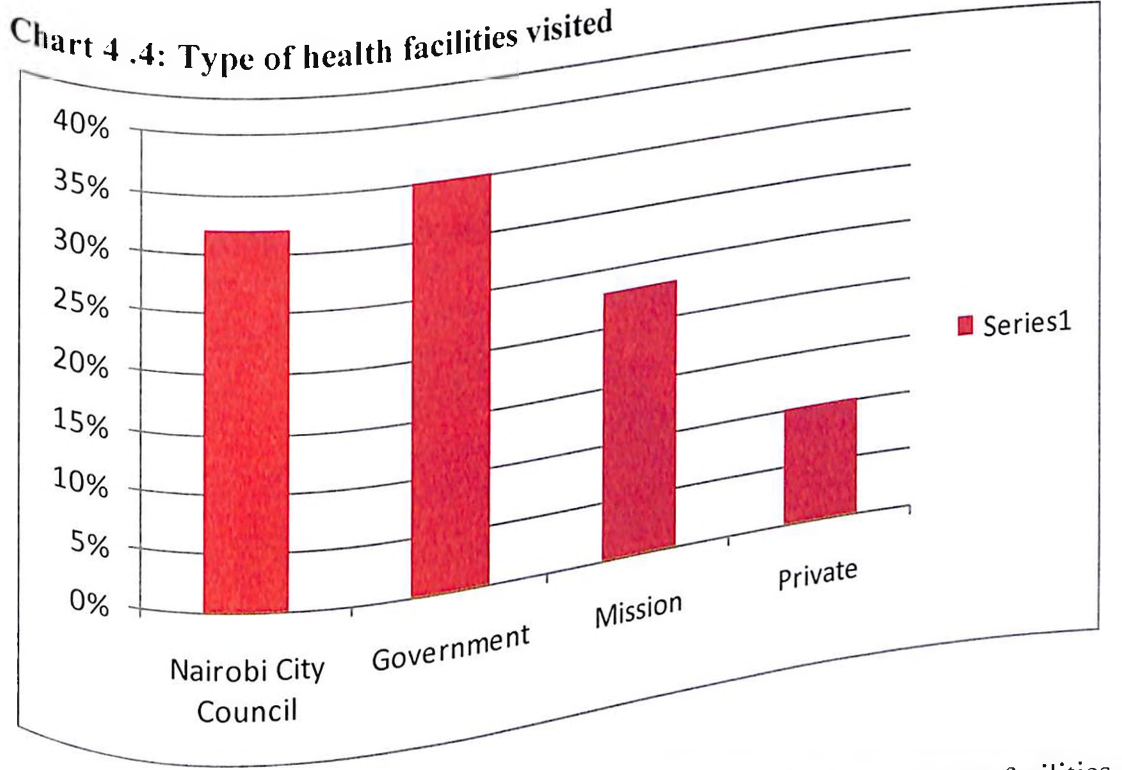
Most of the women interviewed 50% indicated that they always visited a hospital when they were sick. However, twelve of them 40% had not visited a health facility for treatment of a reproductive health illness because they had no such health need. Two of the informants 7% said they did not go to hospital because they could not afford it while others stated that they preferred drugs from the chemists. Lastly, one informant 3% only went to health facilities sometimes (Table 4.10).

Table 4.10: Visits to health facilities

Visit hospital when sick	Frequency	Percentage
Yes	15	50
Has had no need yet	12	40
No	2	7
Sometimes	1	3
Total	**30**	**100**

For those who visited a health facility when sick, a majority went to government and Nairobi city council clinics and these are represented by 35% and 32%, respectively. However, three (10%) visited private health facilities and 23% mission-based clinics. The data also indicate that some visited more than one type of health facility on different occasions depending on distance, need and availability of finances (Chart 4. 4).

Chart 4 .4: Type of health facilities visited



The findings show that many of the informants accessed the health facilities by walking (Table 4.11) and the distances ranged from 15 minutes to a one-hour walk. It was also evident

from the research that most of these women experienced problems going to the health facilities, this is because a majority had to walk since getting onto public transport was difficult.

Table 4.11: Distance to health facilities

Distance to health facilities	Frequency	Percentage
15-20 minutes walking	17	57
30 minutes walking	4	13
1 hour walking	5	17
15-20 minutes by bicycle taxi/vehicle	4	13
Total	**30**	**100**

4.3.5 Quality of services received at the health facilities

Of those who visited health service providers, 53% rated the services as good while 30% thought it was average. Very good and poor services were rated by 7% of the women and very poor at 3%, respectively (Chart 4 .5).

Chart 4 .5: Rating of services at health facilities

4.3.6 Difficulties experienced at health facilities and with personnel

On the question of the difficulties, the women faced when they visited health facilities, fifteen (50%) cited lack of ramps and stairs, high examination beds with no steps and difficulties moving within the facility for various services such as x-rays and laboratory. On the other hand, ten 33% remarked that they had no difficulties accessing the facilities while five (17%) pointed to long distances they had to cover to the facilities (Table 4.12).

Table 4.12: Difficulties experienced in accessing facilities

Difficulties accessing facility	Frequency	Percentage
Difficulty (no ramps, stairs, services far apart, high exam beds, movement within facility difficult)	15	50
Long distance to facility	5	17
No difficulty	10	33
Total	**30**	**100**

As regards their experience with medical personnel, most women (50%) described them as having bad attitudes towards those with disabilities as they were found to be what they described as cruel, rude and humiliating. Despite this, an almost similar number (33%) found the health personnel good and helpful. The informants elaborated that the staff harassed them if they came late for appointments, they were ignored, treated with pity and expected to operate like non-disabled women. In addition, five (17%) of the informants were turned away because they were unable to pay for the services in the health facilities as indicated in Table 4.13.

Table 4.13: Difficulties with health personnel

Difficulties with personnel	Frequency	Percentage
At public facility staff rude, cruel, humiliated, harassed when late, ignored, treated with pity, expected to operate like non-disabled women.	15	50
Experienced no difficulties	10	33
Turned away if unable to pay for services	5	17
Total	**30**	**100**

4.3.7 Thoughts on the services provided at health facilities

On their thoughts about the services they received at health facilities as women with disabilities, a majority stated that it was bad. This is because the services lacked privacy and the staff used abusive language. The women also felt discriminated and disrespected. However, some thought that the services were normal. When asked whether they thought health professionals treated them differently as a result of their disabilities 65% answered in the affirmative, 23% in the negative while those who said sometimes were represented by 12%. Concerning, if they had been denied medical service as a result of their disabilities, 81% said no and 19% said yes. The women, however, added that much as they had not been denied a service they were often ignored until the last minute and they felt that their disabilities hindered faster access. In fact, all those who said they had been denied a service because of a disability felt very bad and helpless and some never went back to that particular facility again.

4.3.8 Effects of difficulties experienced

Twenty seven percent of the informants get discouraged from seeking health care and treatment and they result to buying non-prescribed drugs over-the-counter. Most of these challenges are experienced in government and city council health facilities. Thirty-three percent prefer visiting private or mission health facilities where they are offered better health care regardless of their disabilities (Table 4.14).

Table 4.14: Effects of difficulties on access to health care

Effects of difficulties	Frequency	Percent
Discouraged from seeking services from public facilities and buys drugs instead	8	27
No effect	3	10
Sometimes doesn't get treatment if queue too long	6	20
Fells bad when staff are rude but endures for lack of alternative	2	7
Have to wake up early to avoid long queues	1	3
Prefer to go to missionary than public facility	10	33
TOTAL	**30**	**100**

4.4 Disability and reproductive health

4.4.1 Feelings of women with disabilities

The study also sought the feelings of the women to see whether their disabilities affected their reproductive health. Six of them (29%) stated that they have accepted their disabilities while twenty-four (80%) felt disadvantaged, helpless and a burden to their families (Table 4.15).

Table 4.15: Feelings about their disabilities

How do you feel about your disability	Frequency	Percent
Disadvantaged as have to struggle more than non-disabled women	11	37
Accepted condition	6	20
Helpless, ignored, prefers to die and unable to cope	8	27
Pity on self and a burden to family	3	10
Expensive special shoes and calipers	1	3
Hope of recovery	1	3
TOTAL	**30**	**100**

On whether their disabilities contributed to any reproductive health illnesses they have suffered, 78% answered in the negative while 22% in the positive. The reasons given by those who said that the disabilities had contributed to reproductive problems that they had suffered ranged from loosing babies after delivery, rapes, uterine over bleeding and inabilities to have more children.

4.4.2 Experiences on seeking information on sexuality and family planning

When seeking information on sexuality and family planning, ten (32%) of the women said they received negative reactions because they were disabled. There are those who claimed they had not sought such information (55%). However, those who described the reaction they received as normal (13%) pointed out that they were assisted and counseled appropriately (Table 4.16).

Table 4.16: Experiences on seeking information on sexuality and family planning

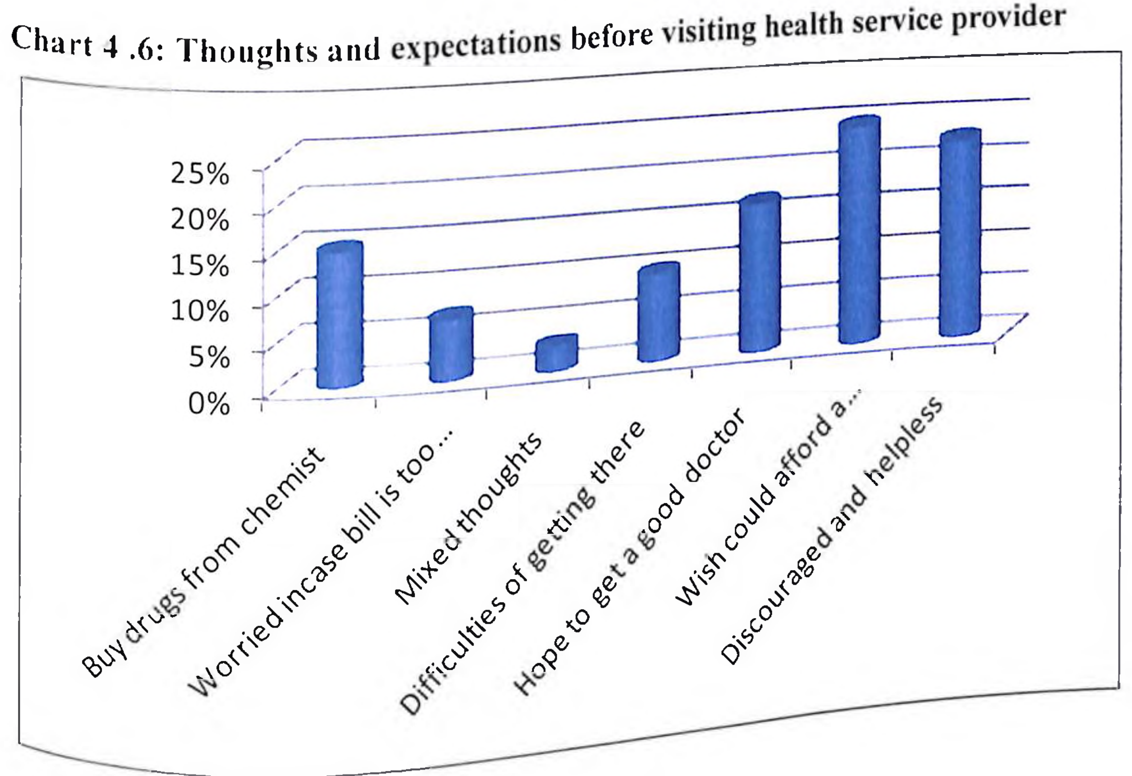
Reactions received when seeking information on sexuality and family planning	**Frequency**	**Percent**
Never asked	17	55
Normal as were assisted and counseled	4	13
Received negative reactions for engaging in sex in their condition.	10	32
TOTAL	**30**	**100**

4.4.3 Thoughts and expectations before seeking health services

The study also wanted to find out what the feelings, thoughts and expectations of the women were before going to seek health services. The findings indicate that the feelings ranged from discouragement to helplessness when they thought of how to get to the facility either by walking or taking public vehicles. Others wondered whether they could afford to pay for the services including buying drugs as some wished they could afford to visit private health

facilities where there are better services. Some are often torn between whether they should go to a health facility or buy drugs over-the-counter (Chart 4. 6).

Chart 4 .6: Thoughts and expectations before visiting health service provider



4.5 Improving access to reproductive health services

Slightly over a quarter 27% of the respondents recommended that provision of accessible facilities be considered. A similar number would like personnel sensitized on how to deal with people with disabilities. Eight percent would want separate facilities for the disabled and a similar percentage indicated those with disabilities should be given priority to avoid the long waiting time which tires them excessively. Public transport was also mentioned as an area that needed improvement, since most women did not find them user-friendly. Specifically, the women found the steps into the public vehicles too high and the doors too narrow such that those with wheel chairs could not fit. They also called for the public transport staff to be accommodating as many harass the disabled women to get in quickly; yet it is something they are not able to do. Since women with disabilities cannot keep up with the speed of the public transport vehicles, most are always left at the bus stops as the vehicles avoid carrying them because of the

inconvenience they cause (Table 4.17).

Table 4.17: Improving access to reproductive health services

Access to reproductive health services	Frequencies	Percentages
Provision of facilities	8	27
Sensitize medical personnel	8	27
Programmes to raise awareness	3	11
Economically empower	3	11
Reduce cost of services	2	8
Get first priority	2	8
Separate facilities for disabled	2	8
Accessible public transport	2	8
Total	**30**	**100**

4.6 Challenges faced by reproductive health providers when dealing with women with disabilities

The reproductive health service providers revealed that their services are not specific to women with disabilities only but they also include the non-disabled ones. All the four health providers interviewed commented that the common reproductive illnesses and needs among women with disabilities are mainly sexually transmitted diseases, unwanted pregnancies, complications arising from pregnancies and family planning services. Financial constraints was pointed out as one of the main factors that hinder these women from accessing reproductive health services. The key informants also remarked that they are not well equipped especially in maternity and antenatal to attend to women with disabilities effectively. The positioning for procedures was additionally pointed out as a challenge that faced the medical professionals in providing services to women with disabilities. This was especially when it came to pelvic examination for those women with paralysis of the lower limbs. The women noted that

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many health service providers are not always trained and equipped to deal with women with physical disabilities. The health providers in addition cited transport to the health facilities as a problem that greatly constrained women with disabilities from accessing health services. On the other hand, lack of information about reproductive health among women with disabilities was also given as a hindrance to accessing reproductive health services. The key informants added that because of their disabilities, many of the disabled believed that they may not suffer any reproductive health illnesses.

On the challenges, they experience in providing health services to the women, it was reported that the women are unable to express themselves about their illnesses and sometimes the medical professionals are not able to communicate with them. Concerning the potential measures to enhance access to reproductive health services, the providers suggested that door-to-door services be offered to women with disabilities. This is because most of such women have mobility problems as a result of their disability and the public transport system. They also suggested that women with disabilities be provided with information and be educated on their reproductive health needs so that they know that they are as vulnerable as non-disabled women and need to seek care. Finally, the providers suggested that the health facilities should be equipped with disability-friendly equipment such as accessible examination tables.

Key informant interviews with programme officers of disability organizations, were of the opinion that in the area of reproductive health and disability, a lot of sensitization still needs to be done, as many are not well informed. In particular, intensive awareness campaigns are needed so that women with disabilities can know that they have a right to seek and access reproductive health care. In addition, they suggested that this sensitization should also target government and policymakers because the reproductive health policy does not articulate well disability issues. In the area of reproductive health services offered, the service providers stated that whatever service is offered for non-disabled people,

should be similarly availed for those with disabilities and that it should be made to be disability-friendly. This is because most of these services are inaccessible, for instance, when facilities are located in high-rise buildings with no lifts or ramps. The health service providers similarly stated that most people with disabilities have low self-esteem. As a result of this, one key informant said that most people with disabilities want everything done for them. A programme officer moreover added that many disabled people are not aware that they can suffer reproductive health illnesses like non-disabled people and, therefore, they do not bother to seek information and health care. He concluded that there is a 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 FIVE

DISCUSSION AND CONCLUSION

5.1 Introduction

This section presents data on discussion, conclusion, and summary of this study. Finally, the chapter makes recommendations relating to the research questions, objectives and assumptions of the study.

5.2 Discussions and conclusion

The findings confirm that the difficulties experienced by the women in terms of access to facilities and with personnel show a generalized assumption that women with disabilities are not sexually active and may, thus, not require reproductive health services. Contrary to this, women with disabilities are sexually active and are able to have children just like non-disabled women. Thus, they require a whole range of reproductive health services provided to them just like those without physical disabilities. Similarly, the findings indicate that getting information about reproductive health issues such as sexuality and contraceptives among women with disabilities is important and that they use the available avenues and channels 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 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 their knowledge is limited to child-bearing and contraceptives, yet there are other concerns like breast and cervical cancers as well as the management of infertility. Antenatal and maternal experiences show that women with disabilities encounter various social, attitudinal and physical barriers while accessing safe motherhood. These include difficulties going to the clinics, getting onto the examination beds, as well as decisions being made for them such as undergoing caesarean sections without consultations assuming disabled women have no capacity

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

The low education levels could limit access to reproductive health services because they contribute to an understanding of the scope of the services, the importance of reproductive health and the kind of services that are available. Education levels also determine 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 abilities to afford reproductive health care. From the findings, 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. This is because of the fact that the physical facilities are disability-unfriendly and personnel have bad attitudes towards disabled women. Personal and shared unfavourable experiences may be factors that prevent disabled women from visiting reproductive health providers. The thoughts and expectations of the women before going to seek health services indicate the multitude of challenges they face before making the decision to either go or not. A large proportion of the women as seen have negative feelings regarding their disabilities. This can be interpreted to mean that they have low self-esteems and negative images, which can be attributed to lack of economic independence and their restricted mobility. This prevents them from doing daily basic chores for themselves including personal care without help. Thus, they should be encouraged to believe in themselves and take care of their health by seeking reproductive health services and information.

The challenges experienced by women with disabilities as they seek care can be addressed and eliminated to increase their access to reproductive health care. For instance, formulation and implementation of relevant policies as per the Persons with Disabilities Act, 2003 to enhance the built environment to make it user-friendly will ease access to health care providers as well as those with disabilities. Medical personnel also need to change their attitudes towards sexuality and disability and treat women with disabilities with respect and consideration as they would to non-disabled women.

5.3 Factors that hinder women with disabilities from visiting reproductive health providers

Women with disabilities experience various difficulties when they visit reproductive health service providers. These factors were found to hinder them from visiting reproductive health providers. Most women with disabilities were engaged in small petty businesses and their financial resources were constrained. This is a major factor that affected their abilities to afford health care. In addition, these women lacked awareness and information on the importance of reproductive health and, thus, did not consider visiting health providers a priority. The main means of transport to the health service providers is by public means, which are unfriendly. Specifically, most vehicles have narrow doors with no ramps and aisles that cannot accommodate for instance, wheel chairs. On the other hand, physical facilities within the premises of the health providers are difficult to access. This is because many have staircases and do not have ramps to ease accessibility by those on wheel chairs and crutches. In addition, most examination beds are too high with no steps to enable the women get on. Conversely, women with disabilities encounter various social, attitudinal and physical barriers when accessing reproductive health services. This is another factor that discourages them from accessing reproductive health services. The women also found the personnel to be unfriendly as well as a generalized assumption that women with disabilities are or should not be

sexually active. This received negative reactions from the informants while seeking reproductive health services such as contraceptives and maternity.

5.4 Challenges reproductive health care providers face when serving women with disabilities

Reproductive health care providers face a number of challenges and these include: financial constraints and cannot afford to pay the health services providers. This means that the providers are not able to serve the women adequately as some are turned away if they cannot pay. There was also lack of appropriate equipment and facilities, limited contraceptive options, lack of knowledge and inadequate training about how to deal with women with disabilities, as well as limited information about their needs.

5.5 Conclusion

The objectives of this study were two. First, to find out the factors that hinder women with physical disabilities from visiting reproductive health service providers. Secondly, to describe the experiences faced by women with physical disabilities when they visit reproductive health service providers. From the findings, it can be concluded that women with disabilities are sexually active and are able to have children just like non-disabled ones. Thus, they require a whole range of reproductive health services provided for the rest of the population. However, education levels determine the kinds 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 abilities to afford reproductive health care.

It was found that polio is the greatest cause of disability among the informants. Polio is a preventable disease through childhood immunization, which is one of the components of reproductive health. Given that women with disabilities have been able to have children, it is

important that the whole range of reproductive health care services be made accessible to prevent disabilities among children of both disabled and non-disabled women. The study also found that living with a disability is very challenging such that some of the informants did not give their reproductive health a priority since they felt that they had enough to deal with as a result of their disabilities. The above findings indicate that getting information about reproductive health issues such as sexuality and contraceptives are important and that the women use different 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 because they had stopped having children, did not have any or were not sexually active. This shows that these women lack awareness of reproductive health issues. Specifically, this knowledge of reproductive health is limited to child-bearing and contraceptives, yet there are other concerns like breast and cervical cancers and management of infertility. Since from the findings it is seen that awareness seminars held for those with disabilities are an important source of reproductive health information these should be enhanced to include topics covering more than child-bearing, STDs, contraceptives and HIV/AIDS.

The findings on antenatal and maternity experiences show that the women with disabilities encounter various social, altitudinal and physical barriers accessing safe motherhood. These include difficulties going to the clinic, getting onto the examination table, decisions being made for them such as undergoing caesarean sections without consultations and lack of assistance during delivery. It was evident from the research that most of these women had problems going to the health facilities. Many have to walk because getting into 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 health facilities and with personnel show a generalized assumption that women with disabilities are not sexually active and may thus not require reproductive health services. These women encounter physical and altitudinal barriers as they seek care. Long queues at the service providers were a problem experienced by most of the women interviewed. The difficulties experienced with access to facilities, with personnel and the waiting time have affected women with disabilities in various ways. These include getting discouraged from seeking care and treatment resulting into buying non-prescribed drugs over the counter or enduring the difficulties for lack of choice. These challenges are experienced in public health facilities, that is, government and city council facilities. Therefore, a minority of those who can afford or have access prefer to visit private or mission health facilities.

The effects of not seeking appropriate care or delays as a result of the difficulties experienced with facilities and health personnel can have far reaching repercussions on the health of 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 concluded 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 bad attitudes towards them. Personal and shared unfavourable experiences may be factors that prevent disabled women from visiting reproductive health providers.

5.6 Recommendations

- There is a need for understanding 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 conduct

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, the 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 sensitized in order to treat people with disabilities with consideration as they are not able to board and alight with the same speed as non-disabled passengers.

- There is a need for political will and commitment to provide the necessary disability awareness and to integrate this 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 human-made. Therefore, these difficulties can be addressed and eliminated to increase access to reproductive health care for women with disabilities. The formulation and implementation of the relevant policies as per the Persons with Disabilities Act, 2003 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 interviewed have negative feelings regarding their disabilities. This can be interpreted to mean that they have low self-esteems and negative images which can be attributed to lack a of economic independence and stigma associated with disabilities. Therefore, there is a need for further research and analysis on this aspect. In general, there is a need for esteem building activities to be incorporated in medical and vocational rehabilitation services. 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 also recommends that the government enters into a private-public partnership with mission and private facilities to enhance access.

- It was evident from the data that most women with disabilities lack awareness and information on reproductive health issues. As policymakers prepare and implement awareness programmes, those individuals with disabilities should be included. This will assist to destroy the myth that such persons 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

Appendix 1: In-depth interview guide

My name is Sarah Muraya, I am a student from the University of Nairobi undertaking a research on the challenges faced by women with physical disabilities in accessing reproductive health services. The research aims at generating information to help women with physical disabilities to access reproductive health services with ease and adequately. All the information that you will provide shall only be used for the study and will be treated with strict confidentiality. However, your participation is completely voluntary and if there is any question you are not comfortable with, you are free not to answer.

A. Personal Information

1. Name (optional)
2. How old are you?
3. What is your marital status?
4. Do you have any children?

   (ii) If yes how many?

5 What is your level of education?

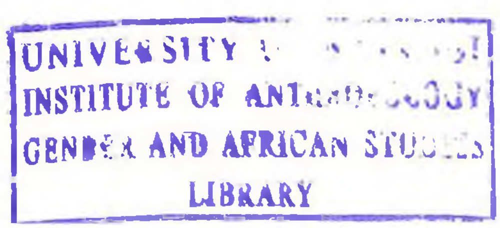
6 Are you employed?

   (ii) If no, what is your source of livelihood?

B. Nature of disability and access to reproductive health services

1. What is the nature of your disability?
2. How did it come about?
3. Do you think it contributes to any reproductive health illness that affects you?

   (ii) If so, how?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4. What are the various reproductive health needs that you require?

   (ii) How have you met these needs?

4 Do you always go to a health facility whenever you have a reproductive-related illness?

5 Have you been denied a medical service because you have a disability?

   (ii) If yes, how did that make you feel?

6 What are your feelings, thoughts and expectations before going to seek health services?

7 How far is the nearest reproductive health facility?

8 Where do you go for reproductive health services?

   (ii) Why do you go to that particular service provider you indicated above?

9 How would you rate the kind of service you receive whenever you go there?

10 Where do you get information on reproductive health issues?

C. Improving access to reproductive health services

1. What do you think can be done to make the reproductive health services more accessible to women with disabilities? (Probe)

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Appendix 2: Key informant interview guide

My name is Sarah Muraya, I am a student from the University of Nairobi undertaking a research on the challenges faced by women with physical disabilities in accessing reproductive health services. The research aims at generating information to help service providers improve their services to women with disabilities. All the information that you will provide shall only be used for the study and will be treated with strict confidentiality. However, your participation is completely voluntary and if there is any question you are not comfortable with, you are free not to answer.

A. Background information

1. Name of organization ....

....

2. Your designation ....

....

3. State the nature of reproductive health services that your organization provides to women with disabilities ....

....

B. Reproductive health services provision

1. From experience, what would you say are the common productive health related illnesses and needs among women with disabilities?

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2. What in your opinion hinders women with disabilities from accessing reproductive health services? ....

....

....

3. What challenges do you experience in providing health services to women with disabilities?

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4. What difficulties do you face when providing services to women with disabilities?

....

....

5. 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

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

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