# UNIVERSITY OF NAIROBI

**OPPORTUNITIES AND CHALLENGES FACED BY WOMEN WITH PHYSICAL DISABILITIES IN ACCESSING AND UTILIZING PUBLIC HEALTH SERVICES IN NAIROBI CITY COUNTY**

**LEAH MUGEHERA KHASOHA**

**REG NO: N69/69964/2011**

**A PROJECT PAPER SUBMITTED TO THE INSTITUTE OF ANTHROPOLOGY, GENDER AND AFRICAN STUDIES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN GENDER AND DEVELOPMENT STUDIES OF THE UNIVERSITY OF NAIROBI**

**2013**

## DECLARATION

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

_____ _____

Leah Mugehera Khasoha Date

This project paper has been submitted for examination with my approval as the university supervisor.

_____ _____

Prof Simiyu Wandibba Date

## DEDICATION

This project paper is dedicated to my mother, Mabel Imali Isolio, who introduced me to the joy of reading from birth, enabling such a study to take place today. To my niece Vanessa Imali, for keeping me company and entertained while I wrote this work. To my late grandmother and namesake, Mama Jenittace Mugehera, for her love of education and women's empowerment, and for her role as my mentor.

To all the women with physical disabilities who participated in this inquiry, formally and informally.

## TABLE OF CONTENTS

## LIST OF TABLES

## LIST OF FIGURES

## LIST OF ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| APDK | Association for the Physically Disabled of Kenya |
| CDT | Critical Disability Theory |
| CEDAW | Convention on Elimination of all forms of Discrimination Against Women |
| CRBS | Central Registered Body in Scotland |
| CRPD | Convention on the Rights of Persons with Disability |
| KNBS | Kenya National Bureau of Statistics |
| KNSPWD | Kenya National Survey for Persons with Disabilities |
| MDH | Mbagathi District Hospital |
| MOH | Ministry of Health |
| NCPWD | National Council for Persons with Disabilities |
| PWDs | Persons with Disabilities |
| WHO | World Health Organization |
| WWPD | Women With Physical Disabilities |

## ACKNOWLEDGEMENT

I am grateful to all those who supported me in various ways during the course of this study.

First, I wish to express my sincere gratitude to Prof. Simiyu Wandibba, my supervisor, for his advice, guidance and suggestions on this project paper. I wish to thank him also for constructive criticism and offering guidance to the series of manuscripts which evolved into this project paper.

I wish to thank the entire staff at the Institute of Anthropology, Gender and African studies for their support in various ways. A special thank you goes to Ann Muthoni, Eunice Wandei and Benson Kiptum of the Association of the Physically Disabled of Kenya (APDK), Nairobi head office, for allowing me to involve its groups of women with physical disabilities in this study.

My sincere thanks to Mbagathi District Hospital staff for their overwhelming input of information and support to this study.

Finally, my heartfelt appreciation goes to my siblings: Kennedy Andrew Isolio, Lilian Muhonja, Godfrey Shitsugane Isolio, Brenda Laura Mbaitsa and my cousin Carolyne Mmbaiza for their encouragement and moral support in the course of my study.

## ABSTRACT

This was a qualitative and quantitative study on opportunities and challenges faced by women with physical disabilities in accessing and utilizing public health services in Nairobi City County.

The study sought to describe the difficulties encountered by women with physical disabilities while seeking healthcare services at public hospitals. It was guided by the critical disability theory which analysed disability issues and viewed the problems of disability explicitly as the product of unequal society.

Data were collected through semi-structured interviews, key informant interviews, focus group discussions and observation. Analysis was done through thematic approach.

The study findings suggest that the research subjects encounter several challenges as they approach public facilities for healthcare services. These challenges include lack of proper health facilities, poor infrastructure and insensitive medical personnel to concerns of PWDs.

The findings also indicate that the main opportunities available for women with physical disabilities in accessing and utilizing services offered at public hospitals would be the building of more ramps, provision of wheelchairs, and provision of low beds. Other issues have to do with free medication, non-slippery floors and establishment of special wings for WWPDs.

On the basis of these findings, the study concludes that lack of proper health facilities in public hospitals negatively affects women with physical disabilities in Nairobi City County. It is, therefore recommended that the administration in public hospitals should ensure facilities such as low beds and low toilets; special units for women with physical disabilities; ramps and floors that are adapted to disability; widen corridors and doorways and give priority services to the WWPDs in the public hospitals.

# CHAPTER ONE

# BACKGROUND TO THE STUDY

## 1.1 Introduction

Throughout history, persons with disabilities (PWDs) have struggled to live full and productive lives as independently as possible in a society laden with stigma, discrimination, attitudinal and environmental barriers. Most legislation policies and practices have regarded persons with disabilities as unfit for society, as sick, as functionally limited, and as unable to work (Brooks, 1991; Brzuzy, 1997; Hahn, 1983; Mackelprang and Salsgiver, 1999; Quinn, 1995a).

According to the findings of the Kenya National Survey for Persons with Disabilities (KNSPWD) that was conducted in 2007, about 4.6% of Kenyans experience some form of disability. According to the planning bulletin article on disability mainstreaming in policy and planning, it is argued that unlike poverty which has major differences in urban and rural areas, disability has no major differences in prevalence in the rural or urban areas or by sex but prevalence increases with age (Republic of Kenya, 2008).

There is a lot of negative perception concerning disability in most societies with the assumption that PWDs face a lot of challenges as members of these societies. For example, giving birth to a child with disability is regarded a taboo in most African communities, which may also attach negative cultural beliefs that bring in stigma and

discrimination to the person with the disability and their family. Because of such attitudes, the rights of persons with disability are overlooked.

Section 2 of the Persons with Disabilities Act of 2003 defines disability as a physical, sensory, mental or other impairment, including any visual, hearing, learning or physical incapability, which impacts adversely on social, economic or environmental participation of a person (Republic of Kenya, 2003).

Article 260 of the Constitution of Kenya, 2010states that 'disability includes any physical, sensory, mental, psychological or other impairment, condition or illness that has, or is perceived by significant sectors of the community to have, a substantial or long term effect on an individual's ability to carry out ordinary day-to-day activities (Republic of Kenya, 2010).

PWDs in Kenya live in a vicious cycle of poverty due to stigmatization, limited education opportunities, inadequate access to economic opportunities and access to the labour market. The women with disabilities are more vulnerable to human rights violations through neglect and exclusion from political, socio-cultural, civil and economic activities. They face discrimination in access to and utilization of public health facilities and services and are under-served in terms of healthcare information(NGO shadow report, 2004).

According to the NGO shadow report on the implementation of CEDAW and women's human rights in Bosnia and Herzegovina 2004, women with disabilities face great difficulties in accessing health institutions and information related to their health.

This is primarily due to the physical inaccessibility of health care facilities such as hospitals, public healthcare centres and out-patient facilities. These facilities lack adequate equipment, especially for gynecological care (NGO shadow report, 2004).

Women with physical disabilities (WWPDs) face unique health and reproductive health problems compared to able-bodied women. The failure of the medical professions to address the reproductive health of WWDs can ultimately lead to infertility among them (NGO shadow report, 2004).

WWPDs must also confront the prejudices of doctors and other health caregivers. Notably, many doctors often demonstrate a level of fear and discomfort when caring for them. Some of the health care professionals do not perceive the WWDs as sexually active enough to have children (NGO shadow report, 2004).

There are no special services to provide assistance to mothers with disabilities. They are often forced to rely on their families, or engage someone whom they must pay for by themselves, to care for their children. The position of mothers with disabilities in the rural communities is even worse. There are no strategies or activities by state bodies or health care institutions that take into account the specific health needs of young girls and women with disabilities. Unfortunately, because of this, women do not receive even the basic primary health care services that are necessary for all children and young women (NGO shadow report, 2004).

## 1.2 Problem statement

Article 11 of the United Nations Convention on the Elimination of all forms Discrimination against Women (CEDAW) states that:

> States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular: The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction (Page 9 of CEDAW, 2003).

Article 12 requires States Parties to take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. Provisions of paragraph 2 of the same article, indicate that state parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation(CEDAW, 2003).

According to Rannveig Traustadottir and Kelley Johnson (2006) of the Norwegian Independent Living Institute, women with disabilities have historically been neglected by disability studies and feminist scholarship alike and issues of importance to them have, for the most part, been ignored by the disability and the women's rights movements. They argue that almost all research on people with disabilities has assumed the irrelevance of gender as well as other social dimensions such as social class, race, ethnicity and sexual orientation, making it easy for disability to eclipse these dimensions of social experience (Rannveig and Kelley, 2006).It is further explained that WWDs have been neglected by researchers in the disability and women's rights movements. Most disability studies in health have used a gender-blind approach to examine the lives of people with disabilities (PWDs) while neglecting to explore the influence of gender in the lives of men and women with disabilities. Ultimately, women

with disabilities become invisible both among those promoting the rights of PWDs and those for gender equality and the advancement of women.

The study assessed the accessibility to and utilization of health services by women with physical disabilities in Nairobi City County. It was guided by the following questions:

i. What are the opportunities available for women with physical disabilities in accessing and utilizing health services in Nairobi City County?

ii. What are the challenges encountered by women with physical disabilities in accessing and utilizing health services in Nairobi City County?

## 1.3 Research objectives

### 1.3.1 General objective

To explore the opportunities and challenges faced by women with physical disabilities in accessing and utilizing public health services in Nairobi City County.

### 1.3.2 Specific objectives

i. To establish the opportunities available for women with physical disabilities in accessing and utilizing public health services in Nairobi City County.

ii. To assess the challenges encountered by women with physical disabilities in accessing and utilizing public health services in Nairobi City County.

## 1.4 Significance of the study

The study sought to address gaps in data and information on accessibility to and utilization of public health services by women with physical disabilities in Nairobi City

County. Currently, most health programmes in Kenya are insensitive to women with disabilities. The recommendations from this study should, therefore, be useful as policy options for the improvement of service delivery systems for WWPDs as well as for further research in this field.

### 1.5 Scope of the study

The study was conducted on women with physical disabilities seeking health care services from public facilities in Nairobi City County. It focused on the opportunities available and challenges faced by women with physical disabilities to access and utilize these public health services.

### 1.6 Limitations of the study

Some of the respondents considered information relating to their reproductive health as personal and were therefore not willing to disclose it as much as possible. However, this did not compromise the quality of the study as the researcher ensured confidentiality of the information provided by making optional the identity and contact details of the respondents on the questionnaires.

# CHAPTER TWO

# LITERATURE REVIEW

## 2.1 Introduction

This chapter reviews the literature relevant to the research problem using the following subheadings: disability, public health services, opportunities and challenges in accessing and utilizing health services by women with disabilities. The chapter also discusses the theoretical framework that guided the study.

## 2.2 Disability

The World Health Organization (WHO, 2001) describes disability as:

> An umbrella term, covering impairments, activity limitations and participation restrictions. Impairment is a problem in body function or structure: activity limitation is difficulty encountered by an individual in executing a task or action, while participation restriction is a problem experienced by an individual during involvement in life situations. (www.lifeonwheels.net/ writings/history.html).

According to Kenya's Persons with Disabilities Act of 2003, "disability" means a physical, sensory, mental or other impairment, including any visual, hearing, learning or physical incapability, which impacts adversely on social, economic or environmental participation. Other types of disabilities are albinism and autism (Republic of Kenya, 2003). The results from the 2009 Census (KNBS, 2010), indicate that the number of people with disabilities in Kenya at the time was 647,689 (3.4%) males and 682,623 (3.5%) females.

Some health conditions associated with disability result in poor health and extensive healthcare needs. These special healthcare needs are due to the fact that WWDs are under-served by health programmes and promotions, for example,

screening for breast and cervical cancer, thereby increasing the risk of further disability at later stages in life (Franklin,1977). This contravenes Article 25 of the UN Convention on the Rights of Persons with Disabilities (CRPD) which was adopted by the UN General Assembly in 2006 which reinforces the right of persons with disabilities to attain the highest standard of health care, without discrimination. (www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx#6).

A woman with disability tends to be judged and found wanting in appearance, in comparison to the conventional stereotypes of 'beauty' in her culture. In most African communities, she is perceived as one who is unable to perform her traditional roles of a wife, mother and home-maker because of her disability, even if she may be able to do so in reality. For example, a woman with mobility impairment may be perceived as one in need of physical assistance in self-care and grooming, and therefore, unable to carry out the domestic tasks that require mobility and physical labour (Franklin, 1977).

Franklin (1977:3) states that women with disabilities are less likely to be married than men with disabilities. This is largely due to negative attitudes and stereotypes about what WWDs can or cannot do, particularly in societies where marriages are arranged by the elders and is a contract between the concerned families rather than the individuals. There are misconceptions that a woman with physical disability may not be competent in most spheres such as learning or being able to be in a gainful employment.

Women with disabilities have fewer chances of meeting potential marriage partners because of restricted mobility and freedom. In a few instances, they may be married off by their families to 'wrong' persons, such as men who are already married, so that the families can 'get rid of the burden' of caring for them. There may also be demands for lower bride wealth due to fear of being divorced or abandoned than able-bodied women, because of perceptions that they are helpless, unable to care for themselves and to contribute to family economy (Franklin, 1977). However, chances of a man with physical disability getting married are much higher compared to his female counterpart.

Child-bearing, like marriage, is considered as the natural law and destiny of every woman, in traditional societies in Kenya and Africa in general. Being childless is considered to be a great misfortune, for which the woman is usually held to be responsible. However, women with disabilities face specific attitudinal barriers in this regard. They are perceived as being in need of care themselves because of their disability, or the common belief is that looking after children requires physical fitness and mobility, which they may lack (Shaul, 1985). Because of these reasons, women with disabilities are perceived as being unable to fulfill a caring and mothering role. On the contrary, as long as a man with disability earns a living, his chances of getting married and having a family are much higher than those of a woman with disability.

Misconceptions also exist about a woman's disability being inherited by her children, which can be attributed to inadequate knowledge and access to information and health care services related to their special needs around pregnancy and child-

bearing. Franklin (1977:8) also argues that when it comes to household tasks, women with disabilities may face difficulties in carrying out the responsibilities of all the domestic chores that are normally expected of a woman in traditional societies, or may take longer to perform the tasks, or may require some assistance in doing so. However, because of their restricted mobility, society considers WWDs as ill-suited to perform the role of home-maker, due to their perceived inability to perform the required tasks independently.

Women with disabilities generally have less access to rehabilitation services compared to their male counterparts. According to the traditional social and cultural norms in most village societies in Kenya, most WWDs do not go out of their houses to seek help for healthcare, especially if the care-provider is male. This has legitimized the shift from a medical model to a social model in which people are viewed as being disabled by society rather than by their bodies (Oliver, 1990:40).

Every generation has faced the moral and political issues of how best to include and support people with disabilities. Responses to disabilities have changed since the 1970s prompted mainly by the self-organization of the people with disabilities (Charlton, 1998) and also by the growing tendency that disability is a human rights issue (Quinn, 2002). Traditionally, people with disabilities have largely been provided for through solutions that segregate them such as schools or residential institutions, (Parmenter, 2008:124).The United Nations Standard rules on the Equalization of Opportunities of Persons with Disabilities (2003) has incorporated the human rights of people with disabilities culminating in the adoption of the United Nations Convention

on the Rights of Persons with Disabilities (CRPD) in 2006 (UN, 2006). Disability itself is complex, dynamic, contested and multidimensional in character. Research in the social and health services has identified the role of social and physical barriers in disability (Barnes, 1991).

## 2.3 Public health services

According to the Central Registered Body in Scotland (CRBS), a public health service is one which is provided or secured by a public health body concerning the treatment, care and support of, provision of advice and assistance to individuals in relation to their health and well-being.

The CRBS further explains that an organization is likely to be a public health service provider when it is registered as an independent healthcare service with the government, is wholly owned by government, or is a privately owned hospital which is used by the public and receives a high proportion of referrals from primary care services. (http://www.crbs.org.uk/Default.aspx?TabId=465).

WHO (1946:100) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."The preamble to the Constitution of the World Health Organization was adopted by the International Health Conference in New York on 19-22 June, 1946 and signed on 22 July, 1946 by the representatives of 61 States and entered into force on 7 April, 1948.

WHO (2001)used ‘access’ to mean *physical availability*, which is defined as the relationship between the type and quantity of product or service needed, and the type and quantity of product or service provided.

## 2.4 Opportunities for accessing and utilizing healthcare services by women with physical disabilities

Article 6 of the United Nations Convention on the Rights of Persons with Disabilities states that State Parties shall recognize that women and girls with disabilities are subject to multiple discrimination and in this regard shall take measures to ensure the full and equal enjoyment by them on all human rights and fundamental freedoms.(www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWith Disabilities.aspx#6).

Some of the opportunities available for women with disabilities include:

- **Maternal health care:** This includes health services on the mother and baby during and after pregnancy. It consists of pre-natal and post-natal care of the mother and the baby.
- **Reproductive health care:** This entails healthcare on family planning.
- **Health care information:** Every woman with disability is entitled to have information related to health on their reproductive and maternal health which includes family planning.
- **Mobility assistance**: Most women with disabilities require mobility aids and buildings should be constructed in a way that will allow for easy access by WWDs in wheelchairs.

## 2.5 Challenges encountered by women with physical disabilities in accessing and utilizing health services

Article 54 (1) of the Constitution of Kenya, 2010 on the application of the rights to PWDs states that:

A person with disability is entitled to be treated with dignity and respect and to be addressed and referred to in a manner that is not demeaning; to access educational institutions and facilities for persons with disabilities that are integrated into society to the extent compatible with the interests of the person; to have reasonable access to all places, public transport and information; to use sign language, Braille or other appropriate means of communication; and to access materials and devices to overcome constraints arising from the person's disability (Republic of Kenya, 2010:60).

According to WHO 2001, women with disabilities encounter a range of barriers when they attempt to access and utilize healthcare services. The barriers include but are not in order of severity or complexity, the following: Financial constraints, limited availability of services, physical barriers, gaps in information, stigma, sterilization of women and girls with disabilities and mobility assistance.

Affordability of health services and transportation are two main reasons why women with disabilities do not receive needed healthcare in low-income countries - 32-33% of able bodied people are unable to afford healthcare compared to 51-53% of people with disabilities. This is compounded by the lack of appropriate services for people with disabilities, which is a significant barrier to healthcare. For example, research in Uttar Pradesh and Tamil Nadu states of India found that after the cost, the

lack of services in the area was the second most significant barrier to using health facilities. (http://www.who.int/mediacentre/factsheets/fs352/en/).

Uneven access to buildings (hospitals, health centres), inaccessible medical equipment, poor signage, narrow doorways, internal steps, inadequate bathroom facilities, and inaccessible parking areas create barriers to health care facilities. For example, women with mobility difficulties are often unable to access breast and cervical cancer screening because examination tables are not height-adjustable and the mammography equipment only accommodates women who are able to stand on their own. (http://www.who.int/mediacentre/factsheets/fs352/en/).

There are gaps in information particularly in areas of pregnancy, menopause, contraception and sexually transmitted diseases (Becker, 1997). Women with disabilities, especially those with visual impairment, find it difficult reading healthcare information from leaflets and brochures because these materials are not brailed.

Becker (1997) reports that most women with disabilities are mistreated by medical practitioners when they go to hospitals for treatment. They feel alienated by health services, or made to feel that they are a burden, especially when providers are unable to provide adequate facilities, consultation time, or advice to meet their needs. Furthermore, health care providers focus on a woman's disability and ignore or overlook other health and social matters, such as sexual and reproductive health or the possibility of violence in the woman's life.

According to a briefing paper jointly prepared by Women with Disabilities Australia (WWDA), Human Rights Watch (HRW), the Open Society Foundations and the International Disability Alliance (IDA) as part of the Global Campaign to Stop Torture in Health Care, women in many parts of the world rely on access to a range of methods to control their fertility, including voluntary sterilization. However, too often, sterilization is not a choice. Women with disabilities are particularly vulnerable to forced sterilizations performed under the auspices of legitimate medical care. The difficulty some women with disabilities may have in understanding or communicating what was done to them increases their vulnerability to forced sterilization. The practice of forced sterilization is part of a broader pattern of denial of the human rights of women and girls with disabilities. A further aggravating factor is the widespread practice of legal guardians or others making life-altering decisions for persons with disabilities, including consenting to sterilization on their behalf, (http://www.wwda.org.au/ confpaps2011.htm).

In the case of fitting of mobility aids in particular, women with disabilities experience a unique difficulty. A large majority of people with disabilities, many of whom are women, require mobility aids because of polio and other physical disabilities. However, most trained technicians in orthotics and prosthetics are male, and women with disabilities who require mobility aids are unable to access the services of measurement and fitting of aids from male health practitioners due to the cultural taboo related to being examined by men (Thomas, 1999).

The study sought to address the gaps of inequalities present in the medical field especially in terms of providing healthcare services or treatment to women with physical disabilities by health practitioners. The implementation of its recommendations has been identified as a contribution to the improvements in accessibility of public buildings so as to ensure the mobility of women with physical disabilities who seek medical care from public hospitals.

## 2.6 Theoretical Framework

### 2.6.1 Critical Disability Theory (CDT)

This study was guided by the critical disability theory (CDT) which was propounded by Michael Oliver (1996).This is an emerging theoretical framework for the study and analysis of disability issues. This theory evolved from the work of scholars who formed the Frankfurt School, a term which refers to a group of Western Marxist social researchers and philosophers originally working in Frankfurt, Germany (Hosking, 2008).

Critical theory sees problems of PWDs 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. 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 “cured” by spending money to ensure that public transport is designed in such a way that it becomes accessible to persons with disabilities. (Devlin and Pothier, 2005).

The impact of this critical theory on healthcare and research has tended to be indirect. It has raised political awareness, helped with the collective empowerment of PWDs and publicized their critical views on healthcare. It has criticized the medical control exerted over the lives of PWDs, 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 to PWDs (Devlin and Pothier, 2005).

This radically different view is called the social model of disability, or social oppression theory. While respecting the value of scientifically based medical research, this approach calls for more research based on social theories of disability if research is to improve the quality of lives of the people with disabilities. Definitions are central to understanding theories of impairment and disability (Oliver, 1998).

CDT accepts that some illnesses have disabling consequences and persons with disabilities at times are ill; it may be entirely appropriate for doctors to treat illnesses of all kinds, such as bronchitis or ulcers. Yet it questions why, for example, doctors should decide about access to welfare services such as education or disability living allowance. Theories of impairment, disability and illness influence which aspects of disabled people's lives require health treatment, or policy developments, or political action as sometimes radical alternatives (Oliver, 1998).

### 2.6.2 Relevance of the theory to the study

The theory views the problems of people with disabilities explicitly as products of an unequal society. The discrimination aspects in the theory helped to explain the experiences of women with physical disabilities in accessing and utilizing healthcare services. This theory finds relevance in the factors that hinder women with physical disabilities from accessing and utilizing health services from public facilities.

# CHAPTER THREE

# METHODOLOGY

## 3.1 Introduction

This chapter describes the research site, research design, study and sample populations, sampling procedure, data collection methods, as well as data analysis. The chapter concludes by discussing the ethical issues that were taken into consideration in the study.

## 3.2 Research site

The study was carried out in Nairobi City County (Fig.3.1), which is the capital of Kenya. Geographically, Nairobi City is located at 1°16' Latitude South and 36°48' Longitude East and sits 1660m above sea level. It is the most populous city in East Africa, with a current estimated population of over 4 million. According to the 2009 Census, the population of Nairobi City County stood at 3,138,369. The number of females was 1,533,139 while that of males was 1,605,203 within the 696 $km^2$.Nairobi is currently the 12th largest city in Africa, having the largest population in its suburbs. (http://www.mapsofworld.com/kenya/cities/nairobi.html).

Nairobi City County was selected because of its highest concentration of PWDs, some of whom moved to the capital in search of greener pastures. The county has four public hospitals and several private healthcare facilities. According to the KNSPWD preliminary report of 2008, it was reported that the County has the highest proportion of PWDs, 32% of whom work for pay.


**Figure 3.1 Location of Nairobi City County**

*(Source: Google maps, 2013)*

## 3.3 Research design

The study adopted both qualitative and quantitative methods. The qualitative method was used to explore the challenges and perceptions of women with physical disabilities in accessing and utilizing healthcare services in Nairobi City County. The quantitative method gathered empirical evidence to substantiate the various issues affecting women with physical disabilities in Nairobi City County.

### 3.4 Study population

The study population consisted of women with physical disabilities of a reproductive age, living and seeking health services in Nairobi City County. The unit of analysis was the individual woman with a physical disability.

### 3.5 Sample population

A sample of 30 women with physical disabilities was drawn from the County as respondents in the survey. The study included six key informants, four of them being health workers and two were NGO officials who provided expert opinion from organizations implementing disability focused initiatives.

### 3.6 Sampling procedure

#### 3.6.1 Snowball sampling

The study used the snowball sampling technique to select the study sample. The study involved identifying individuals from a disability group of persons affiliated to the Association for the Physically Disabled of Kenya (APDK) situated in Nairobi City County. The first respondent directed the researcher to the next respondent, and so on.

#### 3.6.2 Convenience sampling

Convenience sampling was used to establish age categories for respondents to the semi-structured interviews and focus group discussions. Respondents consisted of 30 women with physical disabilities divided into two groups, based on their ages. Each group consisted of 15 young women (18-35 years) and 15 older women (36-60years).

Mugenda and Mugenda (2008) notes that 15% of the study population is an adequate representative sample of the study population. Fifteen per cent of the study population

was selected from the already selected 200 women with physical disabilities, resulting in the total figure of thirty respondents.

## 3.7 Data Collection Methods

### 3.7.1 Semi-structured interviews

A semi-structured questionnaire was administered to 30 women with physical disabilities to generate information on access to and utilization of public health services. It covered the health seeking behaviour of WWDs and attitudes of health practitioners towards them while seeking health services from public facilities. Individual experiences on the effects of disability in accessing and utilizing public health services in Nairobi City County were sought as much as views on improvement of reproductive health services for WWPDs (Appendix 1).

### 3.7.2 Key informant interviews

These were held with individuals who were perceived as having specialized knowledge on issues of disabilities. These included four health workers and two NGO officials. The four health practitioners interviewed were staff of Mbagathi District Hospital: a doctor, a nurse, a mid-wife and a public health specialist. The key informants provided information on their experiences and challenges with healthcare services provision to women with physical disabilities and explored the kind of training they have received for such specialized cases. A key informant interview guide (Appendix 2) was used to collect the data.

### 3.7.3 Focus Group Discussions (FGDs)

Focus group discussions were carried out with two groups of physically disabled women: younger WWPDs (18-35 years) and older WWPDs (36-60 years) to determine the different experiences they encounter while seeking reproductive health services. Each of the FGDs consisted of 8 participants purposively selected from the APDK list of registered members. A FGD guide (Appendix 3) was used for these discussions.

### 3.7.4 Observation

The researcher observed health workers, their actions and situations around WWDs. The observation focused on how they treated WWPDs compared to those women who are able-bodied. An observation check list (Appendix 4) was used to obtain the necessary information.

## 3.8 Data processing and analysis

Data collected using the questionnaire was checked for consistency and accuracy of the responses, coded and analyzed using the version 21 of the SPSS statistical programme. Cross tabulations were undertaken to establish linkages between different variables such as age, type of disability, knowledge and usage of public health services. The qualitative data from key informant interviews and FGDs were analyzed thematically and used to enrich the quantitative results obtained from the survey.

## 3.9 Ethical considerations

During data collection, the researcher explained the importance of the research, respect for confidentiality, individual opinion and sought informed consent from all the

respondents interviewed. Given the personal nature of reproductive health and sexuality issues, the respondents did not have to disclose their identity and contact details on the questionnaires. The study protocol ensured that all interviews took place in a private place where only the interviewer and the respondent were present. No interviews were recorded without the express consent of the respondent. The respondent was allowed to skip any questions they did not wish to answer, while they could also make comments or ask questions to the interviewer. The research protocol provided for referral of WWPDs who required help, especially names and contact information of relevant service centres.

The filled questionnaires were kept in the custody of the researcher and no information contained therein was released to a third party. In writing this project paper, the identity of the respondents was concealed.

# CHAPTER FOUR

# OPPORTUNITIES AND CHALLENGES FACED BY WOMEN WITH PHYSICAL DISABILITIES

## 4.1 Introduction

This chapter presents the findings of the research topic. Demographic results are presented first followed by results on specific objectives.

## 4.2 Socio-demographic results of the respondents

### 4.2.1 Age

Results in Figure 4.1 indicate that 63% of the respondents were aged 18 to 35 years while 29% were aged 36 to 45 years. A further 8% of the respondents were 46 to 55 years of age (Fig. 4.1). This implies that a majority of the respondents were in the age category of the youth.

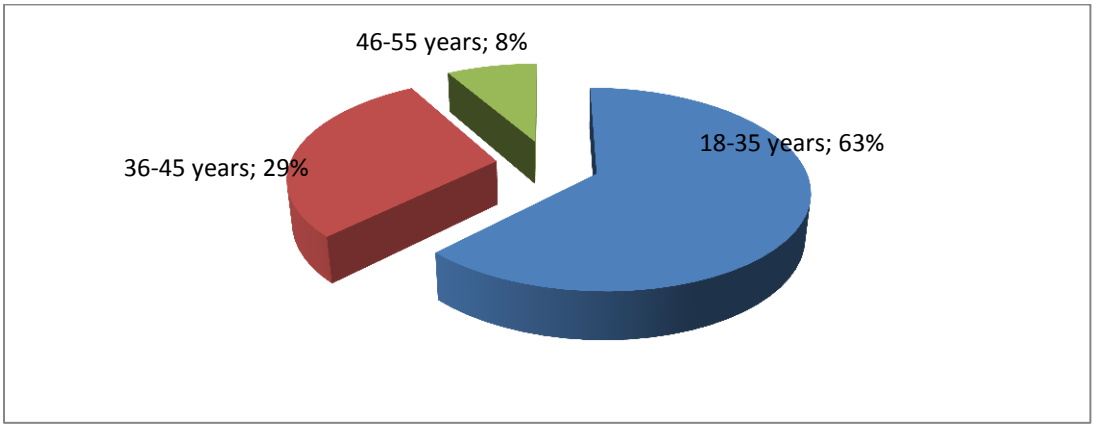


**Figure 4.1: Age of respondents**

### 4.2.2. Educational level

Findings in Figure 4.2 reveal that 67% of the respondents had secondary school education while 25% had college level education. Only 8% of the respondents had university level education, implying that most of the respondents have low levels of education.

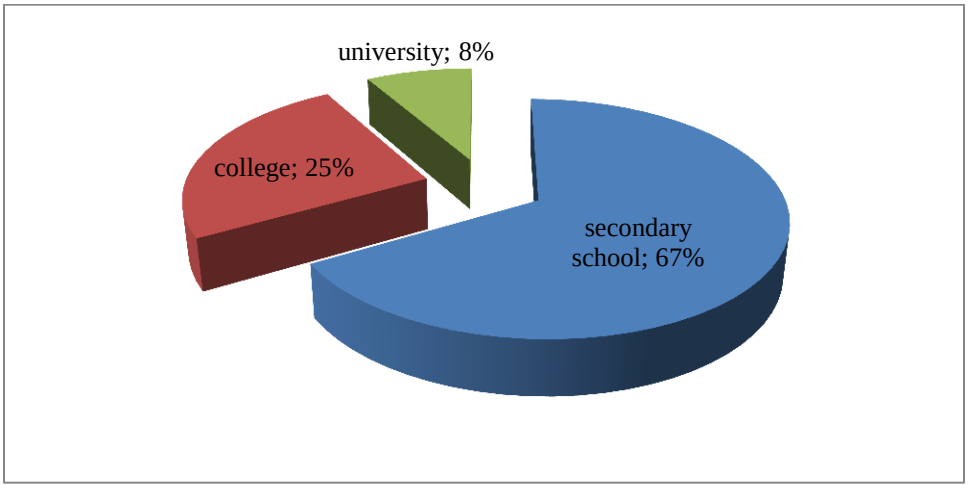


**Figure 4.2: Education level of respondents**

### 4.2.3 Occupation

Results in Table 4.1 stated that 20.8% of the respondents were not employed, while 12.5% indicated that they were hawkers. A further 12.5% of the respondents said that they were business women and 8.3%indicated that they were house wives. About four per cent (4.2%) of the respondents indicated that they were field workers, while another 4.2% said that they were health workers. The remaining ones belonged to the following occupation: 4.2% were receptionists; 4.2% were secretaries; 4.2% were special education teachers; and finally, 4.2% were therapists. The diversity of these occupations is a clear indication of the potential and opportunities which women with

physical disabilities can use to challenge stereotypes of dependency on their families and relatives for survival.

**Table 4. 1: Occupation of respondents**

| Occupation | Frequency | Percentage |
|---|---|---|
| Administrative Assistant | 1 | 4.2% |
| Business woman | 3 | 12.5% |
| Community | 1 | 4.2% |
| Field worker | 1 | 4.2% |
| Hawker | 3 | 12.5% |
| Health worker | 1 | 4.2% |
| House keeper | 1 | 4.2% |
| House wife | 2 | 8.3% |
| Nurse | 1 | 4.2% |
| Receptionist | 1 | 4.2% |
| Secretary | 1 | 4.2% |
| Stationery | 1 | 4.2% |
| Teacher - special education | 1 | 4.2% |
| Therapist | 1 | 4.2% |
| Unemployed | 5 | 20.8% |
| **Total** | **24** | **100.0%** |

## 4.3 Accessibility

Respondents were asked to indicate their understanding of accessibility to a public health service by a person with disability. Slightly less than half (47%) of them understood the question to refer to proper services while 43% said it is facilitation of mobility. On the other hand, 10% of the respondents did not understand the question because they said accessibility is not easy. The findings imply that most of the respondents (90%) are aware of what accessibility means.

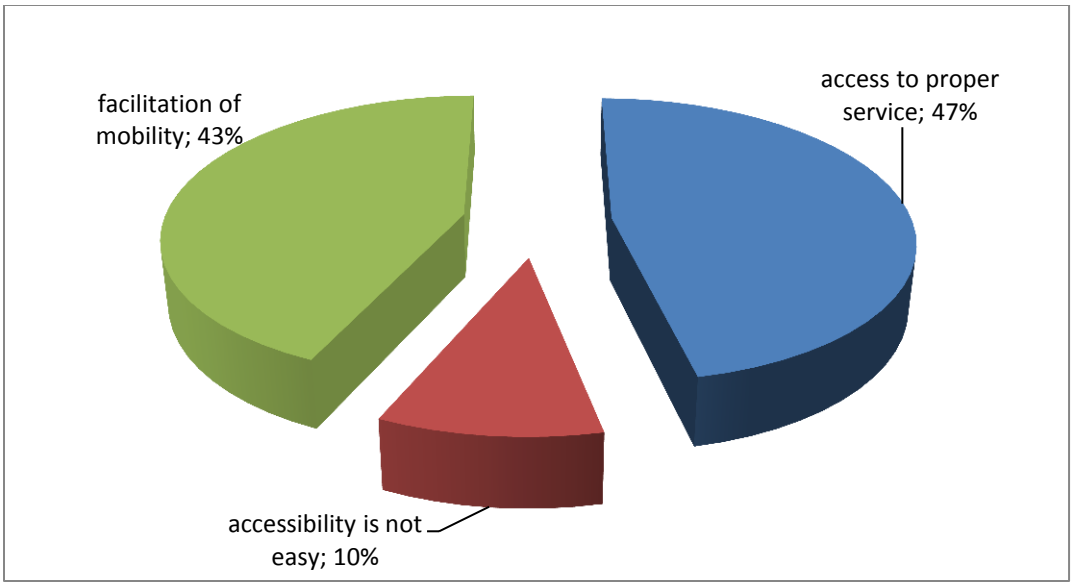


**Figure 4.3: Accessibility to facilities**

The results were confirmed by focus group discussion that accessibility is access to healthcare services and facilitation of mobility. The key informants said that accessibility is access to proper health services, ability to move easily to a place of need and a friendly environment. However, some did not understand what accessibility was, since they described it as lack of equipment.

## 4.4 Opportunities available for women with physical disabilities in accessing and utilizing public health services in Nairobi City County

### 4.4.1 Improving accessibility of women with physical disabilities to public hospitals

The respondents were asked in which way they thought accessibility to public hospitals could be improved for women with physical disabilities. About forty six per cent (45.8%) of them said that more ramps should be built in public hospitals. On the other hand, 16.7% indicated that more wheel chairs should be provided to women with

disabilities while 12.5% said that public hospitals should provide low beds. These and other responses are summarized in Table 4.2.

**Table 4. 2: Ways of improving accessibility in health facilities**

| **Response** | **Frequency** | **Percentage** |
|---|---|---|
| Building more ramps | 11 | 45.8 |
| Clear road network | 1 | 4.2 |
| Comfortable floor | 1 | 4.2 |
| Free medication | 1 | 4.2 |
| Make wide doorways | 1 | 4.2 |
| Patience in matatu | 1 | 4.2 |
| Provide low beds | 3 | 12.5 |
| Provide wheel chair | 4 | 16.7 |
| Special wings | 1 | 4.2 |
| **Total** | **24** | **100** |

These results were confirmed by the FGDs, in which it was agreed that building ramps and providing wheel chairs are opportunities for women with physical disabilities to access public health facilities. The key informants also stated that accessibility can be improved by building more ramps and more disability friendly toilets. They further indicated that accessibility can be improved by training more personnel while others explained that public hospitals should buy more wheel chairs to improve accessibility.

The results from the observation revealed the following opportunities that women with physical disabilities can utilize to maximize on the health services at public hospitals: drinking fountains of 0.61 metres above the ground, a parking with a raised platform to allow for unassisted entry and exit from a car using a wheel chair; ramps; and a seating area with fifty movable seats.

### 4.4.2 Reproductive services needed by women with physical disabilities

The respondents were asked about some of the services that a woman with physical disability may need from a public hospital. About forty-two per cent (41.7%) said that they would need family planning services and voluntary counselling and testing (VCT) services while 4.2% said that they would need free checkups. Other reproductive services include: Free maternity services in public hospitals (20.8%); free medical and general health services (8.4%); and special care during delivery (20.8%). On the other hand, 4.2% of the respondents did not understand the question as they said that low toilets are very few. These responses are summarized in Table 4.3 below.

**Table 4. 3: Reproductive services needed by women with physical disabilities**

| **Response** | **Frequency** | **Percentage** |
|---|---|---|
| Family planning and VCT services | 10 | 41.7 |
| Free checkups | 1 | 4.2 |
| Free maternity | 5 | 20.8 |
| Free medical | 1 | 4.2 |
| General health services | 1 | 4.2 |
| Low toilet are few | 1 | 4.2 |
| Special care during delivery | 5 | 20.8 |
| **Total** | **24** | **100** |

Focus group discussions also indicated that family planning services, VCT services and free maternity as some of the services that a woman with physical disability needs from a public hospital. One key informant observed that there is need for a sign language specialist while another pointed out that women with physical disabilities could benefit from a public hospital which has disability friendly trained specialists. Other key informants thought that disability friendly facilities would provide opportunities for women with physical disabilities to access a public hospital.

### 4.4.3 Existing public facilities to help a woman with multiple severe physical disabilities

Respondents were further asked to indicate the kinds of facilities which a woman with multiple severe physical disabilities would need to ensure that she is served effectively by a gynaecologist in a public hospital. About a third (33.3%) argued that there are no specialized facilities to help women with multiple severe disabilities while 20.8% indicated that there are no special reception tables and examination tables in public hospitals. A further 16.7% indicated that there are no special care units in public hospital while 8.3% said that they did not know of any such facility in a public hospital. Finally, 8.4%observed that there were no interpreters and disability friendly facilities in public hospitals, while 4.2% said that public hospitals should provide special attention to women with physical disabilities (Table 4.4).

**Table 4. 4: Existing public facilities to help women with multiple severe disabilities**

| Response | Frequency | Percentage |
|---|---|---|
| Clean low toilet | 1 | 4.2 |
| I don't know | 2 | 8.3 |
| No interpreters | 1 | 4.2 |
| No facility | 1 | 4.2 |
| No special reception tables and low examination bed | 5 | 20.8 |
| No special care units | 4 | 16.7 |
| No specialized facilities | 8 | 33.3 |
| Only thing that exist is free maternity | 1 | 4.2 |
| Should provide special attention | 1 | 4.2 |
| **Total** | **24** | **100** |

### 4.4.4 Services provided by public hospitals to women with physical disabilities

The respondents were asked about some of the services provided by public hospitals to women with physical disabilities. According to the findings in Figure 4.4, 34% of the respondents did not utilize some of the available services due to lack of a sign language specialist in the hospital, while 22% indicated that the hospital did not have custom made services for women with physical disability. However, 22% of them stated they get family planning services at the hospital, while 11% indicated that most women with physical disabilities shy away from these services. Finally, another 11% said that they do not know of any services offered to women with physical disabilities in that hospital.

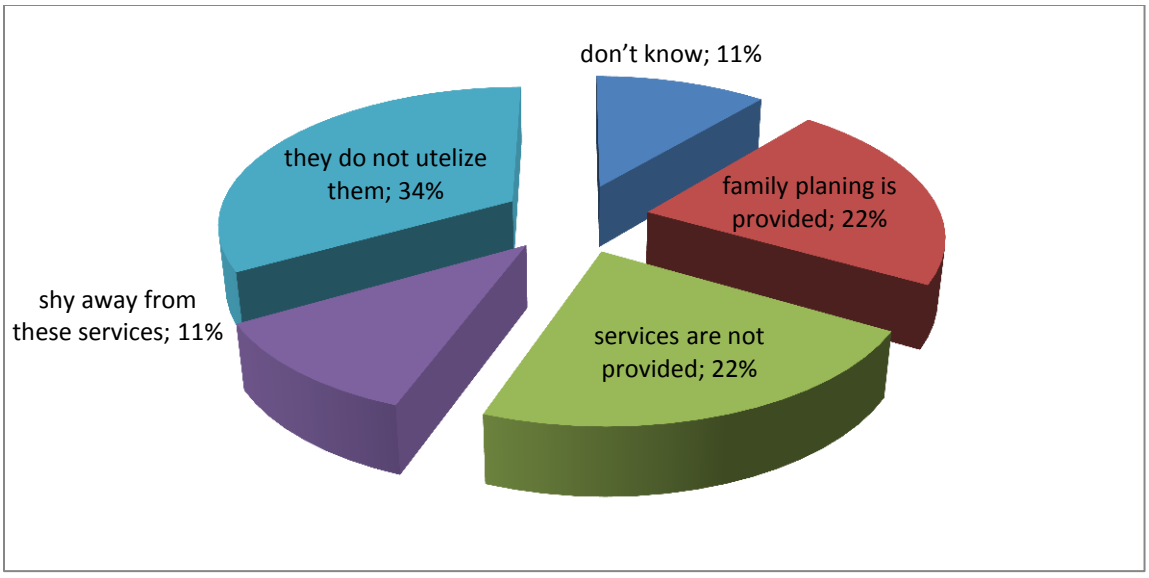


**Figure 4.4: Services provided by public hospitals to women with physical disabilities**

## 4.5 Challenges encountered by women with physical disabilities in accessing and utilizing health services in public hospitals

### 4.5.1 Challenges facing women with physical disabilities in accessing health facilities

The respondents were asked to state some of the challenges facing women with physical disabilities in accessing health services at public hospitals. In particular the respondents were probed for mode of transport, i.e, boarding and alighting with wheelchairs; entrance into the health facility, e.g, signage; ramps; and lifts which do not announce the floor. Forty per cent of the respondents indicated that lack of facilities such as wheel chairs, signage and lifts as the main challenges they face. On the other hand, 16% said that they experience difficulties in boarding and alighting from public vehicles because they are not adapted to disability and that there is no real time assistance provided by public transport service providers. Other challenges include

slippery floors (16%), insensitive professional and social environment (24%);and lack of help from some nurses (4%). These responses are presented in Figure 4.5.

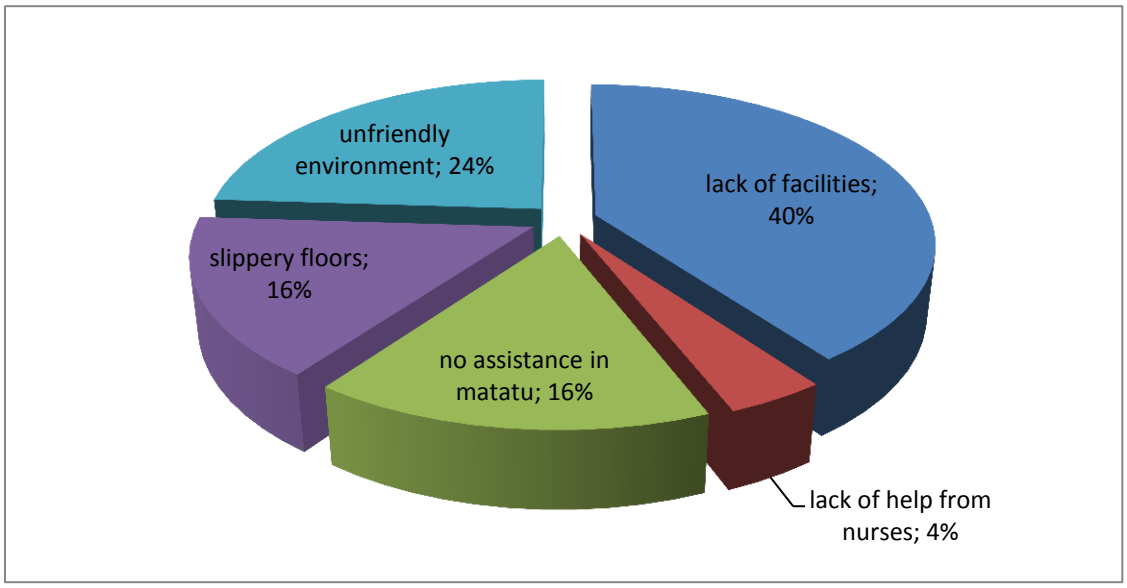


**Figure 4.5: Challenges encountered by women with physical disabilities in accessing health facilities**

Focus group discussions also revealed that lack of facilities such as low beds, low toilets, ramps and wheel chairs were among some of the severest challenges facing women with physical disabilities accessing facilities in public hospitals. The key informants corroborated the information provided by the FGDs. In their view the challenges include lack of appropriate vehicles, lack of ramps and appropriate toilets, lack of appropriate beds, lack of wheelchairs and mishandling by nurses.

### 4.5.2 Challenges facing women with physical disabilities in utilizing health services in public facilities

The respondents were asked to state the challenges they face in utilizing the services provided at public facilities. About thirty-eight per cent (37.5%) indicated that there is communication barrier between women with physical disability and doctors, especially in terms of sign language. On the other hand, 29.2% of the respondents indicated that there are inadequate sign language interpreters while 12.5% argued that there is less attention paid to women with physical disabilities by doctors and nurses. Other challenges included: Lack of audio facilities for the deaf and lack of brailed registry for the visually impaired (4.2%); lack of brailed contraceptives for the visually impaired (4.2%); and poor infrastructure (4.2%). These responses are summarized in Table 4.5.

**Table 4.5: Challenges facing women with physical disabilities in accessing health facilities**

| Response | Frequency | Percentage |
|---|---|---|
| Communication barrier between doctors and patient with disability | 9 | 37.5 |
| Few facilities | 2 | 8.3 |
| Inadequate sign interpreters | 7 | 29.2 |
| Less attention from doctors and nurses as they see disabled women as a burden | 3 | 12.5 |
| No audio for the deaf or brailed registry | 1 | 4.2 |
| No brailed contraceptive for women with disability | 1 | 4.2 |
| Poor infrastructure | 1 | 4.2 |
| **Total** | **24** | **100** |

The above results were supported by findings from observation, which revealed that there was no provision for the use of wheel chair at the main gate. Observation also

confirmed that there was no provision for an access route from the main gate to the entrance of the main hospital building by a person with disability intending to access the health facility.

In addition, observation revealed that there were no parking lots with accessible space for use by PWDs, no appropriate signage, no lifts, no appropriate toilet facilities, no stalls for washroom and toilets which have been custom made for use by PWDs and no wheelchairs in the assembly area.

### 4.5.3 Suggestions for improvement of utilization of health services in public hospitals

The respondents were asked to indicate the way in which the administration of public hospitals can improve the utilization of health services for women with physical disabilities. Twenty-five per cent indicated the need to improve facilities such as beds and toilets while 25% stated that they should provide special units in public hospital. On the other hand, 20.8% of the respondents said that more nurses and doctors who deal with disability only should be employed. Other suggestions included: construction of more ramps and floors that are not slippery (16.7%); construction of appropriate corridors and doorways (8.3%); and preferential treatment of WWPDs (4.2%). These responses are presented in Table 4.6 below.

**Table 4.6: Suggestions for improvement of utilization of health services at public hospitals**

| Response | Frequency | Percentage |
|---|---|---|
| Build ramps and un-slippery floor | 4 | 16.7 |
| Employ more nurses and doctors who deals with disabled only | 5 | 20.8 |
| Improve facilities such as toilets, bathrooms and beds to be disability friendly | 6 | 25 |
| Improve the physical environment like corridor and door ways | 2 | 8.3 |
| Provide first service for PWDs | 1 | 4.2 |
| Provide special unit for PWDs | 6 | 25 |
| **Total** | **24** | **100** |

In focus group discussions, participants agreed that public hospitals should improve facilities such as building low toilets, ramps and low examination beds as well as provide special units for women with physical disabilities. On their part, some key informants suggested that public hospitals should provide facilities that are friendly to people with physical disabilities while others stated that they should provide specialists who can handle women with physical disabilities.

### 4.5.4 Strategies the Government of Kenya should adopt to ensure that issues of concern to WWDs are prioritized in the national agenda

The respondents were asked to indicate what strategies they think the Government of Kenya should adopt to ensure that issues of concern to women with physical disabilities are prioritized in the national agenda. Table 4.7 indicates that 20.8% suggested that the government should build more hospitals for PWDs, while 12.5% indicated that women with disabilities should be exempted from taxation. A

further 8.3% indicated that a female representative should be elected to represent women living with physical disabilities, while a similar member suggested that the government should implement all aspects of the Disability Act of 2003. Another 8.3% stated that the government should provide special institutions where women with disabilities can be taught tasks such as tailoring, baking, etc.

Other suggestions included allocation of funds to support the women with physical disabilities (8.3%), construction of low toilets, ramps and floors which are not slippery in public hospitals (4.2%), provision of vehicles which are adapted to disability (4.2%), employment of doctors specialized in handling disability (4.2%), sensitizing citizens on behaviour change towards women with physical disabilities (4.2%), according equal opportunities to women with physical disabilities (4.2%), provision of counselling services seminars for women with disabilities (4.2%), and provision of mobile doctors to serve women with disabilities wherever they are (4.2%). These findings were confirmed by focus group discussions and key informants as summarized in Table 4.7 below.

**Table 4.7: Strategies for prioritization by the Government of Kenya**

| Response | Frequency | Percentage |
|---|---|---|
| Allocate funds to support women with disabilities | 2 | 8.3 |
| Build hospital for PWDs | 5 | 20.8 |
| Build low toilets and ramps that are not so slippery | 1 | 4.2 |
| Buy vehicle for disabled in hospital | 1 | 4.2 |
| Elect female representative to represent disabled | 2 | 8.3 |
| Employ special doctors for PWDs | 1 | 4.2 |
| Empower citizen on behaviour change toward disabled | 1 | 4.2 |
| Empower disabled and give them opportunity just like others | 1 | 4.2 |
| Give wheelchairs free to disabled | 1 | 4.2 |
| Implement all aspect of the disability act of 2003 | 2 | 8.3 |
| Provide counseling and seminars for disabled | 1 | 4.2 |
| Provide mobile doctors in remote areas | 1 | 4.2 |
| Provide special institution | 2 | 8.3 |
| Tax exemption | 3 | 12.5 |
| **Total** | **24** | **100** |

# CHAPTER FIVE

# DISCUSSION AND CONCLUSIONS

## 5.1 Introduction

This chapter discusses the findings in relation to the study objectives. Following the discussions, conclusions are drawn and recommendations made.

## 5.2 Discussion

### 5.2.1 Opportunities available for women with physical disabilities in accessing and utilizing public health services in Nairobi City County

The first objective of this study was to establish opportunities available for women with physical disabilities in accessing and utilizing public health services in Nairobi City County.

Findings from semi-structured interviews suggest that the main opportunities available for WWPDs in as far as accessing and utilizing services offered at public hospitals would be the building of more ramps, provision of wheelchairs, and provision of low beds. Other issues have to do with free medication, non-slippery floors and establishment of special wings for WWPDs. These findings were backed with those from focus group discussions and key informants.

The availability of drinking fountains which are 0.61 metres above the ground within the compound; a parking lot with a raised platform to allow for unassisted entry and exit from a car using a wheel chair; and the fact the public hospitals have ramps and a seating area of fifty with movable seats at the assembly were presented

opportunities for all women with physical disabilities to utilize health services in Nairobi City County.

The respondents identified disability centered family planning and VCT services (41.7); free checkups (4.2%); free maternity services in public hospitals (20.8%); while 8.4% identified free medical and general health services (8.4%) as opportunities which women with physical disabilities have to utilize health services in public hospitals. Those who did not understand said that low toilets were very few (4.2%) while 20.8% indicated that WWPDs be given special care during delivery. These results were shared by the FGDs and key informants (45%) who want all the personnel in public hospitals to be trained in disability sensitivity.

The respondents, through semi-structured interviews, were asked to point out the kinds of facilities existing in public hospitals to help a woman with multiple severe disabilities to be served by a gynaecologist. Around thirty-four per cent (33.3%) argued that there were no specialized facilities to help women with multiple severe disabilities while 20.8% indicated that there were no special reception tables and examination tables in public hospitals. A further 16.7% indicated that there were no special care units in public hospitals while 8.3% revealed that they did not know of any specific facility in public hospital. Around nine per cent (8.4%) indicated that there were no interpreters and facilities in public hospitals. On the other hand, about five per cent (4.2%) said that public hospitals should provide special attention to women with physical disabilities. This implies that there are few opportunities to help a woman with multiple severe disabilities to be served by a gynaecologist.

The respondents were further asked to identify the kind of services public hospitals provide to women with physical disabilities. Thirty-four per cent stated that they did not utilize the services due to lack of sign language specialist; while a further 22% said that they get family planning services in public hospitals. Eleven per cent revealed that most women with disabilities shy away from these services while others stated that they did not know disability specific services offered in public hospitals.

### 5.2.2Challenges encountered by women with physical disabilities in accessing and utilizing public health services in Nairobi City County

The second objective of this study was to assess the challenges encountered by women with physical disabilities in accessing and utilizing public health services in Nairobi City County.

Forty per cent of the respondents identified the lack of facilities such as wheelchairs, signage and lifts as the main challenges faced by women with physical disabilities. Other challenges faced include difficulties in boarding and alighting from public vehicles as there is no one to assist; slippery floors in public hospitals, a disability insensitive environment and insensitive medical staff to handle concerns of women with disabilities around and within the public hospitals.

Focus group discussions confirmed that women with physical disabilities did not have access to and could not utilize facilities such as low beds, low toilets, ramps and wheelchairs in public hospitals. This is partly due to the cost of reaching the health facility, for example, having to pay for an assistant to get them to the public hospital.

Forty five per cent of the key informants identified difficulties in mobility by women with physical disabilities since public service vehicles are not adapted to disability. This view was also held by 11% of the respondents who believed that WWPDs are mishandled by nurses in public hospitals due to such factors as communication breakdown between them and the nurses who are not conversant with sign language.

About thirty per cent (29.2%) of the respondents believed that the inadequate number of sign language interpreters affects the attention of doctors and nurses from providing services to WWPDs. The situation is exacerbated by poor infrastructure, the absence of audio facilities, brailed registry and brailed contraceptives to assist the visually impaired women access and utilize these services in health facilities in Nairobi City County.

Findings from observation indicated that there was no provision for use of wheelchairs at the main gate as well as an access route from the main gate to main building. There were no parking lots with accessible space for use by WWPDs, no appropriate signage to indicate that the parking was custom made for PWDs and that none of the entrances had been designed to comply with disability sensitivity.

Mbagathi District Hospital, a public hospital in Nairobi City County, had been purposively sampled in this study for observations. It was found that the hospital is a one storeyed building without elevators. Every floor did not have appropriate and detectible signage to indicate the location of specific facilities while the ramps did not change direction at landing and did not have handrails. There were no stalls for

washrooms and toilets which have been adapted to disability; no wheelchairs were provided in the assembly area and the seats were not identified by signs or markers, to notify PWDs of the availability of such seats. Further, there were no hearing aids provided where audible communications are integral part of the hospital operation.

## 5.3 Conclusions

The subjects in this study conveyed an understanding of accessibility to buildings and utilization of health services in public hospitals.

The study found that the main opportunities available for WWPDs in accessing and utilizing services offered by public hospitals would be the building of more ramps and the provision of wheelchairs and low beds. Other facilities would be the provision of free medication, non-slippery floors and establishment of special wings for WWPDs.

The study also established that challenges of accessing and utilizing health services in public hospitals by women with physical disabilities exist. They included lack of facilities such as wheelchairs, lifts, appropriate signage and lack of washrooms which have been custom made for use of PWDS. Others were discrimination, unavailability of hearing aids, access routes from the main gates of public hospitals to the main buildings and difficulties in boarding and alighting from public vehicles.

In the study, it was found that women with disabilities experienced multiple challenges in accessing and utilizing public health services as compared to able-bodied women. Therefore, this turned out to be double tragedy for WWPDs as they strived to attain normal healthy lives.

## 5.4 Recommendations

This study provides recommendations for public hospitals as well as policy makers on the following:

- The public hospital administration should ensure facilities such as low beds and low toilets in the hospitals; special units for women with physical disabilities; ramps and floors that are adapted to disability; widen corridors and doorways and give priority services to the WWPDs in the public hospitals.

- Public hospitals should provide facilities that are disability friendly, starting with trained personnel who are able to handle women with physical disabilities. .

- Public hospitals should provide counselling seminars for women with physical disabilities. This can be done through outreach programmes and involvement of mobile medical professionals including doctors, nurses and counselors.

- The government should implement all aspects of the Disability Act (2003). The political good will should be backed by level of funds allocated by treasury and advocacy programmes on women with physical disabilities. This should include tax exemption for the women with physical disabilities and sensitization workshops on behavior change to demystify their condition and status in society.

- It was recommended that the government enacts a law to ensure certain transport sectors design public vehicles which accommodate the needs of PWDs. This should be supported by improved infrastructure for women with physical disabilities to access and utilize the services provided by these vehicles.

- The government should provide vehicles which are adapted to disability in public hospital. Further, it should employ doctors and nurses who are trained in disability issues to motivate the WWPDs to come for health services at the hospital.
- The government should build or establish special units for women with disabilities in all public hospitals countrywide. It was recommended that a female with physical disability representative be vetted for appointment with the objective of championing the rights of women with physical disabilities.
- This study recommends a comparative study of a county to county level that may indicate whether the opportunities and challenges differ regionally. Further comparative studies can be conducted to assess whether the challenges differ across age and gender.
- Another area of study would be to investigate whether the private health facilities are also plagued by challenges in the provision of health services to women with physical disabilities.

## REFERENCES


Barnes, C. (1991). Disabled People and Discrimination in Britain: The Case for Anti-Discrimination Legislation, Hurst & Co, London.

Becker, G. (1997). Disrupted Lives: *How People Create Meaning in a Chaotic World*. Berkeley: University of California Press.

Brooks, N. (1991). Self-empowerment among adults with severe physical disability: A case study. *Journal of Sociology and Social Welfare, 18(1), (105-120).*

Brzuzy, S. (1997).Deconstructing disability: The impact of definition. *Journal of Poverty, 1(1), (81-91).*

Charlton, J. (1998). Nothing About Us Without Us: Disability, Oppression and Empowerment, University of California Press, Berkeley.

Colin, B. (1991). *Disabled people in Britain and discrimination: A case for Anti-discrimination legislation.* London: C. Hurst& Co. Publishers

Devlin, R. and Pothier, D. (2005). 'Introduction: *Toward a Critical Theory of Dis-citizenship' in R Devlin and D Pothier (eds) Critical Disability Theory: Essays in Philosophy, Politics, Policy, and Law* (University of British Columbia Press, Vancouver 2005).

Finkelstein, V (1980). *.Attitudes and Disabled Persons Geneva*, World Health Organization

Franklin, P. (1977). Impact of Disability on the Family Structure. *Social Security Bulletin, 40(5): (3-18).*

Hahn, H. (2005). Academic debates and political advocacy: The U.S. disability movement. In G. E. May & M. B. Raske (Eds.), Ending disability discrimination: *Strategies for social workers (pp. 1-24).* Boston: Pearson Education, Allyn & Bacon.

Hahn, H. (1983). Paternalism and public policy. Society, 20, (36-46).

Hosking D (2008) ‘Critical disability theory’, paper presented at the 4th Biennial Disability Studies Conference, Lancaster University, 2–4 September.

James .I. Charlton (1998).*Nothing about us without us: Disability, oppression and empowerment.* University of California Press, Berkley.

Kenya National Survey for Persons with Disabilities (2008). Preliminary report available at www.afri-can.org.

Kothari, C. R. (2008).*Research Methodology: Methods and Techniques*. New Delhi: New Age International

Len Barton and Mike Oliver, Editors (1997). Disability studies: Past, Present and Future Leed: The Disability Press.

Mackelprang, R. and Salsgiver, R. (1999). Disability: A diversity model approach in

human service practice. Belmont, CA: Brooks/Cole.

Mugenda, A. and Mugenda, O. (2005). *Research Methods: Quantitative and Qualitative approaches.* Nairobi: African Centre for Technology Studies

NGO Shadow Report to the UN CEDAW Committee (2004) *"On the implementation of CEDAW and women's human rights in Bosnia and Herzegovina"* available at iwraw-ap.org**.**

Oliver, M. (1990).*The politics of disablement: A sociological approach*. New York: St. Martin's Press.

Oliver, M. (1998). Theories in health care and research: Theories of disability in health practice and research BMJ: British Medical Journal.

Oliver, M. (1996).*Understanding disability: From theory to practice.* Basingstoke, UK Macmillan.

Parmenter, T.R. (2008). The present, past and future of the study of intellectual disability: challenges in developing countries. *Salud Publica De Mexico, 50, suppl 2, S124-S131.*

Persons with Disabilities Act enacted in Kenya (31 December 2003).

Priestley, M. (1999).*Disability politics and community care*. London: Jessica Kingsley.

Quinn, G. (2002). *Human Rights and Disability: The current use and future potential of United Nations human rights instruments in the context of disability*. New York: United Nations

Quinn, P. (1995a). Social work education and disability: Benefiting from the impact of the ADA. *Journal of Teaching in Social Work, 12(1), (55-71).*

Quinn, P. (1995b). Social work and disability management policy: Yesterday, today, and tomorrow. *Social Work in Health Care, 20(3), 67-82.*

Rannveig Traustadottir and Kelley Johnson (2006). *Women with intellectual disabilities: Finding a place in the world.* London: Jessica Kingsley Publishers.

Republic of Kenya (2010).Constitution of Kenya 2010.

Republic of Kenya (2008).*Planning bulletin article on disability mainstreaming in policy and planning* by the Ministry of State for Planning, National development and Vision 2030.

Shaul S, Dowling PI, Laden BE (1985). Like Other Women: Perspectives of Mothers with Physical Disabilities. In Deegan MJ, Brooks NA (Eds).*Women and Disability: The Double Handicap.*Oxford; transaction Books.

Thomas, C. (1999).Female Forms: Experiencing and Understanding Disability. Buckingham: Open University Press.

United Nations (2006). Convention on the Rights of Persons with Disabilities, New York: Convention, International.

Wasilwa, G. (2012).*Sexual Harassment of Women Employees at Kenyatta National Hospital, Nairobi County*.M.A project paper, Institute of Anthropology, Gender and African Studies.

WHO (2001).International Classification of Functioning Disability and Health (ICF) Karp, Gary "Early history of disability" available at www.lifeonwheels.net/ writings/history.html.

www.un.org/disabilities

## APPENDICES

### APPENDIX 1: SEMI-STRUCTURED QUESTIONNAIRE

**NAME OF RESPONDENT (Optional)**

**Introduction**

My greeting to you Madam and thank you for giving me your time, I appreciate it. My name is Leah Mugehera Khasoha, a student from the University of Nairobi. As part of my educational requirement, I am conducting a study on opportunities and challenges faced by women with physical disabilities in accessing and utilizing public health services in Nairobi City County. I am carrying out the study to assess the accessibility to and utilization of health services by women with physical disabilities in Nairobi City County; and the extent to which lack of these facilities affect their day to day lives. You've been selected to answer a set of questions and your clear and forthright feedback will be valuable to the study. Your responses will be held in confidence. Findings of this study will be shared with the university, health facilities and organizations which are to be covered in the study. *The interview will take approximately 30 minutes of your time– Do you agree to be interviewed?* Thank you.

**AGE: 18 -35 YEARS ☐ ; 36 – 45 YEARS ☐; 46 – 55 YEARS ☐; OVER 55 ☐ YEARS**

**LEVEL OF EDUCATION: HIGH SCHOOL ☐ COLLEGE ☐; UNIVERSITY ☐ ADVANCED UNIVERSITY EDUCATION ☐**

**EMPLOYER ……SELF EMPLOYED……. ☐**

**DESIGNATION…….**

**OCCUPATION……..**

1. What is your understanding of 'accessibility to' a public health service by a person with disability? (Give examples) .....

.....

.....

What are some of the challenges facing women with physical disabilities in accessing health services at a public hospital? (Probe for mode of transport i.e. boarding and alighting with wheelchairs; and entrance into the health facility e.g. signage, ramps and lifts which do not announce the floor). .....

.....

2. In which way do you think accessibility to and in public hospitals can be improved for women with physical disabilities?.....

.....

.....

3. What are some of the services that a woman with physical disability may need from a public hospital? (Probe for reproductive health, maternal health and general health services) .....

.....

.....

4. What kinds of facilities exist to help a woman with multiple severe physical disabilities to be served by a gynaecologist? (Probe for special reception tables, examination beds, laboratory facilities, sign language specialist, low toilets etc.) .....

.....

.....

5. What are the challenges faced by women with physical disabilities in utilizing the services provided at public facilities? (Probe for Family planning services by

hearing and visually impaired e.g. public health information and contraceptives which are not brailed and registering for vaccinations for their children). .....

.....

.....

6. How do you think the administration of public hospitals can improve the utilization of health services by women with physical disabilities in the institutions? .....

.....

.....

7. What strategies do you think the Government of Kenya should adopt to ensure that issues of concern to women with disability are prioritized in the national agenda?

.....

.....

.....

## APPENDIX 2: KEY INFORMANT INTERVIEW GUIDE

1. What is your understanding of 'accessibility to' a public health service by a person with physical disability? (Give examples)

   .....

   .....

   .....

2. In your opinion, what are some of the challenges facing women with disabilities to access health services at public health facilities? (Probe inconsistency in return visits).

   .....

   .....

   .....

3. In which way do you think accessibility to and in public hospitals can be improved for women with physical disabilities?

   .....

   .....

   .....

4. What are some of the services public hospitals provide to women with physical disabilities? (Probe for assisted services by sign language specialists, brailed publications, disability friendly examination beds and toilets etc).

   .....

   .....

   .....

5. How readily do women with physical disabilities utilize the services provided at public hospitals? (Probe for family planning services by hearing and visually impaired e.g. public health information and contraceptives which are not brailed and registering for vaccinations for children).

   .....

   .....

   .....

6. How do you think that the administration at public hospitals can improve the utilization of health services by women with physical disabilities in the institution?

   .....

   .....

   .....

7. What strategies do you think the Government of Kenya should adopt to ensure that issues of concern to women with physical disability are prioritized in the national agenda?

   .....

   .....

   .....

## APPENDIX 3: FOCUS GROUP DISCUSSION (FGD) GUIDE

1. Understanding of a public building.
2. Understanding of accessibility.
3. Description of a building that is accessible to persons with disabilities.
4. Description of a building that is not accessible to persons with disabilities.
5. Opportunities available in accessing and utilizing health care services by women with physical disabilities.
6. Challenges encountered by WWPDs to access and utilize health services in a public hospital.
7. Specific aspects to be considered when constructing health facility which is friendly to women with physical disabilities.
8. Opportunities for WWPDs to influence decisions on accessibility to public buildings.
9. Ways in which disability advocacy organizations can contribute to accessibility of public health facilities by WWPDs.
10. Ways in which the constitution of Kenya (2010) may contribute to faster mainstreaming of disability into infrastructural development.

THANK YOU VERY MUCH FOR YOUR TIME

## APPENDIX 4: OBSERVATION CHECK LIST

| FACILITY/ SERVICE | FEATURES TO BE OBSERVED |
|---|---|
| Car park | - Presence/ absence of reserved parking for PWDs<br>- Signage for the parking<br>- Assistance and security around the parking area |
| Entrance and exits | - Signage<br>- Slippery / non- slippery floors<br>- Partition for pedestrians and PWDs<br>- Width and height of doors<br>- Emergency exits<br>- Ramps at the entrances |
| Lifts | - Height of buttons<br>- Lighting in the lifts<br>- Signage |
| Ramps | - Signage<br>- Texture of the floor<br>- How sharp the ramps are |
| Toilets | - Low and dedicated for PWDs<br>- Availability of water in toilets |
| Beds | - Trolley beds<br>- Low beds<br>- Adjustable beds |
| Assistance | - Assistants to help PWDS around the health facility |