

**THE CHALLENGES WOMEN WITH DISABILITIES FACE IN ACCESSING  
REPRODUCTIVE HEALTH SERVICES IN PUBLIC HEALTH FACILITIES IN  
NAIROBI**

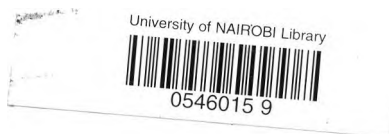
A RESEARCH PROJECT SUBMITTED BY  
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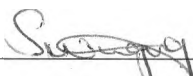
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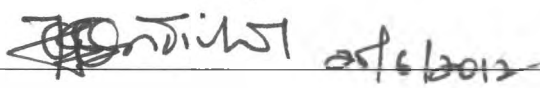


## DECLARATION

THIS RESEARCH PROJECT IS MY ORIGINAL WORK AND HAS NOT BEEN SUBMITTED FOR ANY DEGREE IN ANY OTHER UNIVERSITY

 19/06/12  
\_\_\_\_\_  
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THIS RESEARCH PROJECT HAS BEEN SUBMITTED FOR THE EXAMINATION WITH MY APPROVAL AS THE UNIVERSITY OF NAIROBI SUPERVISOR

  
\_\_\_\_\_  
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## ABSTRACT

Whilst the importance of reproductive health has been acknowledged in international agreements, many countries do not consider sexual health as a legitimate health issue. Women with disabilities face major challenges in realizing their Sexual and Reproductive Health (SRH) due to the challenges they face in hospitals. The research aimed to explore the challenges that women with disabilities face while accessing SRH services in public hospitals in Nairobi. The study specifically assessed public health institutions where women with disabilities access SRH services.

The social model of disability was used in order to better understand the challenges that women with disabilities face while accessing SRH services in public health facilities. A qualitative approach was applied in carrying out the research. An in-depth literature review on understanding disability and sexual and reproductive health was done. Over a period of two months, in-depth interviews and informal discussions were carried out to collect data from women with disabilities who have accessed SRH in public health facilities in Nairobi.

The research findings reveal that women with disabilities seek various services related to their SRH in public hospitals including Kenyatta National Hospital-the largest referral hospital in Eastern Africa- and Pumwani Maternity Hospital (PMH) the largest hospital that specifically deals with SRH. The services sought included family planning, voluntary counselling and testing, maternity related services and also treatments related to their impairments. The findings further revealed that despite the hospital potential to offer gender sensitive SRH services, women with disabilities face a myriad of challenges in accessing the services. These include difficulties in access to the facilities, negative attitude of medical personnel towards SRH of women with disabilities and lack of measures to make the services friendly to women with various forms of disabilities. As a result, disabled women have not fully benefited from the SRH services offered in the health facilities. Rather than empowering them, to enjoy their SRH and rights, the prevailing situation has served to not only marginalise them but also deny them access to these services.

The study suggests that in order for women with disabilities to enjoy their rights, there is need for certain measures to be put in place. They include awareness on SRH and disability, improving physical access to medical facilities, staff development among medical personnel, and adapting materials to fit persons with disabilities.

## **DEDICATION**

This project is dedicated to my cousin Hannah Wangari, a woman living with disability, with hearing impairments. The research has opened me to the challenges faced by women living with disabilities. In your childhood and adult life, you never experienced the benefit of this kind of knowledge among the community, family and services providers. May your children enjoy all the benefits of a loving mother all their lives.

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## **LIST ACRONYMS AND ABBREVIATIONS**

AIDS	Acquired Immuno-Deficiency Syndrome
CRR	Centre for Reproductive Rights
CRPD	Convention on the Rights of Persons with Disabilities
CWDs	Children with Disabilities
DIG	Disablement Income Group
HIV	Human Immuno-deficiency Virus
IPPF	International Planned Parenthood Federation
KNSPWD	Kenya National Survey for Persons with Disabilities
KNBS	Kenya National Bureau of Statistics
NCAPD	National Coordinating Agency for Population and Development
PMH	Pumwani Maternity Hospital
PDA	Persons with Disabilities Act
PMH	Pumwani Maternity Hospital
PWDs	Persons with Disabilities
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STIs	Sexually Transmitted Infections
UDEK	United Disability Empowerment of Kenya
UPIAS	Union of the Physically Impaired against Segregation
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

## CHAPTER 1

### BACKGROUND TO THE STUDY

#### 1.0 Introduction

The research project explored the challenges that women with disabilities face in accessing Sexual and Reproductive Health (SRH) Services from public health facilities in Nairobi. The World Health Organization (WHO) estimates that nearly 10% of the world's population or 650 million people in the world today are living with disabilities (UN, 2010). Arguably, approximately 5% of the world population is made up of women with disabilities. These women face multiple challenges due to the intersection of gender and disability.

The number of persons with disabilities in the developing countries especially those in Africa is growing at an alarming rate due to various factors including civil war, violent crime, unhealthy living conditions, lack of access to essential services such as health care, knowledge gaps on disability, its causes, prevention and treatment among other factors. In Kenya, the most common forms of disabilities are associated with congenital factors, chronic respiratory diseases, cancer, diabetes, malnutrition, Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) and other infectious diseases. Others are associated with injuries resulting from accidents e.g. road accidents that are quite rampant in Kenya; falls from heights and also violence (Kenya National Bureau of Statistics et al., 2008). While acknowledging that some people are born with different forms of impairments, one can get impairments at any stage in life. The PDA, 2003 defines impairment as any loss or abnormality of psychological or anatomical structure or function.

In particular, Kenyan women with disabilities face numerous challenges related to their Sexual and Reproductive Health (SRH). The World Health Organisation (WHO) defines SRH as a state of complete physical, emotional, mental and social well-being in relation to sexuality, in all matters relating to reproductive system and its functions and processes (UN, 2010). It is not merely the absence of disease, dysfunction or infirmity. It includes access to essential services and information in a timely manner. SRH concerns include maternal and newborn health, family planning, adolescents and youth reproductive health, gender related SRH like sexual gender based violence (SGBV) HIV and AIDS, sexually transmitted infections (STIs), reproductive tract

infections, fertility and cancers of reproductive organs like breast, cervical, uterine and ovarian cancers among others.

For women with disabilities, the SRH concerns are further exacerbated by social attitudes towards sexuality of women with disabilities. SRH services are often not easily available, expensive and out of reach for many. In most areas there is lack of adequately trained professionals to attend to their unique needs. In addition, information on disability related services may not easily be available. Sexual and reproductive health concerns are often not prioritised at family level hence it becomes a major challenge for disabled women who are economically dependent on others for their upkeep and livelihood. Kenyan culture is patriarchal hence the power relations between women and men leave women at a subordinate position. As a result men dominate economically, in decision making and prioritisation of needs. Extensive reading indicates a clear link between poverty and disabilities; certainly, persons with disabilities are among the poorest of the poor in Kenya. The most vulnerable groups among people with disabilities are women, children, elderly people, refugees, displaced persons and migrant workers. Women with disabilities in any social categories face multi-faceted challenges and stigma in accessing SHR services. The aim of this study is to analyse the challenges that women with disabilities face in accessing sexual and reproductive health services.

### **1.1 Statement of the problem**

The Kenya government has in addition to domesticating a number of international conventions enacted legislation and policies to protect the rights of persons with disabilities. These rights are enshrined in the Persons with Disabilities Act (PDA) 2003. The intent is not only to provide equal treatment and opportunity for persons with disabilities, but also to eliminate intentional discrimination and change practices that have a discriminatory impact on persons with disabilities (KNBS and NCAPD, 2008). In addition, the Ministry of Health (MOH) adopted the National Reproductive Health Policy 2009-2015 with the theme: *'Enhancing the Reproductive Health Status for all Kenyans'*. This policy aimed at providing a framework for equitable, efficient, and effective delivery of quality SRH services and emphasized on a need to reach the most vulnerable like Persons with Disabilities (PWDs). However, despite these efforts, women with disabilities continue to face myriad problems in accessing the SRH.

Health facilities are mostly designed with no considerations of PWDs. As a result, accessibility to SRH services like prenatal and postnatal care, services and information related to HIV/AIDS, family planning among others often do not take into considerations impairments of PWDs in enhancing access. For example, public institutions and health facilities lack disability access like wide corridors or lifts make access difficult for persons using wheel chairs, ramps, lifts, disability friendly sanitation facilities among others; and where they are available they are often not in good working conditions. The processes in accessing services from registration to consultations and medication are tedious making it difficult for PWDs to easily get their way. In the labour wards, the beds are high which hinders access for women with physical disabilities.

Women with visual impairment find it difficult to manoeuvre their way around the facilities for the different processes required while long queues are a major obstacle for PWDs. The staffs are mostly not trained and prepared to handle women with disabilities. Therefore, patients with visual and hearing impairments are often accompanied to the health facilities by friends or relatives to assist them. This affects their privacy and confidentiality. On the other hand information regarding various SRH services like family planning, sexual violence and HIV/AIDS is not found in a format that persons with visual or hearing impairments can access. Negative attitudes of staff in service provision on the SRH needs of women with disabilities further complicates things for the PWDs and affect how they access these services. The social attitudes that are commonly held regarding sexuality of PWDs in particular result in differential treatment in access to Sexual and Reproductive Health and Rights (SRHR) of persons living with disabilities (United Nations, 2010).

In most health institutions across Kenya women, with disabilities are barely given any special consideration when they seek services e.g., they have to queue for long hours with other patients. Disability-friendly toilets and other sanitary facilities that meet their specific needs are lacking. The research therefore aimed at looking at these issues as they affect women with disabilities living in Nairobi when they seek SRH services.

## **1.2 Research objectives**

### **1.2.1 General objective:**

To explore the challenges that women with disabilities face while accessing sexual and reproductive health services in public hospitals in Nairobi.

### **1.2.2 Specific objectives:**

- a) To assess the experiences of women with disabilities while accessing SRH services in public hospitals in Nairobi.
- b) To describe the effect of the challenges that women with disabilities face in accessing SRH services to the access and use of these services.

### **1.2.3 Research questions:**

The research questions arising from the above study objectives are:

- a) What are the experiences of women with disabilities in accessing SRH services in public hospitals in Nairobi?
- b) How do the challenges that women with disabilities face in accessing SRH services affect their access and use of these services?

## **1.3 Justification of the study**

Despite the issue of women with disabilities gaining prominence in recent years, available literature reveals gaps in the information on the impact of disabilities on the SRH of women. The challenges that women with disabilities in Kenya face in accessing SRH services has remained mostly invisible. This could be attributed to social attitude towards sexuality and disability and further compounded by the patriarchal culture in Kenya. These include the misconception that disabled people are asexual hence are considered not sexually active, not use drugs and are at less risk of violence or rape than the non-disabled people. This then affects how their issues are addressed in the context of HIV/AIDS and other Sexually Transmitted Infections (STIs) prevention (South African National AIDS Council, 2008)). In addition, there are commonly held assumptions that disabled people do not want to have sex or intimate relationships and/or cannot experience sexual pleasure; their bodies are ugly, shameful and/or unattractive(Maxwell, et al 2007).

The research will therefore contribute in highlighting and therefore giving visibility to the plight of women with disabilities in relation to their SRH. In particular the study will be of great interest to inform the Ministry of Health officials and policy makers in coming up with policies that specifically address these challenges. It will also contribute to knowledge in the field of disability and SRH and inform stakeholders in this field. They include health service providers, academicians, researchers, students and community workers. This will therefore contribute in enabling women with disabilities full enjoyment of their sexual and reproductive health rights.

#### **1.4 Scope and limitations of the study**

This study focused on a selected number of women with disabilities living in Nairobi who have accessed SRH services from a public facility in Nairobi. The research was limited to adult disabled women in the reproductive age hence targeted those aged between 18 and 45 years. The actual sample of women, who were interviewed in this research, was women aged between 30 and 49 years of age. The research also aimed to get views from real life experience of women and especially women who have accessed pre and postnatal care hence more interactions with health facilities.

The study faced various limitations. There is lack of statistical data on women with disabilities hence the study could not establish the actual number of population of women with disabilities in the study area. There was also limitation of the sample population hence the sample was not large enough for generalised conclusions of the study. Some of the women with disabilities refused to participate in the study after initially agreeing due to the sensitivity of the SRH issues hence the sample size was small. The study anticipated limitations on language barrier hence a need to involve interpreter for sign language for women with hearing impairments. However the respondent with hearing impairments was interviewed through writing. This limited the depth that could be achieved using probing questions. Hence this may affect the accuracy and interpretation of data gathered.

#### **1.5 Definition of key concepts**

In this study report the following terms are used:

- **Disability:** The concept of disability has been defined by various organizations and institutions in different ways. In Kenya, disability has been defined in the Persons with Disability Act of (PDA) 2003, of Kenya, 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 (GoK, 2004). On the other hand, World Health Organization (WHO) defines disability as any restriction or lack of ability to perform an activity in manner within the range considered normal for a human being (Ingstad and Grut, 1995). In this paper the term 'Disability' is used to refer to any biological, physical or mental impairment that limits major life activities like walking, hearing, speaking, seeing, intellect among other day to day activities and motions that human beings engage in. This will not include persons who are able to engage in the said activities with assistance of a device that has become commonly used like wearing glasses for people with some impairments of sight.
- **Impairment** - The PDA defines impairment as any loss or abnormality of psychological or anatomical structure or function. In this paper impairment is used to refer to any loss or abnormality of a body organ(s) that makes it difficult or impossible for the person to engage in normal daily activities.
- **Sexual and Reproductive Health** - WHO defines SRH as a state of complete physical, emotional, mental and social well-being in relation to sexuality, in all matters relating to reproductive system and its functions and processes. It is not merely the absence of disease, dysfunction or infirmity. This definition will be used in this study to include access to pre natal and post natal care, access to maternity services, HIV/AIDS and reproductive health check-ups for women.

## CHAPTER 2

### LITERATURE REVIEW AND THEORETICAL FRAMEWORK

#### 2.0 Introduction

This section will review literature that is relevant in getting a clearer understanding of the topic of study as well as the theoretical framework that will inform this study. While the literature on SRH does not have much reference to the PWDs it gives an overview in understanding what constitutes SRH and challenges that women face in accessing SRH services in Kenya. An understanding of disability, extent and causes will also be reviewed as well as the social cultural attitudes towards PWDs.

#### 2.1 Literature review

##### 2.1.1 Understanding disability

###### *i) Forms of disability*

There are many types of disabilities where mental or physical impairments limit the person from performing one or more functions, while making life more difficult for the person. Disabilities can therefore be classified according to the nature of impairment (<http://arch-online.org/disabilities-types-the-various-types-of-disabilities.htm>):

- *Visual disability-* this refers to situations where the sight is impaired. There are various categories that include far or near sightedness where the individual has problems seeing either distant or near objects. It varies with various degrees hence in most cases persons with this condition are able to access technology in form of eye glasses or contact lenses which address the issue and the person can see normally. These categories of persons are therefore not considered disabled. Another category of visual impairment is complete and partial blindness where the person has complete loss of sight either in one or both eyes. The other form of visual impairment is colour blindness which is classified as a mild disability.
- *Hearing and speech impairment-* there are various forms of hearing impairments. There are mainly the partially impaired who are 'hard of hearing', and in most cases can do so through hearing aids or hear loud sounds; while others are completely deaf hence unable to perceive any sound. These persons normally communicate using sign language. In most cases the



persons with hearing impairment are also not able to communicate verbally since they cannot perceive the language.

- *Physical disabilities*- There are many different types of disabilities that fall under this category where the mobility of the person is restricted. This can be due to loss, paralysis or other kinds of impairment of limbs or parts of the body that restrict the movements of the person. Various gadgets are used like wheel chairs or clutches.
- *Learning/cognitive disabilities*- This category encompasses different types of disabilities that limit brain functions of an individual. It hinders mental growth and individuals suffering from it usually have a hard time in thinking, solving, expressing and languages. While there are various types of learning impairments some of which are not well recognised, the most commonly known is the mental disability where the individual is not able to mentally construe life issues and sometimes such persons can be a danger to themselves and to others if not well attended to.

Some of these forms of disabilities are well understood like the physical forms that are visible, while some of them are not acknowledged socially as being disabilities, e.g. mental disability. The studies on disabilities have gained more prominence in the recent years. There has been development in the area of research on disability “since 1992 when disabled researchers and their non-disabled peers set out to radically alter the basis of disability research production” (Beazley, et al., 2008: 11). The argument that disability study can function to reproduce disadvantage gained more visibility. Beazley et al. (2008) argues that the language and discourse of disability study often shows investigators to be operating from individual and medical models of disability, in which disability is seen to be intrinsically related to a person’s impairment. The Individual/medical theory of disability is further explained in this paper in the theoretical frame work. Within these approaches, the experience of disability is viewed as a ‘problem’ stemming from individual person with disability hence an ‘individual-blaming philosophy’ informs research design

## *ii) Understanding disability in social and economic context*

In understanding disability there is need to look at other crosscutting issues like gender, social economic status among others. There are various causes of disability which include accidents and

diseases. The risk of persons with disability often starts at prenatal age. While this prenatal diagnosis is often used to reassure the parents that the child is normal it is also used for selective abortion by identifying malformations. In some cases the disabled foetus are considered malformed hence abortion is recommended (Bankowski and Carpon, 1998, et al.). Often times the pre-natal causes of disability are external social factors. A research on poverty and disability in Kenya that was commissioned by the World Bank established a clear contribution of poverty to conditions occurring in late pregnancy and during birth that cause impairment of the child (Ingstad and Grut, 2007). The research established that there were many cases of births at homes where women were attended by unqualified persons. In these instances there was high likelihood of damage of the child at birth as the emergencies occurring at birth were not attended to. The home-births could be due to some cultural beliefs but in most cases it was due to lack of money to access the health facilities. This is demonstrated the following case quoted in that research:

*“A woman on the outskirts of Malindi had been in labour for two weeks with sporadic bleedings before she was taken to the hospital. Not only did she wait in seeking help with the delivery, but she also waited to get anti-malaria medication, receiving it only towards the end of the pregnancy. The boy got severe malaria soon after birth and was now blind, possibly partially deaf and physically quite delayed for his age”* (Ingstad and Grut, et al., 2007: 32).

The linkage of poverty to disability is acknowledged at the international level by the United Nations. The UN Special Rapporteur on Disability of the Commission for Social Development in his statement to the Commission at its 48 session stated that one of his key priorities included mainstreaming disability in the Millennium Development Goals (UN, 2010).

### **2.1.2 Social and cultural attitudes towards disability**

Different social and cultural settings have varying views on persons with disabilities with some giving PWDs status of ‘lesser human beings’. In some communities, disabled persons are considered as non-persons. In a CNN documentary featuring the Kenya’s Mathari Mental hospital released in March 2011; many persons with mental disability are kept in sub-human conditions ([www.cnn.com/video/?/video/international/2011/02/28/wus.locked.up.forgotten.bk.b.cnn](http://www.cnn.com/video/?/video/international/2011/02/28/wus.locked.up.forgotten.bk.b.cnn)). Mathari hospital is the largest public hospital in Kenya that specifically deals with persons with mental

illnesses. Evidently, persons with disabilities have been denied access to basic rights and even faced outright abuse and discrimination to date.

Traditionally, different cultures had varying views of PWDs including the 'explanations' of the causes of disabilities which to a large extent determined how PWDs were treated in the society. Ida, 1995 in Ingstad and Grut, 1995, notes that among the Punah Bah community sometimes disabled children were not fed but left to die. "A newborn baby born disabled could be considered a spirit hence the family would be unwilling to nurture the child. In addition, the gender aspect is notable. In most of the physical impairments apart from blindness were blamed on the mother while other forms of impairments are blamed on the father. Some forms of impairment especially when there are multiple impairments were seen to be spiritual". (Ingstad and Grut, 1995, 1995: 38)

In Africa, among the Somali community of Southern Somalia there was no clear distinction between disability and illness. Family members spent resources and time seeking for 'treatment' of disability. The way that community members related with disabled persons was more out of a religious obligation than intentional effort to enhance the lives of PWDs. PWDs who lead a 'normal' life did so through their own personal ability but the importance of the support extended to them was usually neglected. "The duties of supporting PWDs were seen as religious duties of showing mercy and were not deemed to have any role in enhancing the opportunities for the disabled" (Helander, 1995 cited in Ingstad and Grut, 1995:41)

In Kenya, some of the communities did not distinguish between the disabled and non disabled persons as long as they fulfilled their social expectations. The Maasai community in Kenya, for instance, had a complex understanding and definition of disability. To the Maasai the concept of disability had a very strong dimension of practical incompetency. A person who was recognised as disabled was basically one who was not able to help her/himself practically or was constrained in her/his activities by one or another impairment. Mentally handicapped persons were not referred to as disabled but as 'abnormal'. However, it also worth noting that, among the Maasai giving birth to a disabled child was considered as a misfortune caused by 'nature' or God hence unavoidable. The Maasai therefore tried to avert such misfortunes using certain rituals. 'Engoki' (sin) is a term that was used to define a deformed child, meaning the deformity was a result of sin in the family.

They also believed that certain forms of disabilities could have been due to certain kinds of 'misbehaviour' of the pregnant or nursing woman (Audi, 1995 cited in Ingstad and Grut 1995:61).

While appreciating the non-discrimination, Audi (1995, in Ingstad and Grut, 1995:62) notes that this could have a negative effect as children born with disability were not given special treatment hence some died in infancy. However, generally there was a caring attitude of disabled children more so daughters by their parents. They were often not pushed to get married but allowed to stay within their parents homestead. The practice of non-discrimination was practised not only in the bringing up of children but also in marriage where it was expected that everyone had a right to marry and bear children. The sexual division of labour among the Maasai required more physical presentation among the women hence this affected how severe physical disability is considered among women and men.

Among the Kikuyu community in Kenya, a child born with disability was considered to be a message from the deity. Such a child was put at the entrance of the compound where cattle passed and if the child was killed, this was considered as a curse to the community hence the death was the curse 'being removed' from the community. On the other hand if the child survived, then it was considered that a message of 'good will' was being passed to the community through the child (Okiyo, 2010). It is highly unlikely that a child would survive a herd of cattle hence this would go to show that most of the children born with disability were actually killed at infancy.

Arguably, the social attitude towards PWDs in the traditional setting and even in modern times will determine how life is organized to make life manageable for them in various aspects including SRH and rights.

### **2.1.3 Understanding sexual and reproductive health and rights**

Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. The Committee on economic social and cultural rights has stated that the right to the highest attainable standard of health has four essential

elements: availability, accessibility, acceptable and quality (Centre for Reproductive Rights, (CRR), 2003).

The availability of care includes the availability of facilities, goods and services as well as programs that enables access to reproductive health services including obstetric health care (Cook, et al. 2006, and CRR, 2003). It also requires that deliveries should be by skilled birth attendants. Hence, pregnant women should be able to access pre and post natal care and related services (Ibid). It includes existence of hospitals, clinics, and trained medical personnel among others.

Accessibility includes the physical access, and this affects PWDs more. It can be argued that the accessibility of SRH services affect women with disabilities more due to the lack of physical facilities or trained personnel to make the services friendly to PWDs. Accessibility also includes access to family planning services and information and hence the right to control one's fertility (Cook, et al. 2006). Acceptability of services on the other hand is often determined by acceptable medical ethics, cultural acceptability etc. Lastly, the quality of care is determined by having scientifically and medically appropriate services (Centre for Reproductive Health, 2003). It is expected that any health care providers ensure that the four characteristics are taken into consideration.

According to Cook et al. (2006) maternal mortality is also an indication of the level of health care in a country with developing countries still experiencing many cases of maternal related deaths. The power relations and gender equity gaps in the society directly relates to women's SRH. Continued discrimination against women contributes to women's risk of death during pregnancy and childbirth. "Maternal mortality is a reflection of the devaluation of female life and a measure of the social neglect of women" CRR & FIDA, 2007: 74). Where women are undervalued, their health care needs are ignored, the physical demands put on them by pregnancy and childbirth are underestimated and their nutrition suffers; they are expected to bear children regardless of their health and economic needs.

International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of SRHR for all. IPPF came up with a declaration on sexual rights, which is based on

seven principles which provide a framework for the advancement of SRHR. The declaration states that SRHR are human rights and hence are universal and invisible. The SRHR therefore seek to ensure the rights to freedom, equality, privacy, autonomy, integrity and dignity of people. The principles recognize the need to cater for different categories of age since they have different needs; acknowledge sexuality as integral to human rights; non-discrimination and protection from harm (IPPF, 2010). Notably, the declaration fails to make any explicit reference to PWDs but this can be deduced from the principle of non-discrimination. Arguably, failure to make reference to PWDs often contributes to the invisibility of this category of persons and their SRH needs.

One of the most controversial aspects of SRH is abortion with different countries having different legal provisions on abortion. It has been noted that where there are strict laws against abortion, many women die due to dangerous or incomplete abortions. In Kenya, a research by the Centre for Reproductive Rights in 2009 established that about 2,600 women die from unsafe abortion annually while approximately 21,000 are hospitalised due to complications from unsafe abortions. These numbers do not put into consideration those who die or are disabled from unsafe abortions in the homes and do not visit health facilities (CRR, 2010).

Harmful practices like Female Genital Mutilation (FGM), child marriages, dowry related violence and sons' preference, etc remains a challenge for women's SRH, especially in developing countries. FGM is defined by the WHO as a set of procedures involving partial or total removal of external female genitalia or other injury to female genital organs whether for religious or other non-therapeutic reasons. It has remained a common practice in many cultures in Kenya (CRR, 2006). The Protocol to the African Charter on human and people's rights of women of Africa, popularly known as the 'Maputo Protocol' notes that women in Africa continue facing many forms of discrimination and harmful cultural practices (African Union, 2003). The protocol in Article 5, calls for elimination of all forms of harmful cultural practices. In particular it calls for public awareness regarding harmful cultural practices; prohibition of FGM; provision of medical, psychological, legal and emotional support to victims of harmful practices; and protecting women who are at risk of being subjected to harmful practices. However, it has been argued that the Maputo Protocol has a crawl-back effect by emphasizing on the "right to positive cultural context" in Article 17, yet cultural practices have been known to be detrimental to women's rights. Kenya

only ratified the Maputo Protocol in 2010 with reservations on some of the aspects relating to marriage.

SRH also includes the rights of persons to determine their marriage rights, family planning, and freedom from violence among others. A woman's rights before, within and after marriage determine her ability to control her life and also make decisions regarding her reproductive health (CRR, 2006). Women should be free to choose the marriage partner and even choose whether to get married in the first place hence should be of age to give consent to marriage. Article 6 of The Maputo Protocol sets the minimum age of marriage at 18 years (African Union, 2003). The laws of Kenya in particular the Children's Act, 2001, also sets the minimum age of marriage as 18 years. One should also be free to decide whether to have children and the number of children. In some cultures in Kenya, forced early marriage is still in practice and this is normally linked to other harmful cultural practices like FGM. On the other hand, the society often views disabled women as not being 'women enough' to get married and bear children. The same society denies them education and other resources while believing that one time the disabled woman will 'get someone to take care of her' (South African National Council, 2008).

While HIV/AIDS pandemic is a major issue in SRH, persons with disabilities are more prone to HIV infection. This is due to several factors that include poverty and social exclusion where most of PWDs are not able to earn a living or access information due to social and environmental factors (South African National Council, 2008). Women with disabilities are more affected due to the gender disparity on HIV infection. It is evident in the general population that women are more susceptible to HIV infection hence women with disabilities are even more vulnerable to HIV/AIDS. Women are more susceptible to HIV/AIDS infection, and "the lack of education and training on HIV/AIDS prevention, as well as lack of access to means of prevention are significant factors contributing to the growing incidences of HIV/AIDS among women" (CRR, 2006: 70). In addition, PWDs in general face more rampant sexual violence and the disability often hinders them from reporting the cases due to communication breakdown and social stigma (South African National AIDS Council, 2008)

A research commissioned by Handicap International and carried out by the Steadman group in 2007 established that, in Kenya the HIV and AIDS policies are insensitive and totally exclude PWDS. The research established that Voluntary Counseling and Testing (VCT) centers refer to PWDS as people of 'unsound mind' hence they are not to be tested. The different kinds of disabilities that PWDS face require different ways of accessing information. The deaf require the sign language hence most of the materials on HIV and AIDS awareness has little or no impact on them. The methods used to disseminate information are not friendly to the visually impaired while persons with intellectual disability require special needs from cognitive communication. Some of the basic challenges that the research established is lack of accessibility to the VCT centres to persons with mobility challenges. Like many other public facilities, the centres were found to have no consideration of the physically disabled. The staff serving people at the centres reflected the social attitudes exhibited among many persons on the sexuality of PWDS. In one case the counselor was surprised that the PWD was sexually active (The Steadman group, 2007).

### **2.1.2 Challenges facing women's access to reproductive health services**

The study reviewed a report that is based on research conducted by the Federation of Women Lawyers in Kenya (FIDA-K) and the Centre for Reproductive Rights (CRR) between November 2006 and May 2007 (CRR and FIDA 2007). It was noted that the research report did not have any reference to women with disabilities which implies the research did not include women with disability in their data collection. It can then be argued that women with disability remain invisible even in initiatives that seek to address SRH of women. One of the damning observations that the report notes is that, women in Kenya have a 1-in-25 lifetime risk of dying from pregnancy-related causes.

The research findings established that women in Kenya have faced violations of their rights which include verbal and physical abuse in the process of accessing reproductive health services while cases of detention in health facilities due to lack of money to pay for the services has been a common phenomenon. In addition, shortage of medical staff and equipment in most of the Kenyan public health facilities interfered with the ability of the health facilities to effectively provide services to women. One of the facilities that the research looked into is the Pumwani Maternity Hospital (PMH) the largest maternity hospital in Kenya which is accessed by the poorest of the



poor women. “Women who delivered at PMH described decades of egregious rights violations—including unsafe conditions for delivery and behavior by medical staff that abused and humiliated women and endangered their lives and the lives of their infants” (CRR and FIDA 2007:Page 8).

The report notes the following as the main challenges women face while accessing reproductive health facilities:

- i) ***Discriminatory access of services to poor women-*** Due to lack of funding, the health care facilities in Kenya introduced a two-tiered health care system where there is ‘private’ wing within the public health facilities. The poor women who cannot afford this are therefore discriminated as they face delays in access to services. In the research, “Women expressed a firm belief that money usually buys better treatment” (Ibid: 8). They stated that they received very contrasting treatment when in the ‘private’ wing of the same hospitals. Many women therefore did not seek some of the services that are necessary for them like prenatal health checkups hence problems that could have easily been addressed became more life threatening. The fee waiver didn’t necessarily benefit the poor women since it was not effectively implemented. While medical procedures in some of the hospitals indicated that the fees should be demanded after the women had been attended, the report notes that often the money was required before admission. Women “described being harassed or forbidden from entering hospitals, including public facilities like PMH, if they did not have enough money to pay the deposit or fees” (Ibid: 28). Understaffing was also noted as a major challenge which impacted negatively on the services that women accessed more so in public hospitals often leading to maternal and infant mortality.
  
- ii) ***Physical and psychological abuse*** – women interviewed reported physical and verbal abuse from the health professionals attending them during birth and abuse relating to the medical procedures. This included being stitched when the anesthesia had already worn off. The findings of the report indicate that there has been persistent gross violation of women before, during and after delivery including neglect. Physical abuse was established to be rampant during labour and delivery. “Women reported being pinched on the thighs, slapped, or beaten into compliance during labour” (Ibid: 32). The negative experiences often have lasting psychological and physical impact on the women. This can be said to

impact on the decisions that women would make later on in life regarding their SRH. The violations described in the report constitute violations of human rights that are protected under different laws, and these include the rights to health and life.

- iii) ***Unhygienic conditions and negligence***—women interviewed in the research reported unhygienic conditions in the medical facilities and negligence of the medical staff in attending to them. The negligence normally started from the time women accessed the medical facilities. “Maternal care standards call for every pregnant woman seeking medical care to be attended to by a skilled health care provider within 30 minutes of arriving at a facility” (Ibid: 26). The research established that this was not the case in many instances. In addition, women were often denied opportunity to be accompanied by their spouses or family members during delivery.
- iv) ***Violations of Rights to Consent and Information***—The Kenya Maternal Care Standards require that health professional respect the consent and right to information of the patients including counseling services. However, the report notes that women barely received adequate information about their pregnancies which made it difficult for them to make informed choices. The report notes that the right to information was curtailed by existence the Official Secret Act that criminalized information disclosure.
- v) ***Challenges in accessing family planning and abortion services*** - Like other SRH services, the research established the challenges that women faced in accessing family planning services. This was contributed by user-fees, lack of adequate supplies, and insufficient information among others. Social factors also contributed outside the health system whereby women were often denied ‘permission’ to seek family planning services by their spouses. The legal and social constraint in accessing abortion services was also noted as a major challenge hence many cases of unsafe abortion were reported. Meanwhile abortion continues to be a major cause of maternal deaths.

The report analyses different kinds of negligence that have serious health implications on the lives of women. While the report doesn't have a focus on women with disabilities, it can be argued that

women with disabilities face more multi-faceted challenges than their non-disabled counterparts. Arguably the challenges that women with disability face have not been made visible enough in addressing the SRHR of women and hence this report missed this out.

## **2.2. Theoretical framework**

The research was guided by the *Social Model disability* which was developed in the late 1960s by Mike Oliver. The main tenet of this theory is that disability is a result of social structures, and not deficits in the body or brain. The social model of disability identifies systemic barriers, negative attitudes and exclusion by society as the main hindrances to PWDs and not necessarily the actual impairment. This means that the society is the main hindrance that ‘disables’ people and not the impairments. The theory propagates that social structures and norms disable people by devaluing and denying them access to social services and opportunities including access to education, jobs, public spaces, representation, and social encounters. The social model sees disabled people not as victims but as agents resisting oppression, and overcoming challenges, and thereby changing social structures (Shakespeare, 2000 cited by CREA, 2008).

The social model of disability is based on how society organises its affairs and how the organising discriminates and excludes persons with disabilities from participation in the social, economic, political arena. The other key concept of the social model of disability is the distinction between the terms ‘impairment’, ‘handicap’ and ‘disability’. ‘Impairment’ is used to refer to the actual attributes (or lack of attributes), the abnormality of a person, whether in terms of limbs, organs or mechanisms, including psychological. ‘Disability’ on the other hand is used to refer to the restrictions caused by society when it does not give equivalent attention and accommodation to the needs of individuals with impairments. ‘Handicap’ is used to refer to the resulting social disadvantage that the PWDs face ([http://en.wikipedia.org/wiki/Social\\_model\\_of\\_disability](http://en.wikipedia.org/wiki/Social_model_of_disability) and Okiyo, 2010).

Okiyo, (2010) points to several aspects in which the society denies PWDs ability to fully participate in the society. These include inaccessible physical facilities, discrimination of employees with disabilities, lack of sensitivity to the needs of PWDs, discriminatory policies, information that is not accessible to PWDs, etc. The theory is relevant to the research since the

research looks at the hindrances that women with disabilities experience which makes them not enjoy SRH rights as other non-disabled women.

These are the challenges that women with disabilities face in accessing SRH services as was established by the research findings. There are barely friendly physical facilities to ensure their access, e.g. VCT centres in buildings that do not have lifts to access; the beds in maternity wards are normally very high making it difficult for pregnant women with disabilities to access among others. The policies also fail to put measures in place to ensure they also access the SRH. This includes the language used where Braille and sign language are not understood by the service providers.

The critics of the social model theory argue that it fails to connect with the experiences of impairment yet the physical impairments cannot be solved by the social theory but rather through medical procedure (Oliver, 1996). However it is worth noting that the social theory does not necessary deny the medical aspects but sets out to deal with the social barriers for PWDs. In addition, some forms of impairments are irreversible hence the society needs to organize to accommodate people with these impairments.

## CHAPTER THREE

### RESEARCH METHODOLOGY

#### 3.0 Introduction

The research was carried out in Nairobi and focused on women with disabilities who are in the reproductive age. The respondents interviewed were in the age bracket of 30–49 years and have accessed SRH services from a public health facility in Nairobi. The study collected qualitative data with individual women as unit of analysis. In-depth interviews were carried out with 14 women with various forms of disabilities and have accessed public health facilities seeking SRH services. The research aimed to undertake key informant interviews from Pumwani Maternity Hospital but access to this was denied. Secondary data was also reviewed including past studies to establish the challenges that women face in accessing SRH services. The data was later analysed to establish the challenges that women with disabilities face in accessing SRH services

#### 3.1 Research site

The research was carried out in Nairobi County (Map 3.1). Nairobi is the capital city of Kenya with the both urban and informal-urban populations. Most of the people who access public health facilities in Nairobi are the poor and the middle income population.

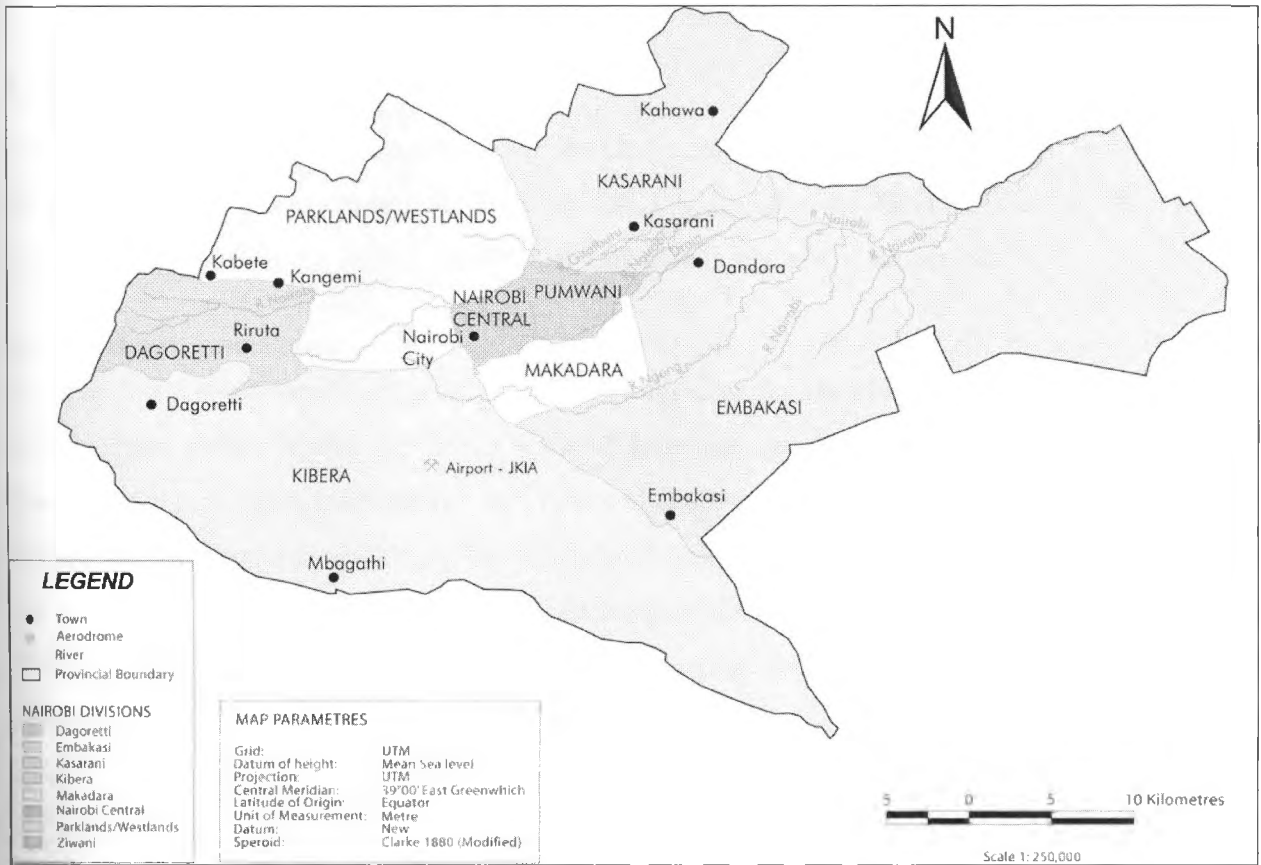
#### 3.2 Study population

The study population was women with disabilities living in Nairobi who have accessed SRH services from a public hospital in Nairobi. It was not possible to establish the actual study population, hence the study dealt with a population of unknown parameter.

#### 3.3 Sample population & sampling procedure

The study focused on a universe of unknown sample population hence the convenience sampling method was used. The sample was reached through the United Disability Empowerment in Kenya (UDEK) a non-governmental organisation that works with PWDS. The snowballing method was used. It was noted that the respondents were more willing to participate in the interviews and informal discussions when referred by other disabled woman. Key informants interviews were pursued with staff of Pumwani Maternity Hospital but permission to conduct this was not granted despite getting ethical clearance from the Provincial Director of Health.

**Figure 3.1 Map of the research area**



Source: [http://www.unep.org/roa/Nairobi\\_River\\_Basin/About\\_Nairobi\\_River\\_basin/cityProfile.asp](http://www.unep.org/roa/Nairobi_River_Basin/About_Nairobi_River_basin/cityProfile.asp)

For the purpose of the study the sample population was anticipated to be composed of 20 women with disabilities and at least 3 medical personnel working in service provision. However, out of the 25 women who were approached only 14 of them agreed to the interviews. It was established that respondents including some of the organisations working with PWDs had mistrust in participating in the research due past experiences with other researchers.

### **3.4 Data collection methods**

#### **3.4.1 Secondary data sources**

The researcher reviewed literature and research findings on the challenges that women face in access to SRH in Kenya medical facilities and the situation of SRH in Kenya. This was not confined solely to women with disabilities as this data is not easily accessible.

#### **3.4.1 In-depth interviews**

In-depth interviews were conducted with 14 women with disabilities who have accessed SRH services from public health facility in Nairobi. Interview guide was used to get qualitative data (See appendix 1). The information that was collected included the nature of services that the women have accessed from the public health facilities, the challenges they faced while accessing this and their perception on the attitude of service providers. The interviews were conducted by the researcher and her research assistant and recorded using note book and audio recorder with the consent of the interviewee. Each interview took approximately one hour. The interviewees were interviewed from their areas of residence or other convenient venue. The respondents were assured of the confidentiality of the information..

#### **3.4.2 Informal discussions**

Informal discussions with the respondents were used to capture important information to the research where women shared personal and second hand experiences in accessing SRH services in medical facilities. The informal discussions lasted for about 45 minutes with the respondents sharing on their life's experiences some of which were relevant to the research data.

### **3.5 Data processing and analysis**

In analysing the data, the researcher used these steps of social research data analysis.

*Data preparation:* This involved checking the data for accuracy; entering the data into the computer using MS Excel; and developing and documenting a database structure that integrated the various issues. Excel computer package was used to create codes and tables that were then used to enter and analyse the information. The codes and tables were prepared prior to data collection and were later revised in the process of data collection to incorporate emerging issues. Immediately after collection of data, the records were checked for accuracy to ensure that the

information collected was clear, audible and complete. Where necessary, the researcher sought clarity from the respondents. Once the data was entered into the computer package, it was then summarized and basic deductions made from the information gathered.

The researcher has used the information gathered to describe the basic features of the research and summary of the issues that have been studied. The information was used to make research findings.

### **3.6 Ethical considerations**

Ethical principles on social research and transgressions of the principles revolve around certain issues that recur in different guises. Crandall et al. (1978) has divided the ethical transgressions into four mainly: harm to participants, lack of informed consent, inversion of privacy and deception to the participants. The researcher upheld ethical principles in order for the research not to be harmful or invalid. The researcher took into consideration the following issues:

- a) The researcher got a research permit before commencing the research from the Ministry of Higher Education, Science and Technology (See appendix 1),
- b) Ethical clearance was also sought from the Provincial Director of Health and granted. The same was sought from Pumwani Hospital administration in order to interview the hospital staff without success.
- c) The researcher and research assistant explained to the respondents the research and its expectations and sought their consent before pursuing the interview.
- d) Throughout the research proposal and report writing, the researcher avoided plagiarism and attributes the information gathered from different sources to the particular sources as concisely as possible. The findings are also reported as accurately as possible hence avoid fraud.



## CHAPTER FOUR

### DATA ANALYSIS AND PRESENTATION

#### 4.0 Introduction

This chapter presents findings of the present study. The first section presents the socio-demographic characteristics of the respondents followed by findings on the challenges they faced growing up and living with disabilities as adult women in the second section. In the third and fourth sections the nature of services sought in the health facilities and the respondents' evaluation of the accessibility of public health facilities including quality of services offered are presented. The fifth section presents the experiences of women with disabilities in health facilities while the sixth section summarizes the experiences with SRH with particular focus on child delivery and labour services. The chapter ends with a brief summary of the research findings.

#### 4.1 Socio-demographic characteristics of the respondents

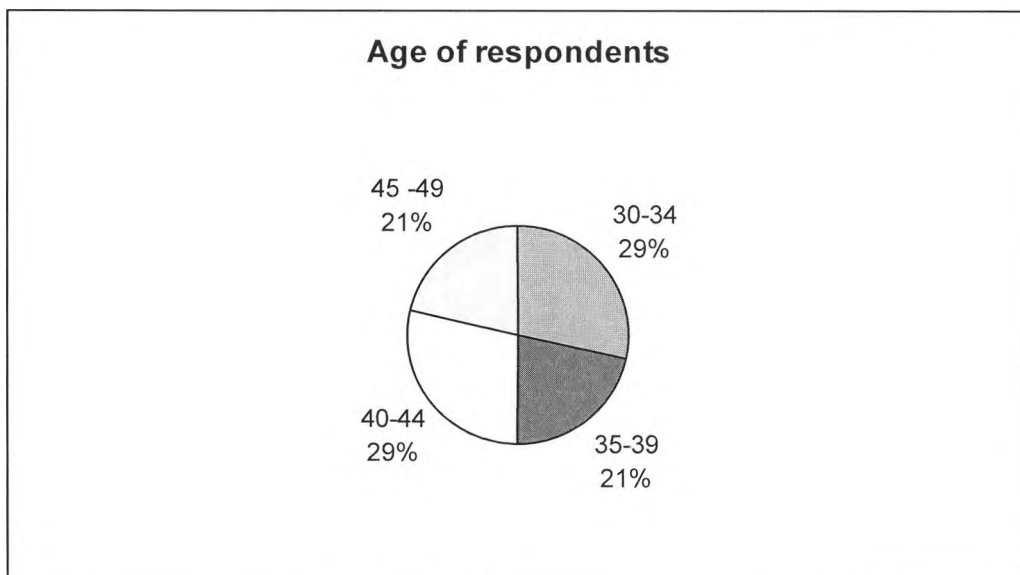
The background information of respondents is critical in identifying the social-demographic nature of the respondents who supplied the data that was used to make deductions for the study findings. This is important in providing more information against which the research findings can be weighed while determining how representative the respondents were of the general population. While the sample size is small and used purposive sampling, the socio-demographic and illuminative data presented in this section aims at presenting aspects that can help determine possibilities of unseen bias in sample selection.

##### 4.1.1 Age

The age of the respondents is an important factor because women below the age of 18 are regarded as children and therefore may not be consumers of SRH services that were the focus of this study. However, SRH needs remain critical at different age groups more so from puberty years when the biological changes present more SRH concerns. Nevertheless, the study focused on women over 18 years due to the nature of information that was sought. Table 4.1 shows that a total of fourteen (14) women with various forms of disabilities were interviewed with the youngest being in the 30-

34 and the oldest in the 45-49 age cohorts respectively. 50% of the respondents were aged between 30 and 39 years of age while the others were between 40 and 49 years.

**Figure 4.1: Age of Respondents**

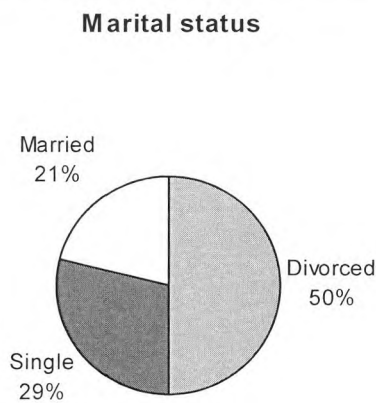


The possibilities of younger women experiencing problems when seeking SRH is much lower because of the support they get from friends and relatives. The social perceptions also affects them and perhaps it takes them slightly longer to get marital partners than non-disabled women. In addition younger women are likely to be supported by other social systems like school. However, as disabled women grow older, give birth and start to live on their own, the need for SRH increases and thus, the frequency of visits to facilities that provides such services.

#### **4.1.2 Marital status**

Marital status is considered a very important factor for most women who seek SRH services in health facilities as it points to other factors that affect SRHR of women with disabilities. Table 4.2 shows the marital status of the sampled women in this study. The research findings established that only, 21% were married at the time of the survey. It is apparently clear about 80% of the disabled women did not have married partners with 50% divorced and 29% single. It is therefore important to note here that disabled women who are divorced are the highest consumers of SRH services. However, this assertion could not be effectively proved in this study due to the small sample size and limitations in the research instrument.

**Figure 4.2: Marital status of respondents**



During the interviews and informal discussions with some of the respondents they suggested that in most instances women were divorced because of reasons related to their disabilities and due to the social gender roles in the community. As one woman quipped *“my husband divorced me when I became disabled in the process of giving birth”*. Another woman stated *“when I got disabled my husband started to be abusive and unfaithful, I could not put up with him so we separated”*. One divorced woman disclosed that she had not thought of the marriage as a long-term or life commitment. *“I was cohabiting for 13 years but deep down I knew this was a short term contract since I had seen several disabled women get divorced because of petty reasons such as not being able take for the man water to the bathroom, cultivate land etc hence I knew my marriage would not last.”*

The gender roles as dictated in the society therefore had a role in the marriages breaking up since the disabled woman was not considered to be ‘woman enough’. Often the husband’s family would hesitate to accept a disabled woman. The social attitude on the sexuality of women with disabilities was often reflected among service providers. One respondent expressed that when she went to seek family planning services, the attending medical personnel wondered if she was married and if married how a man agreed to marry a disabled woman. This already prejudices the kind of treatment that women with disabilities get.

These kinds of experiences often discouraged younger women from getting married as they shared experiences with women who had been disappointed by marriage or relationships. 29% of the respondents were single, and mostly not intending to get married as they feared that their condition would be an impediment. One younger woman expressed that *“it is very hard to get a boyfriend since the men just want to use you and waste you. I have preferred to be alone instead of being wasted since they only want a one-time thing (sex)”*. The marital status was in most cases linked to the disabilities.

#### 4.1.3 Number of children

Table 4.1 shows that on average the respondents in this study have two children. Most respondents stated during informal discussion that due to their disability condition they had to make regular use of SRH services during their entire period of the pregnancy and during child birth. In fact, all those interviewed indicated that they had given birth in a health facility and because of the difficult they went through during pregnancy and child birth they had decided to seek family planning services from health facility. The number of children a disabled woman has is often linked to the treatment she was accorded in the hospital while seeking SRH services.

**Table 4.1: No. of children per respondent**

<b>Response</b>	<b>Frequency</b>
0	4
1	4
2	3
3	1
4	2
<b>Total</b>	<b>14</b>

In addition, the dissuasion from health service providers affected decisions over number of children and spacing. During informal discussions one woman who had four children said that during one visit to a health clinic *“the doctor asked me if I had any children and when I told her four children she exclaimed wondering why I had given birth to so many kids yet I knew I was disabled”*. Other respondents expressed that having a child ensured they got someone to look after them but also they stressed that there was need to have fewer children that they could be able to

look after. Women who did not have any children confessed that they feared giving birth due to shared experiences by other disabled women related to pregnancy and child birth. Many also expressed that they feared getting disabled children and not being able to fully cater for them. This is despite the fact that most of the causes of disabilities are not genetic.

#### 4.1.4 Types of disability

The type of disability is considered a very important variable in this study because the nature of disability determines the specific challenges that the women with disabilities face in accessing SRH information and services in the hospitals.

**Figure 4.3: Type of disability**

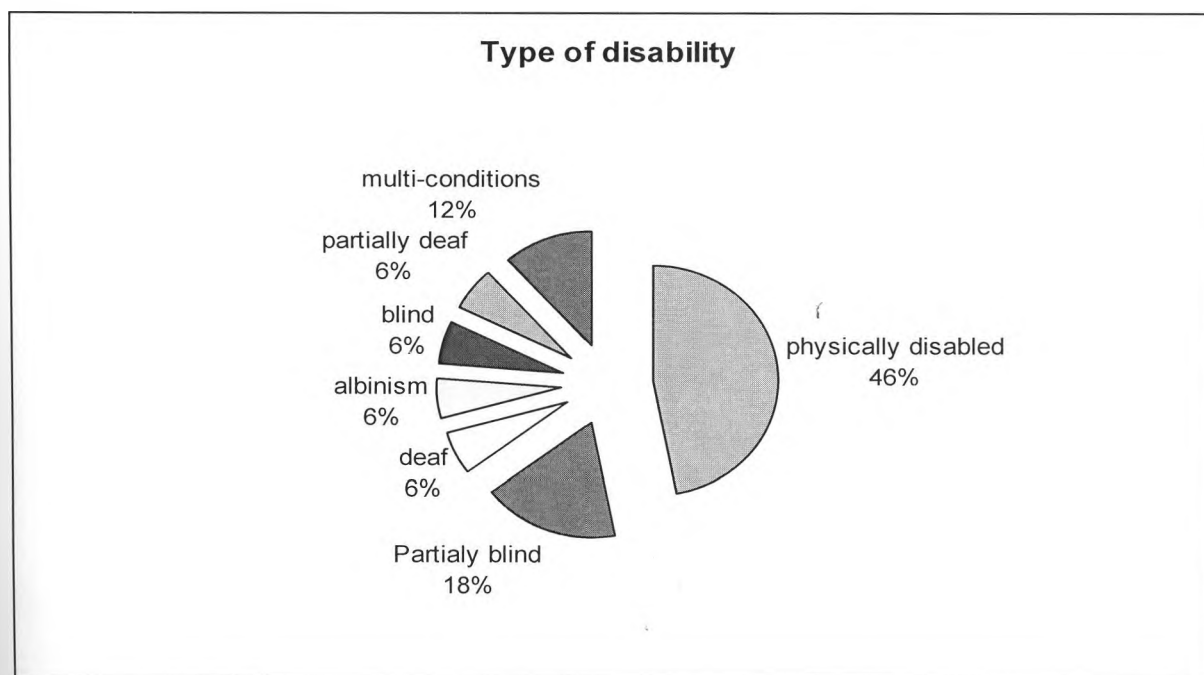


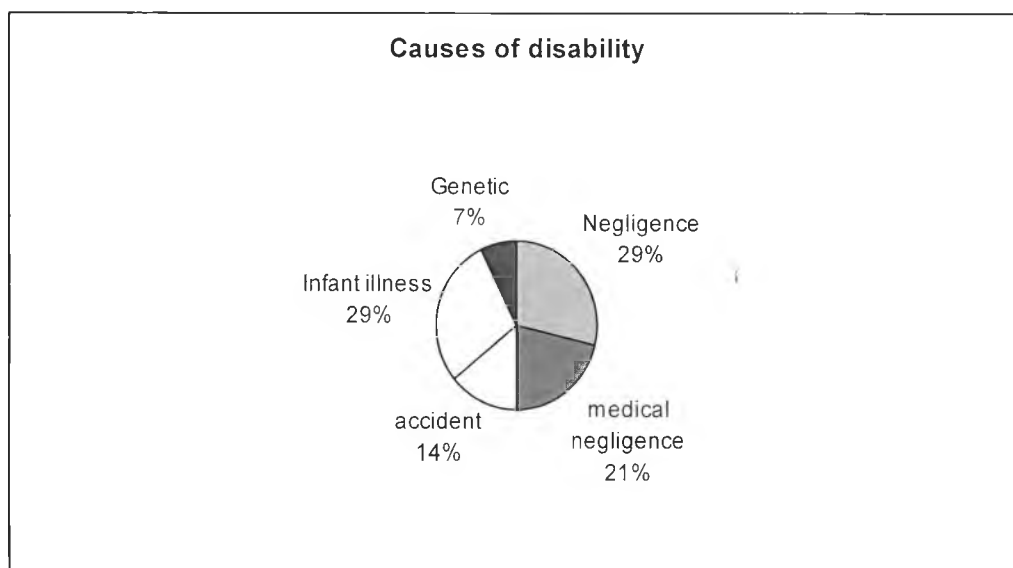
Figure 4.3 shows that slightly less than half of the respondents (46%) had physical impairments while the remaining 54% had a multiplicity of disabilities including albinism, hearing difficulties, deafness and either partial or full blindness. Some of the respondents reported suffering from more than one form of disability. Some albinos for instance, were also blind and deaf at the same time. It is worth noting that some disabilities such as albinism often present the possibility of other disabilities such as visual impairment further complicating the lives of PWDs. More than half of the respondents indicated that had lived with their disability for more than 30 years, hence most of

their life. Arguably the longer that one has lived with a disability the more likely that they have established ways of coping hence the challenges they face were more due to unfriendly environment than the impairment.

#### 4.1.5 Causes of disabilities

When asked about the causes of their disability, most respondents indicated that their impairments were the result of negligence by medical personnel while conducting procedures on them or failure to access timely medical help. It was established that 50% of the disability conditions were as a result of a form of negligence; 29% was negligence that included not getting medical assistance on time while 21% were as a direct result of medical procedures. However, some of the conditions such as albinism were of genetic nature.

**Figure 4.4: Causes of disability**



One woman narrated how she developed disability while delivering a child at a public health facility. *“I became disabled during the delivery of my second child at Pumwani Hospital. After what appeared to be a normal delivery I started to feel a sudden numbness on my legs and hands. I consulted with the delivery nurse and doctors about my condition but they ignored my complaints. Instead they accused me of feigning numbness to get an excuse for other people to do the basic chores for me. After complaining several times, the doctor examined me casually and advised that there was no major problem to worry about. However, after hospital my condition*

deteriorated and I sought medical attention elsewhere. This is when I was informed that I was suffering from paralysis due an injection at the maternity hospital. They later told me the condition would improve after I rested but it never did. I became disabled”.

Another woman indicated that she became blind after the post elections violence in 2007/2008. Due to the violence she was not able to visit any hospital for treatment. “The doctor who saw me said that if I had presented myself for treatment earlier I would not be blind today”.

**4.16 Level of education**

The level of education is considered an important factor because disable women with low levels of education or basic literacy face more challenges in accessing and using SRH services both within the community and in hospitals. The level of education attained also contributes to social economic status of women with disabilities and also their capacity to cope with the challenges of their conditions. Where most public facilities like hospitals lack the necessary skills and arrangements to enable access and benefit for women with disabilities, women with disabilities who have low levels of education or lack training in condition related skills (e.g. Braille, sign language etc) might face more challenges.

**Figure 4.5: Level of education**

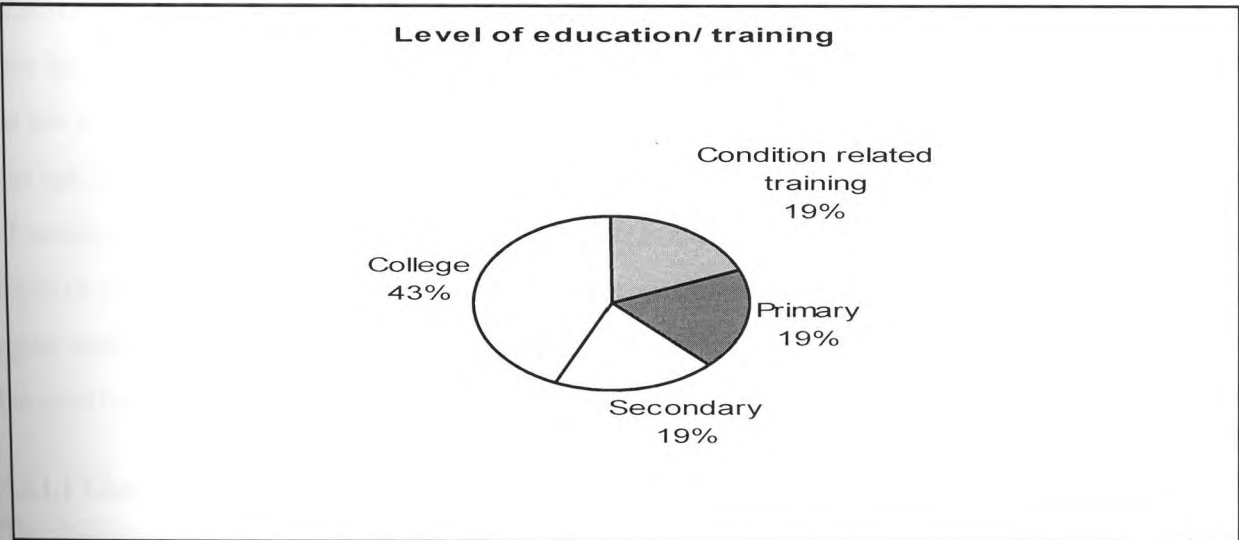


Figure 4.5 above shows that 43% of respondents had attained college level of education, 19% had primary education, 19% secondary education and the remaining 19% had basic literacy. The level of literacy among the interviewed women was arguably more than average of the typical low income women in Nairobi. In spite of the small sample size, the findings from this study suggest that the challenges women with disabilities face when they seek or use SRH services are a not as result of illiteracy but rather factors such as cultural and customary attitudes linked to their condition.

## **4.2 Presentation of research findings**

This section focuses on the findings about the experiences of disabled women when they seek SRH services in public health facilities, assessment of the services received and the challenges encountered in the process of attempting to access such services. The section seeks to provide a broader perspective of the issues under investigation and to answer the following research questions for this study:

- i. What are the experiences of women with disabilities in accessing SRH services in public hospitals in Nairobi? and;
- ii. How do the challenges that women with disabilities face in accessing SRH services affect their access and use of these services?

### **4.2.1: Social challenges living with disability**

The social challenges that women with disabilities face while growing up and as adult women are important in understanding how they view SRH. Some of the social challenges are as a result of how society views their rights including the SRHR and also the institutions which in most cases do not take into considerations their impairment, and this supports the social model of disability that has informed this study. The main tenet of the social model theory is that disability is a result of social structures, and not deficits in the body or brain. The research identifies systemic barriers, negative attitudes and exclusion by society as the main hindrances to PWDs as propagated by the social model of disability and not necessarily the actual impairment. This means that the society is the main hindrance that 'disables' people.

#### **4.2.1.1 Challenges growing up**

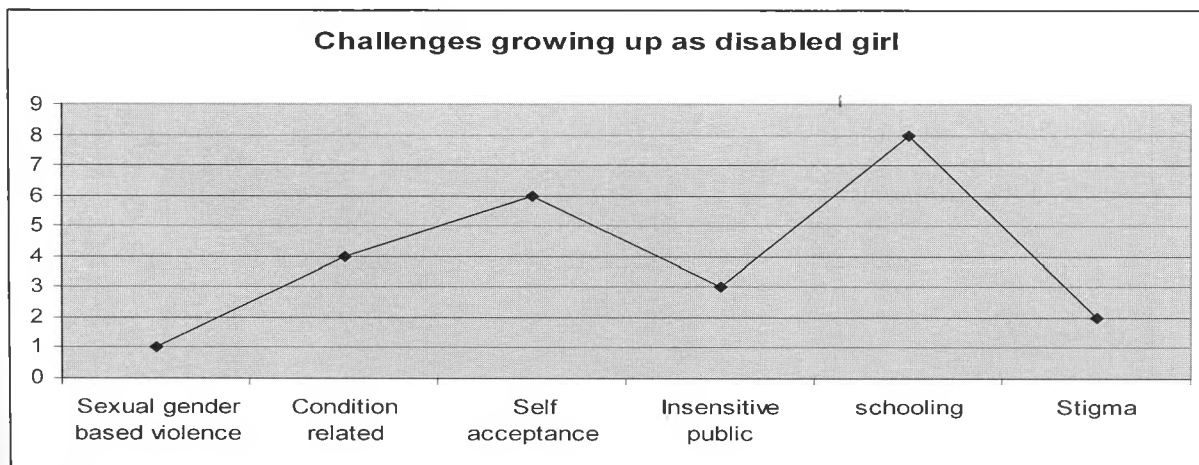
The challenges that the PWDs face while growing up to a large extent will be determined by their outlook and attitude towards life and how the society treats them. The attitude of society towards



persons with disability therefore contributes to determine how life is organized and the measures put in place in public facilities like hospitals. Majority of the women interviewed cited schooling as one of the greatest challenges they had while growing up.

The respondents gave more than one response to the question on challenges they faced while growing up since many of them faced multiple challenges. Some of the challenges mentioned include sexual gender based violence are SRH concerns. It is worth noting that the major challenges were experienced as a result of institutions (schools at 33%) and also self acceptance (25%). Self acceptance could largely also be attributed to the other factors like insensitive public and stigma. Stigma (8%) in this context referred to the stereotypical beliefs that society holds about the PWDs e.g. one respondent said that “people see like we are beggars, and poor, the fact that I am blind doesn’t make me a beggar.” Only 17% were challenges related to the conditions as shown in figure 4.6 below.

Figure 4.6: Challenges growing up as a disabled girl



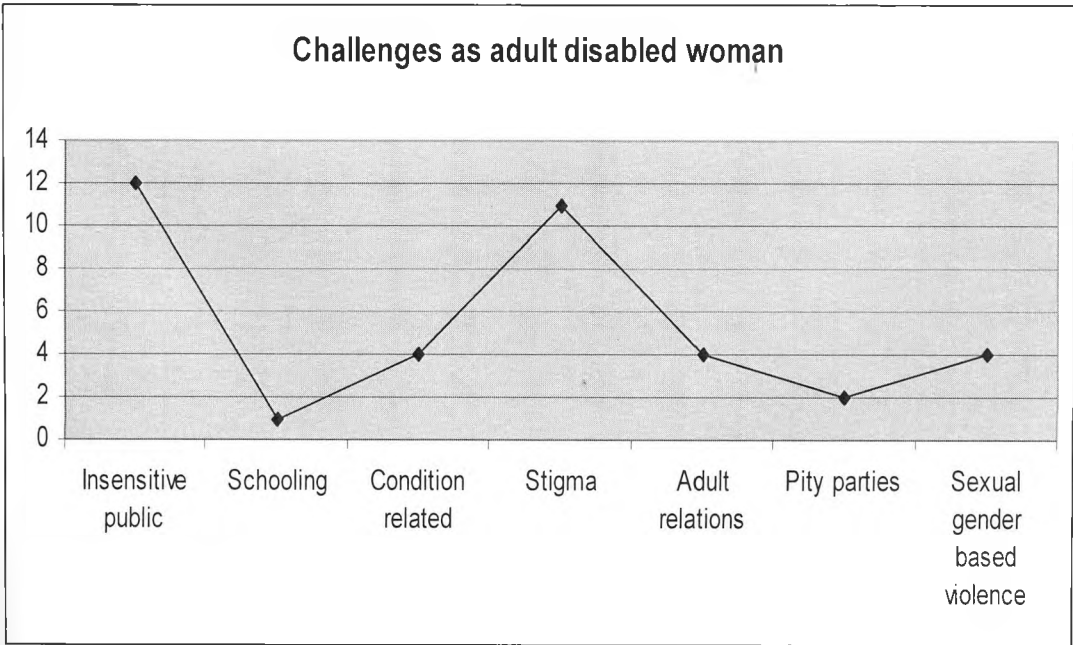
Schools, as public institutions, offer the greatest challenge to girls growing up. It was established during the interviews that the women who did not cite schooling as a challenge were in special schools. The special schools offered facilities that were best suited to the girls with disabilities for example the design of the bathrooms, access to classes and other facilities while the attitude was accommodating. We can deduce from this that, health facilities as social institutions are likely present similar challenges that disadvantage the PWDs like accessibility and insensitive health

workers. Condition related challenges included challenges that one faced since they had a certain condition e.g. inability to read for the visually impaired. Most of these challenges would therefore have been addressed by institutions becoming more sensitive to the conditions.

**4.2.1.2: Challenges as an adult woman**

The challenges that women with disabilities faced increased or reduced in intensity as one grew up, e.g. while 4% reported SGBV as a challenge growing up, this increased to 10% as an adult woman; and challenges of insensitive public increased from 13% while growing up to 31%. The reported cases of sexual violence were linked to disability in that the woman with disability was targeted. In one instance a young woman who escaped rape reported that a friend had been given money to help take her to the perpetrators. She later established that this had been done for other disabled young women. When she reported to the police they did not take her seriously and implied that a disabled person could not have been raped. Other challenges included adult relations which pointed to male female relations including marital problems as shown in Figure 4.7 below.

**Figure 4.7: Challenges as an adult woman living with disability**



As adult women, the major challenges that the respondents cited was insensitive public (31%) and stigma (28%). Other challenges included access to jobs and other empowering opportunities where

several women reported having challenges getting jobs despite being qualified. This further contributes to lack of economic empowerment among women with disabilities.

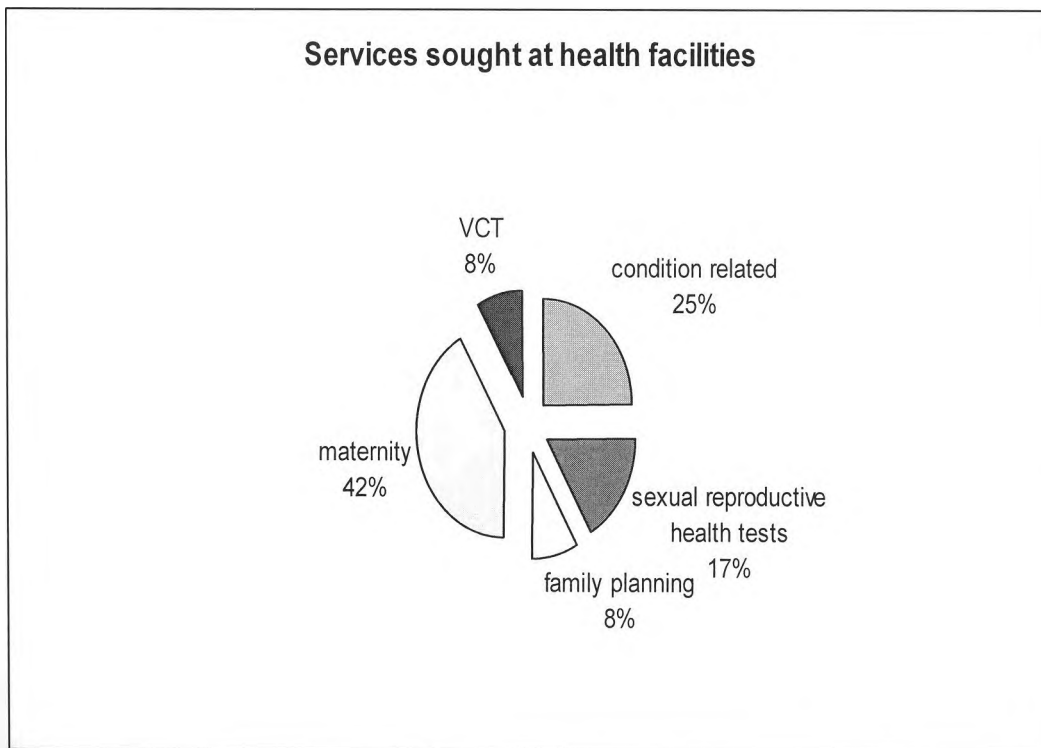
#### **4.2.2. Experiences of women with disabilities in public health facilities**

Women with disabilities have varying experiences in public health facilities. The respondents were asked to rate the different aspects of health facilities, these are: the kind of services they had sought, the access to the facilities, and attitude of the personnel and the rating of services received.

##### **4.2.2.1 Services sought at health facilities**

SRH requires that women recognise the needs they have and the different kinds of services that they need for their SRH needs. However, some women may not be aware of these needs hence never seek them in the first place. The women in this study were asked the kinds of services that they had sought in health facilities. Majority of them (42%) sought maternity services and it was established that none of the women interviewed had home delivery. This can be indication of the level of knowledge on the risks associated with home deliveries. 25% of those interviewed had sought services that were related to treating or addressing their conditions while 17% had sought SRH tests like Pap smear and breast cancer tests as shown in Figure 4.8 below.

**Figure 4.8: Services sought in public health facilities**

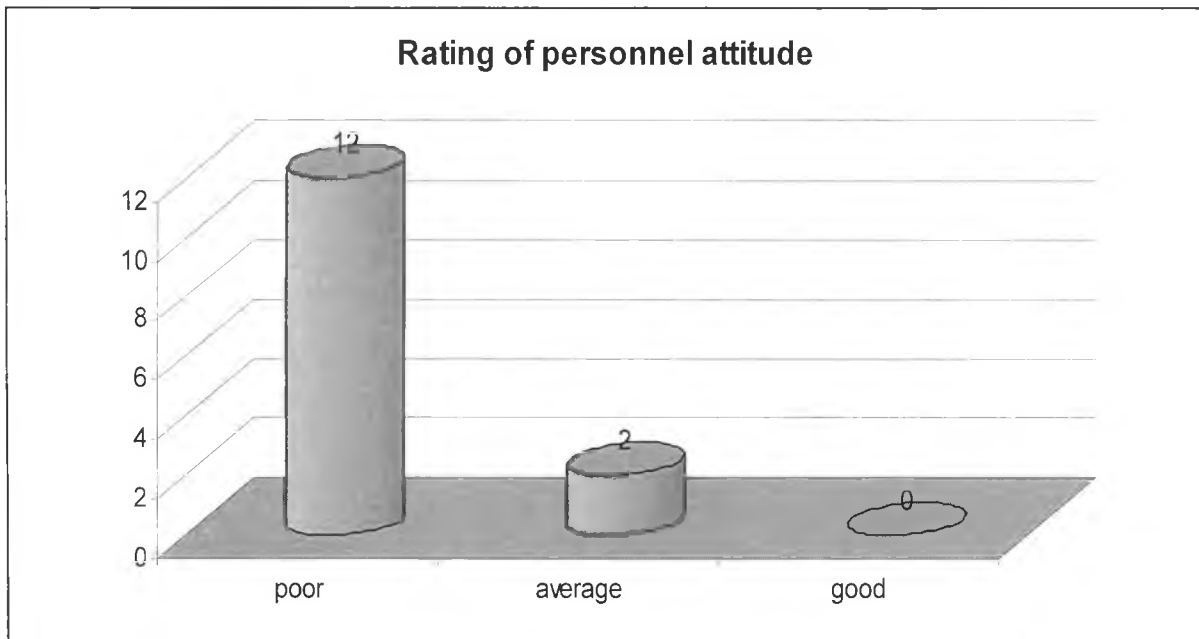


Only 8% sought VCT tests or family planning services. It was noted that none of the respondents had sought services or information related to sexual gender based violence despite being vulnerable to SGBV.

#### **4.2.2.2 Rating of the attitude of health personnel**

The first contact to a hospital is the medical personnel. The manner in which the medical personnel handle patients clouds the patient's general perception about the health facility. The women shared how they perceived the attitude of the health personnel towards them when they visited the health facilities. The responses given were then rated as good, average or poor. None of the women interviewed rated the attitude of personnel as being good while only two rated the attitude as average. Majority of them (86%) rated the attitude of personnel as being poor as shown in the Figure 4.9

**Figure 4.9: Rating of the personnel attitude towards women with disabilities.**



Some of the issues that the respondents raised that reflected personnel attitude towards women with disabilities included use of derogatory language and delay in attending to the women with disabilities. One respondent shared that she witnessed a physically disabled woman give birth on the floor. She could not get into the delivery bed due to the height, and the nurses declined to help her.

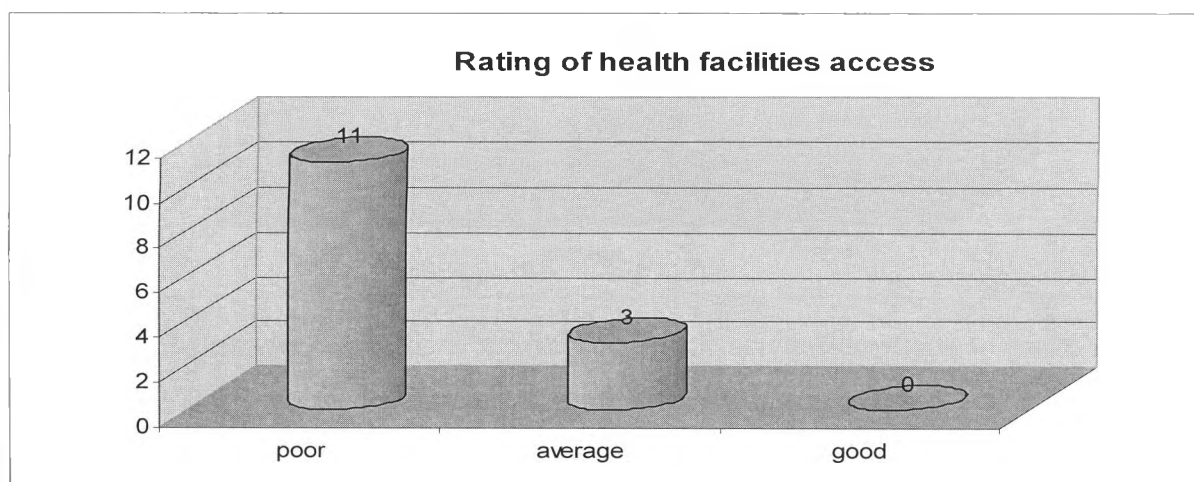
The respondents explained that in some instances, the medical personnel assumed that women with disabilities are not supposed to be sexually active. One of the respondents sought medical treatment due to a condition that was later discovered to be STI, but took long for her to be diagnosed. *"When he (the doctor) was giving me possible causes for my abdominal pains, he made it obvious that in my case it couldn't be an STI as I'm probably sexually inactive"*. In another incident, when a disabled woman went to seek VCT services, the attending counsellor asked her *"hata wewe"* ("even you, are sexually active!").

#### **4.2.2.3 Accessibility of health facilities**

Accessibility is one of the elements of the right to the highest attainable standard of health. This is in particular critical for PWDs. An almost similar rating that had been given for personnel attitude was given on the accessibility of the health facilities. There was a slight increase in number of

respondents that rated the access as average to 21% while none of the respondents rating accessibility as being good as shown in Figure 4.10 below. The rating of accessibility was mainly in terms of physical access to the facility and access to the different processes in the health facilities.

**Figure 4.10: Rating of accessibility of health facilities.**

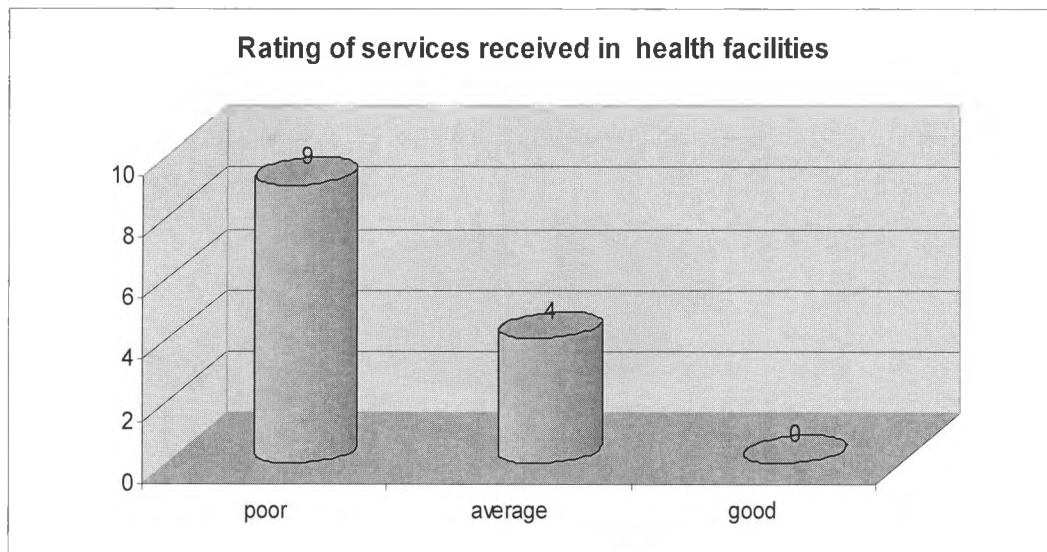


#### **4.2.2.4: Quality of services received**

Quality of medical services is also one of the main elements of determining highest standards of health. The respondents discussed their views on the quality of services received. They generally rated the quality of services poorly with only 31% rating the services as average. The respondents expressed that the services did not take into considerations their disability hence did not adequately meet their needs. The rating could be attributed to the poor rating or of other aspects at the public health services, compounded by disability. One of the commonly mentioned challenges was the requirement to queue which many felt was not responsive to their needs.

One of the respondents shared an incident when she was bypassed in getting treatment and had to wait a long while before she could be attended to. She had gone to look for a place to sit since she had physical disabilities hence was not able to stand in the queue like the rest. As a result she did not hear her name being called out

**Figure 4.11: Rating of quality of services**

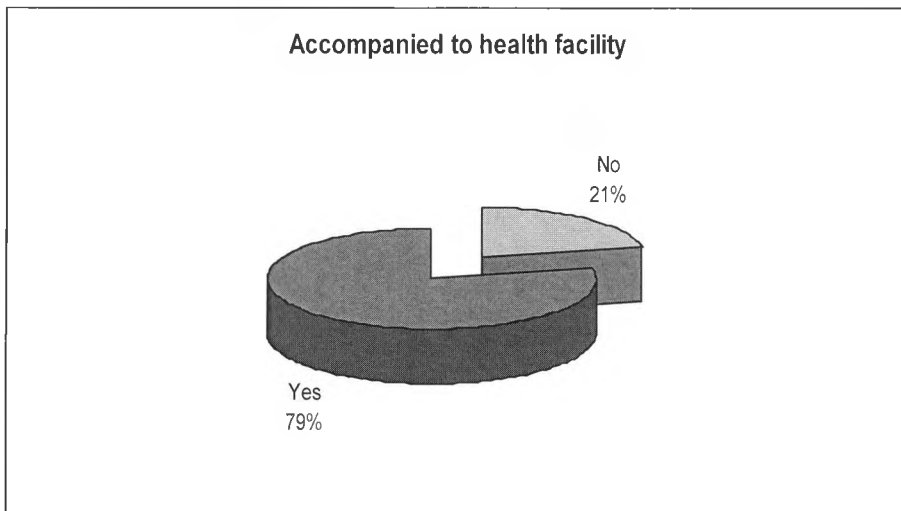


The rating of the services was therefore linked to lack of considerations to make the services friendlier to PWDs. It was also as a result of some assumptions regarding sexuality of women with disabilities hence denied them the right services or delayed them getting the services.

#### **4.2.2.5 Experiences of being accompanied to health facility**

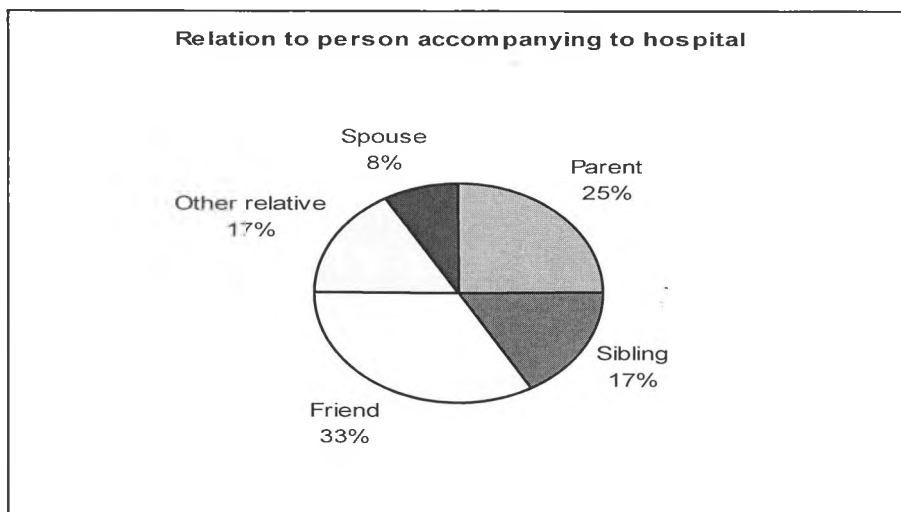
Since most health facilities are perceived as not being friendly to persons with disabilities in access to services and information, most of the PWDS are accompanied by friends or relatives while visiting the hospitals. The respondents were asked if they are usually accompanied when they visit health facilities.

**Figure 4.12: Women accompanied to health facility**



Only three respondents 21% indicated that they usually go to health facilities on their own while 79% are accompanied by other persons. It was further noted that the three respondents who are not accompanied indicated that the reason they are able to visit hospitals on their own is because they have skills and personal character to assert their right to receive the required services. One respondent who is never accompanied to the health facilities said, *"I am usually not accompanied, the reception not bad and also the services I receive are okay. I think I normally get good services because I am assertive and I know my rights"*. Others indicated that at first they used to be accompanied but later on learnt how manoeuvre around the health facilities on their own.

**Figure 4.13: Relation to persons accompanying to hospital**



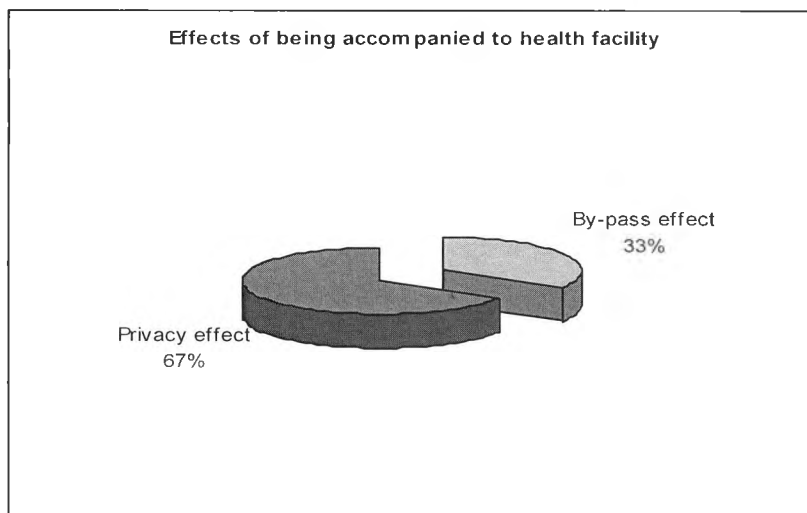


The relation to the person accompanying to hospital greatly affects the aspect of privacy. The respondents were asked the relation to the persons who usually accompanied them to hospital. Larger percentages are accompanied by a friend (33%) or a parent (25%) while only 8% indicated as being accompanied by a spouse as shown in Figure 4.13 above.

It was established that the relation to the persons accompanying determined how the women felt about this and also the nature of the services sought/ received at the health facility. One respondent indicated she had wanted to inquire about some SRH tests and contraceptives but since she was accompanied by her mother she shied off and left the hospital without seeking the information she needed.

This makes it evident that being accompanied to hospital affected the right of the individual to privacy. Sometimes the medical personnel bypass the patient and give instructions or seek for consent from the person accompanying her. The respondents, who are accompanied or had at one time been accompanied, expressed that they face challenges of privacy and being bypassed by medical personnel as the main effects of this.

**Figure 4.14: Effects of being accompanied to health facility**



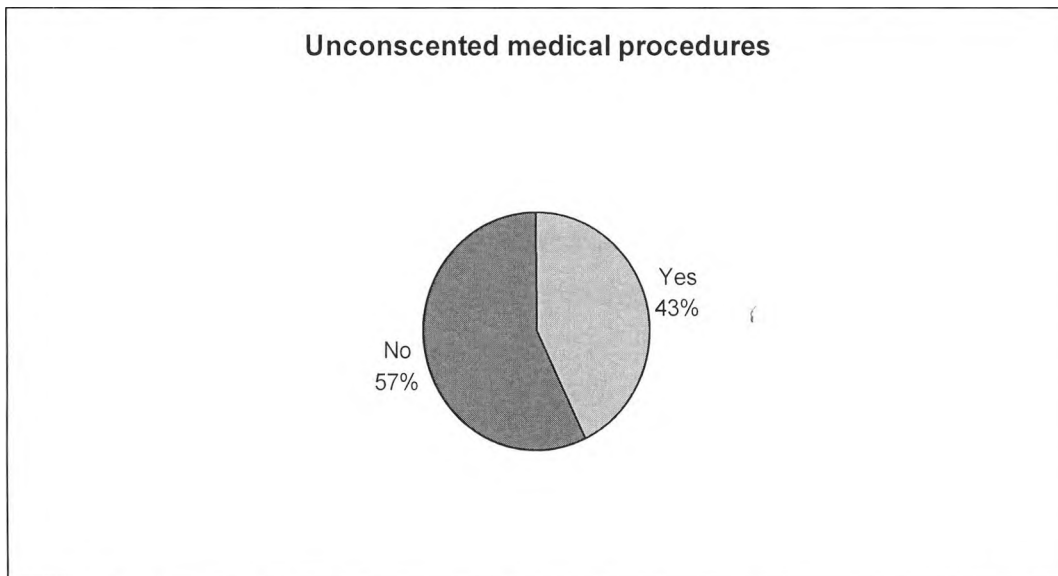
During the discussions one respondent shared that she was bypassed by the doctor and never got to learn the information that was exchanged between the doctor and the person who had accompanied her, yet it was about her health. SRH issues are quite sensitive to most women hence when one is accompanied it hinders her ability to get full benefit of the visit to health facility. This

was particularly grimmer when one was accompanied by a younger person or a relative like a daughter or son. Some of the respondents experienced both of these.

#### 4.2.2.6 Medical procedures without consent

The right to make informed decisions about one's health is imperative in SRH. The respondents reported having been taken through medical procedures such as sensitive medical examinations without consent or prior counselling. Those accompanied sometimes reported that the person accompanying them was asked to leave the examination room or in other cases give consent, without consulting the patient. 43% of the women interviewed reported having undergone medical procedures without consent.

Figure 4.15: Non consented medical procedure



The procedures included induced labour, caesarean section procedures and other medical examination without information or consent. A visually impaired woman shared such an incidence. *“When it came to carrying out the test, I was asked to lie on the bed and the doctor inserted a very large object into my vagina. It was very painful. I wish he had prepared me for the procedure by letting me hold the object so that I can feel its size. He would also have talked to me about what to expect instead of letting me experience the pain and discomfort unprepared”*. This demonstrates the attitude of the service providers as to the (lack of) role for women with disabilities in making decisions that affect their health.

### 4.2.3 Labour and delivery services

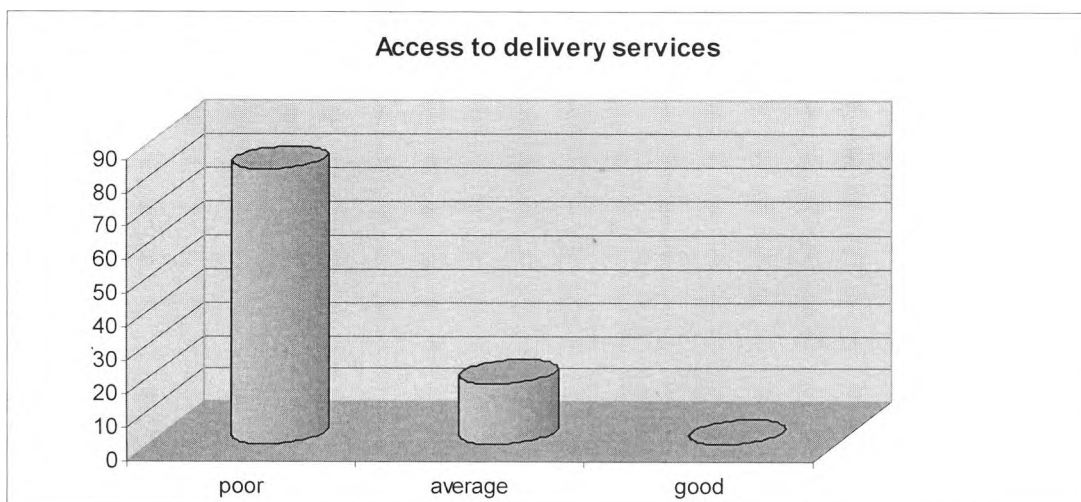
Labour and delivery provides one of the most critical processes in a woman's SRH. The process can risk the life of the mother and child or lead to other SRH complications associated with child birth. The research therefore looked at specific experiences of women with disabilities during labour and delivery.

#### 4.2.3.1 Rating of accessibility to labour and delivery services

Sometimes labour and delivery can be as an emergency while lack of access can further risk the lives of women. The women who had given birth were asked to describe their experience in accessibility to labour and delivery services. This included access to the facility and to the different services offered including bed which some cited as being too high for physically challenged persons.

Most of the respondents (82%) rated accessibility as poor with only 18% of the respondents rating the services as average. All the women interviewed chose to give birth at hospital due to the risks associated with giving birth more so for women with disabilities.

**Figure 4.16: Accessibility to delivery services**



Some respondents shared experiences of giving birth without assistance since they were not able to access the delivery room in time when labour started. This in itself is a great risk for any

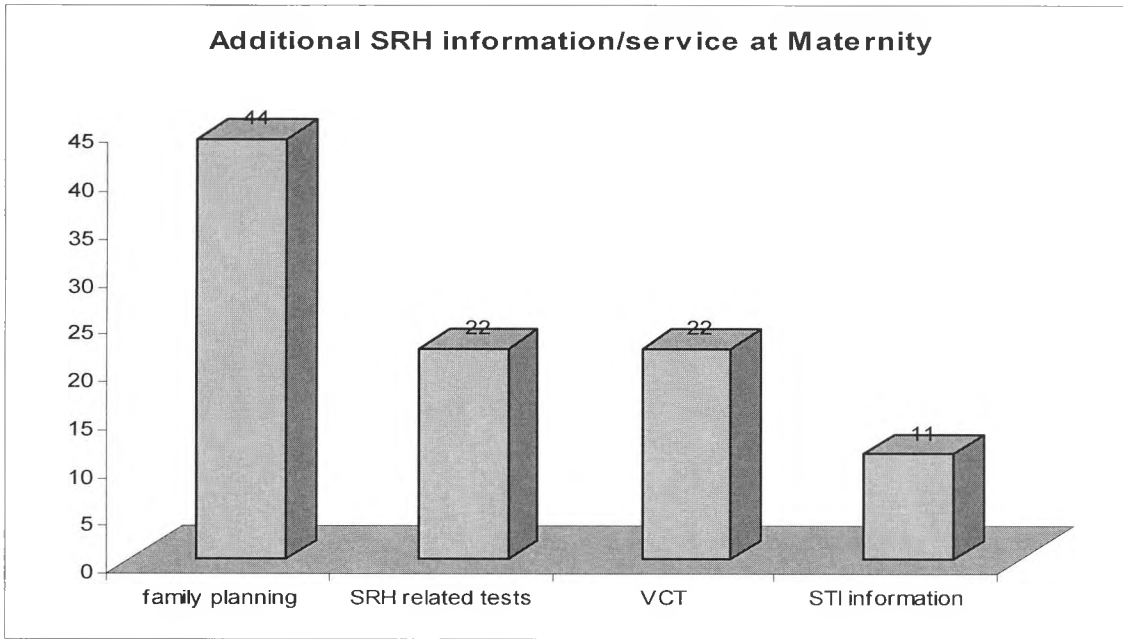
woman. The movement from labour to delivery room and bed were reported as major challenges. The medical stirrups often used to do check up for women could also be a challenge. A woman who was at risk of a miscarriage, reported that since one of her legs was shorter the doctor pulled the leg trying to fit it in the stirrups.

The respondents perceived medical staff as not being supportive in making the facilities friendlier to women with disabilities hence affecting access. One respondent with impairment in her arms shared an incident where she was denied access to her baby. *“Doctors at the Kenyatta National Hospital denied me access to my baby after birth claiming I could not handle her. They insisted we wait for whoever was coming to pick me but I insisted fearing they were playing mischief with my baby. Once the baby was handed to me, the doctors and matron would laugh at how I handled the baby but refused to show me how to correctly handle my baby despite this being my first birth”*

#### **4.2.3.2 Additional SRH services and information at delivery**

Pre and post natal care gives opportunities for women to access other SRH services from the health facilities. The respondents were asked the additional services or information they received during child delivery. Majority of the responses (44%) indicated family planning and equal number SRH related tests and VCT (22%) while 11% received information on STIs as shown in Figure 4.17 below.

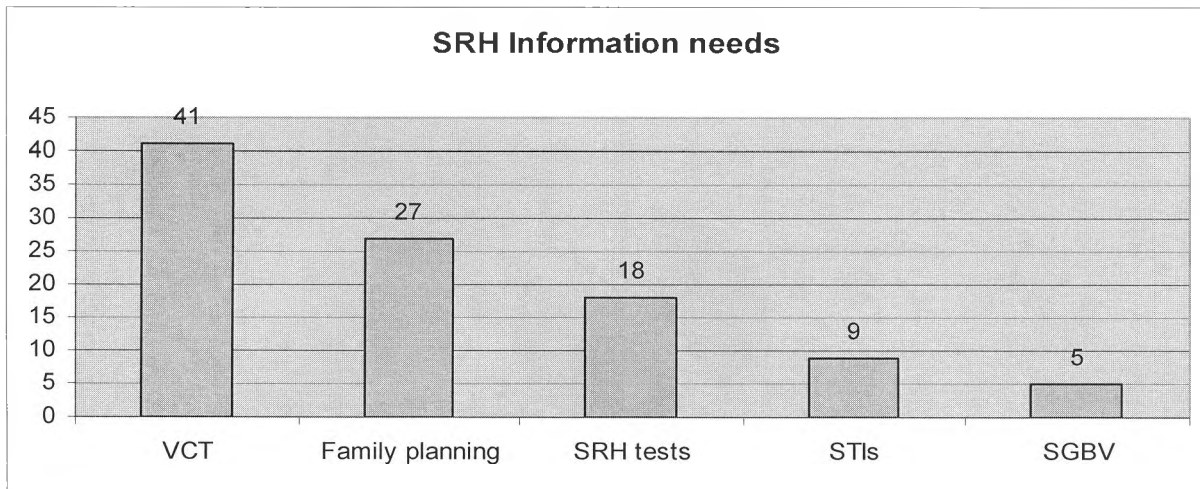
**Figure 4.17: Additional services and information received at child delivery**



It was noted that family planning services were received since in most cases the medical personnel were of the opinion that women with disabilities should not have many if any children. The right to informed consent, choice and health of the women with disabilities are not prioritised but rather bracket advice without considering views and needs of the women. Despite several of the women having reported that they had experienced SGBV or were aware of women with disabilities being more vulnerable to sexual violence, many had not thought of these services and information as being critical for them. Also as noted in Figure 4.17 SGBV information was not offered to women after delivery in hospitals.

The women were further asked what they felt were their critical needs and VCT was rated highest (41%) while family planning was rated at 27% as shown in Figure 4.18 below.

Figure 4.18: SRH information needs



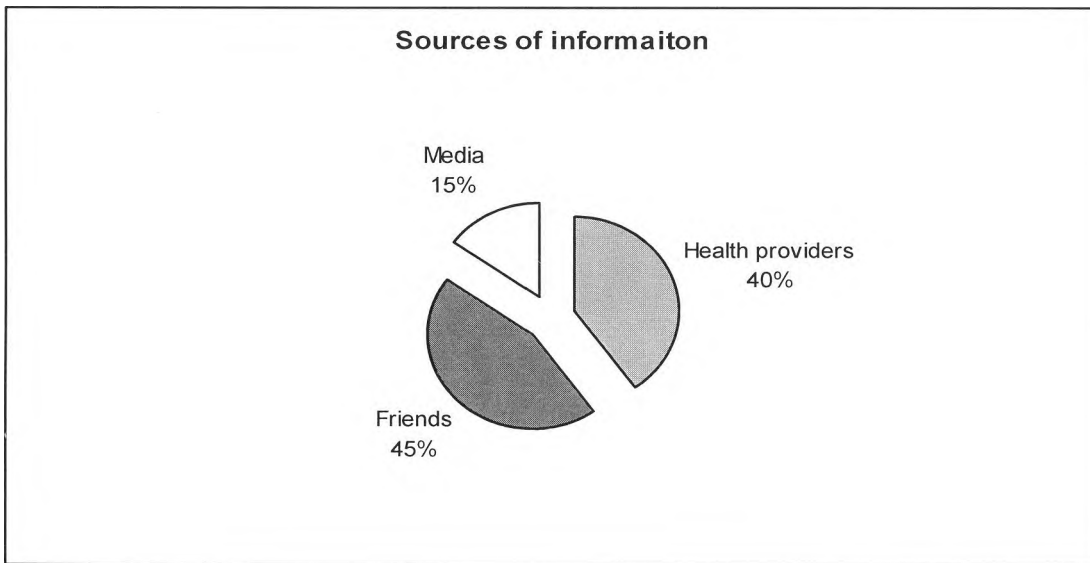
This is contrary to the services that the women had gone out of their way to seek from health facilities where VCT and family planning were rated at 8% (Figure 4.8).

#### 4.2.4 Ranking of sources of information on SRH

Information access contributes to the realization of SRH of women. Restrictions, lack of or inappropriate information about sexuality, contraception, prevention and healthcare around reproductive health, limit people's ability to make choices regarding their own sexual and reproductive health and rights

The respondents were asked their sources of SRH information. The majority of respondents indicated that they seek information from friends which was mostly linked to their assessment of health providers in terms of accessibility and attitude of staff members. This was closely followed by health providers at 40% and media at 15% as shown in Figure 4.19 below. It was noted that most of the respondents who indicated health facilities mentioned that they had stopped accessing the same from health facilities but had instead resorted to friends after some experiences in hospitals.

Figure 4.19: Sources of information on SRH

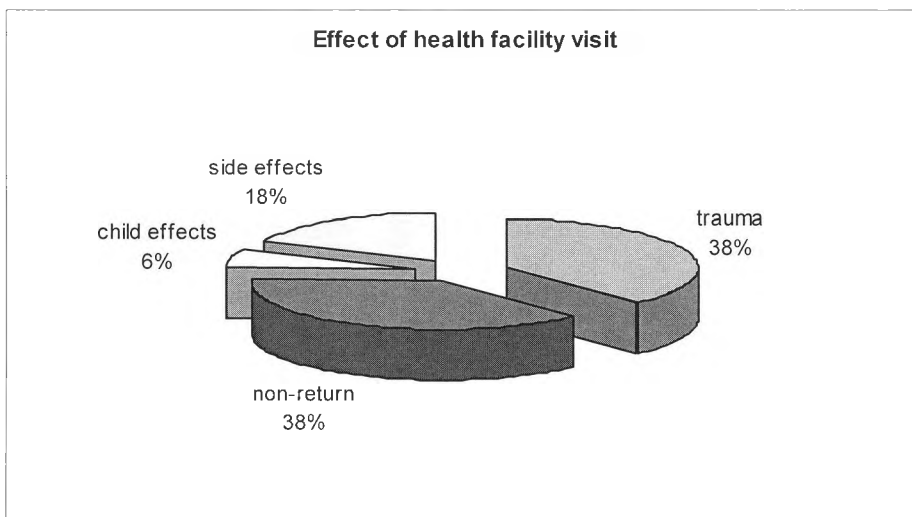


While acknowledging health providers as a useful source of information, the format of the information was seen as a challenge for some of the disabled women. Women with visual or hearing impairments faced challenges in interpreting information which was presented in form of written materials like posters or orally. Other issues that were noted was regarding condom use as part of the SRH package where women with disabilities felt the nature of information given was not enough for visually impaired persons. The staffs are mostly not trained in handling women with disabilities.

### 4.3 Impact of visits to public health facilities on women with disabilities

The research aimed at finding out how the experiences of women with disabilities affect their lives or decisions regarding SRH. An equal number of responses (38%) indicated psychological trauma or decision to never return to the health facilities as impact of this. 18% had experienced side effects on their health while 6% had their babies affected by the treatment in the hospitals as shown in Figure 4.20 below.

Figure 4.20: Effect of visits to health facilities



Some of the side effects included developing certain medical conditions. One respondent explained that she suffered a medical condition. She was not able to establish the nature of ailment but had severe pains in her urethra that she believes resulted from not having been attended to at the time of her child delivery. She disclosed that she had not gone to seek medical attention on the problem as she was afraid of “getting more problems” from the hospital. Another respondent indicated that even when she gets sick from other ailments she rarely goes to hospital. *“After my experience in that hospital, I fear going to hospitals even when am sick I prefer to just sleep and hope that I get better.”*

A respondent who has albinism reported having been traumatised by possibility of her baby being switched at birth. At one time while in hospital a nurse wondered if she had not get given birth since there was an albino child that had been born. When she finally gave birth the nurse called her colleagues wondering at the possibility that she actually gave birth to normal child. This is despite the basic medical knowledge among medical staff on the genetics aspect and possibilities of a mother passing on the genes to the child.

#### **4.4 Conclusion**

Perceived quality of care is an important factor that determines whether people choose to utilize SRH services or not. Health facilities can never be extricated from the SRHR of PWDs. The experiences in health facilities therefore determine the SRHR of women with disabilities to a very large extent. Improving quality of care requires that patients’ perspectives and levels of satisfaction are taken into account hence taking into account the needs of women with different



kinds of disabilities. The research findings show unease on how women with disabilities relate with medical health facilities and personnel. Women with disabilities like any other persons have the right to full enjoyment of their health rights and this includes the SRH.

## CHAPTER FIVE

### SUMMARY OF FINDINGS AND RECOMMENDATION

#### 5.0 Introduction

This chapter summarises the key findings of this research project and gives recommendations in relation to the research objectives.

#### 5.1 Summary of findings

The research aimed at exploring the challenges that women with disabilities face while accessing sexual and reproductive health services in public hospitals in Nairobi. The research sought to answer two questions:

- i) What are the experiences of women with disabilities in accessing SRH services in public hospitals in Nairobi?
- ii) How do the challenges that women with disabilities face in accessing SRH services affect the access and use of these services?

The research findings confirm that women with disabilities face myriad of challenges while accessing public health facilities. The challenges are as a result of not having considerations of persons with disabilities in mind in the design of the physical structures of medical facilities, the packaging of information, and attitude of staff among others.

##### 5.1.1. General challenges for women with disabilities on reproductive health

A total of 14 women with various forms of disabilities were interviewed through in-depth interviews and informal discussions. It was established that most of the disabilities could have been avoided as they were caused by negligence. The challenges that they faced were linked to how society has organised life. The research findings therefore support the *Social Model disability* theoretical framework that disability is a result of social structures, and not deficits in the body or brain. The social model of disability identifies systemic barriers, negative attitudes and exclusion by society as the main hindrances to PWDs and not necessarily the actual impairment. The research findings support this theory since it clearly indicates the challenges they faced as being a result of social and physical structures and less due to their conditions of impairment.

The challenges that PWDs face could therefore also be minimised or avoided by making the facilities friendlier. Majority of the women interviewed had physical disabilities hence their challenges would be more linked to physical access. However, all categories' of women with different forms of disabilities experienced challenges that were more linked to attitude structure of the facilities and the attitude of the public.

It was established that society's attitude to persons with disabilities affect access and benefit to SRH services. The assumption in the society that women with disabilities are asexual was realised among health workers and other members of the society. This delayed and /or affected their access to SRH services as the health workers 'question' why they needed the services in the first place. On the other hand, it could delay the diagnosis like was noted in a case where a doctor did not consider STIs as a possibility for a woman with disability who had lower abdominal pain. In addition, it affects the women who are hesitant to seek the same in case they were judged harshly by the community or health workers. This assumption affects the judgements of the women and reasons for accessing or not accessing the services. Family planning, for example, is a crucial service that a woman needs to make from an informed position. However, when it is pushed down on the women just because they are disabled it fails to meet the real needs of spacing family for women and for the children.

Sexual gender based violence was noted to affect women with disabilities in a different way as their condition(s) make them more vulnerable. One young woman shared that a friend actually planned for her to be sexually abused by prostituting her without her knowledge or consent. Another woman reported three different incidences of sexual violence where in one case she got pregnant. The assumption that disabled women and girls are not sexually active, or are not attractive enough to have sexual partners put them at risk. There is an assumption that they are not likely to have HIV or other sexually transmitted infections hence 'safe'. In addition, non-consented sexual approach could be seen by the perpetrator as a 'favour' to the woman since she is not 'attractive enough'. Some of the women also hold this notion hence affecting their self esteem.

Contrary to this popular belief, women with disabilities are sexually active and have the ability to sire children just like non-disabled women. Thus, they require a whole range of reproductive

health services provided to them. 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 like friends who may not give factual information.

The research findings established that disabled women lack awareness and information on reproductive health issues. Their knowledge is mostly limited to HIV/AIDS, child-bearing and contraceptives, yet there are other concerns like breast and cervical cancers as well as the management of infertility. The few, who had accessed other SRH services such as Pap smear, were more educated and exposed than an average woman. The research established that the challenges that the women face while accessing SRH services in public hospital is not linked to their level of education but more to their conditions and lack of facilities or personnel that take into considerations this disabilities. It was also noted that the social perceptions regarding sexuality of women with disabilities affected their decisions about marriage was mostly based on the perceived disadvantage of marrying a woman with disability.

### **5.1.2 Experiences of accessing public health facilities**

Women with disabilities visit public hospitals to seek services as per their immediate needs. Due to the crosscutting impact of gender, disability and economic empowerment, most of the disabled women are likely to seek medical services from public hospitals since they are more affordable and accessible. Pre and post natal services are some of the most sought services by women with disabilities and are at the centre of their reproductive health. Other services sought include HIV counselling and testing and also contraceptives which are often given as routine for all expectant mothers.

The research findings pointed to various challenges that women with disabilities face while accessing SRH services. The experiences are mostly not pleasant and make the facilities unfriendly. The access to health facilities is a challenge for the PWDs since the facilities were designed with non-disabled persons in mind. Despite having persons with disabilities form a percentage of our population and different protocols and laws addressing the rights of persons with disabilities, little has been done to make the facilities friendlier to them. Accessibility points

to both access to the facility and also to the different services offered in the facility. It was established that some of the hospitals had wide corridors by design which facilitated movement for women with wheel chairs. However, most of them lacked lifts or where they existed were mostly crowded and or not working to facilitate movement of women with physical disabilities. Other aspects of access included the movement from one service point to another from the time one gets to the hospital to the time they leave after receiving the required services. The services are offered at different points hence it is a challenge for a woman with disability to manoeuvre from the registration process to treatment, payments and collecting prescriptions. The queuing process was also noted as a major challenge and the queues in public hospitals are usually quite long due to affordability.

The attitude of medical staff was found to be one of the main challenges as it made it very difficult for women with disabilities to get the required information or service. This further complicated the already hostile environment. The attitude of the medical staff to women with disabilities was seen to be indifferent at best and in most cases rude. They were in most cases seen as an extra burden for medical staff hence many chose to be accompanied by a relative or a friend. Health is usually a private issue and SRH is even more sensitive hence being accompanied to the hospitals by a friend or relative often has more negative effects to the women with disabilities. It affects their privacy and level of decision making on their health. Ignorance among some of the medical staff was noted like in a case where a woman with albino noted the nurses assuming the albino baby who had been born was hers and further getting shocked when she gave birth to a normal child.

One of the critical components of reproductive health among women is the ability to make informed decisions. However, it was found that this right was often denied to the women with disabilities where either their privacy was interfered with making it hard for them to make the decisions or the medical staff bypassed them in making decisions. On the other hand, the lack of appropriate ways of conveying information especially for women with visual or hearing impairments further affected their ability to make informed decisions. In other cases, the research established that women with disabilities were put through procedures that they had not consented

to or had not been made aware of. This completely denied them the opportunity to make decisions over their reproductive health.

### **5.1.2 Impact of experiences in public hospitals**

The experiences that women with disabilities face in public hospitals, affect their attitude towards health care and their own health hence their health is put at risk by the negative experiences. Medical personnel are the best placed to provide information and services on SRH. This is because they are trained to recommend relevant services that are appropriate to each individual. It is common knowledge that even in cases where patients are suffering from similar symptoms, each need to get their own diagnosis and prescription and not rely on their non medical friends or relatives. Over the counter medication and self prescription are discouraged. The research established that the experiences often affect women with disabilities who then opt never to go back to hospitals unless in cases of emergency. As a result they seek information from their friends. SRH is a sensitive issue and when women seek second-hand information on services this is a risk to their lives.

Seeking information from non-medical staff is counter productive as the women are likely to get the wrong information. Family planning in particular can be a challenge since the contraceptives are available over the counter hence without the proper counselling and medical check ups women end up getting the wrong kind of contraceptives. Some of the lasting effects of experiences in the hospitals that were found out are trauma and physical harm. The research findings established that in some instances SRH procedures led directly to the disability.

## **5.2 Recommendations on improving public health facilities**

The research findings indicate that several measures should be put in place in order to mitigate the effect on women with disabilities. The following are the recommendations based on the research findings:

### ***i) Awareness on SRH and disability***

There is a need for understanding to mitigate negative societal attitudes towards sexuality of persons with disabilities. The research findings indicate that the social perceptions of sexuality of women with

disabilities, and specifically the assumption that women with disabilities are asexual to a large extent influences the treatment they receive in hospitals when they seek SRH related services or information. Government and non-governmental organizations working in the area of reproductive health should conduct in-depth research and use the results to create awareness and advocate for policies and practices that can promote the sexual rights of women with disabilities. Public awareness on the rights of persons with disabilities and the need to treat them as human with equal rights will greatly improve the public perception and how the public treats them.

*ii) Improve physical accessibility of services*

The hospitals should be made physically accessible by ensuring that there are ramps and lifts in good working condition. This should also include access to the bathrooms and the beds for delivery that should be adjustable to a level that is convenient for women with disabilities. This may sometimes require working on modifying the design of the hospitals facilities while in other cases it will require more sensitivity e.g. reducing procedures for women with disabilities hence they would not need to access too many service points.

Given the multiple challenges women with disabilities face in accessing reproductive health facilities, the government should establish a responsible authority to assess and ensure adherence to set guidelines to enhance the accessibility of the buildings and facilities in the hospitals. 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. This will ease accessibility as most of them use public transport to access the hospitals. Different ministries therefore need to work together to enforce this.

There is also need for process optimisation where some processes can be made easier for persons with disabilities like having a one stop where persons with disabilities can get all services at once from registration to treatment and prescriptions. This can reduce the movement and number of processes that a person with disability has to access within the facility. Where viable separate facilities can be provided for women with disabilities where they get the one-stop care and/or services.

### *iii) Staff development of medical personnel*

The negative attitude and lack of knowledge among medical personnel in handling women with disabilities was established as one of the major challenges. While appreciating that the facilities are not friendly to the women, the staff play a very critical role in mitigating the impact of this. Staff should be trained in some of the skills in handling persons with disabilities as this would contribute in improving their attitude. The skills included use of sign language and Braille; awareness on the special needs of women with disabilities among others. The awareness among staff will make them more sensitive how they treat the women. On the other hand each hospital should have a few trained personnel who are able to translate for deaf or blind women so that they can get full benefit of the medical facilities. Organisations working on SRH issues as well as government agencies need to create awareness among staff on how to treat PWDs in order to make the facilities friendlier.

### *iv) Materials adaptation*

Materials on SRH and other health related information should be adapted in order to ease access since most of the materials for information are geared towards people who can see or hear like audio and pamphlets. The main issues can be translated to Braille while audio more and advanced visual aid can be used for women who are deaf and heard of hearing.

## **5.3 Conclusion**

Sexual and reproductive health is a critical component of any woman's health. It is widely acknowledged that reproductive health is a concern for all and more so for women with disabilities, with a rise in cases of reproductive health issues. This include rising cases of breast, cervical, ovarian and other forms of cancers, that can be prevented or treated if detected on time. This would require women with disabilities having the knowledge on these services and having friendly health facilities to seek the services.

The Ministry of Health (MOH) formally approved and adopted the National Reproductive Health Policy with the theme: '*Enhancing the Reproductive Health Status for all Kenyans*' in 2009. The policy gives a framework that aims to ensure equitable, efficient, and effective delivery of quality reproductive health services in Kenya and reach the most vulnerable. However the research findings show that the implementation of this policy has a long way to go in targeting measures



aimed at persons with disabilities. The concerns of SRHR for women with disabilities have remaining mostly invisible hence not well addressed. Appreciation of SRH as a critical component of wellbeing should be enhanced. Full enjoyment of rights including access to health has been enshrined in the Kenya constitution as a right of every citizen. Therefore, specific measures need to be put in place to ensure that all Kenyans enjoy the health rights. Disability should not disadvantage any persons in enjoyment of these rights.

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issues that relate to SRH are a very personal experience, please do not be embarrassed. Every question that I ask is important. Please feel free and answer every question as fully and completely as possible.

I once more confirm that your answers will remain completely confidential and anonymous.

Thank you for your kindness and help.

Sincerely,

Sophia Ngugi

Signed by/ on behalf: ..... (Respondent)

Date: .....

**Background information of the respondent:-**

1. Please tell me in briefly about yourself?
  - a. Background information
  - b. History of the disability
  - c. Main challenges growing up as a disabled girl.

**Access to health facilities**

2. Have you visited a hospital for medical services?
  - a) Name of the health facilities that are often visited and reasons.
  - b) Accessibility and general assessment of the services provided and attitude of service providers.
  - c) Were you accompanied to the health facility? If yes, by who and the reasons and how it made you feel?

**Reception at medical facilities and attitude of service providers**

3. Can you recall the last time/ or the most memorable visit you have had to a public health facility seeking SRH services?
  - a. Estimate year/ month of the visit.
  - b. The nature of the services sought.
  - c. Was respondent accompanied or not? Reasons if accompanied.
  - d. Reception at the hospital/ process of getting admission
  - e. Assessment of the services received.
  - f. The attitude of the service providers

- g. Any need for translator during private medical examination and effect on the respondent. How did this make you feel?

#### Services related to child delivery

4. Could you share with me particular experiences related to visiting the health facilities while pregnant?
  - a. Probe home delivery if any and reasons for this.
  - b. How was the physical access to the labour and delivery rooms? (for physically challenged if not addressed in 3 above)
  - c. What additional of advice or services did you receive as pertains your SRH?
  - d. Did you have any procedure performed on you without your consent? If yes describe the procedure and effect of this.
  - e. How have the experiences at medical facilities in child birth affected your life?

#### Information access

5. Have you ever received SRH information from any hospital? Probe- more about how it occurred, how it was given, was it appropriate, understandable language from staff or literature etc Which health facilities have you visited /sought information relating to SRH?
  - a. If none, reasons for this.
  - b. Did you receive the information that you wanted? Share the experiences of this.
  - c. Probe information regarding HIV/AIDS and STIs
  - d. Probe access to information regarding SGBV
  - e. Have you sought information regarding family planning? If yes, what was the experience? If no, reasons for this.
  - f. How do you rate the nature of information offered on SRH in public health facilities?
  - g. What are the other medical health checkups that you have sought in medical facilities?
6. Are there instances that you have required SRH services from hospitals but not sought them?  
Reasons for this
7. How have the experiences at the health facilities affected your views and decisions regarding SRH?
8. What should be done at the maternal hospitals in order to make life more bearable for women like yourself and others with disability?