AFRICA ENVIRONMENTAL REVIEW Journal
ISSN: 1727-8341

AER Journal Volume 3, Issue 2, pp. 224-236, 2019

RESEARCH ARTICLE
Available Online at *http://www.aer-journal.info*

Inhibiting Factors to Equalization of Access to Heath Opportunities among Persons Living with Physical Disabilities in Uasin-Gishu County – Kenya

C. Koech[1], R. Too[2*] and M. Kosgei[3]
[1]*School of Medicine, Moi University, Eldoret Kenya*
[2]*School of Public Health, Moi University, Eldoret, Kenya*
[3]*School of Biological and Physical Sciences, Moi University, Eldoret, Kenya*
[*]*rtookip2000@gmail.com*

Abstract

Disability is one of the least visible yet most potent factors in various areas of marginalization. Majority of Kenyan citizens, living with physical disabilities, experience unfavorable social conditions while seeking health care. Globally, laws have been enacted on equalization of opportunities for the disabled persons including United Nations Convention on Rights of People with Disabilities (UNCRPD, 2006). Though Kenya is a state party to UNCRPD, laws on equalization of opportunities are yet to be fully integrated to the society. A study seeking to explore and investigate factors inhibiting equalization of opportunities to access of health services among persons with physical disabilities was carried out on persons with disabilities in Uasin-Gishu County, Kenya. The study was conducted at Moi Teaching and Referral Hospital (MTRH), Moi University (MU), Uasin Gishu County Government and Outreach Mobile clinic centers of persons with disabilities. The study adopted a mixed method approach involving 375 employed persons with physical disabilities, 4 key informants in selected institutions and 10 service providers in the outreach mobile clinics. Data was collected using Self-Administered questionnaires and interviewer guide. Chi-square tests and Odds Ratio were employed to determine factors associated with access to health services. Inhibiters of access to health care services were evaluated using a Logistic regression model.

Keywords: Disability, Equalization, Opportunity, Health Care, Inhibiters.

INTRODUCTION

People having disabilities are among the most endangered groups in all ways in the society in which we live in today. Dalal (2006) noted that they suffer because of societal discrimination due to their disabling physical situations. Explicitly, they are more possibly to be exposed to risks leading to deprived health because they experience unfavorable societal situations in health care, education, employment and transportation and in recreational facilities as reported by Lin & Yen (2010). According to Van Niekerk *et al*. (1997), environmental obstacles control people with disabilities from getting equal chances. Studies conducted in different elements of the world show that people having disabilities haven't been adequately integrated into the society (Katania, 2012, Andreja *et al*., 2011; Useh, 2000). The United Nations on Rights of Persons with Disabilities (UNCRPD, 2006) affirms the obligation of state parties to identify and eliminate the barriers encountered by persons having disabilities and guarantee complete and effective social integration as highlighted in articles, 9, 24;2 (a), 25 (c), 27(e) and 30(5). Kenya took a step and became a signatory to UNCRPD (2006) on

the 30th day of March, 2007 which was ratified on 19th day of May, 2008 and subsequently observes the worldwide day for persons having disabilities on 3rd December every year. Kenya has enacted laws to promote equalization of chances for persons having disabilities and among the laws but not limited to are:- The Equity Bill of 2000 which stipulates equal rights of persons having disabilities, Affirmative Action Bill of 2000 which stipulates road map to the implementation of equal rights with regard to persons having disabilities and the Enactment of Persons having disabilities Act 2003 which is the 1st lawfully joining tool in Kenya which advocates for balancing of opportunities for all disabled people. The new constitution 2010 puts into operation Act 2003 under article 54, yet even with the endorsement of legislations, persons having disabilities in Kenya are however to be completely incorporated to the general public. Economic authorization of disabled people will generate reduced reliance on national resources as well as aiding sustained people-centered growth (Gathiram, 2007). Article 25(c) obligates state parties to provide health services as near as possible to persons' communities comprising communities in rural areas.

Individuals having physical disabilities are at a high danger of getting secondary infections because they have greater possibilities of engaging in unhealthy risk behaviors however they rarely make use of primary health care services compared to general public (Lin & Yen, 2010). The far distant and inaccessible health care facilities, lack of disability related knowledge for service providers and lack of accessible prevention focus information especially in the rural areas are the main barriers. A part from curative services, rehabilitation is very essential to the disabled person. The United Nations Standard Rules on equalization (1993) of opportunities for persons with disabilities provided a definition of rehabilitation which states that it is a process aimed at enabling persons with disabilities to reach and maintain their optimal, physical, sensory and higher functional levels, therefore higher levels of independence. This may include measures to provide or restore functions or compensate for a functional limitation. Likewise, article (9) of the United Nations Convention for Rights of Persons with Disabilities (UNCRPD, 2006) also recognizes access to essential services to persons with disabilities such as health.

International studies with reference to Cambodia show a constraint in the health care system. In spite of the massive evolution of the health system in Cambodia lack of adequate resources and financial barriers continue to hinder access to health care (Annear, 2010). Persons with disability bear the greatest burden in meeting health care costs given that evidence from developed countries suggests that people with disabilities, need specialist services more, have a higher expenditure on health and spend more of what they earn on health than people without disability (WHO, 2011). As a matter of fact, a Cambodian study found that almost all disabled persons had sold their assets to raise income for medical care with the hope of curing their acquired impairments (Gatrell, 2004). The Ministry of Health in Kenya (MoH) has come up with several initiatives to improve access to health services including the operations. Since 2000 Health Equity Funds (HEFs) have been provided to ensure the poor are exempted from paying user fees, some being the disabled (Ministry of Planning Kenya, 2010; Annear, 2010).

Researches undertaken between 1982 and 1997 in developing countries including Guyana, Botswana as well as Zimbabwe reported rehabilitative services offered to persons with disabilities at a success rate of 26% to 91%. The advancement was in communication, social assimilation and combination to schools. Provision of rehabilitation services in South Africa to the disabled is an essential section of health care system (DOH, 2001). Rehabilitation

services are done at different points of care, at a diversity of organizations including the public segment, (roughly 60%), non-governmental together with disabled people organization as well as private sector (DOH, 2000) therefore ensuring that the disabled acquire rehabilitation services effectively.

In Kenya, rehabilitation services are offered in structure of community or institutional based arrangements, for instance in training centers, special schools or sanatoriums. Helander (2005) reported that in developing countries of which Kenya is incorporated, roughly 70% of people with medium to brutal disability survive, nevertheless only around 3% obtain rehabilitation services. This was pointed to lacking published data on rehabilitation services. Conversely with the opening of community-based rehabilitation services nationwide, service deliverance to persons having physical disabilities has advanced.

Problem Statement

Kenya has endorsed a number of laws to cater for rights of person having disabilities. Along with them is Persons with Disabilities Act, 2003 which was enforced in June, 2004. The legislation envisages, in one of its aims, that people having disabilities should have balancing of opportunities including access to healthcare. The government of Kenya in union with the National Fund for the Challenged of Kenya (NFDK) through the Ministry of Gender and Social Services has been assisting persons having disabilities with assistive tools, access to health together with education. In spite of all the attempts from the government, several obstacles which vigorously discourage involvement of the physically disabled people in accessing healthcare among other services still exist. There are also obstacles to outdoor facilities as well as support that limit the capability of disabled persons to partake on equivalent basis with persons without disabilities. The majority of the public notices the disability earlier and then other people later and hence missing on the immense contribution that Persons Living With Physical Disabilities (PLWPD) can contribute to Nation building. Should these obstacles not be identified and eliminated, the circumstances of the disabled person will keep on becoming poorer and Kenya being a country may not achieve part of its goals envisaged under vision 2030. Consequently, marginalization makes persons having physical disabilities to be short of economic empowerment and as a result depend on national resources (Gathiram, 2007). However, Kenya being a member of UNCRPD is beneath the responsibility to guarantee full rights of persons having disabilities, and failing to do that will break UNCRPD policy**.** Moreover, the Country needs to empower PLWPD to be self-reliant hence allowing the limited resources to be channeled to other sectors of the Economy.

MATERIALS AND METHODS

Study Area and Population

The research was done in four institutions in Uasin Gishu County in Kenya; Moi Teaching and Referral Hospital (MTRH), Moi University (MU), Uasin Gishu County Government Hospital and Outreach Mobile clinic centers of persons with disabilities. The outreach mobile clinics are National Government funded rehabilitation programs conducted by Association of Physically Disabled of Kenya (APDK) throughout the country. The population of persons having disabilities in Uasin Gishu is 20,039 of which 5,949 live with Physical disabilities (Kenya Population and Housing Census Volume II -August 2010).

Study Design

A mixed methods design was employed in this research and 354 participants were enrolled systematically from 9 sites including: MTRH and the 8 APDK centers (Chepkanga, Langas, Moi's Bridge, Olesurungai, Kesses, Burnt Forest, and Segero and Static clinic in Uasin-Gishu District Hospital).

Sampling and Sample Size

Fisher et al (1998) formula was used to determine the sample size for this study.

The prevalence of utilization of health care services among persons with disabilities nationally was taken as 10% (Mont, 2007) and applying a correction factor of 0.939, sample size for the study was obtained as;

$n = \frac{Nn_0}{N+n_0-1}$ = 354 Persons with physical disabilities, where $n_0 = \frac{z^2 p(1-p)}{d^2}$; p=10%-Proportion of persons with disabilities, z=1.96 being the z-score corresponding to a 95% CI, N=5,949 is the study population size and d is the amount of precision on p taken as 3% in this study. The target population was stratified according to institution type. Sample size was proportionately allocated according to stratum size and systematic sampling within the strata was adopted with an interval of 17 applied to obtain a sample of 354 physically challenged persons. Besides, 10 key informants and 10 service providers were purposively selected to participate in this study.

Inclusion Criteria

Persons with physical disabilities aged between 18-60 years and able to communicate in English and/or Kiswahili participated in the research.

Exclusion Criteria

Persons with other kinds of disabilities like visual, speech and mental and those under18 years of age were excluded.

Data Collection

Interviewer administered questionnaires were developed and used to collect information on demographic characteristics of the respondents and factors inhibiting equalization of opportunities to persons with disabilities in health among consenting participants. Trained research assistants were used to fill in the questionnaires. Focus group discussions of 10 participants stratified according to gender were constituted and an interview guide was used to structure the discussions. Translators were also used at this stage alongside voice recording.

Data Management and Analysis

Data was entered in SPSS (Vs 21), coded and cleaned. R-statistical software was used for analysis. Univariate analysis was conducted using means, and standard errors for continuous variables and frequencies were generated for categorical variables. Tables and charts were used to display these summaries. Bivariate analysis was performed to determine factors inhibiting access to health care for persons with physical disabilities. Assessment of these factors was done using chi-square tests and Odds Ratios at 5% level of significance. Multivariate logistic model was used to determine Inhibiters of access to equalization of health care for persons with physical disabilities. Qualitative data was analyzed via thematic content analysis and all the data were interpreted to English from Kiswahili then recorded verbatim. The transcripts were complemented with accumulated data from field notes prepared by research assistants. Transcripts were contrasted to recording to prove precise expression of the responses in Kiswahili. The data was categorized orderly by coding to identify key concepts then filtered into themes. Photographs were also integrated in the analysis.

Ethical Considerations

Approval was sought and given from the ministry of higher education, and institutional research and ethics committee (IREC) of Moi Teaching and Referral hospital and Moi University School of Health Sciences, the director of the hospital, Uasin Gishu County Government and the regional coordinator of APDK services. Consent was sought from the participants before enrolling them in the study. Participation was voluntary with an opportunity to withdraw willingly from the study. Informed written consent was signed by all participants in this study

RESULTS

Respondents' Demographics

This survey constituted of 354 participants, majority of whom were females 57.6%.

Majority of those who took part in the study were aged 46-60 years constituting 38.4% and the married constituting 61.6%. A high number of the participants were unemployed 55.4% with only 26.5% of those employed being in formal employment. Disease was the most common cause of disability among majority of participants in this survey 51.1%. Despite the fact that majority of the participants did not belong to a disability support group, 61%, they were still able to live independently, 67.0%.

Table 1: Demographic Characteristics of the Respondents

Variable	Category	Fre	%
Gender (n=354)	Female	204	57.6
	Male	150	42.6
Age (n=354)	18-25	40	11.3
	26-35	78	22.0
	36-45	100	28.2
	46-60	136	38.4
Marital Status (n=354)	Married	218	61.6
	Single	116	32.8
	Widower/widoww	9	2.5
	Separated	7	2.0
	Divorced	4	1.1
Religion (n=354)	Catholic	96	27.2
	Protestant	240	68
	Muslim	5	1.4
	Others	13	3.4
Employment (n=354)	Employed	170	48.0
Status	Unemployed	184	52.0
Nature of employment (n=170)			
Type of employment (n=170)	Formal	45	26.5
	Informal	125	73.5
No. of Siblings (n=354)	1-2	78	22.0
	3-4	100	28.2
	5-6	53	15.0
	more than 6	53	15.0
	None	70	19.8
Living Arrangement (n=354)	Independent	237	67.0
	Personal attendant	27	7.6
	Parents	72	20.3
	Church members	1	0.3
	Others (e.g home for	17	4.8
Cause of Disability (n=354)	Congenital	77	21.8
	Accident	96	27.1
	Disease	181	51.1
Belonging to a Disability Group (n=354)	Yes	138	39.0
	No	216	61.0

Barriers to Equal Access to Health Opportunities

The study sought to identify the barriers inhibiting equalization of opportunities to persons with physical disabilities with regards to access to health in Uasin-Gishu County, Kenya. The following barriers were examined:

Table 2: Frequency of Seeking Healthcare among Persons Living with Physical Disabilities

Age	Once/Twice a week	More than twice a week	Once/Twice a month	Once /Twice a year	Rarely	Never
18-25	0	1	7	3	24	6
26-35	2	1	15	2	48	6
36-45	1	2	13	10	67	4
46-60	3	2	29	6	86	16
Total	6	6	64	21	225	32

Majority of the respondents 91% sought health care with 63.6% (225) indicating that they rarely seek healthcare, while a section of the respondents 18% (64) sought health care once or twice a month and 9% (32) did not seek healthcare at all. Respondents gave various reasons for not seeking healthcare at all. The nature of disability of the respondents was among the main reasons given, 62.5%. Other reasons include lack of finances, 21.9%.

Table 3: Reasons for not Seeking Healthcare

	Responses	Fre	Percent %
Why don't you seek healthcare?	My disability does not allow	20	62.5
	I am not aware	2	6.3
	I don't have financial resources	7	21.9
	Community workers take care of me	3	9.4
	Total	32	100.0

Healthcare Institutions

Majority of the respondents 91% sought healthcare. An average of 94.3% sought health care from public health facilities. This was the case across all ages and gender, as shown in Figure 1.

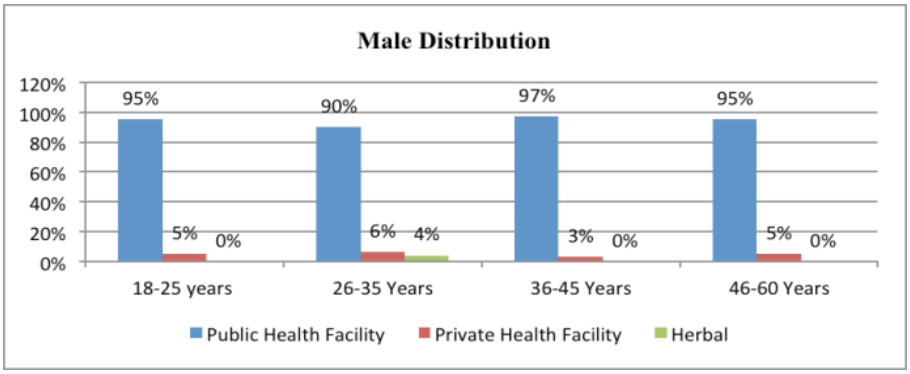

Figure 1a: Male age distribution of those seeking Healthcare in Healthcare Institutions.

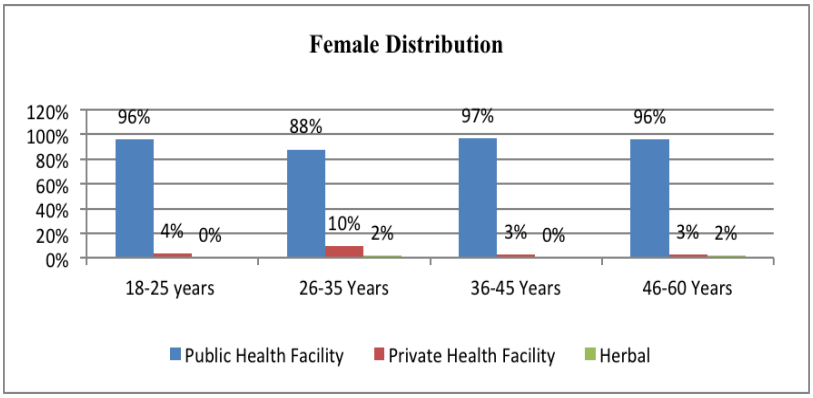

Figure 1b: Women age distribution of those seeking Healthcare in Healthcare Institutions.

Distance to the Nearest Healthcare Facility

Majority of the study participants 82% accessed healthcare if the nearest health facility was within 0-10 km, however a minority 18% (58) could only access health care if the facility was within the radius of 11km and above (Figure 2).

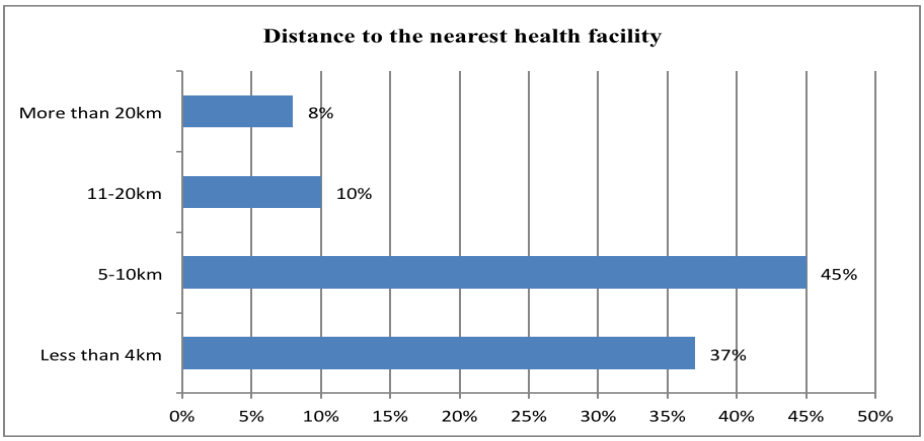

Figure 2: Access to the Health Facility in Relation to Distance.

Health Care Providers' Attitudes

The influence of healthcare providers was a factor in health seeking behavior among persons living with physical disabilities. From table 4, majority of the respondents 38% believe that influences of healthcare providers limit a lot health care seeking compared to 16.7% (59) who believe that providers' attitude has no influence in their participation on healthcare seeking.

Table 4: Influence of Attitude of Health Care Providers on Participation on Health Care Seeking

		Frequency	%
How Does attitude of healthcare providers influence your participation on seeking for care?	Help a lot	93	26.3
	Help somehow	59	16.7
	Have no effect	59	16.7
	Limit some	10	2.8
	Limit a lot	133	37.6
Total		354	100.0

Frequency of Seeing a Therapist

As indicated in Table 5 this study revealed that 34.5% of persons with disabilities rarely sought services from a Therapist, whereas at least 5.1% sought Therapists services more than twice a week. However, 32.2% never sought services of a Therapist at all.

Table 5: Frequency of Seeing a Therapist (Occupational and physical Therapist, Orthopedic Technologist)

		Frequency	Percent
How often do you see a Therapist?	>2/week	18	5.1
	1 or 2/ month	60	16.9
	Rarely	122	34.5
	1 or 2/ week	2	.6
	1 or 2/ year	38	10.7
	Never	114	32.2
Total		**354**	**100.0**

Frequency of Seeking Help for Accessing Healthcare

Table 6 shows how often the respondents sought help from family members and friends. According to this survey, 41% rarely sought help from family members. Only 1.4% seeks help once or twice a week and 61.3% of respondents say that they rarely seek help from friends whereas 13.8% seek help from friends once or twice a year.

Table 6: Assistance from Family Members or Friends to Access Health Care

		Friends	Family Members
How often do you ask for help from family members to access health care?	>2/ week	6.3% (27)	18.6% (70)
	1 or 2/ month	11.5% (40)	19.5% (68)
	Rarely	61.3% (214)	41% (143)
	1 or 2/ week	0.6% (2)	1.4% (5)
	1 or 2/ year	13.8% (48)	12.6% (44)
	Never	6.6% (23)	6.9% (24)
	Total	100.0% (354)	100.0% (354)

Bivariate Analysis

Table 7 shows analysis of relationships ($p \leq 0.05$) between health seeking behavior and the various inhibitors. The results show that health seeking behavior is significantly associated with marital status, distance to facility, attitudes of healthcare givers and help from family members.

Logistic Regression

Logistic regression model was fitted to further examine inhibiters of healthcare seeking among persons with physical disabilities. Table 8 presents the unadjusted and adjusted models to examine presence of confounders and examine relationships controlling for effect of other variables.

Table 7: Association between "Seeking Healthcare" and various Inhibitors

Inhibitors (Covariates)		Once/Twice a week	More than twice a week	Once/Twice a month	Once /Twice a year	Rarely	χ^2 value	Df	p-value
Age of respondent	18-25	0	1	7	3	24	10.43	12	0.379
	26-35	2	1	15	2	48			
	36-45	1	2	13	10	67			
	46-60	3	2	29	6	86			
Sex of respondent	Male	4	3	43	10	138	1.71	4	0.790
	Female	2	3	34	11	93			
Marital status	Married	6	2	54	14	137	32.1	16	**0.010**
	Never Married	0	3	19	5	83			
	Widowed	0	0	2	0	7			
	Separated/Divorced	0	1	2	2	4			
Distance from residence to facility	<4 km	0	2	15	4	103	65	12	**0.001**
	5-10 km	2	1	29	8	107			
	11-20 km	2	2	18	5	13			
	>20 km	2	1	14	4	7			
Attitude of healthcare providers	Help A lot	3	1	15	6	63	43.43	16	**0.001**
	Help Somewhat	2	3	26	6	21			
	Have no effect	1	1	13	4	36			
	Limit some	0	0	2	1	7			
	Limit A lot	0	1	20	3	103			
Help from family	More than 2/week	3	2	19	3	33	102.13	20	**0.001**
	Once/Twice/Month	3	3	35	1	24			
	Rarely	0	1	15	8	116			
	Once/Twice/Week	0	0	3	2	0			
	Once/Twice/Yrs	0	0	1	4	38			
	Never	0	0	3	2	18			

Table 8: A Logistic Model Fitting "Seeking Healthcare" and various Inhibitors

Variable	Un-Adjusted Model			Adjusted Model		
	β-Coeff	p-value	OR	β-Coeff	p-value	OR
Marital status		**0.123**			**0.355**	
Married	0.799	0.244	2.224	0.524	0.607	1.689
Never married	1.275	0.070	3.578	1.011	0.331	2.748
Widowed	1.476	0.158	4.375	1.534	0.303	4.635
Distance from residence to		**0.000**			**0.000**	
facility	2.642	0.000	14.05	2.096	0.000	8.137
< 4 km	2.034	0.000	7.64	1.664	0.003	5.281
5 – 10 km	0.368	0.505	1.44	-0.352	0.592	0.702
11- 20 km						
Attitude of healthcare		**0.000**			**0.013**	
providers	-0.569	0.076	0.566	-0.164	0.670	0.849
Help a lot	-1.982	0.000	0.138	-1.447	0.001	0.235
Help some what	-0.777	0.031	0.460	-0.086	0.856	0.917
Have no effect	-0.569	0.433	0.566	-0.547	0.571	0.579
Limit some what						
Help from family (Never)		**0.000**			**0.000**	
More than	-1.117	0.049	0.327	-1.325	0.050	0.266
twice/week	-1.864	0.001	0.156	-1.402	0.035	0.246
Once or twice/week	0.295	0.594	1.343	0.640	0.341	1.897
Once or twice/month	-22.484	0.999	0.000	-22.218	0.999	0.000
Once or twice/year	0.565	0.399	1.759	0.759	0.337	2.136
Rarely						

DISCUSSION

United Nations Convention (2006) stated that persons with disabilities have the right to benefit from elevated accomplishable standard of health with no discrimination based on disability. Similarly, the rights of persons having disabilities as merged to access to health were legalized in Disability Act 2003 of Kenya as well as Article 54 of the constitution (2010). In this study gender did not turn out as a significant factor in usage of health care services amid persons having disabilities (P=0.790). Generally, male respondents uncommonly seek healthcare compared to female complements and in male as well as female, a number seek health care in public hospitals, 90% while a negligible number seek healthcare from private institutions, 8% and 2% sought herbal medication. From the focus group discussions, respondents from urban area (FGD 1), Peri-urban areas (FGD 4, 5) and the rural areas indicated that more female access healthcare. This result was consistent with findings of Hanson *et al*. (2003) which discovered out that 95% of women with disabilities had health insurance coverage therefore have no difficulty in accessing healthcare. This was also consistent with Centers for Medicare and Medicaid Services (CMS), 2009 report that showed that in 2008, 48.1 million Americans were enrolled in Medicaid, with women living with disabilities comprising the majority. These however contrast Oliver (2003) findings in Kenya which showed that women with disabilities generally have less access to rehabilitation services compared to their male counterparts. This could be due to traditional social and cultural norms in most village societies in Kenya. Most WWDs do not go out of their houses to seek help for healthcare, especially if the care-provider is male. According to the current study women access healthcare more than the male counterparts. This could be attributed to increased awareness on primary healthcare whereby campaigns are carried out in villages and most participants are females since they are mostly available in homes.

This study found a strong significant relationship between the frequency of seeking healthcare and attitude of healthcare workers (p-value 0.001). From table 7, 26.3% (93) of the respondents consider that attitude of health care providers assist a lot in accessing healthcare while 36.2% of the

respondents feel that attitude of healthcare providers limit a lot in seeking healthcare and 16.7%, 16.7% (59) and 4.2% feel that the attitudes of healthcare providers help somehow, have no effect and limit some, respectively. In the focus group discussion majority of the respondents from rural areas (FGD 2, 3, 6) indicated that healthcare providers feel that they should also access healthcare like the non-disabled counterparts and even regard them at times as difficult persons to handle while those from the Rural areas and Peri-urban areas indicated that healthcare providers are friendly to persons with physical disabilities. The results of this survey showed a significant proportion of people with physical disabilities are facing complications in accessing adequate and appropriate primary healthcare services could be due to lack of information from healthcare workers on access to healthcare by persons with physical disabilities like provision of health insurance covers and free medical services.

These findings are similar to a study by Veltman *et al*. (2001) whose findings showed that the negative perceptions of primary healthcare workers towards people with physical disabilities in Canada has led a decline in seeking access to health services by persons with disabilities. Veltman *et al.* (2001) found that up to a third had difficulty in accessing family doctor while one fifth felt that their family doctor was insensitive or oversensitive about their disability. Also, 26.9% of respondents in the same study felt that inadequate time is allotted to medical appointments and they also report that their doctors hurry too much when they treat them. This situation has also been observed in several studies (Maart & Jelsm, 2013; Munthali *et al.,* 2013b; Coomer, 2012; Ravim & Handicap International, 2010; Barrat & Penn, 2009). Many respondents in these studies narrated experiences with regards to inappropriate or unprofessional conduct on the part of the service providers. The study by Barrat and Penn (2009) revealed that just under half of the respondents were unwilling to use healthcare facilities due to the negative attitudes of the health care workers. The negative attitudes included the use of demeaning and offensive language and the general lack of patient-health worker rapport. Similar observations have also been reported in Kenya by Becker (2007) which revealed that most women with disabilities are mistreated by medical practitioners when they go to hospitals for treatment. These left them with a feeling of alienation in reference to provision of health services as they feel they are burdensome, especially when providers are unable to provide adequate facilities, consultation time, or advice to meet their needs. The negative attitudes from healthcare workers could be as a result of lack disability training.

The study indicated that there is a significant relationship between distance to the health facility and access to healthcare (p-value= 0.001). Majority of the respondents 43.7% lived 5-10 km away from the healthcare facility, while 36.5% lived less than 4km away from the health facility. A minority of 13% and 10% access healthcare at 10-20 km and more than 20 km respectively. Distance is a factor in accessing healthcare, the further the healthcare facility the difficult it is for persons with disabilities to access because their disability may not allow to cover the long distances. Similarly, in the focus group discussion, majority of the respondents from the rural areas (FGD 2, 3, 6) indicated that long distances to healthcare facility may not allow them to access healthcare. However, those from urban area (FGD 1) and peri-urban areas (FGD 4, 5) indicated that distance is not a factor in accessing healthcare. These findings are similar to Oanh (2009) which showed that geographical conditions greatly affect access to health services by PWDs. People in mountainous areas irrespective of their economic status, access health services less frequently than people in delta regions. Geographical challenges such as mountains,

gullies, rivers, unpaved roads etc. present physical barriers to accessing healthcare especially by PLWD. It is also similar to Chipp *et al*. (2010) who found that due to geographic challenges, some rural residents rarely seek health care. These findings have also been observed by Van Rooy (2012) and Brems *et al*. (2006) in Namibia. The distance to a health care center determines the utilization of health services. The distance affects the mode of transport utilized and the time taken to reach a health facility. Studies by Maart and Jelsma (2013), Grut *et al.* (2012), Barrat and Penn (2009) and Saloojee *et al*. (2006) in South Africa, Ravim and Handicap International (2010) in Mozambique, Coomer (2012) in Namibia, Muntahli *et al*. (2013b) in Malawi and Chipp *et al*. (2010) in Kenya have all shown long distance as a barrier. The high access of health care in urban and peri-urban areas could be attributed to the close proximity of health facilities of health facilities hence PWDs are able to commute to the facilities.

CONCLUSION

From the findings, it is apparent that physically disabled persons still face disputes in accessing health care services. Policy and law formulation to promote, protect and safeguard the rights of persons with disabilities need (WHO, 2012) to be viewed in a broader context beyond a single piece of legislation. WHO report on disability specifies that, lack of fair access to resources including employment, education, infrastructure, health and recreational facilities with regards to persons with physical disabilities is disproportionately high (WHO Disability Report, 2012). Sustainable fair progress in the agreed global development agenda cannot be accomplished without including of persons with Disabilities. If they are not incorporated, progress in the development will increase their marginalization.

RECOMMENDATIONS

Apart from enacting the legislations, the government must strengthen awareness in both public as well as private sectors so as to encourage the employers to employ persons having physical disabilities. In this regard media ought to be in the front in sensitizing the society on the right to employ persons with disabilities. The government should put into practice every aspect of the Disability Act (2003) for employment of PWDs. Organizations should be educated to have disability policies and legislations in places of work that administer the employment of PWDs and fines for people who do not conform to the policies. The public as well as private hospital administration should make sure facilities like low beds together with low toilets in the hospitals; ramps together with floors that are adapted to disability; vehicles which are adapted widen corridors as well as doorways and also give priority services to the persons with disabilities in the hospitals. These are accomplished by employing doctors as well as nurses who are well trained in disability issues to encourage the persons with disabilities to come for health services at the hospital.

Likewise, community health workers in Uasin-Gishu County, Kenya should be provided special in-depth disability training, so that they can assist in counseling and referring disabled persons to the right service provider. This is essential because of the reality that community health workers live in a close proximity to disabled individuals; the community health workers hence will be able to follow up on referrals to make sure disabled individuals are accessing health services. To enhance access to health services APDK clinics should include the services of doctors, physical therapists, occupational therapists, orthopedic technologists, counselors and social workers among others. By bringing the health professionals to the community would eliminate several barriers that prevent or discourage individuals with disabilities from accessing health services.

REFERENCES

Affirmative Action Bill (2000). The two thirds gender rule on elective or appointive positions.

Altman, B. M. (2001). Disability definition models classification scheme, & application. In G. L. Albrecht (Ed.), *Handbook of Disability Studies*. London: Sage Publications Inc.

Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities Eighth session United Nations, Department of Economic and Social Affairs Division for Social Policy and Development, New York, 14-25 August 2006

De Vaus, D. (2001). Research at grass roots for the social sciences and human science professions. Pretoria Van.

Gary, L. (2005). *Encyclopedia of disability.* Thousand Oaks, CA: SAGE Publications. Bowe

Gathiram, N. (2007). Economic empowerment of physically disabled people in South Africa: challenges and prospects. *Journal of social development in Africa*, 22(1), 143.

Hammel, K. W. & Bury. (2003). *Perspective on Disability and Rehabilitation. Contesting Assumption. Challenging Practice* (1st ED). Churchill Livingstone: Elsevier.

Janet E. L. & Michael, A. S. (2009). Social Rights and The Relational Value of the Rights to Participate in Sport, Recreation and Play. *27 Boston University Journal of International Law*, 249.

Katania, D. (2000). Prepare to care for the physically challenged. *The special Patient.*

Kenya National Bureau of Statistics, Kenya population and housing census 24/25 August 2009 Vol 2

Lin, J. D. & Yen. C. Y. (2010). Factors for healthy food or less-healthy food intake among Taiwanese adolescents with intellectual disabilities. *Research in Developmental Disabilities, 31*, 203–211.

Loeb, E. M., Edie, A. H., Saka, N., Munthali, A., Ngulube, T. J. & Van Rooy, G. (2006). Living conditions of people with disabilities in developing countries.

Milles, S. (2013). Strengthening disability and development work. Discussion paper. BOND Disability and development working group, UK.

National Council for Law Reporting, Kenya Law Reports (K.L.R). Constitution of Kenya (2010). The persons with disabilities (Section 54). Published by the National Council for Law Reporting with the authority of the Attorney-General. www.kenyalaw.org.

National Council for Persons with disabilities (NCPD) . Persons with disabilities act No .14 2003

Oliver, M. (1996). Defining impairment and disability. In C. Barnes & G. Mercer (Eds.), *Exploring the Divide* (29-54). Leeds: The Disability Press.

Polit, D. F., Beck, C. T. & Hungler, B. P. (2001). Essentials of Nursing Research: Methods, Appraisal and Utilization (5th Edition). Philadelphia: Lippincott.

Skosana, D. S. (2006). A usability slides of two practical pamphlets designed to inform small scale farmers about best agricultural practice. Master thesis university of Pretoria.

Swain, J. & French, S. (2002). The relationship between disabled people and Health and welfare professionals. In G. L. Albrecht (Ed.), *Handbook of Disability Studies* (10-12). London: Sage Publications Inc.

Useh, U. (2000). Wheelchair accessibility of public buildings in the central business district of Harare, Zimbabwe. *Disability and Rehabilitation, 23*(11), 490-496.

WHO (2011). *World Health Organization Statistical Report for People with Disabilities*. Geneva: WHO.