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Leadership Support For Disability Participation-Inclusion And Service-Delivery In Level-Six Hospitals In Kenya

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Abstract
Background: *Participation-inclusion facilitates employees with disability through employment, policies and culture, whose implementation falls below colleagues without disability. At level-6 hospitals, participation-inclusion and its influence on service-delivery from employees with disability had not been studied. This research sought to determine the influence of leadership-support for participation-inclusion on service-delivery at level-6 hospitals in Kenya. The objective was informed by aspects of social and human rights models, stakeholder theory, and theory of stigma.*
Methods: *In this cross-sectional study, data was collected from 211 employees with disability and 196 supervisors, sampled by census, in five purposively-selected hospitals. Tools used were two Likert-scale-based questionnaires (with qualitative and quantitative aspects) and observation checklists. Secondary data from study facility employee databases, strategic plans and disability mainstreaming policy documents were used. Data analysis was done using SPSS version 29 and N-Vivo version 15 for quantitative and qualitative aspects respectively, for measures of central tendency, dispersion, percentages; associations using Peason's correlation coefficients and ANOVA for hypothesis testing, with cut of p-value $\leq$ 0.05 indicating significance.*
Results: *Response-rate for employees with disability was 211(92.1%) and immediate supervisors 196(85.6%). Quota employment representation deficit was 0.5-4.1%, influence of employment 71%, promotions 72%, database 48%, policy 75%, disability committees 72%, programs 66%, awareness 72%, support-supervision 78% and collegial-support 78%. Service-delivery from employees with disability was rated 80% and satisfaction of supervisors 86%. The value of R square was 0.423, inferring that 42.3% change in service-delivery was accounted for by leadership-support for participation-inclusion, F statistic was 130.695 being greater than F critical at 3.909 and significant p-value 0.000. Thus, the null hypothesis, 'participation-inclusion has no significant influence on service-delivery at level-6 hospitals in Kenya,' was rejected. An employee with disability said, "… sometimes colleagues assume I need… help when I don't…They should ask us…." A supervisor said, "…Some outperform their colleagues without disability…"*
Conclusions: *Participation-inclusion has positive significant influence on service-delivery from employees with disability. They have potential talent-reservoirs that can be objectively exploited through leadership-led participation-inclusion and timely data to dispel misconceptions.*
Key Words: *Disability, Employees, leadership, participation-inclusion, service-delivery*

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I. Background

Participation-inclusion for employee with disability is a responsibility to improve employment, policies and traits to support employees with disability (EWD) to reveal their potentials. Despite legislations, implementation of employment representation, disability-policy and supportive traits display inequalities. Although leadership support for participation-inclusion, supported by the social and human rights models, stakeholder theory, and theory of stigma, has positive influence on service-delivery from EWD, execution, monitoring, evaluation and dissemination is low. Stigma, misconception and stereotypes around service-delivery from EWD are often not evidence based.[1,2] Employment being a fundamental human-right that promotes well-being and feeling valuable in people with disability (PWD), also creates social connectedness.[2] At workplace EWD in healthcare needs collegial and support-supervision and promotions. These would be executed through disability-policies, disability-committees, having databases and disability-mainstreaming programs led by institutional leadership.

In Kenya service-delivery from EWD, had not been researched and the status of participation-inclusion was scantly documented. Additionally, the influence of participation-inclusion on service-delivery from EWD in level-6 hospitals had not been studied. In 2022 only 1% of 404 public institutions complied to 5% employment

quota of PWD and low employment trends have been reported widely.[3,4] None of the level-6 hospitals had complied. Like elsewhere, it was not documented how disability-policy implementation had been achieved[5] and how participation-inclusion[6] was influencing service-delivery from EWD. With the five study facilities having a population of 229 EWD, it was vital to undertake this research to provide feedback to stakeholders and inform practices and policies through census sampling for representation.[7-8] Leve-6 hospitals were chosen because they ought to be leaders in implementation of policies and provide evidence to support review, identify gaps, resources and support-supervision necessary to realize success in health policies.

II. Method And Materials

Study design: Cross-sectional

Study location: Five purposely selected level-6 hospitals in Kenya. They included Kenyatta National Hospital (KNH), Moi teaching and Referral Hospital (MTRH), National Spinal Referral Injury Hospital (NSIRH), Mathari National Teaching & Referral Hospital (MNTRH) and Mwai Kibaki Teaching & Referral Hospital (MKTRH).

Study duration: 12th June, 2024 to 11th June, 2025

Sample size: 211 EWD and 196 supervisors

Sample calculation: Census-based targeting all 229 EWD and 229 supervisors and study facilities purposively-selected as guided in previous studies.[7-8]

Study participants selection method: Census based for EWD and supervisors and purposive selection of the study facilities.

Inclusion criteria: Those on duty during data collection period, willing to voluntarily participate by giving a signed informed consent.

Exclusion criteria: Those who were not duty during data collection period, unwilling to voluntarily participate by giving a signed informed consent or too sick to participate.

Data collection: Data collection was conducted using two questionnaires, one for EWD and the other for supervisors. Five checklists were filled per study facility. Eligible participants were given information on study title, data collection, risks/discomforts, benefits, ethical compliance, consenting process and handling of results. Those willing to participate signed a written consent and questionnaires were filled at participants' convenience. Secondary data from study facility employee databases, strategic plans and disability mainstreaming policy documents were used.

Reliability and validity test

Table 1: Reliability & Validity Tests using Cronbach Alpha and Principal Component Analysis

Reliability Test Using Cronbach Alpha Test				
NO	**Variable**	**Cronbach Alpha**	**No. of Items**	**Status**
1.	Participation-inclusion	0.89 (good)	9	Acceptable
2.	Service-delivery by EWD	0.76	9	Acceptable
	Validity test using principal component analysis			
1.	Participation-inclusion	0.6218 (High)	9	Acceptable
2.	Service-delivery by EWD	0.5418 (Moderate)	9	Acceptable

Pilot-testing to fine-tune data tools was done in two level-5 hospitals (Mbagathi and Pumwani Maternity). For high precision pilot study sample size should 1-10% of the research sample.[9] Pilot sample size was done on 12 EWD and supervisors, selected by census, forming 5.2% of the study sample. The results of the pilot work have not been included in the overall study findings. Participation-inclusion had a reliability test value of 0.89 (good) using Cronbach Alpha test. Service-delivery had 0.76 (acceptable). Participation-inclusion had a validity of 0.6218 (high) and service-delivery 0.5418 (moderate), shown in Table 1. This is supported by previous studies.[10-12] The instruments did not need modification.

Statistical analysis: Data analysis was done at descriptive and inferential levels using SPSS version 29 and N-Vivo version 15 for quantitative and qualitative aspects respectively. Associations were done using Peason's correlation coefficients and ANOVA for hypothesis testing, with p-value ≤ 0.05 cut off indicating significance.

III. Results

Response rate

Table 2: Response-rate of EWD and supervisors

Response-rate N=211 (Target 229 Employees with Disability)						
	STUDY FACILITIES					
VARIABLE	KNH n=96	MTRH n=95	MNTRH n =8	MKTRH n=7	NSIRH n=6	Overall N =211
Response-rate EWD	95(99%)	95(84.8%)	8(100%)	7(100%)	6(100%)	211(92.1%)
	KNH n=95	MTRH n=82	MNTRH n =8	MKTRH n= 5	NSIRH n=6	Overall N=196
Response-rate Supervisors	95(99.0 %)	82(73.2%)	8(100%)	5(85.7)	6(100%)	196(85.6%)

Response is critical in disability studies. Overall response-rate of EWD was 211(92.1%) and supervisors 196(85.6%), thus a non-response-rates of 18(7.9%) and 33(14.4%), respectively in Table 2.

Biodata of Employees with Disability

Table 3: Biodata of employees with disability

	STUDY FACILITIES (N=211)					
VARIABLE	KNH n=95	MTRH n=95	MNTRH n=8	MKTRH n=7	NSIRH n=6	Overall N =211
Gender for Employees with Disability						
Male	57(60.0%)	45(47.4%)	6(75.0%)	3(42.9%)	4(66.7%)	15(54.5%)
Female	38(40.0%)	50(52.6%)	2(25.0%)	4(57.1%)	2(33.3%)	96(45.5%)
Age of Employees with Disability						
18-24	1(1.1%)	1(1.1%)	0(0.0%)	0(0.0%)	0(0.0%)	2(0.9%)
25-34	8(8.4%)	2(2.1%)	0(0.0%)	3(42.9%)	0(0.0%)	13(6.2%)
35-44	14(14.7%)	30(31.6%)	0(0.0%)	3(42.9%)	0(0.0%)	47(22.3%)
45-54	42(44.2%)	42(44.2%)	5(62.5%)	1(14.3%)	5(83.3%)	95(45.0%)
55-64	30(31.6%)	20(21.1%)	3(37.5%)	0(0.0%)	1(16.7%)	54(25.6%)
Years of Service of Employees with Disability						
0-10	13(13.7%)	14(14.7%)	0(0.0%)	7(100%)	0(0.0%)	34(17.5%)
11-20	22(23.2%)	52(54.7%)	4(50.0%)	0(0.0%)	3(50.0%)	81(38.4%)
21-30	31(32.6%)	11(11.6%)	3(37.5%)	0(0.0%)	2(33.3%)	47(22.3%)
31-40	11(11.6%)	3(3.2%)	1(12.5%)	0(0.0%)	1(16.7%)	16(7.6%)
Missing	18(18.9%)	15(15.8%)	0(0.0%)	0(0.0%)	0(0.0%)	33(15.6%)
Department of Employees with Disability						
Administration	23(24.2%)	40(42.1%)	2(25.0%)	1(14.3%)	5(83.3%)	71(33.6%)
Inpatient	8(8.4%)	12(12.6%)	2(25.0%)	1(14.3%)	0(0.0%)	23(10.9%)
Outpatient	52(54.7%)	27(28.4%)	4(50.0%)	4(57.1%)	1(16.7%)	88(41.7%)
Non-clinical	12(12.6%)	16(16.8%)	0(0.0%)	1(14.3%)	0(0.0%)	29(13.7%)

Biodata is invaluable in disability studies. Biodata, which is critical in disability studies has been presented in Table 3. Out of 211(100%) EWD, 115(54.5%) were male, 95(45%) aged 45-54 years, 81(38.4%) had worked for 11-20 years and 88(41.7%) in outpatient settings.

Additional demographic data

Table 4: Further demographic data of employees with disability

	STUDY FACILITIES (N-211)					
VARIABLE	KNH n=95	MTRH n=95	MNTRH n=8	MKTRH n=7	NSIRH n=6	Overall N =211
Category of School Attended by Employees with Disability						
Mainstream	85(89.5%)	92(96.8%)	8(100.0%)	6(85.7%)	6(100.0%)	197(93.4%)
Special	7(7.4%)	3(3.2%)	0(0.0%)	1(14.3%)	0(0.0%)	11(5.2%)
No schooling	3(3.2%)	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)	3(1.4%)
Category of College Attended by Employees with Disability						
Mainstream	83(87.4%)	87(91.6%)	8(100.0%)	6(85.7%)	6(100.0%)	190(90.0%)
Special	9(9.5%)	7(7.4%)	0(0.0%)	0(0.0%)	0(0.0%)	16(7.6%)
No college	3(3.2%)	1(1.1%)	0(0.0%)	1(14.3%)	0(0.0%)	5(2.4%)
Highest Qualifications for Employees with Disability						
Diploma	47(49.5%)	27(28.4%)	3(37.5%)	4 (57.1%)	4(66.7%)	85(40.3%)
First Degree	12(12.6%)	26(27.4%)	4(50.0%)	3(42.9%)	1(16.7%)	46(21.8%)
Certificate	14(14.7%)	22(23.2%)	1(12.5%)	0(0.0%)	0(0.0%)	37(17.5%)
Master's Degree	9(9.5%)	10(10.5%)	0(0.0%)	0(0.0%)	1(16.7%)	20(9.5%)
No training	10(10.5%)	9(9.5%)	0(0.0%)	0(0.0%)	0(0.0%)	19(9.0%)
PHD	3(3.2%)	1(1.1%)	0(0.0%)	0(0.0%)	0(0.0%)	4(1.9%)
Cadre of Employees with Disability						

Health management & Support	37(38.9%)	52(54.7%)	0(0.0%)	2(28.6%)	2(33.3%)	93(44.1%)
H/professional	51(53.7%)	27(28.4%)	7(87.5%)	5(71.4%)	2(33.3%)	92(43.6%)
H/associate	6(6.3%)	12(12.6%)	1(12.5%)	0(0.0%)	2(33.3%)	21(10.0%)
Personal Care worker	1(1.1%)	4(4.2%)	0(0.0%)	0(0.0%)	0(0.0%)	5(2.4%)
Type of Disability Experienced by Employees with Disability						
Physical	55(57.9%)	51(53.7%)	6(75.0%)	3(42.9%)	5(83.3%)	120(56.9%)
Visual	11(11.6%)	24(25.3%)	0(0.0%)	2(28.6%)	1(16.7%)	38(18.0%)
Hearing	13(13.7%)	8(8.4%)	0(0.0%)	2(28.6%)	0(0.0%)	23(10.9%)
Missing body organ	6(6.3%)	1(1.1%)	1(12.5%)	0(0.0%)	0(0.0%)	8(3.8%)
Epilepsy	2(2.1%)	2(2.1%)	0(0.0%)	0(0.0%)	0(0.0%)	4(1.9%)
Mental illness	3(3.2%)	1(1.1%)	0(0.0%)	0(0.0%)	0(0.0%)	4(1.9%)
Hearing & speech	1(1.1%)	3(3.2%)	0(0.0%)	0(0.0%)	0(0.0%)	4(1.9%)
Vitiligo	1(1.1%)	3(3.2%)	0(0.0%)	0(0.0%)	0(0.0%)	4(1.9%)
Physical & Psychosocial	1(1.1%)	0(0.0%)	1(12.5%)	0(0.0%)	0(0.0%)	2(0.9%)
Psychosocial	1(1.1%)	1(1.1%)	0(0.0%)	0(0.0%)	0(0.0%)	2(0.9%)
Physical & hearing	0(0.0%)	1(1.1%)	0(0.0%)	0(0.0%)	0(0.0%)	1(0.5%)
Psychosocial & Intellectual	1(1.1%)	0(0.0%)	0(0.0%)	0(0.0%)	0(0.0%)	1(0.5%)

Additional demographic data is shown in Table 4. Out of the 211(100%) EWD, 197(93.4%) attended mainstream schools, 85(40.3%) had diploma, 93(44.1%) were in health management and support department and 55(57.9%) had physical disability.

Normality test

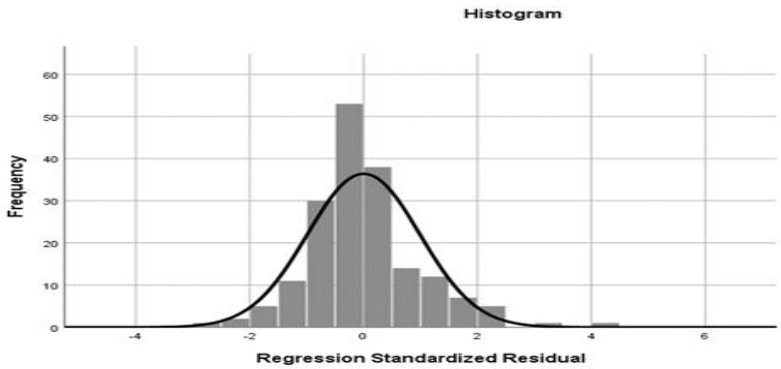

Figure 1: Normality plot histogram

Normality test was determined using Kolmogorov-Smirnov test. Additionally, this was supported by a histogram plotting of the normality results as shown in Figure 1. It presents residuals symmetrically distributed around zero, with only minor deviations at the tails, suggesting normality.

Linearity test

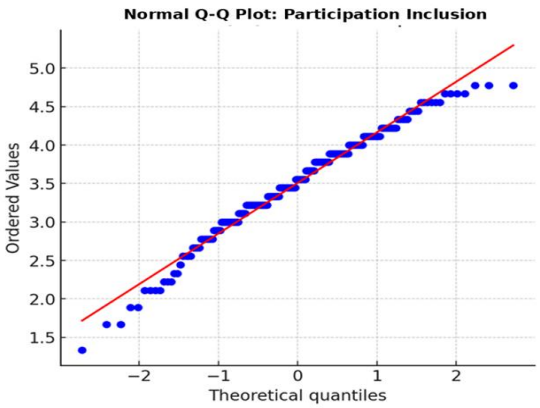

Figure 2: Linearity test for participation-inclusion

Linearity test was done to explore the conditions that guide the modelling and interpretation of the data sets to conduct regression analysis shown in figure 2.

Heteroscedasticity test

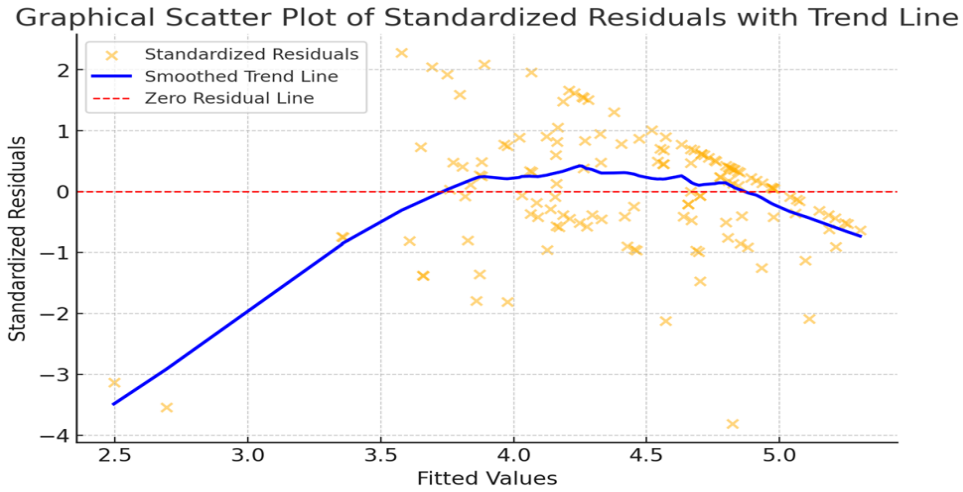

Figure 3: Graphical Representation of p-p plots in Heteroscedasticity Test

Heteroscedasticity was tested and graphical p-p and scatter plots method were used. Results indicate no presence of heteroscedasticity using ordinary least squares (OLS) regression, evidenced by the graphical scatter plots which oscillate along the standardized residual regression line (figure 3).

Participation inclusion: quota representation

Table 5: Quota employment representation of employees with disability

	STUDY FACILITIES (∗W=total Workforce in Study Facility)				
VARIABLE	KNH W=4895	MTRH W=3573	MNTRH W=801	MKTRH W=558	NSIRH W=132
Quota EWD representation target (5% of W)	245(5.0%)	179(5.0%)	40(5.0%)	28(5.0%)	7(5.0%)
Attainment of quota EWD representation	96(2.0%)	112(3.1%)	8(1.0%)	5(0.9%)	6(4.5%)
Quota EWD representation shortfall	139(3.0%)	67(1.9%)	32(4.0%)	23(4.1%)	1(0.5%)

Participation-inclusion included employment, policy guidelines and organizational traits. Study facilities had not attained legal requirement of 5% quota representation in employment for PWD. Mwai Kibaki Referral Hospital had the highest deficit at 23(4.1%) and NSIRH had the least at 1(0.5%) shown in Table 5. However, there were positive efforts to attain this requirement.

Leadership support for participation inclusion

Table 6: Leadership Support for Participation-inclusion of EWD

	Likert scale Choice Responses (n/%)					**Measures of Central tendency, Dispersion and Indices**			
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Mean	Median	SD	Score
Employment of PWD in my hospital positively affects my service-delivery	50(23.7%)	73(34.6%)	53(25.1%)	16(7.6%)	19(9.0%)	3.56	4.00	1.19	71%
Promotions for PWD employees in my hospital positively affect my service-delivery	45(21.3%)	77(36.5%)	57(27.0)	19(9.0%)	13(6.2%)	3.58	4.00	1.11	72%
A PWD database in my hospital assists PWD inclusion	0(0.0%)	0(0.0%)	138(65.4%)	21(10.0%)	52(24.6%)	2.41	3.00	0.86	48%
A policy on disability-mainstreaming in my hospital supports my	43(20.4%)	89(49.2%)	64(30.3%)	8(3.8%)	7(3.3%)	3.73	4.00	0.94	75%

service-delivery									
Disability-mainstreaming committee positively influences my service-delivery	43(20.4%)	75(35.6%)	70(33.2%)	8(3.8%)	7(3.3%)	3.58	4.00	1.08	72%
Disability-mainstreaming programs facilitate my service-delivery	32(15.2%)	56(26.5%)	83(39.3%)	22(10.4%)	18(8.5%)	3.29	3.00	1.11	66%
Awareness on disability positively affects my service-delivery	45(21.3%)	82(38.9%)	53(25.1%)	16(7.6%)	15(7.1%)	3.60	4.00	1.12	72%
Supportive-supervision from supervisor facilitates my service-delivery	62(29.4%)	102(48.3%)	26(12.3%)	10(4.7%)	11(5.2%)	3.92	1.04	1.04	78%
Support from my colleagues positively affects my service-delivery	63(29.9%)	94(44.6%)	34(16.1%)	9(4.3%)	11(5.2%)	3.90	4.00	1.05	78%
Average						**3.64**	**4.00**	**1.05**	**70.2**

Leadership support for participation-inclusion was assessed using nine constructs namely; employment, promotions, policies, data-base, disability-mainstreaming committees, disability-programs, awareness, supportive-supervision and support from colleagues. Majority respondents 73(34.6%) agreed that intention to employment of PWD positively affects their service-delivery, 77(36.5%) agreed that promotions of EWD positively affects service-delivery, 138(65.4%) were neutral whether having data-base influenced service-delivery; 89(49.2%) agreed that a policy on disability-mainstreaming supported service-delivery; 75(35.6%) agreed that disability-mainstreaming committees positively influences service-delivery, 83(39.3%) were neutral whether disability-mainstreaming programs facilitate service-delivery while 82(38.9%) agreed that awareness positively affects service-delivery while 102(48.3%) agreed that support-supervision facilitates service-delivery shown in Table 6. Three facilities had updated databases, disability mainstreaming committees and disability mainstreaming policies for their employees.

The mean values for these constructs ranged between 2.41 (database) to 3.73 (policy). Median ranged between 1.04 (supportive-supervision from supervisor) and 4.00 (employment, promotions, policy, disability-mainstreaming committee and awareness) with an average of 3.64. Mean values that are close to each other with standard deviation, indicate that data distribution is closely symmetrical and median is at the level of the 50th percentile.[13] Standard Deviation (SD) ranged between 0.86 database) to 1.19 (employment). Standard deviation being a measure of variability indicated the average distance of each response in the sample.[13] Index scores for the constructs ranged between 48% and 78%. Having database had 48% and support-supervision and support from colleagues 78% indicated in Table 6. The small standard deviation indicates that most measures are concentrated around the mean.[13]

Additionally respondent Number 22, a female nurse aged wrote, *"…there are inclusive advertisements for employment and promotions but the disability committee does not vouch for us…we do not know the disability-policy and there are no disability programs…we need awareness on disability and welfare too…Support from supervisors and colleagues is good but there is room for improvement…."* Respondent number 84 said, "*...No advertisement, no policy, no committee, no programs for persons with disability in this hospital…*" Respondent number 145, said, "…..*guidelines provide recommendations and best practice for activity…*" Respondent number 69, a 58-year Female Social worker commended, "….*I am not aware of the existing mainstreaming policy nor programs, need for awareness creation…*" This was echoed by respondent number 144, wrote, "…*I am not aware of any PWD facilitation efforts by my hospital in way of policy guidelines thus I cannot say it has influenced my service-delivery in any way…*" Respondent number 206 wrote in capital letters, "…*THE AWARENESS IMPROVE ACCEPTANCE…*"

Regarding hospital disability-mainstreaming-committee, respondent number 159 commented, "…*the committee is asleep, no programs, not aware about policy…there is no budget for our activities even if we had our special programs…*" Respondent Number 41 wrote. "…*If the committee exists then it is dormant...*" Respondent number 181 wrote, "…*Develop an active committee in place that supports the welfare and needs of employees …with disability. Representation to be among the PWDs…*"

Service delivery from employees with disability

Table 7: Service-delivery by Employees with Disability

Construct	SERVICE-DELIVERY FROM EMPLOYEES WITH DISABILITY								
	Likert scale Choice Responses (n/%)					Measures of Central tendency, Dispersion and Indices			
	Always	Often	Sometimes	Rarely	Never	Mean	Median	SD	Score
I verify instructions before I perform my service-delivery	132(62.6%)	62(29.4%)	15(7.1%)	0(0.0%)	2(1.0%)	4.53	5.00	0.71	91%
I practice infection prevention and control during service-delivery	134(63.5%)	60(28.4%)	12(5.7%)	3(1.4%)	2(1.0%)	4.52	5.00	0.75	90%
I utilize alarm systems/bells during service-delivery	105(49.8%)	61(28.9%)	22(10.4%)	9(4.3%)	14(6.6%)	4.11	4.00	1.17	82%
I am friendly to my customers	148(70.1%)	48(22.8%)	11(5.2%)	0(0.0%)	4(1.9%)	4.59	5.00	0.76	92%
I attend to my customers promptly	145(68.7%)	49(23.2%)	12(5.7%)	3(1.4%)	2(1.0%)	4.57	5.00	0.75	91%
I give my customers necessary information	142(67.3%)	52(24.6%)	11(5.2%)	2(1.0%)	4(1.9%)	4.55	5.00	0.80	91%
I show empathy to my customers	131(62.1%)	59(28.0%)	16(7.6%)	0(0.0%)	5(2.4%)	4.47	0.83	0.83	89%
I show respect to my customer	154(73.0%)	40(19.0%)	13(6.2%)	0(0.0%)	4(1.90%)	4.61	4.00	1.05	92%
I provide holistic services to my customers	143(67.8%)	47(22.3%)	16(7.6%)	0(0.0%)	5(2.4%)	4.61	4.00	1.05	91%
Average						**4.51**	**4.20**	**0.87**	**90**

Table 7, provides outputs for service-delivery assessed from nine constructs namely; verification of instructions, infection prevention and control, use of alarms/bells, being friendly, attending to customers promptly, giving customers necessary information, showing empathy, respect and holistic service-delivery. Of the respondents, 132(62.6%) always verify instructions before performing service-delivery, 134(63.5%) always practice infection prevention and control, while 105(49.8%) always utilize alarm/bells; 148(70.1%) were always friendly to customers, 145(68.7%) always attended to customers promptly while 142(67.3%) always give customers necessary information; 131(62.1%) always show empathy to customers, 154(73.0%) always show respect to customers, 143(67.8%) always provide holistic services to customers.

The mean values for the constructs range between 4.11 (alarms/bells) to 4.61 (respect and holistic services) with an average of 4.51. The median ranged between 0.83 (empathy) to 5.00 (verifying instructions, infection prevention and control, friendly, attending to customers promptly, and giving customers information) with an average of 4.20. Rating of these constructs ranged between 82% (alarm/bells) and 92% (friendly and respect) with an average of 90.0%. The small standard deviation indicates that most measures are concentrated around the mean.[13]

Inferential statistics.

Respondent number one said, "…*because I have a hearing issue, I must clarify instructions before acting…we use bells during emergencies, fire and resuscitation…but some customers are difficult even when you want to respect them…* " Regarding empathy, respondent Number 48 said they show empathy during service-delivery, "…*By caring and listening to them…*" Respondent Number 20 wrote, *"...Putting one-self to the situation of your customers always ensures empathy..."* Regarding giving customers information during service-delivery, respondent Number 18 commented, "…*it is good to explain when there are delays on services…*" Regarding giving customers holistic services, respondent Number three wrote, "…*We work hard and give holistic care to our customers…*" Respondent Number 140 wrote, "…*By understanding the customers' needs physical, psychological and spiritual…*" Respondent Number 67 said. "…*Doing ward rounds and giving a listening ear to customers complains and compliments. Attending to their needs at all time…*" Immediate supervisor number four said, "*...PWD work very well. Some outperform their colleagues without disability…but some look down on themselves even when well supported…*"

Supervisors rated supportive-supervision at 92%, service safety at 83%, responsiveness at 85% and client centeredness at 85%. Their rating of service-delivery was different from EWD was 86%. Regarding stigma based on lack of awareness, respondent Number 159 wrote, "… *No awareness on stigma, A lot of stigma, Too much pointing of fingers during service-delivery…*" Respondent Number two recommended, "…*I recommended for periodic continuing medical education on various forms of disability to demystify misconceptions on service-delivery and talent recognition…*" However, respondent Number 94 wrote, "…*sometimes I cannot read (see) well and if I do not accept work related assignments that I cannot read the supervisor gets angry with him…*"

Influence of leadership support for participation-inclusion on service-delivery

Table 8: Influence of Leadership Support for Participation-inclusion on Service-delivery

		Service-delivery					
		Univariate			**Multivariate**		
Predictor Variable		OR	95% CI	P-value	AOR	95% CI	P-value
1.	Inclusive employment	0.73	0.53, 1.00	**0.050***	1.54	0.70, 3.45	1.54
2.	Inclusive promotion	0.75	0.47, 1.23	0.25	0.69	0.29, 1.63	0.40
3.	Inclusive database	0.97	0.52, 1.97	0.92	1.16	0.48, 2.58	0.73
4.	Inclusive policy	0.59	0.39, 0.88	**0.010***	2.89	0.70, 13.3	0.14
5.	Disability-mainstreaming committee	0.74	0.46, 1.23	0.24	0.66	0.19, 2.01	0.47
6.	Disability-mainstreaming programmes	0.69	0.42, 1.13	0.14	0.91	0.36, 2.03	0.84
7.	Disability inclusion awareness	0.54	0.34, 0.85	**0.009***	2.09	1.04, 4.36	**0.039****
8.	Support-supervision to EWD	0.56	0.36, 0.88	**0.013***	1.57	0.71, 3.83	0.28
9.	Support from colleagues	0.54	0.34, 0.84	**0.008***	1.54	0.68, 3.48	0.29

The inferential tests using Chi-square test at confidence interval (CI) of 95% to determine influence of participation-inclusion on service-delivery from EWD, at univariate level employment had Odds Ratio (OR) 0.73 and p-value 0.05 and AOR 1.54 and p-value 1.54. Policy OR was 0.59 and p-value 0.10 while AOR was 2.89 and p-value 0.14. Awareness had an OR of 0.54 and a statistically significant p-value of 0.009 and at multivariate level Adjusted Odds Ratio (AOR) was 2.09 and a statistically p-value 0.039. At univariate level, support-supervision had an OR of 0.56 and a statistically significant p-value 0.013, however, at multivariate level AOR was 1.57 and p-value 0.28. At univariate level, support from colleagues had an OR of 0.54 and was statistically significant with p-value 0.008 while at multivariate level AOR was 1.54 and p-value 0.29. All other constructs under leadership-support for participation-inclusion showed non-significant outputs shown in Table 8.

Regression analysis and hypothesis testing

The objective of this study was to determine the influence of participation-inclusion on service-delivery at level-six hospitals in Kenya. This was established based on the coefficients of the linear regression model participation-inclusion and on Service-delivery.

Hypothesis: H_0: Participation-inclusion has no significant influence on service-delivery at level-six hospitals in Kenya.

Table 9: Regression Analysis for Participation-inclusion

Model of fitness Participation-inclusion					
R	**R Square**	**Adjusted R Square**	**Std. Error of the Estimate**		
.651a	0.423	0.42	0.327		
ANOVA					
	Sum of Squares	**Df**	**Mean Square**	**F**	**Sig.**
Regression	13.95	1	13.95	130.695	.000b
Residual	19	209	0.107		
Total	32.95	210			
Regression of Coefficients					
	Unstandardized Coefficients		**Standardized Coefficients**	**t**	**Sig.**
	B	**Std. Error**	**Beta**		
Constant	1.8	0.2		8.992	0.000
Participation-inclusion	0.575	0.05	0.651	11.432	0.000

a Dependent Variable: Service-delivery; b Predictors: (Constant), Participation-inclusion

The results in Table 9, presents the fitness of regression used to explain the study phenomena. Participation-inclusion has a positive influence on Service-delivery. The R square value of 0.423 implies that 42.3% change in service-delivery in level-six hospitals in Kenya can be accounted for by Participation-inclusion. The other 57.7% change can be explained by other variables. The model was also statistically significant implying that participation-inclusion significantly affects service-delivery. This is supported by the F statistic 130.695 where the value was greater than the F critical value at 3.909 and 0.000 significance level, which is lower than the conventional 0.05. There is goodness of fit in the model and thus, we rejected the null hypothesis that 'participation-inclusion has no significant influence on service-delivery at level-six hospitals in Kenya.' The acceptance/rejection criteria was that, if the p value is less than 0.05, the H_0 is rejected but if more than 0.05, the H_0 fails to be rejected.

$F_{statistic} = 130.695 > F_{critical} = 3.909$ (1, 178).

Regression of the coefficients results, revealed that participation-inclusion and service-delivery in level-six hospitals in Kenya have a positive and significant relationship (**β**=0.575, p=0.000). This implies that a unit change in participation-inclusion results in a 0.575-unit change in service-delivery in level-six hospitals in Kenya.

$Y = B_0 + B_1X_1 + e$ (Service-delivery at level-six hospitals in Kenya. =1.800 + 0.575* Participation-inclusion)

Regarding supportive-supervision respondent Number 159 wrote, "…m*y supervisors and colleagues understand my abilities and are always ready to assist…*" Respondent Number 190 commented, "…m*y supervisor and colleagues support me positively...*" However, respondent Number 85 wrote, "…m*y boss does not work closely with me…*" To improve support-supervision, respondent Number 20, said, "…*all supervisors should be taken through a disability awareness sensitization…*" Respondent Number 53, wrote, *"...consider forming a group which can be supported by the supervisor and also continuous encouragement from ourselves…*" Respondent number 204 said, *"…PWD database needs improvement… some colleagues don't support….we don't have disability-mainstreaming programs…I have not seen the policy…I have never seen a promotion in my life…the disability committee is not active…."*

IV. Discussions

An excellent response-rate of above 80% in all five-facility sub-groups increases representation of target populations, reliability and validity, precision of statistical inferences and reduces margin-error.[14] However, low response-rate causes non-representation, non-response bias and negatively impacts external validity of findings.[8] In one-on-one surveys average response-rate has been 76%.[8] In Ethiopia response-rate was 96.9%, in Finland (85.2%), Africa (77.5%), China (74.7%) and Norway (7.5%).[15] Healthcare managers' slightly lower response-rate was related to satisficing where perceived benefits are weighed against time spent on responding.[8] Thus, lower person-to-person interviews response rate among specialized doctors were achieved.[16] Response-rates can be improved through communication and follow-up, design, piloting, incentives, instructions, rapport, language, length, simplicity, questions, anonymity, privacy, affordability, age, work, improved education and culture and beliefs, among others. In the current research response-rate was enhanced by communication and follow-up, involvement, confidentiality, privacy, and support to those with moderate-severe disability and good-will from administration.[15-16]

Regarding age, there was increased prevalence of disability among older respondents. Being older has been identified a risk for developing disability associated with ageing process and chronic sicknesses, although disability can occur before and after birth, with 3.8% of persons aged above 15-years getting some disability. Thus, demographic data including age are vital in disability studies across all ages. Regarding deployment and workstations, job-mobility was higher among EWD and involuntary job-mobility and deployment was statistically higher. When deterioration of EWD conditions or development of new disability occurred, employers preferred to retain them in the familiar workstations as opposed to employing or training someone new, however junior or unskilled EWD would be laid off. Largely, EWD are reliable, their job-retention affordable and have minimal sick days. However, they may lack confidence to take new employment and promotions due to self-limitations which undermine adaptation, confidence and cause fear of losing supportive-supervisors. Outpatient department/units tend to have routine activities and easy to navigate and more adaptable for EWD, who may require little mobility, lower workloads, sign interpreters, capacity-matched job-tasks, flexible work schedules, reduced work-hours, adapted work-tools and accessibility to restrooms or workspaces. Advocacy for work placements similar to counterparts without disability with adjustments continues, but employers preferred to give unskilled jobs to EWD, even when they qualified for higher work. Those with severe disability were placed in sheltered workshops and restrictive employments. Nevertheless, despite sheltered workshops, barriers to EWD service delivery included institutional, personal and attitudinal. Employees with disability overcame these barriers through collegial-support, training and improvisations.[1, 17-22]

On education and training, evidence points to the need to focus on job market demand. Well trained and supported, EWD for a highly skilled labor-pool contributing to workplace efficiency and effectiveness.

Barriers to education and training included scarcity of schools and colleges, materials, transport, inaccessibility, stigma, violence and bullying, rejection, funding, teachers and inadequate policies Regarding types of disabilities, previous identified were mixed, psychosocial, physical and intellectual, and participation-inclusion barriers were distributed across all types. In the US, types included mobility, cognition and disabilities that caused dependence. in Uganda visual, physical, multiple, intellectual/cognitive types were identified. One research further summarized types of disability into four main categories namely profound, severe, moderate and mild. Like in the current study, the most frequently occurring type of disability among working people was physical.[1,17,21,23-27]

Before factor analysis diagnostic tests were done for suitability. The Keiser-Meyer-Olkin (KMO) for participation inclusion was 0.90 (marvellous) and service delivery 0.81 (meritorious). A KMO value closer to 1.0 suggests that the data is highly suitable for factor analysis, while values below 0.50 are considered unacceptable for factor analysis. This was further enhanced by excellent response rate.[8,14,18-20] Bartlet's test of sphericity showed that the correlation matrix was not an identity matrix since generated results yielded a p-value < 0.05. Thus, the results suggested that the data collected was well-suited for factor analysis. Multocolinearity, linearity, normality and heteroscedasticity tests indicated no multicollinearity, a linear relationship between participation-inclusion and service-delivery, normal distribution of data, and no heteroscedasticity, respectively. Thus, data was suitable for factor analysis.[12, 21-22]

Regarding employment of PWD, evidence shows need for reinforcement using laws and policies to avoid underemployment, lack of recognition, underpayment, poor retention, inadequate adjustments, isolation, negative organizational trends, and misconceptions. Inadequate policies are associated with lack of commitment to employ PWD. Relying on word of mouth, caused discrimination and low monitoring and evaluation. Managers were inadequately trained to work with EWD and EWD were employed in dying companies and efforts to create accommodation were minimal.[17,23-24] Disability disclosure as a double-edged sword, caused EWD did not to disclose due to fear of prejudice and rejection. Leadership support for participation-inclusion would marshal development and implementation of policies to employ PWD, train, empower and promote them and sustain databases for planning and funding their programs. They would promote positive organizational traits that support the productivity, appraisal, monitoring, evaluation and research to give positive feedbacks to improve utilization of talents at work. Commitment to quota representation of EWD makes it intentional for employers to recruit PWD, but notably many organizations have not attained. Awareness in supervisors would enhance participation inclusion, open culture, policies and practices. Supportive-supervisors enhance work-adjustments, appropriate task-allocations, respect, equitability, interpersonal relationship, acceptance, emotional support and motivation to EWD while avoiding micromanagement. Non-supportive one showed intolerance, stigmatization, mistreatment.[22-27]

Barriers to embrace employment of PWD need additional data. Organizational ought to reinforce traits that promote participation-inclusion by normalizing diversity, equitable opportunities and not tolerating discrimination. Unfavorable traits include stigmatization, discrimination, suspicion and doubt from leaders. Some EWD reported that junior employees were promoted before them even when undeserving.[25] Similarly in Kenya despite the 5% quota representation requirement to employ PWD the current research established that all five study facilities had not attained, with a deficit of 0.5% to 4.1%. Two hospitals had disability-mainstreaming committees while three did not, three had PWD databases and disability mainstreaming policies while two did not. Creating awareness on disability inclusion was minimum in all hospitals, supportive-supervision and support from colleagues was varied, but disability mainstreaming programs were largely lacking in all hospitals. In this current study recommendations to implement/improve PWD databases, disability-mainstreaming programs and awareness on disability inclusion has been done. Employment based on quota representation has pros and cons. The requirement ranges from 2-7% as obligation of legislation. Evidence revels that some companies opt to pay regular fines instead of complying. Additionally, for some companies to increase compliance, employees were compelled to declare disability and some rampant practices of discrimination were observed. Thus, disclosures of stigma riddled conditions and disabilities remain a dilemma. Non-disabled workers feel that PWD pose unfair competition and are not qualified for the jobs they get, especially in smaller organizations. Some organizations employ rehabilitation and training to facilitate voluntary approach and subsequent work-adjustment. Leaders, ought to shape safe-environment for disability disclosure, assessment, rehabilitation and integration, in a culture of openness. Some enablers to employment were participation-inclusion, career-inclusion and protection from unfair dismissal. Some barriers include poor laws and policies, limited opportunities, competences, nature of jobs, environmental barriers, negative attitudes and misconceptions, lack of knowledge, lack of confidence, fear of what customers will think being served by EWD, work-hours and too much pressure.[25-5]

Employees with disability reported barriers to getting employment, including having a disability, inability to seek for work, discouragement, disappointments, lack of skills and rejection. Participation-inclusion at work is seen as the gateway EWD to show case their talents and potentials. Participation-inclusion reveals

the place for disability-mainstreaming policies in the attraction, recruitment and retention of PWD in employment and those who get occupational injuries. Notably, too much responsibility and cost has been relinquished to employers who lack expertise to interpret policies. Thus participation-inclusion especially employment of PWD remains lower. Employers markedly prefer to employ younger males PWD below 30 years of age, skilled with articulate communication, hard skills, college degrees or vocational training. Job seekers with amputated limbs, walking disabilities, visual or partial blindness were not preferred.[28-31]

Suggestions to improve support-supervision and support from colleagues, training of EWD to improve recognition and promotions, and visibility of disability-mainstreaming committees have been recommended for endorsement. Supportive colleagues have been shown creating a sense of belonging, integration, interpersonal relationships, and positively impact on the EWD performance. Non-supportive colleagues cause prejudices, discrimination and become a source of stress and demotivation to performance. Lack of support is often caused by lack of awareness on disability inclusion.[25] Disability-mainstreaming programs such as vocational training, where EWD are placed and later trained and services on occupational-health boost EWD performance.[26]

V. Conclusion And Recommendations

Leadership support for participation-inclusion has positive significant influence on service-delivery from employees with disability. Service-delivery from employees with disability was characterized by responsiveness, safety and customer centeredness, and comparable to that of colleagues without disability. Some barriers were identified and recommendations given to foster leadership-support for participation-inclusion and improve/sustain responsive, safe and customer centered service-delivery from employees with disability:

i. Institutional leaders should implement, monitor, evaluate and provide regular feedback on participation-inclusion practices to interested parties and various stakeholders to strong focused collaborations.
ii. Leaders need to track, appraise and improve service-delivery from employees with disability to provide regular information and exploit untapped reservoirs of potentials from a point of knowledge.
iii. Leaders and professionals need to develop strategies and mitigation measures to address barriers identified in service-delivery from employees with disability.
iv. All institutions need to have disability-mainstreaming committees, updated databases for employees with disability, disability-mainstreaming programs and enhanced awareness on disability inclusion.
v. Similar, divergent and comparative regular researches need to be done in other public and private organizations on disability inclusion to maximize shared benefits to stakeholders including policy makers.

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Conflict of interest

The authors declare no conflict of interest to declare

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