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Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

The Influence of Leadership-Supported Accessibility-Inclusion on Service Delivery from Employees with Disability in Level-Six Hospitals in Kenya

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Article's History

Submitted: *19th July 2025*
Accepted: *16th August 2025*
Published: *20th August 2025*

Abstract

Aim: To establish the influence of leadership-supported accessibility-inclusion on service delivery from employees with disabilities in level-six hospitals in Kenya.

Methods: A cross-sectional mixed-methods design was employed. Data was collected using two Likert-scale-based questionnaires, having quantitative and qualitative aspects, and observation checklists. Secondary data from study facility employee databases, strategic plans, and disability mainstreaming policy documents were used. The study was informed by human rights and social models, the theory of stigma and stakeholder theory. The target population was 229 employees with disability and 229 supervisors sampled by census from five purposively-selected hospitals. Data analysis was done using SPSS version 29 and N-Vivo version 15 for quantitative and qualitative data, respectively, associations using Pearson's correlation coefficients and ANOVA to test hypotheses, with p-value $\leq$ 0.05 indicating statistical significance.

Results: Accessibility-inclusion aspects such as assistive devices (77%), building access (77%), and transport (78%) were rated positively. Significant factors influencing service delivery included assistive devices ($p = 0.030$) and accessible information formats ($p = 0.039$). Accessibility-inclusion explained 46.3% of the variance in service delivery ($F = 153.463$, $p < 0.001$). Service delivery by employees with disabilities was self-rated at 90% and by supervisors at 86%, with high ratings in responsiveness, safety, and customer-centeredness.

Conclusions: The study concludes that leadership-supported accessibility-inclusion significantly enhances service delivery by employees with disabilities. Tapping into the talents of these employees through inclusive leadership practices can improve hospital performance and counter prevailing stereotypes and stigma that undermine their employability, independence and opportunity to showcase performance at work.

Recommendations: Leaders should spearhead continuous implementation, monitoring, evaluation and research on accessibility-inclusion to support service delivery from employees with disability, inform policy and stakeholders. They should monitor and objectively reward service delivery from employees with disability, while addressing accessibility-inclusion barriers to productivity.

Keywords: *Accessibility-inclusion, disability inclusion, assistive devices, leadership-support, healthcare service delivery, Kenya*

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Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
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INTRODUCTION

According to the World Health Organization (WHO), accessibility and inclusion refer to the intentional design of environments, services, and information to ensure equitable use by all individuals, including persons with disabilities (WHO, 2022). Accessibility involves eliminating barriers that hinder individuals from accessing environments, information, or services. Inclusion, considered a precondition of human rights, on the other hand, ensures that everyone, including persons with disability (PWD) can participate fully and feel a sense of belonging, supported by the necessary resources and opportunities (McVeigh *et al.,* 2021). In essence, Accessibility-Inclusion serves as a fundamental enabler of disability inclusion. For employees with disability (EWD), inclusive workplace practices are essential to ensure access to physical environments, healthcare services and accessible information, which are factors that directly impact their ability to deliver effective services. Disability inclusion facilitates healthcare service delivery from employees living with a disability. The inclusion is characterized by responsiveness, safety and customer-centeredness (Jahan & Holloway, 2021). Responsiveness is expressed through friendliness, promptness and providing information to customers. Service safety is expressed through infection prevention, verification of activities before implementation and use of alarms. Customer-centeredness is noted in provider empathy, respect and holistic service delivery (Jurado-Caraballo *et al.,* 2020).

Quality healthcare services should be responsive, safe and customer-centered (World Health Organization, 2022). Accessibility-inclusion is a precondition to the enjoyment of human rights (McVeigh *et al.,* 2021). Assistive devices, including wheelchairs, walking sticks, hearing/seeing aids, ramps and elevators/lifts, serve to bridge the gap between EWD special needs and their service delivery. Access to healthcare services addresses treatment of health conditions, rehabilitation and prevention of disability, age-related complications, illnesses, health risk behaviors and premature deaths that EWD face. Evidence indicates that although EWDs have a right to healthcare, they have worse disease outcomes, more unmet healthcare needs and are often overlooked, undermining Universal Health Coverage (Jurado-Caraballo *et al.,* 2020).

According to WHO (2015), persons with disabilities are more likely to experience poorer health outcomes, unmet healthcare needs, and systemic exclusion from essential services. Barriers to healthcare were attitude, infrastructure, policies, information, communication, affordability and transportation. A substantial percentage understood healthcare as a basic concern and subsequently, DPOs developed responsive strategies (World Health Organization, 2022). Access to environment, healthcare and information, informed by the human rights and social models, theory of stigma and stakeholder theory, plays a pivotal role in human life. The human rights model of disability frames accessibility as a fundamental right, while the stakeholder theory recognizes the role of EWD stakeholders as service providers and service receivers in an accommodative work environment.

As stakeholders, EWD are expected to bring profits to the institutions and the country through supportive supervision. In healthcare, they are expected to give responsive, safe and customer-centered services under supportive supervision. Goffman's theory of stigma highlights and seeks to address all forms of stigma by adopting supporting systems, collecting data regularly, sharing information and undertaking regular research. It aims to increase accessibility to buildings, technology, communication, assistive devices, training and promotions of the EWD workforce. It

Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

is a prerequisite for EWD in healthcare settings for them to provide responsive, safe and customer-centered service delivery as required. Employees with disability need information for direction and interactions, but the format, sources and means influence the quality and understandability of information.

Problem Statement

Although there were 229 EWD in the five study hospitals, there was no research to show the safety, responsiveness and customer-centeredness of service delivery from this workforce. Leadership support for accessibility-inclusion was scantily documented and its influence on service delivery from EWD had not been studied. Globally, PWD are one of the largest minority groups (Jarvis *et al.,* 2021) whose potential is poorly tapped at the workplace, leading to non-evidence-based decisions and conclusions riddled with misconceptions, including PWD dependency, low productivity, and stigma, biased behaviour, misplaced potential economic and social effects, and turnover rates (Absolor, 2023). This resulted in non-inclusion and unhappiness, lack of resources and workplace dissatisfaction (Chumo *et al.,* 2023). Previous research shows that promotions for EWD are based on an appraisal basis for improvement (Jarvis *et al.,* 2021). Accessibility to environment and healthcare services and information for EWD improves their interactions, health and service delivery to customers and dissipates widespread discrimination and stereotypes (Carroll *et al.,* 2022). Service delivery from EWD is comparable to that from colleagues without disability.

Timely evidence needs to be increased to dispel existing labels and misconceptions regarding the under-productivity of EWD, especially in service delivery. There has been a tendency to place EWD in product-based settings, label them as less productive, expose them to violence, discrimination, social isolation, lack of inexpensive transport and unequitable promotions (Varma & Nargis, 2024). Moreover, EWD who have employment can offer vital understanding to other job seekers with disability. Such evidence regarding enablers and obstacles to Accessibility-Inclusion was low in Kenya (Varma & Nargis, 2024). Furthermore, leadership support for inclusion of EWD in service firms that implement and evaluate service delivery showed that they outperformed those that did not (Jain *et al.,* 2024; Chumo *et al.,* 2023). More institutions ought to embrace regular service systematic evaluation from EWD and improve accessibility-inclusion to drive further progress. This study aimed to provide current evidence by: (1) Assessing the level of accessibility-inclusion in five hospitals employing Employees with disability; (2) Evaluating the responsiveness, safety, and customer-centeredness of services delivered by Employees with disability; and (3) Examining the role of leadership support in facilitating service delivery among employees with disability.

METHODOLOGY

This was a cross-sectional study employing a mixed-methods approach. Quantitative and qualitative data were triangulated to enhance the validity of findings. Data from five purposively selected level-6 hospitals in Kenya were triangulated to make inferences, as shown in the results section. The study facilities comprised 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). The target population included all 229 employees with disability (EWD) and their 229 supervisors (with or without disability), sampled by census. Data was collected using two

Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

questionnaires, one for each category of population. Both questions sought information covering biodata, accessibility (to assistive devices, buildings, transport, healthcare, confidentiality, affordable healthcare), Information, their sources and means of receiving the information. Service delivery was assessed from service safety (verification of instruction, practicing infection prevention and control, utilization of alarms), responsiveness (being friendly, prompt and giving customers information) and customer centeredness (showing empathy, respect and providing holistic services). Five observation checklists were also filled out per hospital. The checklists assessed accessibility to the physical environment, accessibility to healthcare and access to information. Secondary data used included EWD databases, facility strategic plans and disability mainstreaming policies. Data collection began after obtaining ethical approvals. Eligible volunteers were provided with information on the study title, consenting procedure, data collection, benefits, risks/discomforts, ethical compliance and management of results. Willing volunteers were guided to sign consent forms.

Pilot Testing

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

No.	Variable	Cronbach Alpha	No. of Items	Status
Reliability test using Cronbach's Alpha test				
1.	Accessibility-inclusion	0.84 (good)	9	Acceptable
2.	Service delivery from EWD	0.76	9	Acceptable
Validity test using principal component analysis				
1.	Accessibility-inclusion	0.6186 (High)	9	Acceptable
2.	Service delivery from EWD	0.5418 (Moderate)	9	Acceptable

Source: Researcher's field data (2025)

Pilot-testing was done in two level-5 hospitals (Mbagathi and Pumwani) to fine-tune data tools. High precision pilot study: sample size ought to be 1-10% of the research sample. Pilot study sample size was 12 EWD and 12 supervisors sampled by census, forming 5.2% of the study sample. Results of the pilot study have not been included in the overall results of this research. Accessibility-inclusion had a reliability of 0.84 (good and acceptable) using the Cronbach Alpha test and service delivery 0.76 is acceptable as shown in Table 1. Accessibility-inclusion had a validity of 0.6186 (High) and service delivery 0.5418 (moderate) using principal component analysis. The study instruments did not need alterations.

Data Analysis

Data analysis was done at descriptive and inferential levels using SPSS version 29 and NVivo version 15 for quantitative and qualitative aspects, respectively. Associations were tested by Pearson's correlation coefficients, significance with Chi-square and ANOVA for hypothesis testing, with p-value ≤ 0.05 indicating significance.

Journal of Leadership and Governance
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FINDINGS

Response Rate

Table 2: Response Rate of Employees with Disability and their Supervisors

Variables	Scores					
Employees with Disability						
Study Facility	KNH n=96	MTRH n=95	MNTRH n=8	MKTRH n=7	NSIRH n=6	Totaln =211
Response rate	95(99%)	95(84.8%)	8(100%)	7(100%)	6(100%)	211(92.1%)
Immediate Supervisors to EWD						
Study Facilities	KNH n=95	MTRH n=82	MNTRH n=8	MKTRH n=5	NSIRH n=6	Overall N=196
Response rate	95(99.0%)	82(73.2%)	8(100%)	5(85.7)	6(100%)	196(85.6%)

Source: Researcher's field data (2025)

Biodata of Employees with Disability

Table 3: Biodata of Employees with Disability

Variables	Scores					
Study Facility	KNH n=95	MTRH n=95	MNTRH n=8	MKTRH n=7	NSIRH n=6	Total n=121
Gender for employees with disability						
Male	57(60.0%)	45(47.4%)	6(75.0%)	3(42.9%)	4(66.7%)	115(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%)

Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
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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%)

Table 3 provides biodata of EWD, whereby males were 115(54.5%), 95(45.0%) aged 45-54 years, 81(38.4%) had worked for 11-20 and 88(41.7%) were working in outpatient departments/units.

Additional Demographic Data for Employees with Disability

Table 4: More Demographic Data of Employees with Disability

Variables	**Scores**					
Study Facility	KNH n=95	MTRH n=95	MNTRH n=8	MKTRH n=7	NSIRH n=6	Total 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%)

Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

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%)

Source: Researcher's field data (2025)

Table 4 gives further demographic data for EWD, where 197(93.4%) attended mainstream schools, 85(40.3%) had a diploma, 93(44.1%) were deployed in the health management and support department and 120(56.9%) had physical disability.

Diagnostic Tests

Diagnostic tests were done before factor analysis. Kaiser-Meyer-Olkin (KMO) was used to test sampling adequacy. The KMO for accessibility-inclusion was 0.91 (marvellous) and service delivery 0.81 (meritorious), thus the data was appropriate for factor analysis, because KMO values closer to 1.0 suggest high suitability for factor analysis. Normality test was determined using the Kolmogorov-Smirnov test. Significance value, skewness and kurtosis were calculated. Normal distribution is indicated by a probability value (sig) greater than 0.05. Accessibility-inclusion had a probability value significance of 0.272 and service delivery 0.056. Moreover, the response rate was excellent.

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Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

Normality test

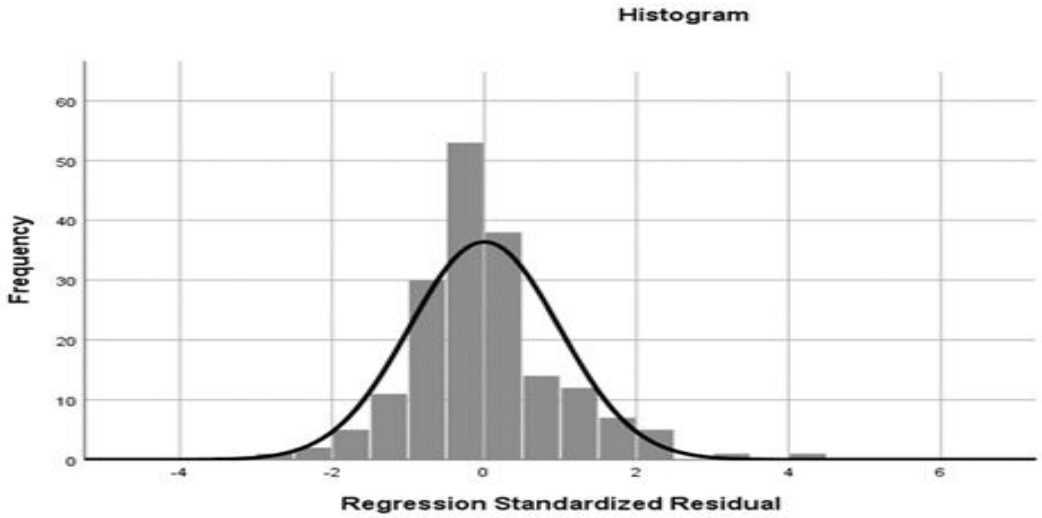

Figure 1: Normality Plot Histogram

Source: Researcher's field data (2025)

The data were normally distributed, as shown in Figure 1.

Linearity Test

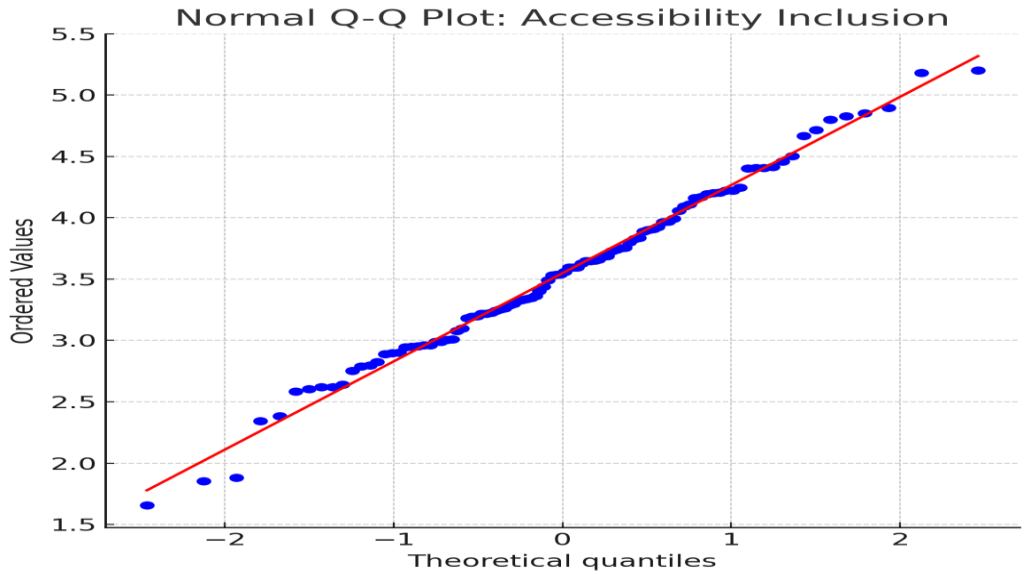

Figure 2: Linearity Test of Accessibility-Inclusion

Source: Researcher's field data (2025)

A linearity test was done and outputs are shown by the fit regression line in the plot shown in Figure 2. Variables had a linear relationship.

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Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

Test for Heteroscedasticity

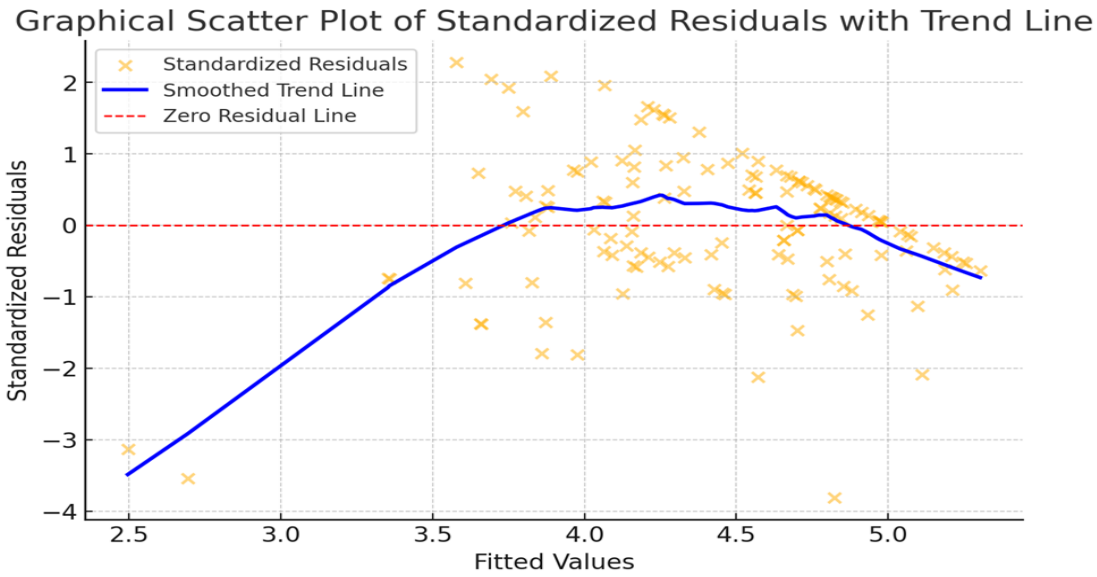

Figure 3: Graphical Representation of p-p Plots in Heteroscedasticity Test

Source: Researcher's field data (2025)

A heteroscedasticity test using ordinary least squares was done. Graphical scatter plots oscillated along the standardized residual regression line shown in Figure 3.

Analysis of Leadership-support for Accessibility-inclusion

Table 5: Leadership-support for Accessibility-inclusion

Construct	**Leadership-support for Accessibility-inclusion**								
	Likert scale choice responses (n/%)					**Measures of central tendency, dispersion and indices**			
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Mean	Median	SD	Score
Accessibility to assistive devices facilitates service delivery	56(26.5%)	91(43.1%)	47(22.3%)	10(4.7%)	7(3.3%)	3.85	4.00	0.98	77%
Accessibility to buildings influences my service delivery	50(23.7%)	109(51.7%)	34(16.1%)	5(2.4%)	13(6.2%)	3.84	4.00	1.01	77%

Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

Accessibility to transport influences my service delivery	56(26.5%)	103(48.8%)	39(18.5%)	5(2.4%)	8(3.79%)	3.92	4.00	0.94	78%
Confidentiality when accessing healthcare affec ts my dignity positively	79(37.4%)	88(41.7%)	26(12.32 %)	10(4.7%)	8(3.8%)	4.04	4.00	1.02	81%
Privacy when receiving healthcare services affects my respect	83(39.3%)	82 (38.9%)	26(12.3%)	9(4.3%)	11(5.2%)	4.03	4.00	1.08	81%
The affordability of healthcare facilitates my utilization of healthcare services	81(38.4%)	91(43.1%)	26(12.3%)	7(3.3%)	6(2.8%)	4.11	4.00	0.94	82%
Information in formats that I understand facilitates my service delivery	74(35.1%)	103(48.8%)	29(13.7%)	4(1.9%)	1(0.5%)	4.16	0.76	0.76	83%
Sources of information facilitate my service delivery	78(37.0%)	98(46.5%)	29(13.7%)	4(1.9%)	2(1.0%)	4.17	4.00	0.80	83%
Means/media of receiving information facilitate my service delivery	69(32.7%)	103(48.8%)	33(15.6%)	5(2.4%)	1(0.5%)	4.00	4.00	4.00	82%
Average						**4.01**	**3.64**	**1.28**	**80.4**

Source: Researcher's field data (2025).

Likert scale used:1=Strongly agree, 2=Agree, 3=Neutral, 4=Disagree, 5=Strongly disagree

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Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

Table 5 presents an analysis of leadership support for accessibility-inclusion outputs assessed using nine constructs, namely, accessibility to assistive devices, buildings, transport, confidentiality, privacy, and affordability in healthcare, and information in formats and means and good sources that allow understanding. Of the respondents, 91(43.1%) agreed that assistive devices facilitates their service delivery, 109(51.7%) agreed that accessibility to buildings influences their service delivery; 103(48.8%) agreed that accessibility to transport influences their service delivery, 88(41.7%) agreed that confidentiality when accessing healthcare positively affects their dignity, 83(39.3%) strongly agreed that privacy when receiving healthcare services affected their respect while 91(43.1%) agreed that affordability of healthcare services facilitates their utilization of healthcare services; 103(48.8%) agreed that receiving information in formats that they could understand facilitated their service delivery, 98(46.5%) agreed that available good sources of information facilitates their service delivery, 103(48.8%) agreed that appropriate means of receiving information facilitates their service delivery.

The mean values of constructs ranged between 3.84 (access to buildings) and 4.17 (good sources of information), with an average of 4.01. Median ranged between 0.76 (understandable information formats) to 4.00 (assistive devices, buildings, transport, confidentiality, privacy and affordability while receiving healthcare services, good sources of information and appropriate means of receiving information) with an overall average of 3.64. Standard Deviation ranged between 0.76 (format of information) to 4.00 (means of receiving information) with an average of 1.28; while overall ratings ranged between 77% (access to assistive devices and buildings) to 83% (format of information and good sources of information), with an average of 80.4%. While this research recognizes the biases in the medical model of disability, the positive aspects have been borrowed to address access to healthcare services while bringing out the independence (not objects of charity and pity) of the EWD, role of the society and community and integration and mainstreaming of PWD as valued members of the talented pool in the workforce. Regarding accessibility to assistive devices, respondent number 1 commented, "*... assistive devices assist persons with disability to work fast, be safe during emergencies, and to be joyful... access to buildings and healthcare is also important for us...but we need to improve on privacy, confidentiality, affordability and the quality of care given... When healthcare information given is too technical, I tend to feel bad for those who are not healthcare professionals and also may be having a disability...They need good information...Even when one has disability, they need privacy and other good things...* "

Service delivery from Employees with Disability

Table 6: Analysis of Service Delivery from 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 service delivery	132(62.6%)	62(29.4%)	15(7.1%)	0(0.0%)	2(1.0%)	4.53	5.00	0.71	91%

Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

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 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 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 customers the 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 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 customers	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 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**

Source: Researcher's field data (2025)

Likert scale used:1=Always, 2=Often, 3=Sometimes, 4=Rarely, 5=Never

Table 6 provides results of service delivery from EWD evaluated from nine sub-constructs, namely verification of instructions, infection prevention and control, use of alarms/bells, being friendly, attending to customers promptly, giving customers information, showing empathy, respect and holistic service delivery. Of the respondents, 132(62.6%) always verify instructions before executing 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 them promptly while 142(67.3%) always give them necessary information; 131(62.1%) always show empathy, 154(73.0%) always show respect and 143(67.8%) always provide holistic services.

Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

The mean value for the sub-constructs ranged between 4.11 (use of alarms/bells) and 4.61 (respect and providing holistic services), with an average of 4.51. The median ranged between 0.83 (empathy) to 5.00 (verifying instructions, practicing infection prevention and control, being friendly, attending to customers promptly, and giving customers necessary information), with an average of 4.20. Ratings ranged between 82% (alarm/bells) and 92% (friendly and respect), with an average of 90.0%.

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, "…*we always show empathy to customers…by caring and listening to them…*" Respondent Number 20 said, *"...putting oneself in the situation of your customers always ensures empathy..."* On availing customers with information as part of service delivery, respondent Number 18 commented, "…*it is good to explain when there are delays of services…*" Regarding holistic services, respondent Number 3 wrote, "…*We work hard and give holistic care to our customers…*" Respondent Number 140 said, "…by *understanding the customers' needs, physical, psychological and spiritual…*" Respondent Number 67 said, *"…doing ward rounds and giving a listening ear to customer complaints and compliments. Attending to their needs at all times…*" Immediate supervisor number four said, "*...PWD works very well. Some outperform their colleagues without disability…but some look down on themselves even when well supported…*"

Influence of Leadership-support for Accessibility-inclusion on Service Delivery from EWD

Table 7: Influence of Leadership Support for Accessibility-inclusion on Service Delivery

	Predictor Variable	Service delivery from EWD					
		Univariate			Multivariate		
		OR	95% CI	P-value	AOR	95% CI	P-value
1.	Accessibility to assistive devices	0.66	0.45, 0.96	0.031	2.42	1.09, 5.91	0.030
2.	Accessibility to transport	0.75	0.47, 1.23	0.25	0.69	0.29, 1.63	0.40
3.	Accessibility to buildings	0.97	0.52, 1.97	0.92	1.16	0.48, 2.58	0.73
4.	Confidentiality when accessing healthcare	0.58	0.41, 0.82	0.002*	1.83	0.66, 5.14	0.24
5.	Privacy when accessing healthcare	0.61	0.44, 0.84	0.003*	0.93	0.34, 2.71	0.88
6.	Affordability of healthcare	0.54	0.37, 0.78	0.001*	1.29	0.60, 2.80	0.52
7.	Information in understandable formats	0.48	0.29, 0.78	0.003*	2.09	1.04, 4.36	0.039**
8.	Good sources of information	0.41	0.25, 0.66	<0.001*	1.82	0.48, 7.72	0.38
9.	Appropriate means of receiving information	0.42	0.25, 0.68	<0.001*	1.16	0.24, 5.11	0.85

Source: Researcher's field data (2025)

Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

Regarding statistically significant constructs under accessibility-inclusion, at the univariate level, inferential test statistics indicated that accessibility to assistive devices OR was 0.66 and p-value 0.031 and AOR was 2.42 and p-value 0.030. Observing confidentiality when accessing healthcare had OR 0.58 and p-value 0.002, observing privacy when accessing health had 0R 0.61 and p-value 0.003 and AOR 0.93 and p-value 0.88. accessible information in understandable formats had an OR of 0.48 and a statistically significant p-value of 0.003 and at the multivariate level, AOR was 2.09 and the p-value remained significant at 0.039. Access to good sources of information had an OR of 0.41 and p-value < 0.001 at the univariate level, while at the multivariate level, AOR was 1.82 and p-value 0.38. Accessibility to appropriate means of receiving information, OR was 0.42 with a statistically significant p-value <0.001, but AOR was 1.16 and p-value 0.85 at the multivariate level as shown in Table 7. None of the sociodemographic factors was statistically significant.

Hypothesis Testing

Table 8: Regression Analysis for Accessibility-inclusion

Model of Fitness Accessibility-Inclusion					
R	**R Square**	**Adjusted R Square**	**Std. Error of the Estimate**		
.680a	0.463	0.460	0.315		
ANOVA					
	Sum of Squares	**Df**	**Mean Square**	**F**	**Sig.**
Regression	15.255	1	15.255	153.463	.000b
Residual	17.695	209	0.099		
Total	32.95	210			
Regression of Coefficients					
	Unstandardized Coefficients		**Standardized Coefficients**	**T**	**Sig.**
	B	**Std. Error**	**Beta**		
Constant	1.248	0.229		5.444	0.000
Accessibility-inclusion	0.703	0.057	0.68	12.388	0.000

a Dependent Variable: Service delivery.

b Predictors: (Constant), Accessibility-inclusion

Source: Researcher's field data (2025)

The objective was to establish the influence of leadership support for Accessibility-Inclusion on service coefficients of the linear regression model between accessibility-inclusion and service. Table 8 shows the outputs.

Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

Hypothesis H_0: Leadership-support for accessibility-inclusion has no significant influence on service delivery at level-six hospitals in Kenya.

The results show the fitness of the regression used in explaining the study phenomena. Leadership support for accessibility-inclusion positively influences service delivery in level-six hospitals in Kenya, as shown by the R-squared value of 0.463. This implies that a 46.3% change in the dependent variable (service delivery) can be accounted for by accessibility-inclusion, and the other 53.7% by other variables. The model was statistically significant, implying that accessibility-inclusion statistically influences service delivery. This is further supported by the F statistic 153.463, where the value was greater than the F critical value of 3.909 at a 0.000 significance level, which is below the 0.05 threshold. Therefore, the null hypothesis that states that leadership support for accessibility-inclusion has no significant influence on service delivery at level-six hospitals in Kenya was rejected.

$F_{statistic} = 153.463 > F_{critical} = 3.909$ (1, 178).

Coefficients regression results revealed that accessibility-inclusion and service delivery in level-six hospitals in Kenya have a positive and significant relationship (β=0.703, p=0.000). This implies that a unit change in accessibility-inclusion leads to a 0.703-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 =1.248 + 0.703* Leadership-support for accessibility-inclusion).

DISCUSSION

The response rate of both EWD and supervisors in all the hospitals was excellent (above 80%). The high response rate (above 80%) among both EWDs and supervisors strengthens the reliability and representativeness of the study. Factors contributing to this success included follow-up communication, support for participants with severe disabilities, and institutional goodwill. This is particularly important in marginalized populations where low response rates can result in underrepresentation and bias (Booker *et al.,* 2024).

In the current study, the majority of respondents were male, while globally, there are more females with disability. Although gender was not statistically significant in this study, this contrasts with global data showing that women with disabilities face higher unemployment and greater exclusion (UNCRPD, 2020). The majority of respondents were male, which may reflect underreporting or sampling patterns within the hospitals. In Kenya, healthcare workers comprised more females, 70% being nurses (Ahmat *et al.,* 2022). Variations in gender among PWD have been identified, with populations having more women and unemployment being higher among women with disability. Disability was also higher among the older women (Gutterman, 2023). Both genders suffer from a lack of accessibility-inclusion, but this is higher among females due to gender biases and stereotypes. Males are more tolerated as spouses or as employees due to resource controls and social hierarchies. Exclusion has been compounded by low data and the exclusion of gender from disability studies. Thus, poor family, social and employer support, limited mobility, and accessibility barriers have been identified. Self-rating leaders have been reinforcing these biases (Wu *et al.,* 2025; Tresh *et al.,* 2019).

Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

Most EWD were aged 45-54 years old. Age was not statistically significant, but there was increased prevalence of disability among older respondents collectively and in individual study facilities. Comparable pointers have been identified previously and thus being older is a risk for disability. This is due to deterioration during ageing and chronic sicknesses, but disability can occur at any time before and after birth, with those above 15 years of age being prone to some form of disability (Gutterman, 2023; Lee *et al.,* 2020). Therefore, researchers recommend that gender and other sociodemographic data be routinely included in disability studies, especially in accessibility-inclusion studies, to mitigate the paucity of data and develop mitigation measures during emergencies (Morris, 2022).

Regarding years of service, the majority had worked for 11-20 years. Years of service were not statistically significant. Years of service and job-mobility, previous research shows varied forms of job mobility among EWD. Job mobility was higher among EWD than among their counterparts without disability. Employees with disability with deteriorating conditions were retained in their familiar workstations as opposed to training or employing a new person. Contrastingly, when the EWD was junior or unskilled, they would possibly be laid off. It was noted that sick leave was minimal and EWD were reliable and job-retention cost was low. However, EWD lacked confidence to move to new employment and workstations/employment due to fear of losing supportive supervisors (Jahan & Holloway, 2021; Bonaccio *et al.,* 2020; Baldwin & Schumacher, 2002).

The majority of EWD had attended mainstream and schools and colleges. Neither school nor college education were statistically significant. Evidence shows that good basic training and education programs that focus on the job market were critical. Well supported, educated and trained, EWD provided skilled labor contributing to workplace efficiency and effectiveness. However, barriers to education and training were rampant. They included cost of transport, trainers/teachers, materials, inaccessibility to the environment, violence, rejection and bullying due to inadequate policies or lack of implementation (Jahan & Holloway, 2021; Jarvis *et al.,* 2021; Scherer *et al.,* 2024; Tinta *et al.,* 2020; Gréaux *et al.,* 2023).

Most EWD had physical disability, but the severity of disability was not assessed. Future studies need to consider the severity of disabilities and their implications in service delivery. Types of disability were not statistically significant; however, like in the current study, globally there are mixed, psychosocial, physical and intellectual forms of disabilities, among others. Other studies identified types in terms of mobility, cognition and forms of disability that caused dependence on others. One study classified disability into visual, physical, intellectual/cognitive and multiple disability and further into mild, moderate, and profound, which was not done in the current study. The most frequently occurring type has been physical disability, whose leadership-support for accessibility-inclusion is most critical for in their service delivery (Bonaccio *et al.,* 2020; Gutterman, 2023; Gréaux *et al.,* 2023; Ssemata *et al.,* 2024; Niraula, 2022). The current study did not categorize the severity of disability and this needs to be included in future research.

Before factor analysis, diagnostic tests showed data were suitable for analysis, because the KMO value is closer to 1.0, which implies that the data is suitable for factor analysis, while values below 0.50 are unacceptable. Additionally, response rates for EWD and supervisors were excellent (Watkins, 2018). Evidence shows that high response rates (above 80%) are associated with accurate representation of target populations and reduced non-response bias (Meyer *et al.,* 2022).

Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

This is principally central in studies involving marginalized groups, where underrepresentation can give results causing biased interventions (Booker *et al.,* 2024). This was enhanced by study tools with sub-constructs having good to excellent reliability determined using the Cronbach's Alpha reliability test and validity of moderate to high levels, using principal component analysis. Non-response rate was minimum and thus low non-response bias (Meyer *et al.,* 2022). Bartlett's test of sphericity was done and showed that the correlation matrix was not an identity matrix since the generated results yielded a p-value < 0.05, which was 0. Thus, data collected were well-suited for factor analysis.

Normality test determined using the Kolmogorov-Smirnov test, helped in the calculation of significance, skewness and kurtosis. For the data to be normally distributed, the probability value (sig) must be greater than 0.05. Leadership-support for accessibility-inclusion had a probability value significance of 0.272 and service delivery 0.056. Additionally, the response rate was excellent. Data was normally distributed by significance and histogram (Altman & Bland, 1995; Ghasemi & Zahediasl, 2012). The data was also linear by scatter diagram (Kim *et al.,* 2024), and heteroscedasticity was likewise ruled out by the graphical p-p diagram.

Leadership-support for accessibility-inclusion was assessed using nine sub-constructs. Outputs indicated that leadership support for accessibility-inclusion for assistive devices, and information in an understandable format were statistically significant influencers of service delivery from EWD. Previous evidence showed that PWD lacked accessibility to assistive devices and sign language interpreters and thus environmental accessibility was hampered (Maende *et al.,* 2024). Compromised environmental accessibility occurred due to a dearth of ramps and elevators, disability friendly washrooms and wheelchairs (Acheampong *et al.,* 2021). The perception of healthcare workers of People with Disabilities presenting for care at peri-urban health facilities in Ghana (*Health & Social Care in the Community*. https://doi.org/10.1111/hsc.13496).

In the current study, accessibility to assistive devices was statistically significantly associated with service delivery. Employees with disability use assistive devices to work fast and safely during emergencies. They recommended that there is a need to improve privacy, confidentiality and affordability as they received their healthcare and understandable information in understandable forms and simple language. In previous studies, accessibility to affordable healthcare services was facilitated by health insurance. Affordable healthcare improved PWD quality of life but those who survive beyond the age of 65 years had increased healthcare demands and challenges getting comprehensive insurance. Both healthcare services and insurance coverage need to improve for the population of PWD above 80 years of age, which is expected to triple by the year 2050 (Gutterman, 2023).

In the current study, barriers to healthcare services among PWD included lack of accessibility, affordability, privacy, prejudices, and receiving healthcare information in formats they could not comprehend. Previously, although healthcare expenditure was twice as high for PWD, plans were underway to improve healthcare affordability (Smythe *et al.,* 2022; Mangundu *et al.,* 2020; Nhapi, 2019). PWD seeking healthcare were described as being stressed, feeling inferior, inconsiderate, selfish, never patient to queue, complainers, violent and too demanding (Acheampong *et al.,* 2021).

Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

In the current study, Barriers Identified by Participants were poor signage and inaccessible formats (Braille, large print), lack of confidentiality and privacy while receiving healthcare services and limited affordability, lack of awareness, pointing of fingers, reserved parking lots, PWD-friendly washrooms, and accessibility to one of the administration blocks. Some PWD look down on themselves despite being supported. Some facilities have disability mainstreaming policies. Participants requested improvement of accessibility to buildings, toilets, more awareness, understandable information, improved privacy and confidentiality during treatment and affordable healthcare services. They needed more car parking spaces and improved signage.

Previous studies showed that Accessibility-Inclusion barriers were pegged on compromised leadership support, inadequacies in policies, reinforcement, accountability and donor dependency (Gréaux *et al.,* 2023). Elsewhere, barriers were caused by gaps in awareness, inadequate coordination, biases, communication and attitudes (Ssemata *et al.,* 2024; Lagu *et al.,* 2022; Bosua & Gloet, 2021; Agbelie, 2023). Recommendations for improvement were understanding gaps, audits, monitoring, evaluation and research to provide data for improvement, and infusing innovations into the healthcare systems (Morris, 2022; Maende *et al.,* 2024; Teborg *et al.,* 2024).

In the current study, service delivery provided by EWD was assessed from nine sub-constructs. Self and supervisor assessments rated service delivery excellent at 90% and 86%, respectively, and the satisfaction of the supervisors was high. Previous findings indicate that EWD results in improved tax revenues, earnings, productivity and wellbeing. Some employers fear that EWD will not be effective/efficient due to adjusted work hours, absenteeism, lower concentrations, lower productivity, inability to efficiently use work tools, lower understanding and/or poor communication. These claims are mainly biased and empirical data is required and awareness. Findings show that EWD cherish work, are punctual and loyal, have lower turnover and serve longer hours and their service delivery is comparable to colleagues without disability. Some theories support organizational diversity by improving cognitive capital and work attitude, inclusive culture, satisfaction and altruism. Research findings indicated that having EWD in the workforce drew customers with disability, resulting in business growth. The corporate image and social responsibility improved due to customer engagement and employee loyalty (Gutterman, 2023; Jing *et al.,* 2022; Lindsay *et al.,* 2018).

In this study, service delivery from employees with disability was self-rated at 90% based on responsiveness, safety and customer centeredness. Similarly, their immediate supervisors rated it at 86% dispelling the self-reported rating. Previous evidence indicates that employees with disability need to meet similar quantitative and qualitative standards as their counterparts without disability and that lowering standards and quality of service (or products) because an employee has disability is not disability inclusion. However, disability Accessibility-Inclusion marshalled and supervised by institutional leaders is often necessary to meet service (or product) specifications and customer demand. The report indicated that although the same quality and quantity is expected from all employees, an employee with disability may not be expected to perform their duty in the same way as colleagues without disability, because assistive devices may be required which were statistically significantly (p-value 0.030) related to service delivery in the current research (Acheampong *et al.,* 2021).

These findings support the human rights model of disability, which advocates for Accessibility-Inclusion as a basic right and. stakeholder theory, which recognizes that everyone is not only an

Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

agency in the institution but a valued stakeholder to bring positive outputs, outcomes and impact in a conducive environment. Although it is important to assess the productivity of EWD, evidence shows that their performance must not be based on the amount of work done or profit generated to avoid generating stigma, prejudice, and negative attitudes based on idealized views. Neoliberalism measures based on (creating competition, economic pressure and straining relationships in workplaces) need to be used sparingly. Thus, other differentiation criteria are invaluable because EWD face numerous challenges that employees without disability do not have level playing fields (Teborg *et al.,* 2024; Lindsay *et al.,* 2018). Nonetheless, performance of EWD has been reported as being comparable to that of colleagues without disability following integration, appropriate task-allocation and support. Many companies said employing EWD improved public image and organizational climate. They recommended disability inclusion in line with the social model of disability. Willingness and openness to employ PWD regardless of the type of disability were feasible (Seva, 2020; Marques *et al.,* 2020; Grześkowiak *et al.,* 2021).

Most employees with disability showed eagerness to participate in this current research. A supervisor indicated that supervisor Number 22 commented, "*…most PWD are motivated to work very hard when supported and when given regular positive performance feedback… they boost our organizational image…"* Employees were shown to be motivated to work hard by known quality and quantity standards applied uniformly and consistently with regular objective feedback. The findings showed that although service delivery assessment and general performance are not a favourite aspect of leadership and management. However, evaluation leads to production improvement based on the identification of the need for further disability inclusion measures, support and increased service delivery (ADA, 2021). In the current study, there were implications that EWD were not only socially profitable to the institution but profitable too. This is evidence in previous research where EWD were profitable in economic aspects.

In the current study, results indicate that leadership support for accessibility-inclusion has a positive effect and improves service delivery at level-six hospitals in Kenya. Provision of assistive devices, transport accessibility, and buildings was vital. Confidentiality, privacy and affordability when accessing healthcare were important to EWD in varying levels. Information in an understandable format, received in appropriate means and from good sources, were underscored. Recent studies have highlighted the influence of accessibility-inclusion on service delivery. Previous evidence asserts that obstacles to disability accessibility were readily overcome, existing barriers dismantled, through involvement of EWD in planning, creating awareness among colleagues and positive attitude of institutional leadership (Aichner *et al.,* 2024). The Kenya Community Health Strategy 2020–2025 emphasizes the importance of accessibility to the environment, healthcare and information to enable employees to perform service delivery. Customer choice and provider competition were highlighted. Healthcare safety, responsiveness and customer-centered approaches led to improved service delivery in the eyes of the customer (Kazungu *et al.,* 2024).

Supervisors rated supportive-supervision at 92%, service safety at 83%, responsiveness at 85% and client centeredness at 85%. Their rating of service delivery from EWD was 86%. Regarding supportive supervision, supervisor Number 22 commented, "*…most PWD are motivated to work very hard when supported and when given regular positive performance feedback…"* Regarding stigma based on lack of awareness, respondent Number 159 wrote, "*… No awareness, stigma, too*

Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

much pointing of fingers during service delivery…" Respondent Number two recommended, "*…I recommend 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 me…*" A supervisor said, *"...we need more PWD reserved parking lots and PWD-friendly washrooms…the administration block needs to be accessible for all PWD regardless of their disability. They, too, can have engagements with the CEO…"*

CONCLUSION

This study examined the relationship between accessibility-inclusion and service delivery by employees with disabilities (EWD) in level-six hospitals in Kenya. It identified key service characteristics and assessed the influence of leadership support for inclusion. Service delivery from EWD was characterized by responsiveness, safety and customer-centeredness. EWD demonstrated strong service delivery in responsiveness, safety, and customer-centeredness. These attributes were consistently affirmed by both the employees and their supervisors, highlighting the competence and commitment of EWD in healthcare environments. Leadership support for accessibility-inclusion had a positive influence on service delivery from EWD. Increased rating of accessibility-inclusion translated to increased rating of service delivery. Accessibility-inclusion based on accessibility to assistive devices, buildings, transport, healthcare services (characterized by confidentiality, privacy, affordability), information in understandable formats, good sources of information and appropriate media/means. Rating ranged between 77- 83% with an average of 80.4%. Accessibility to assistive devices (p-value 0.030) and accessibility to information in understandable formats (p-value 0.039) were statistically significant. The study found a significant positive correlation between leadership support for accessibility-inclusion and improved service delivery by EWD. This underscores the importance of accessible environments and inclusive policies in enhancing workforce performance.

Barriers were identified in limited accessibility to appropriate assistive devices, transport and buildings, undermining the speed of work, workplace safety during emergencies. Joy at work, access to the building. Respondents recommended improvement of confidentiality, privacy, affordability and quality of healthcare services for EWD. Voices repeatedly echoed the need to create awareness on disability. Participants highlighted persistent barriers such as inadequate assistive devices, inaccessible infrastructure, and limited privacy and confidentiality in healthcare settings. They emphasized the need for disability-awareness and "good information," "good things," initiatives and systemic improvements to healthcare service access.

These research findings imply that EWD display responsiveness, service safety and customer-centeredness like colleagues without disability, when leaders implement disability-inclusion. This dispels stereotypes, biases and misconceptions around productivity and quality of service delivery from EWD. Therefore, leadership-support to implement accessibility to assistive devices, buildings, transport, confidentiality, privacy, and affordability in healthcare, and information in formats, means and sources that allow understanding, enhances service delivery from EWD.

Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

RECOMMENDATIONS

Leaders should prioritize and ensure access to assistive devices and information in understandable formats, given their significant influence on service delivery (p=0.030 and p=0.039, respectively).

Institutional leaders should establish disability-inclusion performance indicators and hold quarterly review meetings with EWD and their supervisors.

Institutional leaders should establish a structured monitoring and evaluation framework to specifically track service delivery outcomes of EWD based on accessibility-inclusion indicators and benchmarks.

Intuitional leaders should develop a recognition and reward system tied to performance and organizational inclusion initiatives to motivate EWD and inclusive managers.

Leaders need to address the barriers (assistive devices, inaccessible buildings and transport, incomprehensible information, lack of privacy, confidentiality and affordability while accessing healthcare services) identified in service delivery and accessibility-inclusion, collaboratively with all stakeholders.

Hospital administrators should work with disability advocacy groups and infrastructure experts to redesign facilities for improved accessibility-inclusion.

Future studies should explore disability inclusion in lower-tier healthcare facilities (levels 2–5) and conduct comparative analyses across hospital levels to generalize findings and inform national policy.

Acknowledgements

My appreciation to God, the research facilities, my colleagues, family, my college, and my supervisors. Special acknowledgement goes to the African Development Bank, courtesy of East African Kidney Institute, Ministry of Health.

Funding

Partial funding was received from the African Development Bank, courtesy of East African Kidney Institute, the Ministry of Health and my family.

Conflict of Interest

The authors declare no conflict of interest.

Ethical Approvals

Kenyatta National Hospital-University of Nairobi Ethics Research Committee (KNH-UON-ERC)-P2/01/2024 (12th June, 2024 to 11th June, 2025)

MTRH/MU- Institutional Research and Ethics Committee (IREC) -IREC/754/2024 (27th June, 2024 to 26th June, 2025)

National Commission for Science, Technology and Innovation (NACOSTI)- 489210 (5th September, 2024 to 5th September, 2025)

Journal of Leadership and Governance
ISSN 2958 - 3845 (Online)
Vol.4, Issue 2, pp 1 – 26, 2025

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