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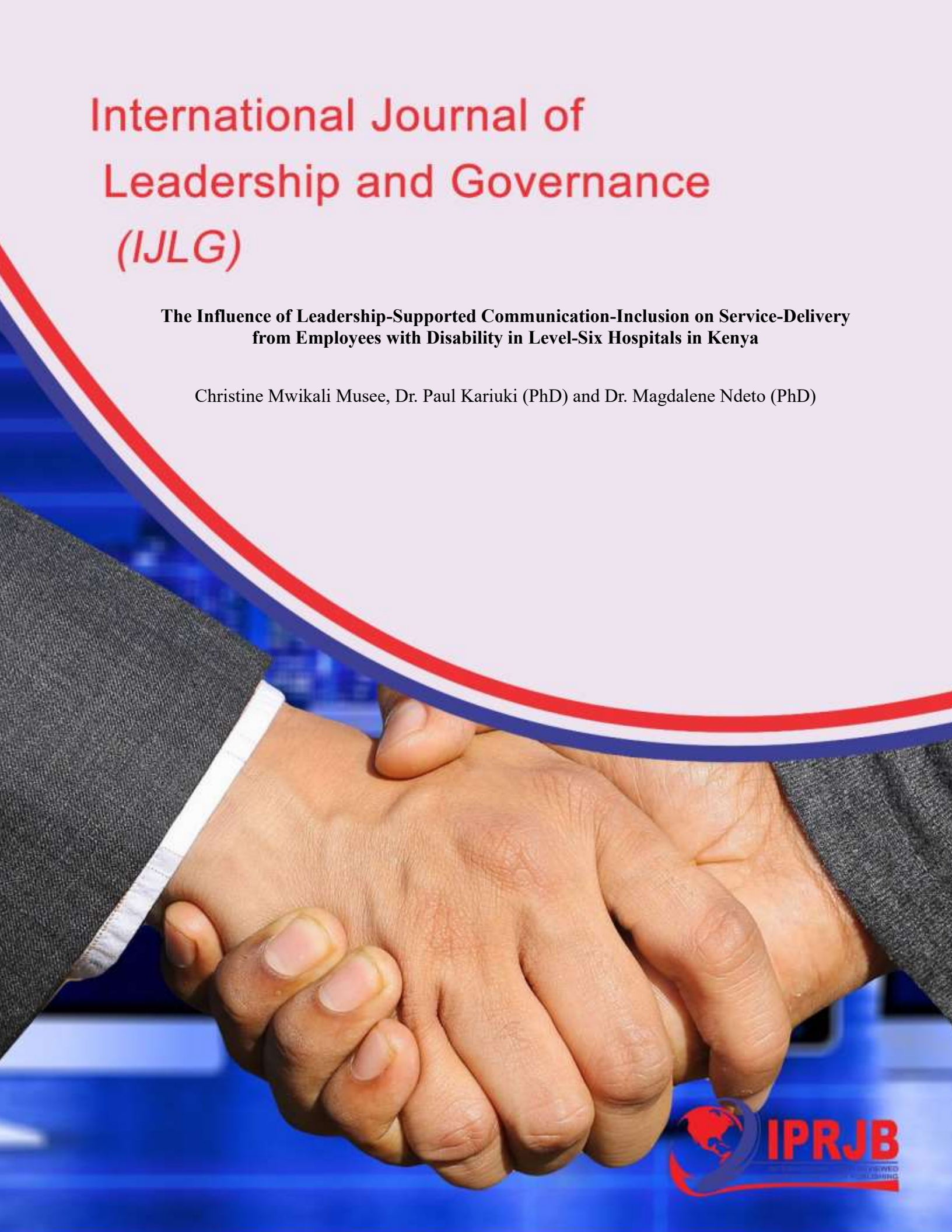

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The Influence of Leadership-Supported Communication-Inclusion on Service-Delivery from Employees with Disability in Level-Six Hospitals in Kenya

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Abstract

Purpose: Communication-inclusion facilitates employees with disability in their service-delivery, through knowledge management, technology and attitudes. In level-six hospitals in Kenya, leadership-support for disability communication-inclusion and its influence on service-delivery from employees with disability had not been researched. To assess influence of leadership-supported communication-inclusion on service-delivery from employees with disability.

Methodology: This cross-sectional research, used two self-administered and/or assisted Likert-scale-based questionnaires, and observation checklists. Population was 229 employees with disability and 229 supervisors sampled by census from five purposively-selected hospitals. Data analysis done using SPSS version 29, N-Vivo version 15, Peason's correlation coefficients and ANOVA to test hypothesis, yielded measures of central tendency, dispersion, percentages; associations using. Cut of p-value < 0.05 indicated significance.

Findings: Employees with disability and supervisors rated service-delivery at 90% and 84.3%, and communication-inclusion 71.9% and 84%, respectively. Attitude (0.044), team support (>0.001) and capacity-matched-task-allocations (0.006) were significant. Communication contributed 34.7% (R 0.347) positive change in service-delivery with F statistic of 106.347 greater than critical value 0.000 and p-value 0.000 < 0.05. Null hypothesis, 'Communication-inclusion has no significant influence on service-delivery at level-six hospitals in Kenya,' was rejected. A respondent said, "*...I use a special touch, speaking phone, very expensive but it was not tax exempt…Internet is available… most times…, in some places, it is not…this affects our communication…Negative…attitude needs to be addressed…"*

Unique Contribution to Theory, Practice and Policy: Employees with disability are uniquely talented with potentials that can be objectively exploited through leadership-led communication-inclusion and regular evidence to dispel misconceptions. Communication-inclusion has positive influence on service-delivery from employees with disability.

Keywords: *Communication, Disability, Employment, Inclusion, Leadership, Service Delivery, Workplace*

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INTRODUCTION

Employees with disability experience compromised communication inclusion in the workplace and this may show negatively in their service delivery where their talents and potentials fail to get optimized. There was lack of research evidence on talents and potentials of 229 employees with disability in level-six hospital in Kenya in their service delivery. The influence of communication inclusion on service delivery from this work force had not been researched, yet level-six hospitals offer apex specialized of healthcare services and research in the country and the region. Service-delivery in the workplace is pivoted on inclusive communication for employees with disability (EWD) to give direction, understanding and expected productivity targets (Nogueira, 2022).

Good communication translates to appropriate service-delivery from employees with disability. Communication inclusion for EWD is beyond verbal and non-verbal messages, thus the key role of technology and attitude. Communication-inclusion for EWD relates to knowledge management, use of technology and appropriate attitude. Evidence shows that communication-inclusion creates understanding and evidence based decision-making (Nogueira, 2022). However, gaps in communication-inclusion result in inappropriate work attitudes, feeling lost at work and low productivity. Healthcare ervice-delivery from EWD ought to be characterized by responsiveness, safety and customer centeredness. Communication-inclusion is a basic human-right on which others are human rights are anchored and on which institutional success is fueled (Jagoe et al., 2021; Nogueira, 2022).

Communication inclusion refers the conduit that enables creation of, access to, sharing of and utilization of information in ways that are inclusive in order for all stakeholders to experience objective identity, experience relations that foster meaning in individual and collective roles, while overcoming barriers (Kearns et al., 2025) in different setups including workplace. The authors emphasize the need to pay special attention to employees with disabilities in communication. Adoption of responsive and respectful interactions using technology and attitude play critical roles. Application of communication-inclusion sub-constructs identified (as knowledge management, use of technology and attitude) steer service-delivery from EWD, particularly with auditory, visual, intellectual, speech, psychological and seizures. Researchers recommend that communication-inclusion challenges be addressed through census-based disability studies to identify and address inequalities, inform practices and policies (Jagoe et al., 2021), thus this study. Evidence showed that communication-inclusion was clearer to managers than lower EWD cadre implying lack of transparency and awareness (Holt et al, 2024) thus the need to improve communication-inclusion through knowledge management, technology and attitude (Jurado-Caraballo et al., 2020). Accordingly, the current study interviewed both EWD and supervisors on census basis, as recommended (Nogueira, 2022).

Problem Statement

Even in the absence of challenges in communication inclusion, employees with disability need leadership supported efforts to realize their service delivery potential and talents (Musee et al., 2025a). Evidence ought to be researched and/or documented otherwise implementation of inclusion would not have been done (Musee & Wagoro, 2025), thus the current systematic research aimed to address this gap. Legally communication inclusion, is addressed by the Communication Bill of Rights, which identifies communication rights of PWD and respectful interactions, dignity,

and meaningful linguistically and culturally acceptable conversations (Bruce et al., 2025). In psychosocial dimensions, communication inclusion helps overcome depression and anxiety and enhances workplace performance. Bullying and social stigma which undermine workplace performance are overcome (Kearns et al., 2025). Organizational communication inclusion, ought to focus on employing strategies to foster, workplace equality and equity, diversity and respect to improve collaborations, team dynamics, workplace performance and employee satisfaction (Ylmaz, 2024). Thus, legally and psychosocially communication inclusion is binding if organizational communication will translate to optimum service delivery from employees with disability.

However, there is largely limited data to show the influence of communication inclusion on healthcare service delivery in level-six hospitals, characterized by responsiveness, safety and client centeredness (quality) which the current research addresses (Musee, Mweu, et al., 2025; Musee et al., 2025). Communication inclusion facilitators and barriers needed to be identified from those affected in order to address them objectively (Musee, Mweu, Okutoyi, et al., 2025). Leadership support for communication inclusion shapes organizational communication practices including knowledge management, use of technology and builds positive attitude in workplaces (Cheng et al., 2025). Thus, leadership support is central in navigation organizational service delivery by creating understanding in business processes, changes, and accommodation and adjustments among employees with disability (Sacavém et al., 2025).

Leadership support for disability communication-inclusion is supported by the human rights and social models, theory of stigma and stakeholder theory and shown to have positive influence on service-delivery from employees with disability. Firstly, communication inclusion is a basic human right and dignity that is protected by law (Sedova, 2024) and secondly, a social justice expectation (Lawson & Beckett, 2020). The stakeholder theory recognizes employees with disability as value adding stakeholders in tangible and intangible aspects in organizations, boosting tolerance and reputation (Migliaccio, 2017). Theory of stigma reveals that stigma hampers employability, equity and equality and productivity of PWD, their active roles in healthcare service delivery as professionals, among colleagues without disability. For employees with disability to give more focus on their customers, organizational leaders need to pay attention disability communication inclusion. Largely execution of communication inclusion, monitoring, evaluation and dissemination of findings has been low (Degener, 2014). Furthermore, misconceptions, stigma and stereotypes regarding service-delivery from employees with disability are often not evidence based (Musee, et al., 2025).

Evidence shows that communication exclusion for employees with disability was directly related to perceptions of communication marginalization and organizational practices (Wolfgruber et al., 2021). This implies gaps in getting workplace direction, understanding of performance targets and workforce diversity. In India, 95% employees expressed concerns and barriers in attitude, communication inclusion, harassment and discrimination and these were barriers to employee performance resulting in underperformance. Need-based planning anchored on timely evidence, was recommended (Ramachandra et al., 2017). In a global report use of technology and attitude influenced communication inclusion and employees with disability needed to participate in knowledge acquisition, dissemination and researches (WHO, 2011).

Despite, there being 229 EWD in the study facilities, there was no study evidence to rate safety, responsiveness and customer centeredness of their service-delivery (Musee et al., 2025), being indicators of quality healthcare services (Musee et al., 2025a). Leadership-support for communication-inclusion, was scantly documented and the influence of communication-inclusion on service-delivery from EWD had not been researched. Equitable knowledge management, use of technology and appropriate communication attitudes comes in handy to improve interactions (Holt et al, 2024), understanding, decision-making and service-delivery and dissipates misconceptions. There was no research evidence to this effect in the study facilities, although it has been shown that EWD have untapped talents/potentials and their service-delivery is comparable to that of colleagues without disability in interactive environments. Barriers to communication inclusion were undocumented, yet communication tools with high demands form barriers, leading to underrepresentation in research, workplace performance and rising to decision-making positions. Identifying barriers collectively with PWD has been shown to provide affordable feasible solutions (WHO, 2022).

Locally, out of 404 public institutions in Kenya, only 18 employed PWD, 181 created awareness on disability inclusion, and only 234 had disability inclusion champions. Two of the five study facilities partially reported their disability inclusion status and the others did not. Moi Teaching and Referral Hospital was 68% compliant and Kenyatta National Hospital 56.25% (NCPWD, 2023) indicating gaps in disability inclusion. There was no disability communication inclusion data for Mathari National Referral Hospital, National Spinal Injury Referral Hospital and Mwai Kibaki Teaching and Referral Hospital. Yet, leadership-support for communication-inclusion was shown elsewhere to improve communication inclusion and subsequent EWD productivity (Jagoe et al., 2021). The authors also showed that this improves workplace outputs, interactions, livelihoods, overcomes exclusions, misconceptions and stigma. Building evidence to assist PWD during workplace practices and research improves completion of assignments and research tools (Jagoe et al., 2021), thus this study. The study objective was to assess the influence of leadership supported communication inclusion on service delivery from employees with disability in level-six hospitals in Kenya.

METHODOLOGY

This was cross-sectional study, with quantitative and qualitative aspects. Study facilities comprised of five purposively sampled level-six hospitals namely; 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 study population included EWD working in the facilities and their supervisors (with or without disability). The sampling frame is shown in Table 1, total targeted EWD and supervisors were 229 each and sampling was by census.

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Table 1: Sampling Frame

No	Facility	No. of EWD	No. of supervisors	Total
1.	KNH	96	96	
2.	MTRH	112	112	
3.	NSIRH	6	6	
4.	MNTRH	8	8	
5.	MKNRH	7	7	
	Total	**229**	**229**	**458**

As shown in Table 1, in KNH target was 96 each, MTRH 112 each, NSIRH 6 each, MNTRH 8 each, MKNRH 7 each, forming a total of 229 each.

Data collection was conducted using two questionnaires, one for EWD and the second for supervisors. Both questionnaires covered socio-demographic data, sub-constructs of service delivery (responsiveness, safety and customer-centeredness), sub-constructs of communication-inclusion (knowledge management, use of technology and attitude), assessed using five-point Likert scale questions. Five checklists were filled per research facility, covering evidence on responsiveness, safety and customer centeredness in service delivery and communication-inclusion evidences on inclusion of EWD in knowledge creation and dissemination, use of technology and actual communication between EWD, supervisors and colleagues in the workplace. Pilot study was conducted in two level-five hospitals. Pilot data was not included in the actual research.

Data collection begun after ethical approvals. Lists of respondents were obtained from human resource departments. Eligible volunteers were given information on research title, data collection, risks/discomforts, benefits, ethical compliance, consenting procedure and management of results. Respondents were interviewed after voluntarily signing informed consents.

Pilot-testing was done in Mbagathi Level-5 hospital and Pumwani Maternity hospital to exam understanding and suitability of responses. Meticulous pilot study sample size being 1-10% of research samples, pilot study size was 12 EWD, 12 supervisors selected by census, and five observation checklists per facility, an equivalent of 5.2%, 5.2% and 40%, respectively, of the study sample. Two pilot facilities were identified owing to the lean population of EWD. Pilot data was analyzed and the instruments did not need adjustments.

Table 2: Reliability & Validity Tests using Cronbach Alpha and Principal Component Analysis (PCA)

Reliability Test Using Cronbach Alpha Test				
NO	**Variable**	**Cronbach Alpha**	**No. of Items**	**Status**
1.	Communication-inclusion	0.93 (great)	9	Acceptable
2.	Service-delivery by EWD	0.76	9	Acceptable
	Validity test using principal component analysis			
1.	Communication-inclusion	0.7892 (High)	9	Acceptable
2.	Service-delivery from EWD	0.5418 (Moderate)	9	Acceptable

As shown in Table 2, reliability was tested using Cronbach Alpha Test (CAT) and communication-inclusion nine constructs CAT was 0.93 (great) and acceptable. The CAT level for service-delivery

was 0.76 which was acceptable. Validity test was done using Principal Component Analysis (PCA) and communication inclusion PCA was 0.7892 (high) and acceptable while service-delivery PCA was 0.5418 rated as acceptable.

RESULTS

Table 3: Response Rate of EWD and their Supervisors

Response rate N=211 (Target 229 EWD)						
	STUDY FACILITIES					
VARIABLE	KNH n=96	MTRH n=95	MNTRH n= 8	MKTRH n=7	NSIRH n=6	Overall N =211
Response Rate of EWD	95(99%)	95(84.8%)	8(100%)	7(100%)	6(100%)	211(92.1%)
Response Rate of supervisors N=196 (Target 229)						
	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%)

As shown in Table 3, target population of EWD from the five study facilities was 229. The response rate of EWD was 211(92.1%) thus a non-response rate of 18(7.9%) respectively and response of the immediate supervisors was 196(85.6%) thus a non-response rate of 33(14.4%).

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Biodata of Employees with Disability

Table 4: Biodata of EWD

	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 EWD						
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 EWD						
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 EWD						
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 EWD						
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%)

As shown in Table 4, majority EWD respondents were male at 115(54.5%), majority 95(45.0%) were aged 45-54 years; majority 81(38.4%) had worked for 11-20 years and majority 88(41.7%) were working in outpatient departments/units.

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Table 5: Further Demographic Data of EWD

	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 EWD						
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 EWD						
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 EWD						
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 EWD						
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 EWD						
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%)

Additionally, shown in Table 5, majority 197(93.4%) EWD attended mainstream schools, majority 85(40.3%) had diploma, 93(44.1%) were deployed in health management and support departments. Majority 120(56.9%) had physical disability.

Diagnostic tests

Diagnostic test sowed Keiser-Meyer-Olin (KMO) for Communication-Inclusion was 0.85 (meritorious) and SI 0.81 (meritorious), thus appropriate for factor analysis. The normality results as shown in Figure 1.

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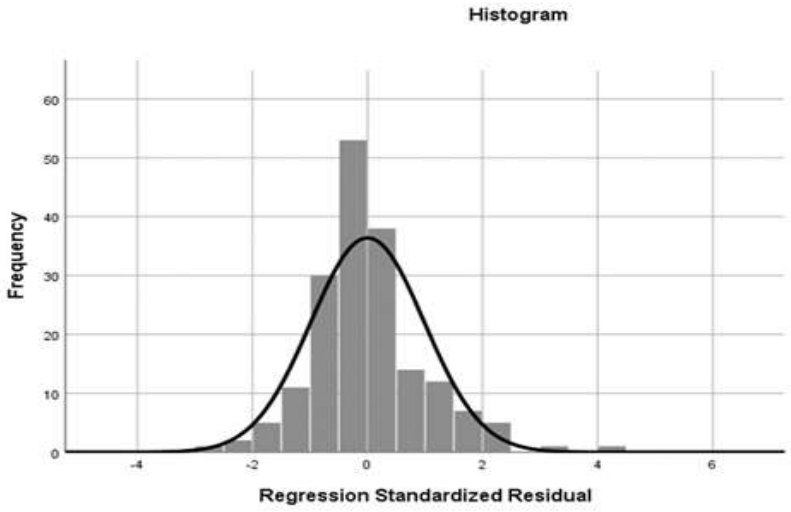

Figure 1: Normality Plot Histogram

As shown in figure 1, the data was normally distributed. The histogram of regression standardized residuals visually assessed the normality. The x-axis represents the residuals, while the y-axis denotes their frequency. The superimposed black curve represents a normal distribution, aiding in evaluation whether residuals exhibit a bell-shaped pattern. In this case, the residuals are symmetrically distributed around zero, with only minor deviations at the tails, suggesting that normality is approximately met.

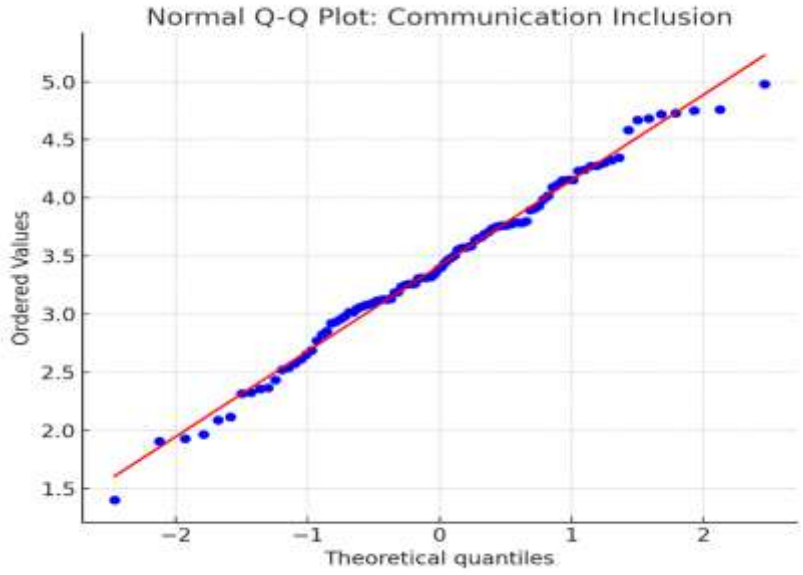

Figure 2: Linearity Test of Communication-inclusion

As shown in figure 2, the variables had had a linear relationship.

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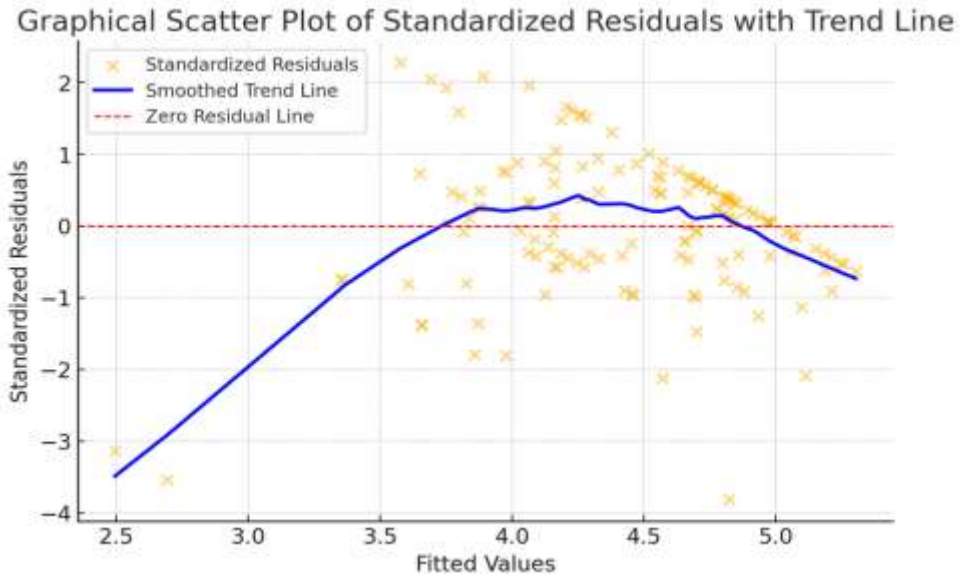

Figure 3: Graphical Representation of p-p plots in Heteroscedasticity Test

To test for heteroscedasticity, the graphical p-p and scatter plots method were used. Since, the null hypothesis of this study indicates that the error variance is homoscedastic, the results indicate that there is no presence of heteroscedasticity in the use of the ordinary least squares (OLS) regression. This is evidenced by the graphical scatter plots (Figure 3) which oscillate along the standardized residual regression line.

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Leadership-Support for Communication-Inclusion

Table 6: Leadership-support for Communication Inclusion

Sub-Construct	LEADERSHIP-SUPPORT FOR COMMUNICATION INCLUSION								
	Likert scale Choice Responses (n/%)					Measures of Central tendency, Dispersion and Indices			
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Mean	Median	SD	Score
Opportunities to create knowledge facilitates my service-delivery	50 (23.7%)	86 (40.8%)	49 (23.2%)	15 (7.1%)	11 (5.2%)	4.01	4.00	0.82	72%
Taking part in research facilitates my service-delivery	45 (21.3%)	71 (33.7%)	67 (31.8%)	17 (8.1%)	11 (5.2%)	3.90	4.00	0.94	80%
Sharing of knowledge facilitates my service-delivery	61 (28.9%)	100 (47.4%)	45 (21.3%)	2 (1.0%)	3 (1.4%)	3.75	4.00	1.17	78%
Access to communication technology equipment(s) facilitates my service-delivery	64(30.3 %)	75(35.6%)	63(29.9 %)	4(1.9%)	5(2.4%)	2.40	2.00	0.54	28%
My communication equipment(s) were exempt from taxation	0 (0.0%)	0 (0.0%)	32 (15.2%)	41 (19.4%)	121 (57.4%)	3.99	4.00	0.93	75%
Affordable internet for communication facilitates my service-delivery	73 (34.6%)	49 (23.2%)	66 (31.3%)	9 (4.3%)	14 (6.6%)	4.00	4.00	0.97	80%
Communication attitude at work facilitates my service-delivery	59 (28.0%)	112 (53.1%)	29 (13.7%)	1 (0.5%)	10 (4.7%)	4.00	0.90	0.90	80%
Awareness on attitude influences communication at work	66 (31.3%)	101 (47.9%)	31 (14.7%)	3 (1.4%)	10 (4.7%)	3.89	4.00	1.02	80%
Equitable channels of communication facilitate my service-delivery	63 (29.9%)	103 (48.8%)	34 (16.1%)	5 (2.4%)	6 (2.8%)	3.74	3.43	0.93	71.9
Average						**4.01**	**4.00**	**0.82**	**72%**

Table 6, displays the output of the nine constructs used to assess leadership support for communication inclusion, namely, creating, sharing knowledge and participating in research, use of communication technology, tax exempt technology and affordable internet, communication

attitude, creating awareness on attitude and equitable channels of communication. Of the respondents 86(40.8%) agreed that opportunities to create knowledge at work facilitates their service delivery, 71(33.7%) agreed that taking part in research facilitates their service delivery while 100(47.4%) agreed that sharing knowledge facilitates their service delivery; 75(35.6%) agreed that access to communication technology equipment facilitates their service delivery, 121(57.4%) strongly disagreed that their communication equipment were exempt from taxation, 73(34.6%) strongly agreed that affordable internet for communication facilitates their service delivery while 112(53.1%) agreed that communication attitude at work facilitates their service delivery; 101(47.9%) agreed that creating awareness on attitude influences communication ate workplace and 103(48.8%) agreed that equitable open channels of communication facilitates their service delivery.

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 (*customers*)…*" Respondent Number 20 wrote, *"...Putting one-self to the situation of your customers always ensures empathy..."* Regarding giving customers information as part of service-delivery, respondent Number 18, , commented, "…*it is good to explain (*to customers*) when there are delays in services…*"

On knowledge creation, respondent Number 25, wrote, "…*I would Like to participate in research activities involving PWD*…" Respondent Number 161, said, "…*Create more opportunity for us to participate in research studies..."* Respondent Number 76, said, "…*Employees can use research to improve services based on evidence..."* Respondent Number 8, suggested, "…*do more research about PWDs. Give seminars about disability and how to accommodate them…*" However, respondent Number 159, said, "*Doing research is not open to equitability...*" Respondent number 7, wrote, "*...I use a special touch and speaking phone, very expensive but it was not tax exempt…Internet is available at work most times where I work but, in some places, it is not…this affects our communication at work… negative communication attitude needs to be addressed…"* Respondent number 12, wrote, "*...open door communication policy needs to be improved…*"

The importance of sharing research findings was highlighted by respondent Number 9, who wrote, "…*by sharing research findings to many with PWD to get enlightened and empowered*…" Respondent Number 24 wrote, "…*The hospital should come up with a framework on how to share research information with persons with disability…*" Respondent Number 144 said, "…*There is breakdown when it comes to giving research feedback…Most research webinars are held during working hours thus, it is difficult to participate in…I have never attended a research conference…"*

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Table 7: Analysis of Service-Delivery from Employees with Disability

Construct	SERVICE-DELIVERY FROM EWD								
	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 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 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 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 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 customer	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 from 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 their service delivery, 134(63.5%) always practice infection prevention and control during service delivery, while 105(49.8%) always utilize alarm/bells during service delivery; 148(70.1%) were always friendly to customers, 145(68.7%) always attended to their customers promptly while 142(67.3%) always give their customers necessary information; 131(62.1%)

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always show empathy to their customers, 154(73.0%) always show respect to their customers, 143(67.8%) always provide holistic services to their customers.

The means for the nine constructs range between 4.11(use of alarms/bells) to 4.61 (showing respect and providing holistic services) with an average of 4.51. The median ranged between 0.83 (showing 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. Indices ranged between 82% (use of alarm/bells) and 92% (being friendly and showing respect) with an average of 90.0%. The small distance of mean from the standard deviation (SD) indicates that the respondents were a homogenous population.

Regarding holistic services, respondent Number 3, 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 patients complains and compliments. Attending to their needs at all time…*" A respondent gave a general comment, "….*this questionnaire is lengthy and detailed…it is a good thing…but if I did not have someone to assist, I would not have filled it fully…*"

Supervisor number four said, "*...PWDs work very well. Some outperform their colleagues without disability…but some look down on themselves even when well supported…*" Another one said, "…*sign language interpreters are few. We need more because communication runs our businesses and functions…. Some colleagues are jealous when PWDs get tax exemption and service tenure is prolonged…it is human factors….*"

Table 10: Regression Analysis for Communication-Inclusion

Model of Fitness Communication Inclusion					
R	**R Square**	**Adjusted R Square**	**Std. Error of the Estimate**		
.612a	0.374	0.37	0.34		
ANOVA					
	Sum of Squares	**Df**	**Mean Square**	**F**	**Sig.**
Regression	12.323	1	12.323	106.347	.000b
Residual	20.627	209	0.116		
Total	**32.95**	**210**			
Regression of Coefficients					
	Unstandardized Coefficients		**Standardized Coefficients**	**t**	**Sig.**
	B	**Std. Error**	**Beta**		
Constant	1.28	0.272		4.707	0.000
Communication-inclusion	0.68	0.066	0.612	10.312	0.000

a **Dependent Variable**: Service-delivery

b **Predictors**: (Constant), Communication-inclusion

$Y= B_0+ B_1X_1+e$ (Service-delivery at level-six hospitals in Kenya. =1.28 + 0.68* CI).

Discussions

Overall, these census-based sampled, triangulated results of EWD and supervisors' contribution yielded generalizable results (Booker et al., 2021; Musee, et al., 2025a). Leadership-led communication-inclusion contributed 34.7% to service-delivery. Employees with disability service-delivery was characterized by responsiveness, safety and patient centeredness (Musee, et al., 2025) although they experience barriers that need to be addressed. Census sampling is advocated for in studies covering marginalized groups, each individual being different and their inputs being critical (Holt et al, 2024; Musee, et al., 2025b). Those who lacked capacity to fill questionnaires were assisted as recommended in previous studies (Jagoe et al., 2021). On average in-person-surveys show a response rate of 76%, while excellent response rates of above 80%, increases representation, reliability, validity, precision of inferences and reduce margin error (Meyer et al., 2020; Booker et al, 2021; Musee, et al., 2025b).

The response rate was excellent, above 80% and was enhanced by communication, administration good-will, follow-up, involvement, confidentiality, privacy, and support. Additionally, respondents and key informants provided open comments which were supported by findings in the checklists. Response rates are influenced by communication, follow-up, design, piloting, incentives, instructions, rapport, language, length, simplicity, questions, anonymity, privacy, affordability; age, work-pressure, education and culture (Musee, et al, 2025). Underrepresentation in PWD studies has been identified and is related to poor databases, unwillingness to declare disability, discrimination, episodic-disabilities and stigma (Booker et al, 2021; Weaver, Beebe and Rockwood, 2019). In Ethiopia response rate of 96.9% was realized (Teame, Debie and Tullu, 2022), Finland (85.2%), Africa (77.5%), China (74.7%) and Norway (7.5%) among junior staff. Managers had lower response rates related to satisficing (Meyer et al., 2020) with lower rates among specialized doctors (Weaver et al, 2019). Assisting PWD during research and shortening interviews addressed *lengthy* aspects highlighted in the current research (Musee et al, 2025b).

The current study reported more male employees with disability, while globally there are more females PWD, which might have been related to underreporting or non-disclosure. Gender was not significant. Correspondingly, findings revealed healthcare workers with disability having more females, 70% being nurses (Okoroafor et al., 2022). Unemployment was higher among women with disability (Gutterman, 2023; Lee et al., 2020). In the current study, age was not statistically significant, however, previously being older was a risk for disability although disability could occur any time (Lee et al., 2020). In congruence, globally 3.8% of persons aged above 15 years get disability which is higher in older populations linked to ageing and chronic sicknesses (Gutterman, 2023). Thus, age ought to be included in all PWD studies (ADB, 2024, Musee, et al, 2025a).

More EWD were working in outpatient settings where routines are easy to navigate but some worked in more complex setups. Research shows that EWD in workstations with little mobility, customer-flow, sign interpreters and accessibility is adopted better (Bonaccio et al., 2020). Previously, involuntary job mobility was higher among EWD (Baldwin and Schumacher, 2002). Notably, despite deterioration, employers preferred to retain EWD as opposed to employing/training new employees but junior/unskilled EWD would be laid off (Jahan and Holloway, 2021). Employees with disability lack confidence when taken to new workstations/employment and/or new promotions (Bonaccio et al., 2020). Researchers, advocate for work deployment of EWD in similar workstations to colleagues without disability with

adjustments and sheltered workshops for severe disability (Cheausuwantavee and Keeratiphanthawong, 2021). However, despite sheltered workshops, barriers are experienced which can be addressed through communication-inclusion and training (Musee et al, 2025b; Tinta, Steyn and Vermaas, 2020; Jarvis et al, 2021). In Zambia barriers to training included schools/colleges, materials, transport, inaccessibility, stigma, violence, bullying, rejection and policies (Scherer et al., 2024). Types of disabilities identifies were similar to previous studies and barriers were distributed across all types, in America, Nepal and Uganda (Gutterman, 2023; Gréaux et al., 2023; Ssemata et al., 2024) and physical disability was most rampant (Bonaccio et al., 2020).

Diagnostic tests identified that data was appropriate for factor analysis, where KMO values closer to 1.0 suggested suitability and values below 0.50 would be unacceptable (Watkins, 2018). Response rates being 92.1% for EWD and 85.6% for supervisors (above 80%) indicated representation, increased precision of inferences and reduced margin of error (Musee et al, 2025a; Musee et al, 2025b; Booker et al, 2021). Bartlet's test of sphericity was done which showed that the correlation matrix was not an identity matrix since generated results yielded a p-value < 0.05, at 0.

Normality test was determined using Kolmogorov-Smirnov test. For data to be normally distributed, probability value (sig) needed to be greater than 0.05 (Watkins, 2018). Communication-inclusion had a probability value significance of 0.096 and service-delivery 0.056. The results were supported by a histogram plotting of the normality results shown in figure 1. Linearity test was done and a scatter graph indicated that majority of the points formed a linear pattern from bottom left to top right, implying linearity of the two variables (Watkins, 2018) shown in Figure 2. Heteroscedasticity tested using graphical p-p and scatter plots method with ordinary least squares regression identified no heteroscedasticity (Figure 3).

Therefore, data analysis of nine constructs was used to assess leadership-support for communication-inclusion. Rating ranged between 28-80% with an average of 72%. More efforts are required to improve communication-inclusion which often translates to service-delivery from EWD. Stakeholders in line with, '*our voices, our views,*' suggested/implied ways for improvement including, participation in creating and sharing knowledge, research, tax exemption of communication equipment, internet, attitude, sign interpreters and awareness. Previous researchers recommended knowledge management, inclusive policy, interdisciplinary research (Jagoe et al., 2021; Bailie et al., 2023), workplace adjustments and colleagial support to avoid miscommunication (Teborg et al, 2024; Dong et al, 2021), however, lack of knowledge and negotiation power were barriers (Dong et al, 2021).

In the current research, special communication technology gadgets for EWD were not exempt from taxation and internet was not uniformly available in all workstation and this adversely affected their communication. Respondents said that communication attitude needed to be addressed. Internet needs to be improved, there needs to be consideration of tax-exemption on communication equipment for PWD and creating awareness needed to be done regularly to improve attitude among stakeholders, creating an atmosphere to communicate repeatedly to clarify instructions when required. However, some colleagues were jealous when PWD got tax-exemption.

In previous studies, colleagues found it difficult to communicate with PWD during service-delivery. Some used gestures, vocalizations and eye gaze leading to helplessness, frustrations,

strain and struggles. Acoustics, lighting, temperature and noise affected communication-inclusion. Consequently, communication technology and multimodal methods would improve communication-inclusion (Rathiram et al., 2022). In Ghana providers experienced barriers when providing healthcare to EWD (Acheampong et al., 2021). Communication technology, smartphones, computers and televisions inputted with hearing, speech and sight abilities improved service-delivery from EWD (Malik et al, 2024).

In the current study, characteristics of service-delivery from EWD were analyzed using nine constructs. They rated service-delivery between 82-92% with an average of 90% while the average satisfaction of supervisors was 86%. Service safety sub-constructs were rated 82-92%, responsiveness 91-92% and customer centeredness 89-92%. Employees with disability worked hard, showed empathy and give information to customers and performed holistic service-delivery, paying attention to physical, psychological and spiritual aspects. Sign interpreters were few and respondents requested for more. They listened to their complaints and compliments. Supervisors indicated that some EWD outperform their colleagues without disability but some looked down on themselves despite support. Previous evidence revealed productivity of EWD as 'high' (Pielago, 2020), despite challenges (Teborg et al, 2024). The current research has shown that service-delivery from EWD was characterized by responsiveness, safety and customer centeredness when supported by leadership-led communication-inclusion, amidst some colleagues without disability displaying jealous when EWD benefit from inclusion (Bonaccio et al., 2020). Overall EWD add value to their workplaces.

Communication-inclusion had positive influence on service-delivery. The higher the rating of communication-inclusion, the higher was the service-delivery rated. The scoring of communication-inclusion constructs ranged between 28%-80% with an average of 72%. Knowledge sharing (p-value 0.025) and attitude (p-value 0.044) were statistically significant. Regression of the coefficients results, revealed that communication-inclusion and service-delivery in level-six hospitals in Kenya have a positive linear and significant relationship ($\boldsymbol{\beta}$=0.68, p=0.000). Communication-inclusion contributed to 37.4% (R square value of 0.374) change in service-delivery, F statistic 106.347 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.

This implies that there was 37.4% (variation) chance that communication inclusion improved service delivery from employees with disability. Therefore, the responsiveness, safety and client centeredness of service delivery from this workforce was positively influenced by communication inclusion in the organization, a practice that is implemented through leadership guided institutional culture. An immediate supervisor said, "…*most PWD are motivated to work very hard when supported and when given regular positive performance feedback in an understandable language…* A supervisor said that some EWD outperform their colleagues with disability. This outperformance has been attributed to an inclusive environment and not making biased assumptions regarding employees with disability (Lindzon, 2019). This triangulated data shows that service delivery from employees with disability is not just an artifact but a possible product of communication inclusion and other unobserved factors (Lee, 2025).

In congruence, thus the null hypothesis, '**H_0**: Communication-inclusion has no significant influence on service-delivery at level-six hospitals in Kenya was rejected.' This was because 37.4% variation in service delivery could be explained by communication inclusion. However,

respondents requested for improvement and opportunities to participate in research, to create evidence-based service-delivery, more awareness on disability and open-door communication policy, sharing research findings and opportunities to attend conferences. A Technician with disability said, "…*Create more opportunity for us to participate in research studies…"* A Nurse with disability said, "…*Employees can use research to improve services based on evidence..."* Another nurse with disability suggested, "…*do more research about PWD. Give seminars about disability and how to accommodate them…*"

This implies that despite the variance of R-Squared of 0.374, additional effort is necessary to improve communication inclusion in Level-six Hospitals in Kenya and leadership support is critical to ensure further adoption, implementation, regular monitoring, evaluation, research, and sustainability. An immediate supervisor with disability said *…Internet is available at work most times where I work but, in some places, it is not…this affects our communication at work… negative communication attitude needs to be addressed…"*

CONCLUSION AND RECOMMENDATIONS

Conclusion

This study provides new insights regarding the characteristics of healthcare service delivery from employees with disability. This was characterized by responsiveness, safety and customer centeredness. Service safety was pegged on verification of instructions before performance, infection prevention and control and use of alarm systems, during service-delivery, which were rated at 91%, 90% and 82%, respectively. Responsiveness was based on being friendly to customers, giving information and holistic services, rated at 92%, 91% and 91%, respectively. Customer centeredness was based on showing empathy, respect and having a holistic approach during service-delivery, rated at 89%, 92% and 91%, respectively.

The study also contributes new empirical data and quantification of service delivery from employees with disability. Employees with disability rated service-delivery 90.0% and communication-inclusion 71.9%. Supervisors rated service-delivery from employees with disability at 84.3% and communication-inclusion 84%. Nevertheless, the voice of EWD, being the "wearers of the shoe," is comparatively louder and more critical in this study. Experiences of communication-inclusion for EWD is a direct expression of how "the shoe either pinches of fits" and how this influences their service-delivery. Despite "the shoe pinching or fairly fitting EWD in some aspects," the supervisors indicated that they were 86% satisfied with service-delivery from EWD.

The research contributed to the identification of local facilitators and barriers to enhance and address them respectively, in order to improve service delivery through communication inclusion organizational practices.

These findings have several implications. Employees with disability provide responsive, safe and customer centered services when leaders implement communication-inclusion. This dispels stereotypes, biases and misconceptions regarding the value of EWD. Supportive policies, creating awareness and opportunities to create knowledge, participate in research, share information, communication technology and internet, equitable open-channels of communication and attitude facilitative. Communication-inclusion is invaluable to drive service-delivery from EWD.

Study limitations were related to a study sample limited to level-six hospitals only, reliance on self-reported data with possible social desirability bias which may compromise consistency of results. Strategies adopted to address these were census sampling, collecting evidence data from EWD and their supervisors and use of triangulated qualitative and quantitative piloted data collection tools. Future studies are suggested including longitudinal researches in level-six hospitals, comparative researches in lower-level healthcare institutions and qualitative exploratory studies.

Recommendations

Proposals have been made to improve service-delivery from EWD, maximize untapped talent/potential via leadership-led communication-inclusion, elimination of exclusions and policies:

1. From the measured influence of communication inclusion on service delivery, institutional leaders and policy makers need to develop monitoring frameworks to regularly monitor and evaluate communication-inclusion status to inform improvement efforts.
2. Institutional leaders need to address inclusion shortfalls, barriers and deficits identified including (but not limited) to negative attitude, lack of equity and equality in participating in research, increasing sign language interpreters, internet supply and backup, and creating awareness on disability inclusion while paying attention to communication inclusion.

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