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Assessing Attitudes, Feelings and Opinions of Women Living With Disability on Their Reproductive Health in Kakamega County, Kenya

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ABSTRACT

Disability is defined as "an umbrella term, covering impairments, activity limitations, and participation restrictions [1]. One billion people, or 15% of the world's population, have some form of disability, and the prevalence is higher in developing countries. This adds up to between 110 million and 190 million people. Eighty percent of persons living with disabilities live in developing countries, according to the UN Development Program [1].

Objective: This study set out to assess attitudes, feelings and opinions of disabled women on their reproductive health in Kakamega County, Kenya

Design: cross sectional survey study with both quantitative and qualitative approach in 2018 and 2019. Setting: 12 Sub Counties in Kakamega County.

Sample: snow balling sampling technique. (n = 117) Analysis: Data was analyzed by use of descriptive statistics, descriptive narratives, chi squares and content analysis method of the main four themes namely pregnancy state, pregnancy care, society support and government support.

Results: WLWD (women living with disability) had distorted marriages, more children, dependents, and less ANC attendance unlike the able bodied women. Conversely, able-bodied women were more likely to have their pregnancy planned compared to WLWD (OR: 1.8; 95%CI: 0.6 – 2.2; p=0.008) and some didn't consent for the pregnancy I was raped". Able bodied women were 60% more likely to perceive distance to facility≤ 1 hour compared to the WLWD (OR: 1.6; 95% CI: 1.4- 3.5; p=0.01) and were two times more likely to agree with that facility had provisions unlike WLWD. Pregnant WLWD had more health problems, 16.5% (17) babies of WLWD who were from un-partnered areas died and some babies were not immunized postnatally 2.9% (3). Some of the nice moments included love in the family increased, assistance in house chores and happiness of motherhood. Some of the hard moments included pregnancy related sickness, lack of finances, stigmatization from family members, difficulty in accessing healthcare and being abandoned by spouse during pregnancy period. Importance of ANC attendance included knowing their status, baby position and to avoid infection. All of them planned to deliver in a government hospital because they say it is affordable. Society doesn't assist them much and majority received assistance from people other than their spouses. They believe to be neglected because of their disability status.

"The community does not support us because they don't expect us to get pregnant"
Conclusion; Pregnant disabled women should not be discriminated and stigmatized especially by their spouses. This will lead to positive health seeking behavior during pregnancy and improved maternal and child outcomes. The government should improve the health care to be disability friendly.

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Introduction

Background Information of the Study

There is no universal agreement on a definition of people living with disability. However, the International Classification of Functioning Disability and Health (ICF) defines disability as "an umbrella term, covering impairments, activity limitations, and participation restrictions"; adding that "disability is a contextual variable, dynamic over time and in relation to circumstances; its prevalence corresponds to social and economic status". Disability is thus seen as "a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives" [2].

There is a strong link between poverty and disability. Poor people have a higher risk of acquiring a disability; they are more exposed to disabling diseases and conditions. At the same time, disability increases the possibility of falling into poverty by being excluded from participation of development initiatives. This cycle of disability and poverty must and can be [1].

The World Bank estimates that 20 per cent of the world's poorest people have some kind of disability, and tend to be regarded in their own communities as the most disadvantaged. Women with disabilities are recognized to be multiply disadvantaged, experiencing exclusion on account of their gender and their

disability. To ensure a safe pregnancy and a healthy baby it is argued that healthcare professionals should focus more on women's abilities than their disabilities and that care and communication should be about empowering women. Evidence from qualitative research suggests that maternity care needs have not been met for many pregnant disabled women. Many women with disabilities say they feel invisible in the healthcare system, stressing that their problems are not simply medical, but also social and political, and that access means more than mere physical accessibility. Because many women with disabilities face a great deal of unpredictability in their daily lives, they want care that is well planned and which helps to eliminate the unexpected [2].

Women living with disability face many issues that can inhibit or prevent them from effective parenting. Some of these include the overwhelming scarcity of information and resources on mothers living with disabilities. With the availability of the internet, a number of women living with disability have created websites and list serves that allow disabled parents to exchange information and resources. While mothers living with disability encounter numerous barriers to parenthood, they also find effective solutions that are comfortable with them [3].

The recommendation of the current UK NICE Antenatal Care Guidelines is that all pregnant women should access health care services early. In general, people living with disability may face considerable challenges in accessing health care services. Little research exists on addressing maternity issues among Pregnant women living with disability generally focuses on their disability rather than their reproductive capability [2].

To ensure a safe pregnancy and a healthy baby it is argued that healthcare professionals should focus more on women's abilities than their disabilities and that care and communication should be about empowering women [4]. Evidence from qualitative research suggests that maternity care needs have not been met for many pregnant women living with disabilities Many WLWD say they feel invisible in the healthcare system, stressing that their problems are not simply medical, but also social and political, and that access means more than mere physical accessibility [4]. WLWD face a great deal of unpredictability in their daily lives, they want care that is well planned, and which helps to eliminate the unexpected [5].

Demographic factors of the women living with disabilities and the able-bodied women have to be considered when looking at maternal and neonatal health indicators. These included age, level of education, religious affiliation, number of pregnancies, and occupation status.

People with disabilities (PWDs) in Kenya live in a vicious cycle of poverty due to stigmatization, limited education opportunities, inadequate access to economic opportunities, and access to the labor market. Women with disabilities are more vulnerable to human rights violations through neglect and exclusion from political, socio-cultural, civil, and economic activities. They face discrimination in access to and utilization of public health facilities and services and are under-served in terms of healthcare information [6].

A woman living with a disability tends to be judged and found ineffective in appearance. This is largely due to negative attitudes and stereotypes about what they can or cannot do. There are misconceptions that a woman living with a disability may not be competent in most areas such as learning or being able to be in gainful employment [3].

Over the past 2 decades, childbirth In Kenya has become more medicalized and women living with disabilities may therefore be at risk of being viewed through a medical lens solely because of their particular.

There are limited special services to assist WLWD and they are often forced to rely on their families or engage someone whom they must pay for by themselves, to care for their children and the position of WLWD in the rural communities is even worse [7]. There are limited strategies or activities by state bodies or health care institutions that take into account the specific health needs of young girls and women living with disabilities [6]. Unfortunately, because of this, women do not receive even the basic primary health care services that are necessary for all children and young women [6]. Kenya National Survey of People with Disability (KNSPWD) was the first survey of its kind to be conducted in Kenya. It found that around 4.6% of the population, or 1.7 million Kenyans, live with a form of disability. More PWDs reside in rural than in urban areas There is no discrete data for pregnant women living with a disability [7].

The recommendation of the current UK NICE Antenatal Care Guidelines is that all pregnant women should access health care services early. In general, people living with disabilities may face considerable challenges in accessing health care services. Little research exists on addressing maternity issues among pregnant women living with disability focuses on their disability rather than their reproductive capability [5]. Therefore the aim of this study was to assess attitudes, feelings and opinions of women living with disability on their reproductive health in Kakamega County, Kenya

Literature Review

Demographic factors of both the women living with disability and able-bodied women have to be considered when looking at maternal and neonatal health indicators. These included age, level of education, religious affiliation, number of pregnancy, occupation status. Pregnant women living with disabilities face many challenges including stigma, inability to access health care services, poverty, rejection, and discrimination which change their perception of their reproductive health in terms of attitude, opinion, and feelings.

The study by indicated that approximately 7% of women in Rhode Island reported a disability [8]. Women living with disabilities reported significant disparities in their health care utilization, health behaviors, and health status before and during pregnancy and during the postpartum period. Compared to able-bodied women, they were significantly more likely to report stressful life events and medical complications during their most recent pregnancy, were less likely to receive prenatal care in the first trimester, and more likely to have preterm births compared to able-bodied women. As for pregnancy experiences, women living with disabilities were over twice more likely to report a health complication during pregnancy compared to able-bodied women. Women living with disabilities were more likely to report experiencing stressful life events and physical abuse during pregnancy, and over twice as likely to report feeling unsafe in their neighborhood than able-bodied women. Nearly 84% of able-bodied women received prenatal care in their first trimester, compared with approximately 78% of WLWD. Women living with disabilities were nearly twice as likely to begin prenatal care after their first trimester, and more likely to report inadequate

prenatal care and were less likely to report having a postpartum check-up within six weeks of birth. This may be due to movement challenges, language barriers, and other in accessibilities. Findings from this study also suggested that recent WLWD have lower levels of education, are less likely to be married, and more likely to be receiving public insurance and have lower household income. This study also highlights significant disparities in their pre-pregnancy, pregnancy-related and postpartum health status, health behaviors, health care utilization, and adverse birth outcomes between women with and without disabilities. They also reported higher rates of physical abuse from a current or former partner during their pregnancy and reported receiving less social support following delivery. The additional medical complications of pregnancy among women living with disabilities compounded by the high levels of financial, partner-related, traumatic, and emotional stress and the lack of perceived social support could potentially further compromise their health and the health of their babies. The delay in accessing health care could be partly because of the bad experiences of women living with disabilities with their health care providers. Women with disabilities often reported that their health care providers are not able to manage their pregnancies effectively, possess negative stereotypes about their sexuality, disapprove of their pregnancy, and question their ability to parenting. These negative and humiliating experiences with health care providers could potentially prevent women with disabilities from seeking timely prenatal and postpartum care. Pre-pregnancy differences in the health of women with disabilities in this study, including a significantly increased likelihood of unplanned pregnancy, have implications for clinicians caring for women with living with disabilities during their childbearing years. Delayed prenatal care increases the likelihood that these health problems may result in poor maternal and neonatal outcomes, including the delayed recovery of women with disabilities during the postpartum period. The increased likelihood of poor infant outcomes in women living with disabilities necessitates greater attention of healthcare providers to the health of women with disabilities before and during pregnancy.

Findings by indicated that although women living with disabilities do want to receive institutional maternal healthcare, their disability often made it difficult for such women to travel to access skilled health care, as well as gain access to unfriendly physical health infrastructure [4]. Other related access challenges include healthcare providers' insensitivity and lack of knowledge about the maternity care needs of WLWD, negative attitudes of service providers, the perception from the society that women with a disability should be asexual and health information that lacks specificity in terms of addressing the special maternity care needs of women with disability. This study gives insight into why WLWD has poor access to health care institutions and their inability to access professional care.

A study done in Ethiopia found out that "Maternal healthcare services that are designed to meet the needs of able-bodied women might lack the flexibility and responsiveness to meet the special maternity care needs of women living with disability". More disability-related cultural competence and patient-centered training for healthcare providers as well as the provision of disability-friendly transport and healthcare facilities and services are needed." The findings of this study indicate that despite the policy for provision for people with disabilities [4]. The health care institution has not complied with the policy. More so the health workers have not received sufficient knowledge on the care of WLWD. This contributes to poor maternal health outcomes.

In a study by a total of 247 women with a disability and 324 age-matched controls aged 15-45 years were recruited for the study. 87% of women with disabilities had a physical disability [9]. The mean age of women with a disability was 29.86 against 29.71 years among able-bodied women. A significantly lower proportion of WLWD experienced pregnancy compared to able-bodied women. A higher proportion of able-bodied women (7.7%) compared to WLWD (5.3%) reported a successful pregnancy in the past two years. There were no statistically significant differences between women with and without a disability with regard to the utilization of antenatal care and pregnancy outcomes. The proportion that was illiterate was similar between the two groups. However, a significantly higher proportion of able-bodied women had been educated to graduation or beyond, compared to none among WLWD. The findings suggested that WLWD has poor ANC attendance as a result of their disability status. Discrimination and stigmatization by society deny them the chance to have sufficient formal education. Furthermore, reproductive health experiences differed significantly between the two groups. A significantly lower proportion of women with a living disability experienced pregnancy compared to able-bodied women. Despite this, women living with disabilities had more living children compared to able-bodied women. There was a significant difference between the proportions of WLWD reporting diabetes compared to able-bodied women. In the same study, women who had delivered a live birth during the past two years were administered additional questions regarding the last pregnancy. A higher proportion of able-bodied women compared to WLWD reported a successful pregnancy in the past two years. Delivery at hospitals and delivery through the surgical Caesarean section were common among able-bodied women but these differences were not statistically significant. WLWD reported less attention during their pregnancy by health providers compared to peers but these differences were again not statistically significant. Comorbidities like convulsions and depression were reported to be significantly higher among WLWD, though there was no difference in relation to diabetes and hypertension between the two groups.

A 2004 report by Save the Children Norway found that sexual abuse of children with disabilities is increasing in Zimbabwe, and that 87.4 percent of girls with disabilities had been sexually abused. Approximately 48 percent of these girls were mentally challenged, 15.7 percent had hearing impairments and 25.3 percent had visible physical disabilities [10]. As indicated in the study, WLWD has a tendency to be abused sexually because of their inability to make an informed decision like the women living with mental disability, also the physical disability hinders them from running to safety. Sexual abuse affects one psychologically therefore may affect the maternal and child health outcomes. Child deaths in developing countries make the largest contribution to global mortality in children younger than 5 years. 90% of deliveries in the poorest quintile of households happen at home. We postulated that a community-based participatory intervention could significantly reduce neonatal mortality rate [11].

Prior studies have shown that women living with disabilities are at greater risk of intimate partner violence (IPV) than the able-bodied women. A study by found out that women living with disabilities have a greater risk for all six measured forms of IPV [12].

The findings of the study by show that all WLWD who have had the experience of giving birth to a child or children faced immense challenges in childbearing [3]. A participant living with disability reportedly felt that the inability of healthcare staff to use sign language was perhaps the cause of the loss of her babies.

"All my babies died because the doctors and nurses could not use sign language."

Another participant who was epileptic; it was difficult to travel from the rural areas where she lived with her grandmother because she was divorced. The worst was that her husband married an able-bodied woman in order to frustrate her.

study stated that a great number of refugees living with disabilities and their caregivers in Kenya and Uganda complained about challenges to accessing health services [5]. Negative and disrespectful health provider attitudes were reported as the most influential barrier that interferes with refugees living with disabilities from accessing services. In Uganda, negative health care provider attitudes were a big problem at health centers and the national referral hospital. An adult male participant with physical, vision, and mental impairments felt that the health workers think PWD did not have a right to sex, yet they are normal people like everyone else. Another refugee with mental impairment stated that PWD did not receive proper care from nurses and doctors and they were not treated as human beings. Other reported barriers included waiting for long on the queues (Kenya and Uganda), costs of seeking care (Uganda), refugee status (Uganda), communication with health providers (all three sites), caregiver and community health workers attitudes (Uganda), lack of transportation (Kenya and Uganda), and limited accessibility (all three sites). In Uganda, where all mentioned concerns were raised, refugees living with disabilities and caregivers listed as barriers to accessing care: the lack of translation, for both spoken and sign language; lack of transportation to health facilities; limited wheelchair availability at the referral hospital; stock-outs of medicines; and lack of money to pay health workers. This shows that disability on its own is a major factor on the accessibility and utilization of quality health care services.

Theoretical Framework

Critical Disability Theory (CDT)

This study was guided by the critical disability theory (CDT) which was propounded by This is an emerging theoretical framework for the study and analysis of disability issues. This theory evolved from the work of scholars who formed the Frankfurt School, a term which refers to a group of Western Marxist social researchers and philosophers originally working in Frankfurt, Germany A Critical theory sees problems of PWDs explicitly as the product of an unequal society [14]. It ties the solutions to social action and change. Notions of disability as social oppression mean that prejudice and discrimination disable and restrict people's lives much more than impairments do. For example, the problem with public transport is not the inability of some people to walk but that buses are not designed to take wheelchairs. Such a problem can be "cured" by spending money to ensure that public transport is designed in such a way that it becomes accessible to persons with disabilities. The impact of this critical theory on healthcare and research has tended to be indirect. It has raised political awareness, helped with the collective empowerment of PWDs and publicized their critical views on healthcare. It has criticized the medical control exerted over the lives of PWDs, such as repeated and unnecessary visits to clinics for impairments that do not change and are not illnesses in need of treatment. Finally, it suggests a more appropriate societal framework for providing health services to PWDs This radically different view is called the social model of disability, or social oppression theory. While respecting the value of scientifically based medical research, this approach calls for more research based on social theories of disability if research is to improve the quality of lives of the people with disabilities. The theory views the problems of people with disabilities explicitly as products of an unequal society. The discrimination aspects in the theory helped to explain the experiences of women with physical disabilities in accessing and utilizing healthcare services. This theory finds relevance in the factors that hinder women with physical disabilities from accessing and utilizing health services from public facilities.

Materials and Methods

This was a mixed study design which utilized cross sectional both descriptive analytical study design and experimental study design (randomized controlled trial) in 2018 and 2019. The study utilized both qualitative and quantitative data collection techniques. Data was collected using interview, structured questionnaire and focused group discussions. The study targeted women living with disability who are confirmed pregnant. The area of study was Kakamega County. The target population comprised of pregnant, women living with disability aged 15 to 49 years in Kakamega County who are confirmed pregnant in their first or second trimester preceding the survey A priory sample size calculation was done using the software G*Power 3.1.9.4 for windows. The results yielded a 103 total sample size, 54 in the control group and 49 in the experimental group

The study used a multistage probability sampling design. Simple random sampling technique to identify the sub counties, stratified simple random technique to identify urban and rural sub counties and purposeful and snow balling sampling technique to identify the pregnant women living with disabilities. Data collection was by Focus Group Discussions using recorders and pen and note books to capture what the respondents discuss.

Data analysis For quantitative data, the data was entered, cleaned, coded and analyzed using SPSS software (statistical package for social sciences) Version 25. Variables were examined through bivariate and multivariate analysis by computing odds ratio at 95% confidence interval. A p-value of ≤ 0.05 was considered statistically significant. Multiple logistic regression was applied to determine the relationship between the independent variables that showed significance with outcome variable. During analysis, the researcher omitted those questionnaires without responses on vital information of this study. The researcher conducted analyses of normality, for the outcome variable, prior to hypothesis testing by examining kurtosis and skewness of the data. In order to test and identify possible outliers in the data, graphical assessment visuals, including scatter and box plots were used. Elimination of observed outliers was based on a case by case basis, dependent on standard deviations, and on normality and homogeneity of variance assessments. Normality was assessed using examination of the histograms by seeing how they related or deviate against a normal bell curve distribution and observing the levels of kurtosis and skewness present. Univariate analysis was used to describe the distribution of each of the variables in the study objective; appropriate descriptive analysis was used to generate frequency distributions, tables and pie charts. Bivariate analysis was used to investigate the strength of the association and check differences between the outcome variable and other independent variables. Chi square test of independence at 0.05 level of significance was used to determine if there is a relationship between socio-demographic characteristics and disability status. Data analysis for qualitative data was by content analysis of the four main themes: pregnancy state, care of the pregnancy, society support, government support and way forward and opinion.

Results

The study designed was to identify and examine the challenges faced by women living with disabilities during pregnancy, childbirth and find interventions to bridge the gaps and improve maternal-child health outcomes by use of partnership model intervention in Kakamega County, Kenya. The sample size was a total of 103 WLWD. This chapter provides a detailed description of the results obtained from the data analysis of the survey. Results are described as simple percentages, means, and standard deviations as appropriate depending on the nature of the variable. FGD collected data in terms of the feelings, opinion and way forward of both the pregnant mothers living with disability and the about pregnancy, delivery and postnatal care.

Table 1: Summary of the Research Sample, Assistants and Design

SUBCOUNTY	Lurambi	Mumias West	Shinyalu	Ikolomani	Malava	Lugari	Likuyani	Mumias East	Matungu	Khwisero	Butere	Navakholo	TOTALS
No. of WLWD	3	5	10	2	2	1	8	10	16	10	14	22	103
No. of able bodied women	2	0	0	1	2	0	0	2	0	6	0	22	34
No. of CHVS	2	2	2	2	2	2	2	2	2	2	2	2	24
No. of disability contact persons	1	1	1	1	1	1	1	1	1	1	1	1	12
Partnered(p)/ unpatrnered(up)	P	Up	Up	P	P	Up	Up	P	Up	P	Up	P	6:6
Number in unpartnered model	0	5	10	0	0	1	8	0	16	0	14	0	54
Number in partnered model	5	0	0	3	4	0	0	12	0	16	0	43	83
Type of disability- sensory motor	3	0	1	0	0	0	0	0	5	1	2	7	19
- epilepsy	0	1	0	0	0	0	0	0	2	2	3	1	9
- Mental	0	1	3	1	1	1	2	2	3	3	4	4	25
- Physical	0	3	6	1	1	0	6	8	6	4	5	10	50
- None	2	0	0	1	2	0	0	2	0	6	0	21	34

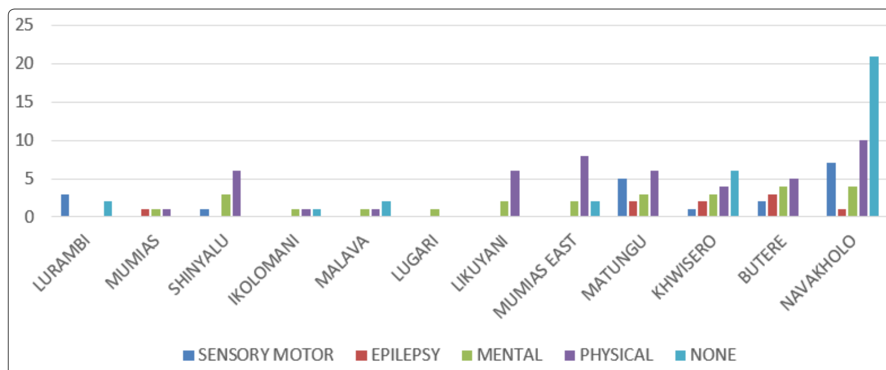

Figure 1: Types of Disability per Sub-County

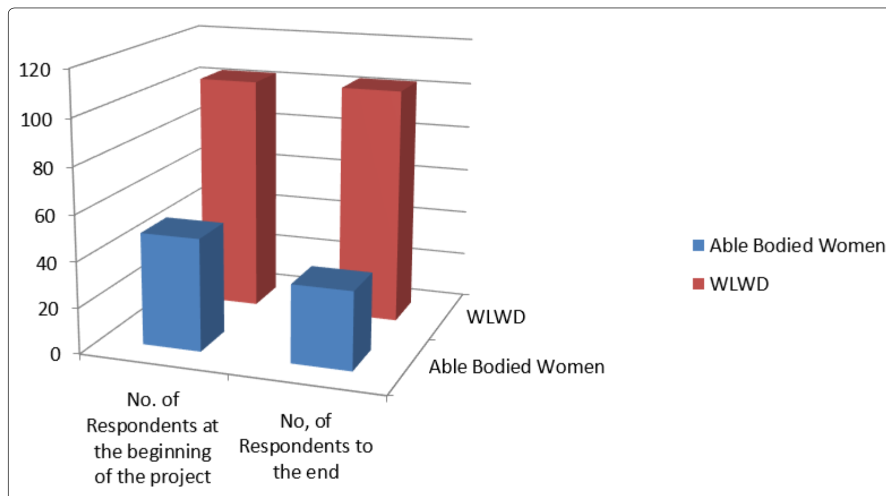

Figure 2: No of Respondents during the Research

Table 1 above showed a summary of the samples, research assistants, and the design used. Six sub-counties were partnered (case) and six which were not partnered (control). In each sub-County, two CHVs and one disability contact person were used as research assistants. Both WLWD and able bodied women were involved in the research as indicated in Fig 2 above. There were 103 WLWD and 34 able-bodied women. 54 of WLWD were not partnered while 83women comprising of 49 WLWD and 34 able-bodied women were partnered. 15 of able-bodied women were not available up to the end of the research giving reasons of being dragged behind by the WLWD, the company of the WLWD being unacceptable because of the culture and others just disappeared without giving any reason. In figure 1 below, of the 103 WLWD, the majority had physical disability 49.5% (51), followed by those who had mental disability 24.2% (25), then 18.4% (19) had a sensory-motor disability and 8.7% (9) had epilepsy.

Table 2: Summary of findings

	N	Able bodied women		WLWD	
		N	%	N	%
No. of respondents at the beginning of the project	152	49	32.2%	103	67.8%
No. of respondent to the end Pregnancy planned	137	34		103	75.2
Pregnancy planned		Yes 20	58.8	33	32
		No 14	41.2	70	68
ANC attendance≤4visits	137	22	64.7%	61	59.2%
Child status;	137				
Alive		34	100	86	85.4
Lost pregnancy		0	0	2	1.9
Died at birth		0	0	12	11.2
Died postnatally		0	0	3	2.9
Baby congenital abnormalities	137	0	0	8	7.8
Baby Immunized	137	Yes 34	100	100	97
		No 0	3	3	3
Post-natal attendance	137	25	73.7	56	54.9
Place of delivery;	137	34		103	
Hospital		33	2.9	98	95.1
Home		1	97.1	5	4.9

In Table 2 above, it indicates the summary of the study as follow; 17 babies died; 2 were lost pregnancies, 12 died at birth and 3 died during postnatal period. This infant mortality rate if calculate would be 109 deaths per 1000 live birth which was higher than the worlds 29 deaths per 1000 live births in 2017 All of them were from women living with disability and majority (16 babies) from unpartnered groups [1]. All the babies of able-bodied women had no complications at birth and six weeks postnatal unlike the babied of women living with disability who had some forms of complications at the same period. None of the able-bodied women had some form of congenital abnormalities unlike 7.8% (8) babies born of women living with disability who had some form of complications. All babies of able bodied women received both polio and BCG immunization unlike 2.9% (3) who had not received any form of immunization by the time postnatal period was over. Generally postnatal attendance was poor at 73.7% (25) for able bodied women and 54.9% (56) for women living with disability. Majority of women delivered at the hospital 95.6% and slept under the LLMTN nets 78.9%. Averagely, a good number received family planning advice 52.5%. Almost all the women delivered in the hospital at 95.6% while only 3.5% (5) delivered at home. Majority had SVD deliveries at 96.9% (131) while only 2.9% (4) had CS deliveries.

The study population was observed from the first trimester up to six weeks after delivery. The findings of study show several differences between women living with disability and able-bodied women and partnered and unpartnered groups during pregnancy, childbirth and postnatal.

Table 3: Pregnancy client characteristics associated with disability state

Risk factor	N	Disability status		Overall OR	95% CI	p value
		Able bodied	WLWD			
Lifetime total pregnancies						
<=4	125	85.3(29)	93.2(96)	1.1	0.7 – 1.5	0.06
4<	11	14.7(5)	6.8(7)*			
Was pregnancy planned						
Yes	54	58.8(20)	33(34)	1.8	0.6 – 2.2	<0.001
No	83	41.2(14)	67(69)*			
Attended antenatal clinic in current pregnancy						
Yes	104	88.2(30)	71.8(74)	2.0	1.3 – 3.2	0.05
No	33	11.8(4)	28.2(29)*			

Major important findings as shown in table 3 above to note were as follows: - able-bodied women were about two times more likely to have had their pregnancy planned in contrast to the WLWD (OR: 1.8; 95%CI: 0.6 – 2.2; p=0.008). Findings of this study suggests that more able-bodied women than women living with disability attended ANC four times and over at 64.7% (n=22) of the able-bodied women and 59.2% (n=61) of the disabled women.

Unplanned pregnancy was among the WLWD. In one of the sub-counties, majority said that pregnancies were unplanned and the reasons were; the husband visited unexpectedly and she would find herself pregnant, another one said that she was raped. Majority of the women living with disability did not prepare or plan for the pregnancy; some of the women were raped while others just found themselves pregnant without any plan. In another Sub-County only two out of the seven mothers planned to get pregnant. The rest had unplanned pregnancies. One of the respondents who was raped refused to talk about how she got pregnant instead she kept on crying and looking away.

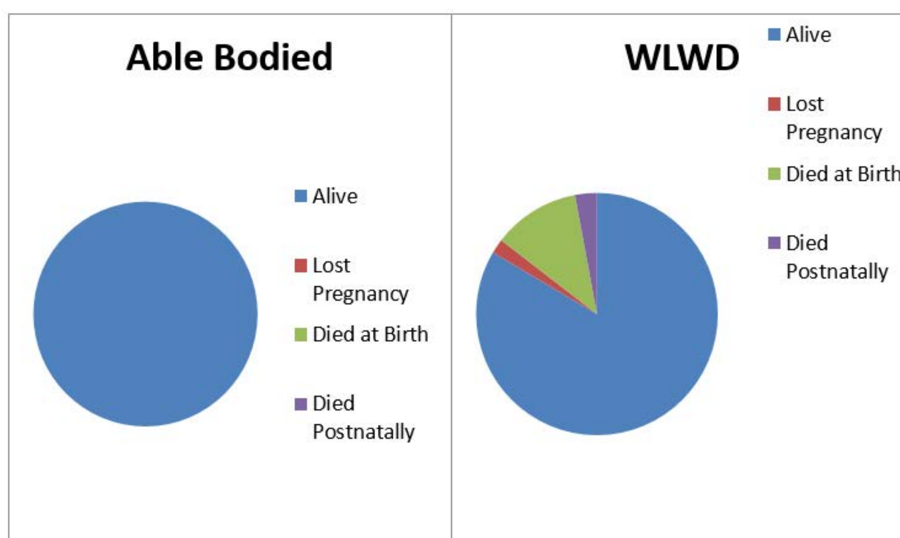

Figure 3: Child Status

Figure 3 above indicate the child status. 17 babies died; 2 were lost pregnancies, 12 died at birth and 3 died during postnatal period This infant mortality rate if calculate would be 109 deaths per 1000 live birth which was higher than the worlds 29 deaths per 1000 live births in 2017 All of them were from women living with disability and majority (16 babies) from unpartnered groups [1].

The Socio-Demographic Characteristics of Both Pregnant Women Living With Disabilities And Able-Bodied Pregnant Women in Kakamega County, Kenya

This section focuses on the disability status, age, relationship to house hold head, education status, main source of income, marital status, religion, type of housing, pregnancy related demographics and hospital related demographics. This information aimed at getting the demographics of the respondent so that the researcher would get information that was necessary in the carrying out of inferential statistics and in determining possible cause of emerging patterns.

Table 4: Socio-demographic characteristics of Study Participants

		Able-bodied		Disabled		X^2	P
Subcounty	Butere	0	0.0%	14	100.0%	35.02	<0.001
	Shinyalu	0	0.0%	10	100.0%		
	Ikolomani	1	33.3%	2	66.7%		
	Matungu	0	0.0%	16	100.0%		
	Mumias east	2	16.7%	10	83.3%		
	Mumias west	0	0.0%	5	100.0%		
	Khwisero	6	37.5%	10	62.5%		
	Navakholo	21	48.8%	22	51.2%		
	Lurambi	2	40.0%	3	60.0%		
	Malava	2	50.0%	2	50.0%		
	Likuyani	0	0.0%	8	100.0%		
	Lugari	0	0.0%	1	100.0%		
Relationship to the H/Head	Head	0	0.0%	5	100.0%	12.75	.026
	Spouse	31	34.1%	60	65.9%		
	child by birth	3	8.6%	32	91.4%		
	grand child	0	0.0%	3	100.0%		
	other children by relationship	0	0.0%	2	100.0%		
	house girl	0	0.0%	0	0.0%		
	Others	0	0.0%	1	100.0%		
Education status	None	0	0.0%	12	11.6%	8.617	.031
	Primary	25	73.5%	55	53.4%		
	Secondary	8	23.5%	22	21.4%		
	Tertiary	0	0.0%	5	4.9%		
	N/A	1	3.0%	9	8.7%		

Table 4 above is a summary of the socio-demographic variables of the respondents. 75.2% (n=103) of the respondents were WLWD and 60.6% (n=83) were partnered. Proportionally, many respondents were of age category 25-29 years (27.7%, n=38) and were a spouse to the household head (66.4%, n=91). The self-report results showed that many completed primary education (58.4%, n=80) and did not have a main source of income, and they were dependents (47.4%, n=65). A great proportion of the respondents were of indigenous religion (46%, n=63) and about 54.7% (n=75) lived in a semi-permanent house. In marital status, 48.2% (n=66) were in a monogamous marriage while a few were in polygamous marriage (4.4%, n=6).

Chi-square tests showed that there were significant associations between sub-county χ^2 (11, N=137)35.022, $p<0.001$ which was due to the study design. Relationship to Household head χ^2 (5, N=137) =12.754, within status, the women living with disability seem to have a distorted family unlike the able-bodied women. Women living with disability were less educated while some had no education at all unlike the able-bodied women who at least had some education. These findings were in line with the findings in the Focus Group Discussion whereby a respondent stated that;

“Am happy because I have had a problem of epilepsy for a long time and the community and my family never encouraged me to get pregnant but unfortunately my husband did not accept my epileptic condition and now am living with my parents”
To support this notion, another respondent stated that;

“Am happy about this pregnancy but the truth is that was not ready for this pregnancy. Its unfortunate that due to my epileptic condition, my husband did not like my seizures, I was chased away from my matrimonial home and I have difficulties in getting assistance the community whenever I get seizures”

Demographic differences between able bodied women and women living with Disability

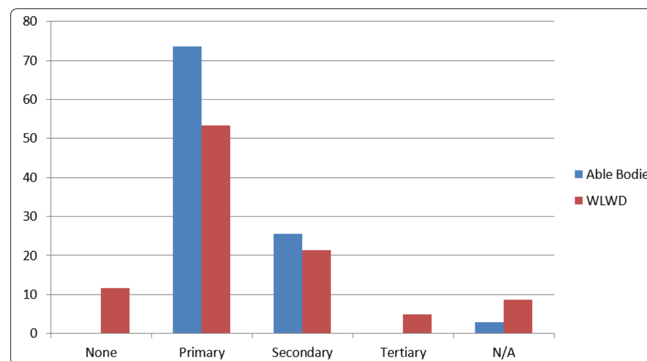

Figure 4: Education Status in Percentage

In figure 4 above showed that able bodied women were more educated than WLWD. All able bodied women had some form of education unlike some WLWD had no form of education and therefore achieved no tertiary education.

Bivariate analysis of pregnancy-related characteristics associated with disability status

Table 5: Pregnancy client characteristics associated with disability state

Risk factor	N	Disability status		Overall OR	95% CI	p value
		Able bodied	WLWD			
Lifetime total pregnancies						
<=4	125	85.3(29)	93.2(96)	1.1	0.7 – 1.5	0.06
4<	11	14.7(5)	6.8(7)*			
Was pregnancy planned						
Yes	54	58.8(20)	33(34)	1.8	0.6 – 2.2	<0.001
No	83	41.2(14)	67(69)*			
Attended antenatal clinic in current pregnancy						
Yes	104	88.2(30)	71.8(74)	2.0	1.3 – 3.2	0.05
No	33	11.8(4)	28.2(29)*			

Source: Researcher 2019 *=Reference category

Table 6: Pregnancy client characteristics associated with disability state

Risk factor	N	Disability status		Overall OR	95% CI	p value
		Able bodied	WLWD			
Lifetime total pregnancies						
<=4	125	85.3(29)	93.2(96)	1.1	0.7 – 1.5	0.06
4<	11	14.7(5)	6.8(7)*			
Was pregnancy planned						
Yes	54	58.8(20)	33(34)	1.8	0.6 – 2.2	<0.001
No	83	41.2(14)	67(69)*			
Attended antenatal clinic in current pregnancy						
Yes	104	88.2(30)	71.8(74)	2.0	1.3 – 3.2	0.05
No	33	11.8(4)	28.2(29)*			

Bivariate analysis on pregnancy-related client factors that are associated with disability status shows that there was a borderline significant relationship between lifetime total pregnancies and disability status in the study area (OR: 0.7; 95% CI: 0.7 – 1.5; p=0.06) as shown in Table 5 above. The able-bodied women were 1.1 times more likely to have four children or less compared to disabled women. Women who confirmed their pregnancy within two months or less were one-point-three times more likely to be able-bodied (OR: 1.3; 95% CI: 0.7 – 2.3; p=0.97). The mode of pregnancy confirmation was not statistically significant with disability status with the results showing that women who were able-bodied being one point seven times more likely to have known they are pregnant through test kits or clinic attendance compared to their counterparts with disabilities (OR: 1.7; 95% CI: 1.5 – 3.0; p=0.14). Similarly, able-bodied women were about two times more likely to have had their pregnancy planned in contrast to the disabled women (OR: 1.8; 95%CI: 0.6 – 2.2; p<0.001).

These findings were in line with the group discussion held whereby majority of the respondents were happy that they were pregnant though they were not prepared for the pregnancy. It was found out that most women living with disability desire to be pregnant and have children although they had unplanned pregnancies. Motherhood is not only desired by able-bodied women but also the women living with disability. This was stated below by some of them;

A Respondent Said
"I have been using family planning for long because my disability was caused by my first pregnancy that developed complications but unfortunately, I found myself pregnant"

Another Respondent Stated That
"Am happy about this pregnancy but the truth is I was not ready for this pregnancy".

Another Respondent Stated
"Am happy to have my own children though I had not prepared for this pregnancy"

Another Respondent from Another Sub County Said
"Am happy about the pregnancy but Ihad not planned because I am a student in form 1"

ANC clinic attendance was significantly associated with the disability status (P=0.05). Women living with disability had delayed ANC attendance because their status interfered with movement to a health facility. They needed someone to escort them to the clinic because they faced challenges because the means of transport available was not improvised to meet their disability status and the terrain wasn't favorable. One of the respondent in the Sub-County was completely crippled and needed to be carried to the health facility to attend which could not afford motorbike or taxi services.

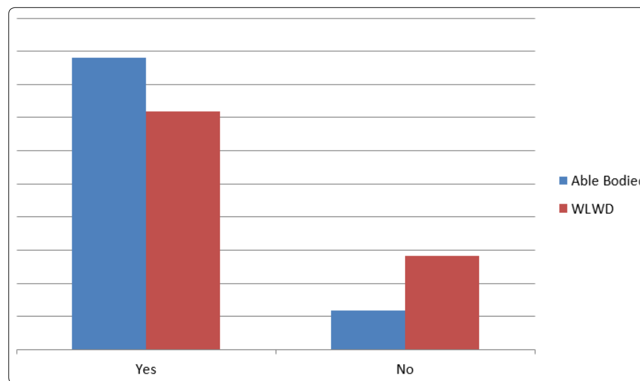

Figure 5: Planned and Unplanned Pregnancy in Percentage

Figure 5 above indicated that more of unplanned pregnancy was among the WLWD. In one of the sub-counties, majority said that pregnancies were unplanned and the reasons were; the husband visited unexpectedly and she would find herself pregnant, another one said that she was raped. Majority of the women living with disability did not prepare or plan for the pregnancy; some of the women were raped while others just found themselves pregnant without any plan. In another Sub-County only two out of the seven mothers planned to get pregnant. The rest had unplanned pregnancies. One of the respondents who was raped refused to talk about how she got pregnant instead she kept on crying and looking away.

Bivariate Analysis of Hospital Related Characteristics Associated With Disability Status

Table 4.5 below presents findings on access to the nearest health facility and reveals a significant relationship between distance to the health facility and disability status. Able- bodied women were 60% more likely to perceive distance to facility to be less than an hour compared to the women with disability (OR: 1.6; 95% CI: 1.4- 3.5; p=0.01). Similarly, able bodied women were 20% less likely to use vehicles or boda-boda to the health facility compared to the WLWD (OR: 0.8; 95% CI: 0.7- 1.4; p=0.02). Response of facility provisions for women living with disability was statistically associated with disability status and able-bodied women were almost two times more likely to agree the facility had provisions for women with disability compared to their counterparts (OR: 1.6; 95% CI: 0.7- 1.4; p<0.001). The provisions included ramps and modified coach for the physically challenged. Braille for the blind and sign language interpreter the deaf and dumb.

Table 7: Factors associated with access to health facility and disability status

Risk factor	N	Disability status		Overall OR	95% CI	p value
		Able bodied	WLWD			
Distance from home to health facility						
<=1 hour	85	61.7(21)	62.2(64)	1.6	1.4 – 3.5	0.01
>1 hour	52	38.3(13)	37.8(39)*			
Mode of transport to facility						
Vehicle/boda-boda	78	76.5(26)	50.4(52)	0.8	0.7 – 1.4	0.02
On foot	59	23.5(8)	49.5(51)*			
Facility provision for the disabled						
Yes	64	73.5(25)	37.9(39)	1.6	0.7 – 1.4	<0.001
No	73	26.5(9)	62.1(64)*			

Table 6 above presents findings on access to the nearest health facility and reveals a significant relationship between distance to the health facility and disability status. Able- bodied women were 60% more likely to perceive distance to facility to be less than an hour compared to the women with disability (OR: 1.6; 95% CI: 1.4- 3.5; p=0.01). Similarly, able bodied women were 20% less likely to use vehicles or motor cycle (boda boda) to the health facility compared to the WLWD (OR: 0.8; 95% CI: 0.7- 1.4; p=0.02). Response of facility provisions for women living with disability was statistically associated with disability status and able-bodied women were almost two times more likely to agree the facility had provisions for women with disability compared to their counterparts (OR: 1.6; 95% CI: 0.7- 1.4; p<0.001). The provisions included ramps and modified coach for the physically challenged. Braille for the blind and sign language interpreter the deaf and dumb.

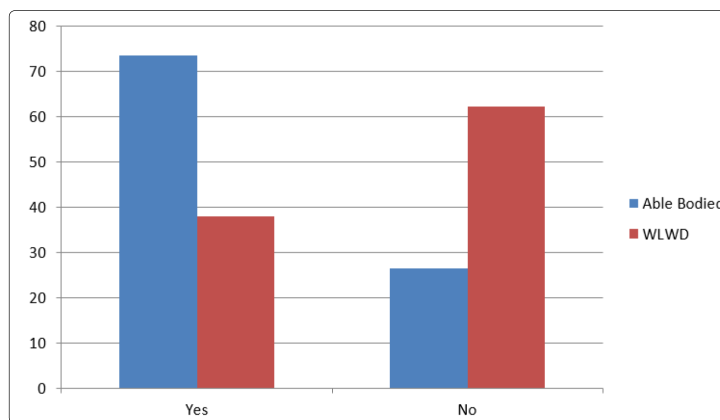

Figure 6: Facility Provision for the Disabled

In figure 6 above, in response of facility provisions for women living with disability, majority stated that they lack health facility provision for their status. The provisions included ramps and modified coach for the physically challenged. Braille for the blind and sign language interpreter the deaf and dumb.

Determining if Significant Difference Exists in Maternal and Child Health Outcomes Between Able Bodied and the Women Living With Disability Before and After Birth

Maternal factors that were observed during pregnancy included; vaginal bleeding, fits, severe abdominal pains, paleness, Severe headache, foul smell, any abnormal vaginal discharges, pain while passing urine, reduced or no kicking by the baby, Blurred vision, fast or difficulty in breathing, Unusual swelling of the face and legs, few slept under LLMTN, and had poor nutritional status.

Additional maternal outcomes observed at birth included hand washing technique, breast feeding technique, any other illness, advise on family planning, number of ANC visits, any treatment given during pregnancy, method of delivery, place of delivery and PNC visit. Child outcome included weight of the baby at birth, condition of the baby at birth(alive/dead), health status of the baby at birth, Fever, Fast or difficulty in breathing, inability to breastfeed, Chest drawn, unconsciousness, unusually sleepiness or drowsiness, lack of energy or a feeling of weakness, feeling very cold, redness of the umbilical cord, pus from the umbilical cord, stiffness of the neck, yellow soles, any congenital abnormalities detected, any other signs of sickness/ Local infection, Immunization of BCG and Polio. It also tested the difference of the outcome between the women living with disability and able bodied women.

Focus Group Discussion

Theme One: Pregnancy State

Feelings about Being Pregnancy

Majority of the respondents were happy that they were pregnant though they were not prepared for the pregnancy. This shows that most women living with disability desire to be pregnant and have children. Motherhood is not only desired by able bodied women but also the women living with disability. This is as stated below by some of them;

A Respondent from Butere Said
"Am happy because I have been using family planning for long because my disability was caused by my first pregnancy that developed complications"
Another Respondent from Navakholo Stated That
"Am happy about this pregnancy but the truth is that I was not ready for this pregnancy. It's unfortunate that due to my epileptic condition, my husband did not like my seizures, I was chased away from my matrimonial home and I have difficulties in getting assistance the community whenever I get seizures"

A Respondent from Shinyalu Said
"I am happy to have my own children" another respondent said "I am happy because where am married, I want them to accept me and help me in the future."

A Respondent from Khwisero Stated That
'Am happy because I have had a problem of epilepsy for a long time and the community and my family never encouraged me to get pregnant but unfortunately my husband did not accept my epileptic condition and now am living with my parents"

Another Respondent from Butere Said
"Am happy about the pregnancy but had not planned because I am a student a Form 1"
One of the respondent who has mental retardation, the mother in law said that she is happy about the pregnancy because she is a daughter in law who is giving birth to her grandchildren. Unfortunately this is her third pregnancy but she is not able to do anything. The husband on the other side has not been responsible from the beginning. She said that she is happy because her lineage has been extended.

In navakholo, one Respondent Said
"I love this pregnancy because it is a way of continuing on God's generation"

Planning for the Pregnancy

Most of women living with disability confessed to have had unplanned pregnancy. In Shinyalu majority said that the pregnancy was unplanned and the reasons were; the husband came abruptly, she just found herself pregnant, another one said that she was raped. Some of the women were raped while others just found themselves pregnant without any plan. In Butere Sub County only two out of the seven mothers planned to get pregnant. The rest had unplanned pregnancy.

Consent for the Pregnancy

Some women living with disability were raped,
"Yes I consented but later on my partner disowned the pregnancy"
"yes I consented because all my peer group have children and they use to laugh at me. Now I can walk with my head high"

Hard Moment of a Pregnant Disabled Mother

"The pregnancy has made me poor due to prolonged illness and

I keep on accessing medical care"
"My family has loved me more"
"My family did not like my daughter in law's pregnancy to a point that they have stigmatized her."
A respondent from Navakholo said
"A nice moment of this pregnancy was when my mother in law noticed that I was pregnant and was happy."
Another respondent said
"There is so much love in the house because of this pregnancy, I do little house chores"
Some difficult moments of during pregnancy were handling pregnancy complications, hospital payments, being abandoned by spouse during pregnancy period and also financial challenges.
A respondent in Navakholo said
"I since I got pregnant, I have had to close my business because I have a lot of problem with movement and now I don't have any income of my own"

Theme Two: Pregnancy Care
Importance of an Attendance
Most of them said that the importance of ANC attendance was to know their status, to know the position of the baby and to avoid infections.

Birth Plan
A complete birth plan includes, financial preparation, preparing the place of delivery, preparing means of transport that will be required during delivery, prepare the baby's clothes and nutrition care during pregnancy. Most of the respondents did not have birth plans and few hard incomplete birth plan.
In Lurambi a respondent said; " I haven't prepared for the baby clothes, I have never been advised to prepare but I want to give birth first before I buy the clothes"
In Butere, only one out of seven respondents had a birth plan.

Decision Made on Place of Delivery
All of the pregnant women living with disability are planning to deliver in the hospital. No one is ready to deliver in a private hospital. they will deliver in a government hospital because it is cheaper. One said;
"I am planning to deliver in the hospital because I had pressure in the previous pregnancy"
Another respondent in Navakholo said;
"I will deliver in the hospital because the previous pregnancy, I labored for long"
A respondent in Lurambi said;
"GOK hospitals are cheaper, I don't like TBAs. In the Kakamega county referral hospital, nurses and doctors are qualified to handle pregnancy. One nurse knows sign language and in hospital deliveries are free, TBAs are unqualified."
In shinyalu all of them plan to deliver in the hospital. The reasons given were as follows; "I will get help in the hospital in case of complication" another one said;
"My child will get immunized immediately if delivered in the hospital"

Theme Three: Society Support
Assistance during Pregnancy
Most of the women living with disability in this study feel that the society has neglected, discriminated and stigmatized them. Most of them were assisted by their parents and other people other than their spouses.
In Navakholo majority of the respondent were assisted by other people rather than their spouses. These other people are mother in laws, mothers and even fathers.

In Butere, 3 respondents live in their homes, 4 are married. Two of the married are supported by in laws because the husbands have disappeared."
"no they do not support us because we are disabled but give birth to beautiful children than them"
"My spouse and the community did not like the fact that I got pregnant"

"It is only my husband who supports me, no one else"
"I am supported by my husband and mother in law"
"it is only my spouse who supports me"
"the community does not support us because they don't expect us to get pregnant"
There was one encouraging response from Lurambi a respondent said;
"My neighbors tell me not to do a lot of work they sometimes assist me in fetching water"

Theme Four: Government Support
They all sadly said that the government does not assist them as people living with disability. The health facilities are not disability friendly. They are neglected
Deaf respondent from Lurambi said;
"We are not helped because we can't speak"

Discussion
Socio-Demographic Characteristics of Study Participants
This study established enormous socio demographic difference between the able-bodied women and women living with disability. The women living with disability find themselves in health risks that lead to poor maternal and child health outcomes. These findings are similar to other studies with profile of high fertility rate, high infant mortality and low socio-economic status [3]. The findings in this study indicates that as much as women living with disability experience challenges, they desire to have children of their own just like the able bodied women. This was unlike the findings of a study by that showed that significant low proportion of women with disability experienced pregnancy (X2 –16.02 P <0.001) compared to able-bodied women [9]. The self-report results showed that many completed primary education (58.4%, n=80). A significantly higher proportion of able-bodied women were educated up to and including university education and beyond, compared to the lack of education among women living with disability (X2- 5.3; p = 0.02) and 11.7%(12) despite the fact that there was the provision of free primary school education in Kenya. This is an indication that illiteracy level among the women living with disability is high and therefore affects their ability to understand the instruction given in the hospital on how to take care of themselves during pregnancy. This explains poor ANC attendance, unplanned pregnancy and also lack of written birth plan among the majority of them. This was alike findings whereby about 67% of PWDs had a primary education and 19% attained secondary education [7]. Few of PWDs had attained middle level of education, but only 2% had reached university level [7]. However, this was unlike to where the proportion of illiteracy was similar between the two groups [9].

Majority of the women living with disability did not have a main source of income and were dependents. This is due to lack of financial empowerment to take care of their maternity care needs. This explains why they are unlikely to use other forms of transport to go to a health facility apart from going on foot. They lack the

money to pay for transport service this was similar to the findings by a third of people living with disabilities work in their family business, but a quarter are dependents [7]. As per marital status, generally the women living with disability had more distorted type of marriages unlike the able-bodied women. This is an indication the community is yet to accept women living with disability as spouses who able to raise families just like the able-bodied women. They also lack spousal support during pregnancy and delivery instead they rely on other people for support who may feel that it is not their full responsibility.

A great proportion of the respondents were of indigenous religion (46%, n=63) unlike the able bodied women which is a sign of desperately looking for the spiritual intervention as a consolation to cure there disability as said by a woman living in in one of the sub counties; "They are laughing but I am visiting a spiritual healer and I know that I will one day be healed." It may also point to a high illiteracy levels and not realizing that disability has health causes that are beyond spirituality and curses. These findings were similar to who found out that women living with disabilities in India were younger, less educated, more likely to be unmarried, and have a high household poverty status compared to able bodied women [8].

Pregnancy-Related Characteristics Associated With Disability Status

Pregnancy status was more complex for women living with disability than able bodied women. Bivariate analyses on pregnancy-related client factors that are associated with disability status show that there was a borderline significant relationship between lifetime total pregnancies and disability status in the study area. The able-bodied women were 1.1 times more likely to have four children or less compared to women living with disability. Disability status is never a reason not to have a family and children. Women living with disability desire to have a continuity of their own generation. They wish to bear and raise their own children. Women who confirmed their pregnancy within two months or less were one-point-three times more likely to be able-bodied because they had planned for the pregnancy and were more educated to identify the changes in their bodies. Able-bodied women were able to confirm their pregnancy test results. This was one point seven times higher than their counter parts. This was unlike the women living with disability who only discovered that they were pregnant by chance; some went to be treated for other illnesses only for them to be told that they were pregnant. The mode of pregnancy confirmation was not statistically significant with disability status. This was similar the findings by whereby reproductive health experiences between women living with disability and able bodied women differed significantly [9].

In terms of planning for pregnancy, most of the women living with disability did not plan for the pregnancy and neither did they consent. Able-bodied women were about two times more likely to have had their pregnancy planned. (OR: 1.8; 95%CI: 0.6 – 2.2; p=0.008). Some women living with disability were raped, some just found themselves pregnant because they were not on any family planning method and some just discovered that they were pregnant after a sickness or a visit to the hospital. There was an indication that the community took advantage of the sexual life of women living with disability and used them as sex objects because some like those with mental disability cannot make informed decision on when, how and with whom to have sex with. The ones with physical disability have challenged movement and cannot run away from rapist. The deaf and dump cannot easily communicate with the rest in the community there for were unable to report those who rape them. Others felt inferior and hence the men took the advantage and misused them sexually and finally dumping them when they get pregnant. The ones with epilepsy were married of to any available man either because of embarrassment by her family members or the culture which paints them to be possessed with evil spirit. Where there are married off, once pregnant, their spouses disowned them and were left helpless. This agrees with which indicated Pre-pregnancy differences in the health of women living with disabilities meant an increased likelihood of unplanned pregnancy [8]. In the FGD, majority of the respondents living with disability said that though they were not prepared for the pregnancy, they were happy that they were pregnant. This shows that most women living with disability desire to be pregnant and have children. Motherhood is not only desired by able-bodied women but also by women living with disability. This study was similar to the findings of which showed that participants who had not had any childbearing experiences at the time of the study, wanted to have their own biological children [15]. For example, a respondent who was 22 years old with intellectual impairment, and lived in a mental hospital, said that she wished to have a boyfriend and have children with him.

Hospital Related Characteristics Associated With Disability Status

There was delayed accessibility to the health facility by women living with disability unlike able bodied women. Findings on access to the nearest health facility reveal a significant relationship between distance to the health facility and disability status. Able bodied women were 60% more likely to perceive distance to facility to be less than an hour compared to the women with disability. This is partly because of their disability status: physical impairment, for the blind the need of a walking stick or someone to direct her and many other barrier challenges. Similarly, able bodied women were 20% less likely to use vehicles or motorbikes to the health facility compared to the disabled women. High level of poverty amongst them made it impossible to pay for the public vehicles or motorbikes. They are also not modified to meet the needs according to their disability. This was noted during FGD where by a respondent said; "since I got pregnant, I have a lot of problem with movement."

Findings by suggested that although women living with disability do want to receive institutional maternal healthcare, their disability often made it difficult for such women to travel to access skilled care [4]. He also found out that it was common practice for women with disability living in rural areas to walk to health facilities. In some cases, they were carried to health facilities when there were no vehicles available to transport them due to the difficult terrain and poor roads. Traveling was a major challenge because it was costly and time-consuming to transport people living with disability to health facilities generally and it was even more costly when an additional person was required to accompany them.

A 35-year-old woman with physical disability said "I had gone for check-ups in good time so I didn't wait but I had to walk for half an hour to reach there for ANC check-ups……. I gave birth to all my babies at home since I didn't have money to rent a vehicle." The finding was also similar to where most respondents reported that the reason for their home delivery is due to poor terrain and transportation expenses.

Response of facility provisions for women living with disability was statistically associated with disability status; able-bodied women were almost two times more likely to agree that the facility had provisions for women living with disability compared to their counterparts. Despite the policy of provision for people living

with disability in all public places in Kenya, the government has not done much to implement this policy. The health facilities lack ramps for those with physical impaired, braille for the blind, sign language interpreter for the deaf and dump and many others. This affects utilization of these facilities by the women living with disability and therefore puts them at risk for poor maternal and child health outcomes. These findings are consistent with the findings by that found out that although women living with disability do want to receive institutional maternal healthcare, their disability often made it difficult for such women to travel to access skilled care, as well as gain access to unfriendly physical health infrastructure. In this study, some respondent showed satisfaction with specific hospital provisions like the Kakamega County referral Hospital. During FGD, one respondent said "Government hospitals are cheaper, I don't like TBAs. In the Kakamega county referral hospital, nurses and doctors are qualified to handle pregnancy. One nurse knows sign language and hospital deliveries are free, TBAs are unqualified."

If government implements the disability policy and provide disability provisions in the hospitals, it will tremendously reduce health risks to the women living with disability and that of their children. However, a study by found out that a greater number of refugees living with disabilities and their caregivers in Kenya complained about challenges to access health services [5]. Negative and disrespectful provider attitudes were reported as the most influential barrier that deterred refugees living with disabilities from accessing services. In Kenya, one Somali caregiver, explained, "In hospitals, we face a lot of pressure". It was also similar to a study in Ethiopia by who found out that "Maternal healthcare services that are designed to address the needs of able-bodied women might lack the flexibility and responsiveness to meet the special maternity care needs of women living with disability"[4]. More disability-related cultural competence and patient-centered training for healthcare providers as well as the provision of disability-friendly transport, healthcare facilities and services are needed." in his study conducted in Ethiopia, also found out that the popular cultural believes of disability, which associates disability with evil spirits, taboos and witchcraft, may be taken into contemporary reproductive healthcare Centres by staff, as culture, gender and disability intersect to frame the discrimination against women with disability [15]. A key discussion in FGD indicated that disability is a social issue in which standard practices in society fail to embrace disability as human diversity, but instead interprets disability to a category of inferiority. In a discussion in a local Kenya Radio Maisha discussion on February 7th 2017 at 12:37 it was noted that in 2013, health functions were devolved to Kenya's 47 counties, which were bound by the 2010 constitution to implement health policies developed at the national level, including free maternity services. But human rights activists say those services have not been adapted for women living with disability, partly because the government is not gathering information on them.

Focus Group Discussion

Pregnant women with disability experience vast challenges during pregnancy. Majority of the respondents were happy that they were pregnant though they were not prepared for the pregnancy. This shows that most women living with disability desire to be pregnant and have children. Motherhood is not only desired by able bodied women but also the women living with disability. This study is alike the findings of showed that participants who had not had any childbearing experiences at the time of the study, wanted to have their own biological children [15]. For example, Vimbai who was 22 years old has intellectual impairment, and she lives in a mental healthcare institution in an urban area. She has never married, has no children and she is formally unemployed. She recounted that she wishes to have a boyfriend and to have children with him.

In terms of planning for pregnancy, most of the women living with disability did not plan for the pregnancy neither they didn't consent for the pregnancy. Some women living with disability were raped, some just found themselves pregnant because they were not in any family planning method and some just discovered that they were pregnant after a sickness or a visit to the hospital. This is alike which indicated Pre-pregnancy differences in the health of women living with disabilities which included a significantly an increased likelihood of unplanned pregnancy [8].

Pregnant women living with disability have had hard moments and nice moments just like the able bodied pregnant women. Some of the nice moments were that the love in the family increased, some were assisted in their house chores and they found happiness of motherhood.

Some of the hard moments included pregnancy related sickness, lack of finances needed to take care of the pregnancy, stigmatization from family members due to her disability status, difficulty in accessing healthcare facilities and being abandoned by spouse during pregnancy period. This findings were alike where by women living with disabilities compared to their able bodied peers were more likely to report medical complications and stressful life events during pregnancy [8]. In addition women living with disabilities were at greater risk of stressful life events during their pregnancy. Also study done in Ethiopia found out that "Maternal healthcare services that are designed to address the needs of able-bodied women might lack the flexibility and responsiveness to meet the special maternity care needs of women with disability". More disability-related cultural competence and patient-centred training for healthcare providers as well as the provision of disability-friendly transport and healthcare facilities and services are needed." [4].

Study found out that despite positive feedback, a greater number of refugees living with disabilities and their caregivers in Kenya and, especially, Uganda complained about challenges to accessing health services [5]. Negative and disrespectful provider attitudes were reported as the most influential barrier that deterred refugees with disabilities from accessing services. In Kenya, one Somali caregiver, explained, "In hospitals, we face a lot of pressure.

They reported the importance of ANC attendance as;-to know their status, to know the position of the baby to avoid infection This study is alike whereby women living with disabilities were more likely to delay prenatal care until after the first trimester, report inadequate prenatal care, and were less likely to report having a postpartum check-up within six weeks of birth [8]. The delay in accessing health care could be partly attributed to the negative experiences of women with disabilities with their health care providers.

Most of the respondents did not have birth plans which included preparation in terms of babies clothes, place of delivery, transport to the hospital, an assistant during pregnancy and delivery and financial preparation in fact majority of them didn't know about birth plans. The few who had done a bit of preparations would just include baby's clothes.

When asked who assist you in care for this pregnancy, Most of them confirmed to be assisted by their parents. This is an indication

of lack of spouse support during pregnancy and delivery of people living with disability.

All of them are planning to deliver in the hospital whoever none is ready to deliver in a private hospital; they will deliver in a government hospital because some say it is affordable and some say they are free. Other reasons for hospital deliveries are;- bad obstetric history in previous pregnancy, hard labor, they don't like traditional birth attendants because they are unqualified, nurses and doctors are qualified to handle pregnancy, in Kakamega County referral hospital, one nurse knows sign language, will get help in the hospital and some said that their child would get immunized immediately if delivered in the hospital"

When asked about the society support, majority of the respondent were assisted by other people rather than their spouses. These other people are mother in laws, mothers and even fathers. The reasons they gave for lack of societal support were as follows;- their disability status, they believe that they give birth to beautiful children than them than the able bodied women, The spouse and the community did not like the fact that they got pregnant and the community does not support because they don't expect them to get pregnant. The few time the respondent got support was on assistance on the house chores like fetching water.

Mako's narrative also shows that the popular cultural understanding of disability, which associates disability with evil spirits, taboos and witchcraft, may be taken into contemporary reproductive healthcare facilities by staff, as culture, gender and disability intersect to frame the discrimination against women with disability. This creates a need of disability training and awareness creation which reduces the negative impact of traditional practices on the health and well-being of women with disability. A key argument of FDS is that" disability is a social construction in which standard practices in society fail to embrace disability as human diversity, but instead relegate disability to a category of inferiority [15].

Pregnant women living with disability said that the government does not help them. Government includes government healthcare providers and government organisations. They were mostly neglected because of their disability status which limit them in accessing government aide for example they said the deaf couldn't talk to express their need. This was in line with study stated that "Despite positive feedback, a greater number of refugees living with disabilities and their caregivers in Kenya and, especially, Uganda complained about challenges to accessing health services [5]. Negative and disrespectful provider attitudes were reported as the most influential barrier that deterred refugees with disabilities from accessing services also." The belief of most people is that every person should be able bodied, thereby viewing disabled people as "damaged beings" who are generally ignored and treated as sub-standard. The narration indicates an attitude of healthcare staff which seeks to deny women living with disability space in reproductive healthcare, on the grounds of the woman's disability status and are hence an inconvenience noted by Belaynesh FGD, a number of healthcare providers assume that people living with disability are sick persons who should only consult healthcare centres for issues relating to disability also studied women living with disability and reported less attention during their pregnancy by health personnel compared to peers without who are able bodied [15] [9].

Conclusion and Recommendation

The study found out that disabled women experience a lot of challenges in maternity care. Their opinion is that they are neglected because of their disability status. They also feel discriminated by their spouses, community they live in, the healthcare facility and health care provider during pregnancy, child birth and delivery.

There is a need of programs on awareness of disability issues in community, family and spouse in order to reduce stigma and increase acceptance of women living with disability. This will create positive energy in them to assist these women to feel accepted and seek positive assistance during pregnancy and delivery. Health professions should be trained on handling women living with various disabilities in order to appropriately assist pregnant women living with disability [16-27].

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